HCRTP

Promising Approaches

for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems

8: Clinical Decision Making Approaches

Sheila A. Pires
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USF
UNIVERSITY OF SOUTH FLORIDA

A Series of the

HCRTP Health Care Reform Tracking Project

Tracking Behavioral Health Services to Children and Adolescents and Their Families in Publicly-Financed Managed Care Systems

HCRTP Health Care Reform Tracking Project

Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

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HCRTP Health Care Reform Tracking Project

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HCRTP Health Care Reform Tracking Project

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8: Clinical Decision Making Approaches for Child/Adolescent Behavioral Health Care in Public Sector Managed Care Systems

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Introduction

Health Care Reform Tracking Project

Over nearly a decade, beginning in 1995, the **Health Care Reform Tracking Project** (**HCRTP**) tracked publicly financed managed care initiatives, principally Medicaid managed care, and their impact on children with mental health and substance abuse (i.e. behavioral health) disorders and their families. The HCRTP was co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding was provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children involved in the child welfare system. The HCRTP was conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at Georgetown University.[1]

The HCRTP's Series on Promising Approaches highlights, within publicly financed managed care systems, strategies, approaches and features that have been tailored for children and adolescents with behavioral health treatment needs and their families, particularly children with serious and complex disorders. The Series is comprised of a number of thematic papers, each

1 All reports of the Health Care Reform Tracking Project (HCRTP) are available from the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL, (813) 974-6271: For a complete Listing of HCRTP Publications see pages 107–110.

HCRTP publications are also available on-line as Adobe Acrobat PDF files: http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/index or http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

Readers are advised to review the research literature for more complete information on the tests and measures referenced throughout this document.

describing strategies or approaches related to a different aspect of managed care systems as they affect children with behavioral health disorders. The Series draws on the findings of the HCRTP, highlighting relevant issues and strategies that have surfaced through the HCRTP's all-state surveys, in-depth impact analyses, and national consensus conference. The papers are intended as technical assistance resources for states and communities as they refine their managed care systems to better serve children and families.[2]

Methodology for Study of Promising Approaches

The strategies and approaches that are described in the Series on Promising Approaches were identified by key national, state and local informants who responded to the HCRTP's state surveys, who were interviewed during site visits to states for the HCRTP's impact analyses, and who participated in the HCRTP's 2003 Consensus Conference. Once promising approaches and features were identified through these methods, members of the HCRTP team, including researchers, family members and practitioners, engaged in a number of additional methods to gather more detailed information about identified strategies. In some cases, site visits were conducted during which targeted interviews were held with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members, and representatives of other child-serving agencies. In other cases, telephone interviews were held with key state and local officials and family members to learn about promising strategies. Supporting documentation was gathered and reviewed to supplement the data gathered through the site visits and telephone interviews.

The series intentionally avoids using the term, "model approaches." The strategies, approaches, and features of managed care systems described in the Series are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families; however, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each would require adaptation in new settings to take into account individual state and local circumstances. Also, a given state or locality described in the Series may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

The series does not describe the universe of promising approaches that are underway in states and localities related to publicly financed managed care systems affecting children with behavioral health disorders and their families. Rather, it provides a sampling of strategies and approaches, identified through the HCRTP to date, and a snapshot in time of the states and communities that are profiled. New, innovative approaches are continually surfacing, both in general, as well as in the profiled sites, as the public sector continues to experiment with managed care.

Each approach or strategy that is described in the series is instructive in its own right. At the same time, there are commonalities across these strategies and approaches that can help to inform the organization of effective service delivery systems within a managed care environment for this population.

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2 For a complete Listing of HCRTP Publications see pages 107–110.

HCRTP publications are also available on-line as Adobe Acrobat PDF files:
http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm or http://pubs.fmhi.usf.edu click **Online Publications** (By Subject)

Each paper in the series focuses on a different aspect of publicly financed managed care systems. This paper focuses on Clinical Decision Making Approaches.

Overview

I. Promising Approaches — 8: Clinical Decision Making Approaches

Purpose

Driven by a combination of factors, including broader dissemination of clinical research, expanded family and consumer voice, consent decrees, media reports and escalating health care costs, state regulatory and fiscal managers have taken on a greater role in oversight of child and adolescent behavioral health care delivery. The result is a plethora of attempts to organize, rationalize and account for the processes that children and families encounter from the earliest point in their recognition that they have a mental health or substance abuse treatment need to the highest level of restrictive care they might experience.

Amid state and local level efforts to make sense of the complex clinical arena of child and adolescent behavioral health care, there is an emerging knowledge base among clinicians and clinical services researchers that has led to a growing number of instruments that are available to help with some, if not all, of the decision points. However, these instruments or measures range from well established to newly created and have differing degrees of validation or standardization of the meaning of their results. Furthermore, despite the repeated calls from administrators for an "assessment tool" to answer their questions, no one instrument meets all possible administrative or clinical decision making needs.

It is also the case that different state and local administrators employ clinical decision making instruments for different purposes. In addition, the nomenclature that differentiates clinical decision making terms, such as measure, indicator, criterion, guideline, protocol, etc., is poorly specified, leading to non-standardized usage. (A pragmatically driven, unofficial, glossary of commonly used terms is available at **Appendix A**.) Even when the same term is agreed upon, it may mean different things to people with different professional training, backgrounds, or positions within the service system. **Table 1** provides an illustration of this point.

Table 1.
Variations in Meaning of "Clinical Guidelines" Based on Context

Context	Determinates	Purpose	Specifics
Business	Driven by contract	Defines insurance "benefit"	Describes "ceiling" or outer boundaries of care available via benefit
Legal	Driven by liability	Defines community "standard"	Describes "floor" or minimal expectations of care to be provided
Clinical	Driven by child and/or family characteristics	Defines "appropriate" care	Describes a series of treatments, services and supports which are either more or less intensive depending on the clinical needs and strengths of the child and his/her family

Given the opportunity for improvement in both the overall service systems available to families and in the selection of appropriate services and supports for individual children and adolescents, it is timely to take a look at what some of the state and local entities with the most specified processes are finding in their search for useful supports to clinical decision-making at all levels of the system.

This study examines various clinical decision making approaches that a sampling of states or management entities within states are utilizing for child and adolescent behavioral health service delivery within a managed care environment. The study profiles a representative sample of 12 states and/or local managed care entities (MCE) that are using formal clinical decision making protocols, guidelines, and/or processes to inform decisions about the services and supports provided to children and adolescents with behavioral health disorders and their families. The study explores the types of clinical decision making guidelines, protocols or processes that are being used, state and MCE reasons for their use of formal tools and processes, their experience with the various tools being used, and the strengths and challenges of particular approaches.

The study explores the length of time states or MCEs have been using particular guidelines and adaptations made over time. It examines the reasons states are using particular guidelines, such as to improve consistency or quality of service provision. The study identifies how states are using protocols, for example, in initial eligibility screening, for treatment decision making, for monitoring clinical status and the like. The study describes the extent and nature of states' efforts to incorporate the use of clinical decision making protocols systemically, efforts to train providers, clinicians, families and other key stakeholders about clinical protocols, and any supervision or monitoring regarding the use of protocols. It also examines state and MCE perceptions about the impact of using formalized approaches on quality, consistency, and cost of care, as well as on access to care. The study reviews how various protocols take into account individual characteristics of children and families, in particular, language, ethnicity, severity and co-morbidity. The study examines the "politics" of using standardized guidelines and what happens when guidelines call for services that are not available. It explores how guidelines support family and youth involvement, interagency involvement, and an individualized, strengths-based approach to care. Reflecting the emphasis on an individualized approach to care in the President's New Freedom Mental Health Commission report[3] and the children's system of care movement, the study examines issues of compatibility between use of formalized decision-making protocols and an individualized, child and family team-driven approach to care. The paper discusses these various issues across the 12-site sample, as well as with respect to each particular state or MCE in the sample.

The study provides an opportunity for a sample of states and local management entities to reflect on their experiences using particular clinical decision making approaches and protocols, to identify the strengths and challenges of their approaches, and the refinements they have made based on their experiences. Their reflections provide useful "lessons learned" for other states and MCEs who are considering use of clinical care guidelines for child and adolescent behavioral health care delivery within managed care environments. The ultimate purpose of the study is to provide a technical assistance resource for states and MCEs as they implement and refine clinical decision-making approaches for this population of children and families.

3 New Freedom Commission on Mental Health (2003.) Achieving the promise: Transforming mental health care in America. Final report, (Pub. No. SMA-0303832) Rockville, MD: U.S. Department of Health and Human Services

Method

As noted, the Health Care Reform Tracking Project tracked state managed care reforms, largely Medicaid managed care, over the past decade, using a combination of methods. Periodic surveys of all states over time have allowed for identification of the types of managed care arrangements states were implementing and the kinds of refinements they were making. Site visits to selected states, as well as telephone interviews, have yielded information about the impact of state managed care activities on children and adolescents with behavioral health disorders and their families. These methods also have led to the identification of promising approaches, that is, features of managed care design and implementation that seem to be associated with a more customized approach for this population, particularly for children with serious disorders.

Included among the areas targeted by the Tracking Project for identification of promising approaches was that of clinical decision making guidelines or protocols. State surveys and telephone interviews have asked key informants in states whether clinical protocols were being used within states specifically for children's behavioral health care decision making. The surveys and interviews yielded a number of customized approaches in this area. Further information was gathered through telephone interviews with national experts, interviews with the states in question and analysis of documentation to determine whether a given identified approach would remain in the sample. As a result of this process, eight states and four local management entities were included in the sample for this study.

Semi-structured telephone interviews were conducted with key state and MCE informants in each of the states and localities included in the sample. Key informants included: state and local administrators, clinical directors and care managers, family members, providers, and university researchers. In addition, documentation provided or referenced by key informants, as well as relevant state and local websites, were reviewed.

Sample of States and Local Management Entities

The states included are: Arizona, Delaware, Hawaii, Michigan, New Jersey, North Carolina, Pennsylvania, and Texas. The local management entities included are: the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties in Michigan; the DAWN Project in Marion County, Indiana; the Mental Health Services Program for Youth operating in several local areas in Massachusetts; and, Wraparound Milwaukee in Milwaukee County, Wisconsin.

Table 2.
Sample of States and Local Management Entities

States	Local Management Entities
Arizona Delaware Hawaii Michigan North Carolina Pennsylvania Texas	Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (MI) Dawn Project, Marion County, (IN) Massachusetts Mental Health Services Program for Youth (MHSPY) Wraparound Milwaukee, Milwaukee County, (WI)

This sample of states and local management entities lends itself to a high-level grouping by the following categories:

- **Group One:** States or MCEs using clinical decision-making protocols that the state or MCE itself has developed
- **Group Two:** States or MCEs using existing standardized tools (e.g., proprietary and open domain instruments), including states/MCEs that have adapted a standardized protocol with the permission or involvement of the tool's developer
- **Group Three:** States or MCEs using primarily an individualized, wraparound approach to service decision-making.

Table 3.
High-Level Grouping of State/MCE Sample

• Group One: State-Developed Guidelines	
• Arizona	Arizona Uniform Behavioral Health Assessment Tool
• Delaware	Clinical Services Management Criteria
• Hawaii	Interagency Performance Standards and Practice Guidelines
• Pennsylvania	Guidelines for Mental Health Necessity Criteria ("Appendix T")
• Texas	Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)
• Group Two: Existing Standardized Protocols (Including Both Proprietary and Open Domain)	
• Hawaii	**Multiple Instruments** (e.g. … Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Service Intensity Instrument (CASII), Child Behavior Checklist (CBCL), and Youth Self Report (YSR))
• Michigan	Child and Adolescent Functional Assessment Scale (CAFAS)
• Community Mental-Health Authority of Clinton, Eaton, and Ingham Counties (MI)	Child and Adolescent Functional Assessment Scale (CAFAS)
• New Jersey	Child and Adolescent Needs and Strengths (CANS)
• North Carolina	Child Levels of Care Criteria with CAFAS
• Group Three: Formalized Wraparound Process	
• DAWN Project, Marion County, (IN)	
• Massachusetts Mental Health Services Program for Youth (MHSPY)	
• Wraparound Milwaukee, Milwaukee County (WI)	

States or MCEs using standardized guidelines, whether proprietary or homegrown, may be using them in a manner consistent with an individualized approach to service decision-making. By the same token, the three local management entities that use a formalized wraparound approach may also use standardized instruments for initial and ongoing assessment purposes, as well as to document clinical and functional outcomes. These issues are explored more fully in the analysis and descriptions sections of the paper.

Issues in Clinical Decision Making in Public Sector Managed Care

Issues Identified by the Health Care Reform Tracking Project (HCRTP)

In the initial survey and impact analyses conducted by the Tracking Project in 1997-99, most Medicaid managed care systems were reported to use fairly traditional medical necessity criteria, which failed to take into account psychosocial and environmental factors. Stakeholders felt that initial implementation of these criteria were problematic for children and adolescents with behavioral health disorders, particularly for those with serious disorders. Reported problems included not only narrow definitions of medical necessity based on a medical model, but inconsistent interpretation and application of criteria across managed care organizations and, in some cases, rigid interpretation of the guidelines. By 2003, however, the Tracking Project found that most public sector managed care systems (89%) had broadened their medical necessity criteria to allow for psychosocial and environmental factors, and that most MCEs (73%) reportedly were interpreting the criteria broadly enough to encompass these factors.

The Tracking Project also has explored over time the use of clinical care guidelines specific to children with behavioral health problems. In the early years of the Tracking Project (1997–98), there was considerable variability in the extent to which states were mandating, or managed care entities were utilizing, standardized clinical decision making protocols specific to child and adolescent behavioral health. Nearly two thirds (62%) of integrated (physical-behavioral health) managed care entities, for example, indicated that they were not using such criteria in 1997–98, and over a third (38%) of carve outs. By 2003, however, virtually all carve outs and integrated managed care systems (94%) indicated that they were using standardized clinical care guidelines and decision making protocols specific to children's behavioral health, and virtually all reported that use of such criteria improved consistency in clinical decision making.

While most managed care systems in 2003 reportedly were utilizing clinical care guidelines specific to child and adolescent behavioral health care delivery, stakeholders in 2003 continued to report challenges in the use of these clinical criteria. These challenges included differing interpretations by managed care organizations of state-mandated criteria, as well as differing interpretations by providers of state or MCE criteria. Additionally in 2003 stakeholders reported problems in criteria being applied too rigidly, impeding the ability to provide individualized, flexible care. On balance, however, increased use of clinical decision making criteria specific to children's behavioral health, including the use of statewide standardized criteria (in use in about half of the states in the 2003 sample), was reported primarily to improve consistency in clinical decision making.

Other Issues

In addition to issues identified by the HCRTP, other researchers and practitioners have raised issues regarding clinical decision-making guidelines in the children's behavioral health care arena. For example, one study that interviewed managed care administrators and clinicians on use of clinical practice guidelines identified such issues as: (1) clinical resentment of and resistance to use of guidelines; (2) lack of sensitivity of guidelines to patient variables, such as race and ethnicity, complexity, and co-morbidity; (3) criteria being used to cut off service provision when symptoms improve (when subsequent deterioration is considered by the clinician to be likely); (4) guidelines being too complex, or alternately, too broad and, therefore, meaningless; and, (5) clinicians' lack of familiarity with guidelines promulgated by state or managed care entities.[4]

A practitioner writing in a national trade publication noted a number of barriers to using clinical practice guidelines for clinical decision making and ongoing care, including:

(1) criteria that relate poorly to actual assessment processes;

(2) inter-rater reliability;

(3) lack of clarity;

(4) lack of diagnostic flexibility and incompatibility with individualization and creativity in care delivery;

(5) lack of integration of criteria into ongoing clinical processes; and,

(6) relevance to consumers and families trying to understand clinical issues.[5]

This observer also noted, however, some evolution in the development of practice guidelines, producing criteria that are more flexible, user-friendly for both clinicians and families, and reliable. This paper focuses on a number of these less traditional, second-generation criteria, exploring strengths, issues and challenges.

Description of Clinical Guidelines/Criteria Being Used

Following is a brief description of the clinical guidelines or criteria being used in the 12 states or local management entities in this study. The individual state/locality summaries provide more detailed description (See Site Descriptions).

4 Taub, J., Gómez, A., & Armstrong, M. I. (2002). Use of clinical practice guidelines in managed care environments: Policy, practice, and clinical utility. In C. Newman, C. Liberton, K. Kutash, & R. M. Friedman (Eds.), The14th annual research conference proceedings: A system of care for children's mental health: Expanding the research base (pp. 397-400). Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health.

5 Sowers, W. (2002). Medical necessity: a critique of traditional approaches. Behavioral Healthcare Tomorrow, 11(6), 43-44.

Standardized Instruments (Proprietary and Open Domain)

Child and Adolescent Functional Assessment Scale (CAFAS)[6]

(Used by Hawaii, Michigan, and North Carolina in this sample)

The CAFAS, a proprietary instrument developed by Dr. Kay Hodges, is a rating scale based on an adult's report of a child's degree of functional impairment in day-to-day activities due to emotional, behavioral, psychological, psychiatric or substance abuse problems. It is intended to be used by trained clinicians or staff members, and takes about twenty minutes to complete for someone who knows the child or as a structured interview of someone who knows the child (such as the caregiver). The instrument consists of eight child scales: school/work role performance; home role performance; community role performance; thinking; behavior toward others; mood/emotions; self-harmful behavior and substance abuse; and, two child caregiver resource measures: material needs and family/social support. For each of the eight scales, the extent of problems is rated on a four-point scale, and the instrument also yields a child total score (i.e., the sum of scores on the eight individual child scales).

Child and Adolescent Service Intensity Instrument (CASII)

(formerly known as the **Child and Adolescent Level of Care Utilization System**, or **CALOCUS**)[7] (Used by Hawaii in this sample)

The CASII is a semi-open domain tool developed by the American Academy of Child and Adolescent Psychiatry's (AACAP) Work Group on Community Systems of Care. It can only be accessed via AACAP, and there is a charge for training on the use of the instrument. The CASII is a tool to help determine level of care placement for a child or youth. It links a clinical assessment with standardized levels of care. It can be used for children or adolescents with psychiatric disorders, substance abuse disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. It is designed to be used by a variety of mental health professionals. The instrument consists of rating scales on six dimensions, including: risk of harm; functional status; co-morbidity; recovery environment; resiliency and treatment history; acceptance and engagement (child and parent). The dimensional ratings combine to generate a level of care recommendation. The CASII includes seven levels of care: basic services; recovery maintenance and health management; outpatient services; intensive outpatient services; intensive integrated service without 24-hour psychiatric monitoring; non secure, 24-hour, services with psychiatric monitoring; and, secure, 24-hour, services with psychiatric monitoring.

6 Bates, MP. (2001). The Child and Adolescent Functional Assessment Scale (CAFAS): review and current status. Clinical Child and Family Psychology Review, 4(1), 63-84. See also http://www.cafas.com.

7 American Academy of Child & Adolescent Psychiatry (s.d.). CASII: Child and Adolescent Service Intensity Instrument. Available http://www.aacap.org/clinical/CASII/index.htm <http://www.aacap.org/clinical/CASII/index.htm>. See also Sowers, W., Pumariega, A., Huffine, C., & Fallon, T. (2003). Level-of-care decision making in behavioral health services: the LOCUS and the CALOCUS. Psychiatric Services, 54(11), 1461-1463. Available http://ps.psychiatryonline.org/cgi/content/full/54/11/1461 <http://ps.psychiatryonline.org/cgi/content/full/54/11/1461> .

Child Behavior Checklist (CBCL) and Youth Self Report (YSR)[8]

(Used by Hawaii in this sample)

The CBCL, a proprietary instrument developed by Dr. Thomas Achenbach, is designed to assess the behavioral problems and social competencies of children as reported by their parents or caregivers. It can be self-administered or administered by an interviewer. It consists of 118 items related to specific emotional and behavioral problems, which are scored on a three-point scale, and 20 social and school competency items. It allows clinicians, parents, and teachers to crosscheck behaviors of children.

The YSR, also developed by Achenbach, is derived from the CBCL and is designed to be used by adolescents, ages 12–18, with the adolescent himself/herself completing the form. The YSR contains the same 20 social and school competency items and 112 items related to symptomatology and behavior.

Child and Adolescent Needs and Strengths (CANS)[9]

(Used by New Jersey in this sample)

The CANS is an open domain, strengths-based, information integration tool developed by Dr. John Lyons. It is designed to support individualized care planning, as well as the planning and evaluation of service systems. The CANS provides a structured profile of children and their families along a set of six dimensions related to service planning and decision making, including: problem presentation; risk behaviors; functioning; care intensity and organization; caregiver/family needs and strengths; strengths of the child. It is not designed to yield an overall score but to create a picture of strengths and needs to inform service planning. The CANS can be used by clinicians and other staff as well as by parents/caregivers, with minimal training. It comprises a system of scales relevant to youngsters in different systems (e.g., mental health, child welfare, juvenile justice), and is intended to support communication across these systems.

State-Developed Clinical Guidelines

Arizona Uniform Behavioral Health Assessment[10]

These are qualitative guidelines developed at the state level, through a multi-stakeholder input process, including families, providers, researchers, and others, that provide guidance to Arizona's regional managed care entities and providers on intake, assessment, and service planning expectations. Embedded within them are practice guidelines for child

8 Achenbach, T. M. (1991). Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles. Burlington, VT: Department of Psychiatry, University of Vermont.

9 Buddin Praed Foundation (s.d.). About the CANS: The Child & Adolescent Needs and Strengths Methodology. Available http://www.buddinpraed.org/cans/ <http://www.buddinpraed.org/cans/>. See also Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale. Journal of Child and Family Studies, 12(3), 279-289.

10 Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS/DBHS Revised Assessment Process. Available http://www.azdhs.gov/bhs/assess_process <http://www.azdhs.gov/bhs/assess_process> .

and family team processes that incorporate a strengths-based, individualized wraparound approach to service planning and care management. The guidelines are not used to determine eligibility for services or to indicate levels of care but to ensure safety and access to appropriate services.

Delaware Clinical Services Management Criteria[11]

These are qualitative clinical care guidelines for every level of care in the system, including both mental health and substance abuse services. They were developed at the state level by the Division of Child Mental Health Services, based on a review of the literature and input from clinical team leaders. The guidelines are used by Clinical Services Management Team Leaders and their care managers to help determine appropriate levels of care. They are also used as referral guidelines for contracted providers.

Hawaii Interagency Performance Standards and Practice Guidelines[12]

These are qualitative performance standards and practice guidelines developed at the state level by the Departments of Health (DOH) and Education (DOE) through a multi-stakeholder process that included families, providers, researchers and others. They are intended for use by DOH and DOE personnel and contracted providers when developing individualized plans of care for children and youth. They also are used by the two Departments to monitor service performance. They define service content standards and are intended to improve the efficiency and effectiveness of school-based behavioral health and intensive mental health services. They include both general performance standards, such as for coordination of care, the referral process, risk management, and the like, as well as service-specific performance standards, including a broad array of service types (e.g., emergency mental health; school-based behavioral health; home-based, etc.), and they include guidelines for particular types of disorders, (such as childhood schizophrenia, conduct and oppositional disorders, depression, etc.). The standards incorporate research on effective practices. The guidelines also specify use of certain quantitative rating scales, including the CAFAS, CASII, CBCL, and YSR.

Pennsylvania Guidelines for Mental Health Necessity Criteria ("Appendix T") and Guidelines for Best Practice[13]

The State Office of Mental Health and Substance Abuse Services (OMHSAS) developed these guidelines with the advent of behavioral health managed care in Pennsylvania to serve as broad, "medical necessity" criteria that would take into account psychosocial and environmental considerations, as well as medical. They are intended to be used by

11 State of Delaware, Department of Services for Children, Youth, and Their Families. Available http://www.state.de.us/kids/default.shtml <http://www.state.de.us/kids/default.shtml>.

12 See standards of practice at http://doe.k12.hi.us/sbbh/standardsofpractice/ <http://doe.k12.hi.us/sbbh/standardsofpractice/> and the Integrated performance monitoring report: Sustainability report performance period July 2005-September 2005 (October 2005) at http://165.248.6.166/data/felix/report/Q7/IntegPerfMonReport.pdf <http://165.248.6.166/data/felix/report/Q7/IntegPerfMonReport.pdf>.

13 State of Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (04/01/2004). Appendix T: Guidelines for mental health necessity criteria. Available http://www.dpw.state.pa.us/omap/rfp/hlthchcrfp/HlthChBHappdxTpartB.asp.

managed care entities and providers to guard against application of too rigid medical necessity criteria that would impede access to services. Appendix T provides decision-making guidance for the admission, continuing stay and discharge of children and adolescents in various treatment settings governed by the State Medicaid and mental health agencies. It includes such services as inpatient hospitalization, home-based, targeted case management, outpatient, etc. The State uses the adolescent patient placement criteria of the American Society of Addictions Medicine (ASAM) for adolescent substance abuse treatment services.

Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)[14]

The State mental health authority developed the CA-TRAG, through a multi-stakeholder input process that included families, local mental health authorities and researchers, as part of the State's Resiliency and Disease Management Initiative. This Initiative defined service packages and State practice expectations, based on research on evidence-based practices, for both adult and child and adolescent community mental health services. The CA-TRAG is used by local mental health authority clinicians and contracted providers to assess service needs and recommend levels of care. Use of the guidelines yields quantitative scores that determine eligibility for service and service level. In addition, the guidelines are used at the State level for utilization management and for outcome monitoring.

Formal Wraparound Approaches and the Wraparound Fidelity Index[15]

Three of the sites in this sample (the DAWN Project, Massachusetts Mental Health Services Program for Youth, and Wraparound Milwaukee) employ a highly individualized, wraparound approach to service planning, in which standardized instruments play an adjunctive role, primarily to track progress. Initial treatment decisions, ongoing care, and treatment monitoring are done within the context of a structured Child and Family Team. The team is led by a trained facilitator, and the team determines the plan of care (with the plan being signed off on by either a psychologist or psychiatrist). Service planning is guided by structured "life domains" documents. These sites tend to adhere closely to the essential elements of a wraparound approach as defined by the Wraparound Fidelity Index (WFI), although this instrument is used specifically only by the DAWN Project and not by either MHSPY or Wraparound Milwaukee. WFI is an interview instrument designed to be used with three types of respondents: caregivers, youth (ages 11 and up), and resource (e.g., wraparound process) facilitators. The interview forms address 11 essential

14 State of Texas, Department of State Health Services (December 16, 2005). Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG) <http://www.dshs.state.tx.us/mhprograms/RDMCAtrag.shtm> . Available http://www.dshs.state.tx.us/mhprograms/RDMCAtrag.shtm <http://www.dshs.state.tx.us/mhprograms/RDMCAtrag.shtm> . [Site includes User's Manual for the CA-TRAG (Version 3.0 - November 2005), Reliability and Validity Study of the CA-TRAG (Version 1.0) , and Validation and Norms for the Ohio Scales Among Children Served by the Texas Department of Mental Health and Mental Retardation.].

15 The National Wraparound Initiative (s.d.) Wraparound Fidelity Index 3.0. Available http://depts.washington.edu/wrapeval/WFI.html. [University of Washington, The Research and Training Center on Family Support and Children's Mental Health at Portland State University, and the national Federation of Families for Children's Mental Health].

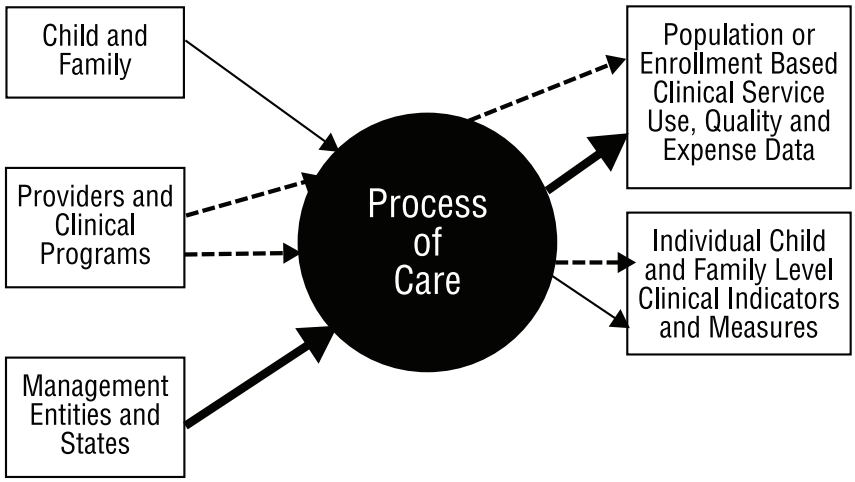
elements of wraparound (e.g., parent voice and choice; strengths-based services; natural supports, etc.), and yield quantitative scores for each element. In addition, the WFI yields a Combined Overall Fidelity score. The WFI is intended for use as a quality monitoring tool, to ensure fidelity of the wraparound process.

Synthesis of Findings Based on 12-Site Sample

This section explores a number of findings and issues identified during the study across the 12-site sample.

As indicated by **Figure 1**, clinical care guidelines can be used to measure the process of care in a variety of ways and to meet a variety of user needs. Some needs (i.e. identification) may impact all participants in a system, ranging from the individual child being screened to administrators engaged in system-wide quality improvement efforts. In reviewing the experience of those using clinical care guidelines, it is important to keep in mind the perspective and needs of the user and the impact or meaning of the information being gathered. Generally speaking, children and families are most impacted by individual measures. Service providers may use both individual measures and program or population based information, while state and local administrators or management entities primarily monitor guideline use at the overall population level.

Figure 1.
Clinical Care Guidelines



User Need	Guideline Impact
Identification/Screening	Child, Family, Providers and System
Access and Equity	Child, Family, Providers and System
Family/Consumer Driven Care	Child, Family, and Providers
Appropriate Level of Care	Child, Family, Providers and System
Individual Clinical Care Quality	Child, Family, and Providers
Fiscal Management	Providers and System

Multiple Uses for Clinical Decision-Making Guidelines

Based on the 12-site sample in this study, states or management entities in states use clinical guidelines and criteria in different ways and to meet different needs. Some states, for example, North Carolina and Texas, use relatively circumscribed clinical criteria to determine both eligibility for entry into the system as well as to determine eligibility for certain types of services or levels of care. Other states, such as Michigan, use clinical criteria to determine access to certain types of services but not for initial entry into the system, for example, in Michigan's case, for determining access to a category of services called "home-based," including in-home, crisis, and targeted case management. Michigan's rationale is that it does not want to ration access to services in general, but it does want to ensure appropriate use of expensive and limited services by those most in need of these services. Texas stakeholders, however, believe that because resources in their state are severely limited in general, they have little choice but to limit eligibility to those most in need, and thus their criteria do control initial entry to the system.

Some states, such as Pennsylvania and Delaware, utilize broad clinical guidelines, not to determine eligibility for entry into the system, nor to determine eligibility for specific levels of care or types of services, but as general guidance to managed care entities and providers as to state expectations about appropriate use of services. Pennsylvania purposely developed broad guidelines in the early days of managed care in the state, to ensure that managed care organizations would not employ more restrictive medical necessity criteria as the state was interested in broadening access to behavioral health services for children. Today, nearly a decade later, with relatively broad access to services being achieved, some stakeholders believe the guidelines should be defined more specifically to ensure appropriate access. This issue is discussed more fully in the Pennsylvania state description.

There were also examples of states and local management entities utilizing clinical protocols as decision support tools to guide the process of service planning and ongoing care management in a relatively dynamic manner. New Jersey, for example, uses the Child and Adolescent Needs and Strengths (CANS) tool at several levels in the system for this purpose. The Community Mental Health Authority of Clinton, Eaton, and Ingham (CEI) Counties (the local management entity serving three counties in the Lancaster, Michigan area) and the MHSPY program in Massachusetts have integrated the state-mandated Child and Adolescent Functional Assessment Scale (CAFAS) into their ongoing care planning and monitoring functions.

This study also looked at the use of standardized protocols by three local management sites that principally employ a formal, wraparound approach to service planning, in which a child and family team, in effect, determines "medical necessity" and appropriate services (i.e., DAWN Project, Massachusetts Mental Health Services Program for Youth, and Wraparound Milwaukee). All three sites utilize standardized clinical tools, such as the CAFAS or Child Behavior Checklist (CBCL), as aids in the monitoring of clinical progress. They are not used to determine eligibility for certain types of services or to drive specific service decision-making. However, MHSPY operates within a state that requires use of the CAFAS for both State mental health and child welfare service provision and has a CAFAS cut-off score for admission into the MHSPY program.

A few states, such as Hawaii, Michigan and New Jersey, are also in the process of utilizing the data generated by use of standardized clinical decision-making protocols for outcomes monitoring and quality improvement purposes. These states point out that if local management entities and the providers they engage are utilizing the same state-specified, standardized protocols throughout the state, the state should be able to analyze systemically such factors as the severity of youth being served by one locality versus another, improvements in clinical and functional scales in one locality versus another or improvements for certain populations of youngsters versus others. With such data, a state could introduce quality improvements, such as targeted evidence-based practices, the need for which is informed and supported by the clinical data. These states reported that data-driven quality improvement initiatives help to defuse local or provider challenges to state-initiated quality efforts.

In sum, the states and localities in this sample use clinical guidelines and protocols in multiple ways, including for:

- Eligibility determination for access to the system (i.e., pre-admission criteria)
- Eligibility determination for certain types of services or levels of care
- Utilization management regarding continuation with certain types of services or levels of care
- General guidance to managed care organizations and providers as to state expectations (not requirements) regarding service provision
- Decision support to guide individual service planning and care management
- Outcomes monitoring and quality improvement for the system.

These uses meet different needs. Often because of very limited resources, some states use clinical criteria to ration access to the system, or to certain types of limited or expensive services in the system, to those most in need. A few states, often as a result of a consent decree or a class action suit, have used clinical guidelines to broaden access to the system, to ensure that children in need are identified and can access services. Other states and local management entities, by integrating standardized instruments into dynamic care planning and care management processes, including formalized wraparound processes, find that the protocols can be used to help inform the service planning process without dictating or restricting service type or mix. Finally, a few states are utilizing standardized protocols as a means to gather data on clinical care provision statewide, to shed light on system outcomes and inform overall quality improvement.

Similar Goals

While states and management entities are using clinical guidelines in different ways to meet different needs, virtually all, with the exception of the three sites using formal wraparound approaches, described similar goals or objectives that they thought are being achieved as a result of using standardized criteria. These goals include:

- Ensuring that children receive the appropriate type and amount of service
- Ensuring appropriate access to services
- Promoting consistency and equity in service provision
- Providing objective rationales for service authorization decisions
- Moving the system to evidence-based and effective practices

- Providing data to better inform practice
- Providing visible progress indicators to families and youth consumers
- Aligning practice with system goals (e.g., priority to serve children with serious emotional disorders; priority to reduce use of restrictive levels of care)
- Monitoring system performance
- Improving the quality of care
- Increasing accountability throughout the system.

While MHSPY, Wraparound Milwaukee and the DAWN Project view the care planning team or wraparound process itself as the key variable to supporting these types of goals, all three do incorporate the use of standardized clinical criteria toward many of the same goals, specifically:

- Moving the system to evidence-based and effective practices
- Providing data to better inform practice
- Providing visible progress indicators to families and youth consumers
- Monitoring system performance
- Improving the quality of care
- Increasing accountability throughout the system.

It should be noted that a number of the other sites in this study also employ an individualized, wraparound approach to service planning to varying degrees, including embedding wraparound principles into practice guidelines, for example Arizona. However, standardized clinical criteria, in general, play a more central role in most of the state systems in determining choice of service type and access to levels of care for defined categories of youth than they do in the three smaller sites for whom a target population has already been selected, within which the individualized child and family teams determine service type and amount.

This study did not have the resources to formally evaluate whether states are meeting their stated goals with their use of clinical guidelines. Reports from the states and sites themselves suggest a mixed picture, with degree of success affected greatly by a number of challenges and issues, as described below, and the presence of targeted strategies to address challenges.

Common Challenges and Issues/Strategies to Address

The states and local management entities in this sample described many similar challenges and issues in implementing standardized clinical protocols or guidelines statewide or throughout a provider network, and several sites identified strategies to address each of these challenges. Many of the issues described below also make it challenging to “go to scale” with the use of standardized clinical guidelines and tools, either statewide or throughout a provider network, an overarching issue described by many respondents.

Resistance and/or Lack of Capacity on the Part of Providers/Clinicians/Local Management Entities

Many of the sites in this sample described the challenges of getting clinicians, provider agencies, and, in some cases, local management entities, to make the necessary changes to adopt use of standardized clinical instruments and guidelines. In some cases, clinicians did not accept the face validity of the instruments chosen, or felt that mandated use of the protocols was an intrusion on their clinical expertise and judgment. In a number of cases, provider agencies objected to the amount of time and resources that would have to be spent on training clinicians and incorporating standardized protocols into daily agency operations. This was particularly the case if the new protocols were seen as "add-ons" to what an agency already was doing, rather than a fundamental transformation of clinical operations. In this case, agencies and clinicians would be in the position of having to do additional documentation, seen, understandably, as an added burden. In some cases, provider agencies or local management entities (such as county-based community service boards) lacked the training and data infrastructure to shift clinicians to wide-scale use of standardized protocols.

Sites that seem to have experienced greater provider and clinician acceptance of new guidelines and protocols were those that included these stakeholders from the very beginning in the decision making or development process for clinical guidelines. In addition, states that have been able to dedicate ongoing resources to orientation, training, and coaching activities related to new protocols also seem to have experienced greater acceptance and use of the protocols.

Costs and Level of Effort Associated with Training and Fidelity

Many of the sites cited the challenges of training and re-training staff, providers, clinicians and local management entities in use of formalized clinical protocols. The task is difficult because resources often are limited to do training, coaching, certification and re-certification, and because there is often initial resistance on the part of those who need to be trained. Also, turn-over among staff, providers and clinicians, as well as attention to quality, requires that there be an ongoing training and fidelity monitoring effort that is difficult to sustain because of limited resources, as well as changes in state priorities.

Several states conduct ongoing, statewide training, using a variety of training approaches. Arizona, for example, uses both in-person and video training and provides follow-up technical assistance. New Jersey has all of its training material and schedules on-line, uses a web-based certification system and an on-line help desk. Texas and Michigan adopted a "train-the-trainers" approach.

Several states tie training in use of clinical guidelines to state credentialing or continuing education credits. For example, the Arizona Office of Behavioral Health Licensing is a partner in ensuring a link between its credentialing criteria and the behavioral health system's practice guidelines. New Jersey and Hawaii provide continuing education credits for training in their guidelines and tools, and University of Hawaii medical residents, psychology and social work students routinely do rotations and internships in the children's mental health system with exposure to use of the clinical guidelines and tools in use in the system, which the state noted helps to build a future workforce knowledgeable about Hawaii's practice standards.

States also have mandated requirements related both to training and fidelity. Texas, for example, has performance contracts with its local mental health authorities that mandate skills training, and the state has developed written fidelity measures. Hawaii also has contractual requirements with its providers related to use of the clinical guidelines, and the state requires annual re-qualification of its clinicians and providers in use of its clinical tools.

Costs Of Collecting, Analyzing And Using Data Generated By Clinical Tools And Guidelines for Quality Improvement

Both frontline practitioners and state-level respondents pointed out that there are costs associated with collecting, analyzing, and utilizing data captured by clinical protocols. These costs exist at both the service and the systems level. Stakeholders noted that there often is a lack of dedicated staff, or staff time, or dollars to contract for collection and analysis of the data and then for using the data to inform quality processes. These costs partly, though not solely, influence the extent to which managers and supervisors take advantage of clinical data generated by the use of protocols for additional purposes, such as utilization management and quality improvement. Besides costs, managers and supervisors also are influenced by the extent to which they have "bought into" the use of protocols, as discussed earlier.

A number of states, Hawaii and Michigan, for example, have tried to integrate their clinical guidelines into their accountability systems. Hawaii has devoted staff resources for quality assurance, both within the child mental health division at the state level, as well as in its family guidance centers to collect, analyze and utilize data related to its clinical guidelines. Similarly, the Massachusetts MHSPY program commits internal staff resources for regular clinical and administrative quality assurance data review to identity training needs for the purposes of continuous improvement. Michigan's state child mental health system partners with university researchers to analyze data and utilize it to inform quality improvement and provide technical support to its local management entities.

Consistency Between Use of Standardized Clinical Guidelines/Instruments and Individualized, Family-Driven, Culturally and Linguistically Competent Service Planning and Ongoing Care

A number of state-level stakeholders noted that, even when state guidelines emphasize the importance of individualized service planning, clinicians can be implementing formal criteria with a rigidity that does not allow for flexible, family-driven, culturally competent care. A significant identified challenge is to ensure that implementation of standardized tools and protocols does not derail individualized care planning and provision.

Cultural and linguistic competence is, of course, a fundamental element of individualizing care. Stakeholders in some states noted that, even when steps were taken to translate instruments into different languages, translation issues, as well as cultural differences, could lead to under-identification or over-identification of problems. One state, for example, reported finding that Hispanic families might be under-reporting levels of functional impairment related to school behaviors, due apparently to translation issues with the CBCL. Another problem noted by a frontline practitioner was that it can be difficult to implement standardized instruments, such as the CAFAS, with families with multiple problems when they are in serious crisis, although this practitioner also noted that, over time, families become receptive to use of the CAFAS as it measures progress and establishes tangible benchmarks that are transparent to families.

Hawaii, which is especially rich in cultural diversity, has involved a range of interpreters, multi-lingual and multi-cultural staff, and families in the development and implementation of its guidelines. In addition, the guidelines emphasize that assessment tools are to be used to inform clinical judgment but that final care planning decisions are to be made by the child and family team. Arizona also developed its guidelines with the involvement of family members, and the guidelines emphasize a child and family team approach to care planning. New Jersey stakeholders pointed out that issues related to culture, race and ethnicity are integrated into the CANS. Pennsylvania noted that its clinical guidelines specifically address issues related to cultural competence, and that it has instituted an "early warning system" that tracks access to services by racial and ethnic minority populations.

The sites that employ a formal wraparound approach to service planning and provision assert that, if implemented well, a wraparound approach is inherently culturally and linguistically competent and family-driven because it brings to the table those whom the family itself believes are critical, including natural helping networks and extended family members, and the child/family team drives service decision-making. As noted earlier, a number of the states in this sample that are utilizing formal instruments also are utilizing a wraparound approach, and in some of them, the child and family team process does play a central role in decision making, with clinical tools being used to help inform but not determine the process.

Issues Associated with Lack of Service Availability

The Health Care Reform Tracking Project consistently identified insufficient home and community-based service capacity as an issue in most states. In this study, several states raised this issue as well, noting that, sometimes, the clinical care guidelines point to the need for services that are not available, and that clinicians' knowledge that services are not available influences their recommendations, even with the use of a manualized clinical protocol. One state indicated that lack of services was a factor in clinicians' resistance to using the clinical protocols. Some states also noted concerns that too many children would be receiving "inappropriate services" because of insufficient service capacity, even though clinical guidelines might lead to appropriate service recommendations.

One state reported that use of clinical guidelines has changed the "waiting list" picture in their state. This state explained that, historically, the unmet demand was for residential treatment whereas now the "wait" is for home and community-based services (noting also, however, that as residential beds remain filled because of the lack of alternatives, dollars are not available to build home and community-based capacity, thus creating a circular problem.) This state also noted that because Medicaid-eligible children theoretically are not supposed to experience waiting lists for services, the lack of sufficient service capacity particularly has an impact on non-Medicaid populations.

The DAWN Project, Wraparound Milwaukee and MHSPY, as well as the states that emphasize an individualized, child and family team approach to service planning, require teams to be creative in finding "close" alternatives when the exact service needed is unavailable. Some entities, such as MHSPY, also develop resources in the community to meet program service needs. This is a fundamentally different approach from other states where children simply receive what is available, for example, office-based outpatient services or residential treatment, when recommended services are not available. Some states, such as Texas and New Jersey, are trying to collect data systematically from their

local providers on service gaps to document the need with legislators and others. Hawaii reported that its close partnership with the Department of Education and Hawaii schools helps to fill gaps with alternatives. A number of states (e.g., Hawaii, New Jersey, Texas) also provide a small flexible funding pool to help local management entities or providers create alternatives.

Observations About Particular Instruments

The stakeholders interviewed for this study had a number of observations to make about the particular standardized tools or guidelines being utilized, as summarized below. These are observations, not the results of a systematic review.[16]

Child and Adolescent Functional Assessment Scale (CAFAS)

- Relatively simple to use and "teachable"
- Useful in assessing impairment across life domains
- Incorporates concrete examples for each level of the measure
- Allows for input from multiple informants
- Is not too labor-intensive
- Facilitates communication between families and practitioners
- Can be used to support outcomes monitoring and quality improvement at a service and systems level
- Supports long-term planning with trends observed over time
- Is not intended to be a practice tool to inform ongoing service planning
- May not be as relevant for children and youth with developmental disabilities
- Focuses primarily on identifying functional impairments, not strengths
- Requires collection of a fair amount of clinical data before it can be completed

Child and Adolescent Needs and Strengths (CANS)

- Works well as a practice tool for ongoing service planning
- Can be used by both clinicians and non-clinicians
- Promotes information sharing and communication across agencies and with families
- Is pragmatically-oriented and "levels the playing field" for non-clinician team members, such as families
- Is highly strengths-oriented
- Is useful for outcomes monitoring and quality improvement at both a service and systems level
- Is in a flexible format that can be customized for different populations, such as youth involved in the juvenile justice or child welfare system
- Is not intended to be linked to specific levels of care or treatment settings

16 For a discussion of several standardized instruments based on a systematic review, see: Winters, N., Collett, B. and Myers, K. *Ten-year review of rating scales, VII: Scales assessing functional impairment*. Journal of the American Academy of Child and Adolescent Psychiatry. 44:4, April 2005, 309-338.

Child and Adolescent Service Intensity Index (CASII)

- Is designed to link to specific level of care recommendations
- Focuses on an integrated assessment related to symptomatology, functional impairment, and treatment planning
- Requires clinical background and training to complete
- State may not have applicable levels of care, which could affect relevance of instrument

Wraparound Fidelity Index

- Fast and easy to use
- Relevant to quality improvement in adherence to "Child and Adolescent Service System Program (CASSP)" values (e.g., family-driven, individualized, coordinated, culturally and linguistically competent, strengths-based, individualized care)
- Provides program or system-level data
- Is not designed as a practice tool for service planning at the individual child level

Lessons Learned/Recommendations

The sites in this sample had a number of recommendations for others interested in implementing wide-scale use of standardized clinical protocols or guidelines based on "lessons learned," which are summarized below.

- Select protocols that are meaningful to stakeholders, including clinicians, local management entities, provider agencies and families, and make protocols transparent to these stakeholders. Related to this is the recommendation to involve these stakeholders in the selection or development of protocols or guidelines and in implementation strategies.
- Select or develop and utilize protocols and guidelines within a values-based and systemic context. In other words, know what values, principles, and goals you are trying to promote in your system, and be clear that the protocols you have chosen or developed will support these values and goals.
- Provide adequate staffing and resources at a state or management entity level to implement a protocol-based system. Very much related to this is the recommendation to create an adequate infrastructure for training, re-training and coaching in the use of the protocols.
- Some of the featured states and localities have received significant grant support for collection and analysis of information from clinical measures. However, for settings without such support, it is important to include resources for data collection and analysis, or else to build such costs into rates assigned to management entities responsible for reporting the data.
- Integrate use of the protocols into everyday documentation requirements and everyday practice, rather than implementing them as an "add-on;" make them a part of the culture of the system.
- Keep open lines of communication with those using and affected by use of the protocols, i.e., families and youth, clinicians, provider agencies, and other child-serving systems, such as child welfare, education, and juvenile justice.

- Establish quality control in the use of protocols, which requires attention to data collection and analysis at both the service and systems level, and attention to use of the data to inform quality efforts.
- Do not use data related to use of clinical protocols to “beat up” on providers; use data to improve quality, including providing technical assistance, consultation and coaching to providers and clinicians.
- Use data generated by the use of clinical protocols to document results, which will help to shed light on system strengths and accomplishments, service gaps, and resource needs, which, in turn, promotes sustainability.
- The use of standardized instruments works best for children and families when it is embedded into a system that is strengths-based, family-driven, and committed to the principle of individualized care. Clinicians that embrace and are skilled in this practice model tend to make the most appropriate use of standardized instruments to help guide service planning and care provision.

State and Local Descriptions

I. Sample Sites Using State-Developed Guidelines

Arizona (**Group One:** State-Developed Guidelines)

- Arizona Uniform Behavioral Health Assessment Tool

Overview

The state of Arizona initiated a process in 2001 to substantially redesign its process of mental health and substance abuse service delivery to children and adolescents. The state already possessed a unique behavioral health infrastructure due to the combined challenges of urban and rural needs, tribal and non-tribal cultures, and linguistically diverse populations. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. ADHS/DBHS contracts with five separate organizations, known as Regional Behavioral Health Authorities (RBHAs), and three additional organizations, known as Tribal Regional Behavioral Health Authorities (T/RBHAs), to administer behavioral health services throughout six specified geographic service areas and three Tribal service areas. These RBHAs and T/RBHAs function in a fashion similar to a managed care behavioral health carve-out, contracting with a network of service providers to deliver a full range of behavioral health care services for adults and children, including children with serious emotional disturbance[17].

Known as the "Arizona Vision," the new comprehensive vision for caring for the state's children is built on twelve principles to which ADHS and AHCCCS (Arizona Medicaid) are both obligated and committed. These principles are a modification of the original CASSP Principles articulated by Stroul and Friedman in 1986[18] and emphasize the necessity of orienting service delivery around a "system of care" approach. To be consistent with the state's new vision, the Arizona Department of Health Services/Division of Behavioral Health Services has worked aggressively to significantly revise and standardize its intake, assessment and service planning processes. In an effort to support implementation of these changes, the state developed the strengths-based Arizona Uniform Behavioral Health Assessment[19] tool, which has been in use since January of 2004. Additionally, Arizona has developed and defined and is testing and standardizing a wraparound practice, called the Child and Family Team process, to be the foundation of its new system of care.

17 More information on the Arizona public behavioral health system may be found on the Arizona Department of Health Services website at: www.azdhs.gov/bhs/index.htm

18 Stroul, B. A.; Friedman, R. M. (1986). A system of care for severely emotionally disturbed children & youth (ED 330167). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center: U.S. Dept. of Education, Office of Educational Research and Improvement, Educational Resources Information Center.

19 Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS/DBHS Revised Assessment Process. Available http://www.azdhs.gov/bhs/assess_process <http://www.azdhs.gov/bhs/assess_process>.

Arizona (**Group One:** State-Developed Guidelines)

- Arizona Uniform Behavioral Health Assessment Tool

The state also developed and is implementing related Practice Improvement Protocols, consistent with the "Arizona Vision." A recent example is directed toward providers of services to children in therapeutic foster care, with targeted areas of improvement framed in the context of the twelve principles.

Goals

The Arizona Vision is summarized on the state website, where it is described as having the following goals and objectives:

"In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage."

New instruments and protocols needed to be created to support these goals, since existing methodologies were not deemed sufficiently strengths-based or family driven. The reconfiguration of the public sector behavioral health system is intended to ensure that every child in the system will be served by a child and family team.

Background

In Arizona, the 1997 suicide mortality rate among adolescents 15–19 years old was 23.7 per 100,000, the second highest rate in the U.S. This, along with other consumer concerns, helped fuel a class action suit regarding state obligations inherent in the federal EPSDT regulations to screen for and treat child mental health needs. Arizona had been constrained for the previous 23 years by the impact of an earlier lawsuit regarding adequacy of adult behavioral health services and did not wish to repeat that experience. Instead, in 2001, the federal suit, referred to as "Jason K" was settled; the "Arizona Vision" and the twelve principles were the foundation of the Jason K settlement agreement. In the process of reforming the public behavioral health system, the Arizona Department of Health Services has used the expertise of the Office of the Medical Director, the Children's Bureau, and the Office of Quality Management. These three entities collaboratively provide development, implementation, enforcement, monitoring, and clinical oversight of the state's behavioral health service provision. Working closely with the Medical and Clinical Directors of the RBHAs, as well as providers, clinicians from other State agencies, and family members, the Office of the Medical Director has established guidelines for treatment and non-categorical service delivery, quality of care measurement, and best practice standards throughout the State. The Medical Director and Associate Medical Director coordinate with the AHCCCS (i.e., Medicaid) Medical Director and AHCCCS Health Plans for the joint management of clients' physical and behavioral health needs. The Associate Medical Director is responsible for children's behavioral health issues.

Arizona (**Group One:** State-Developed Guidelines)

- Arizona Uniform Behavioral Health Assessment Tool

Over a period of eighteen months, a work-group of consumers, providers and family members developed the Arizona Uniform Behavioral Health Assessment tool for persons five years old and up. A second group developed a parallel assessment tool for children below the age of five, which was piloted in September of 2004 and anticipated to be rolled out state-wide in 2005.

Description

As part of an AHCCCS contract deliverable, the state has instituted annual administrative review and audit of service use. In order to facilitate this, it was clear that the state needed a new assessment tool. As noted, the new tool is based on clinical experience, consumer review, expert opinion and common elements within known instruments. Guidelines are not used in Arizona to represent either a floor or a ceiling for service provision. The state does not use level-of-care criteria and rejected the proposed use of the CALOCUS (now called the CASII) because it was deemed at odds with "voice and choice" by family members. The only exception to this is for Level I care: defined as Acute Hospital and Locked Residential. These settings are required by Federal legislation to have prior authorization. AHCCCS (Arizona State Medicaid) contracts with the Arizona Department of Health Services, to oversee the provision of behavioral health by chosen vendors (RBHAs), who then subcontract, through varied mechanisms, with providers. Level I admission and "continued stay" criteria are determined by the Arizona Department of Health Services.

The Arizona Behavioral Health Assessment tool lays out a number of clinical decision making guidelines for RBHAs and their contracted providers. As of July 2003, assessment and service planning was expected to be strengths-based and person/family centered. An interim service plan, built upon a clinical formulation, was to be developed with an emphasis on immediate needs. On-going service planning is to follow, using a team approach in a culturally competent manner.

Key to this process is the Core Assessment. The purpose of the Core Assessment is to collect enough information to "ensure safety and get the person to the appropriate next service(s)."[20] The areas covered by the Core Assessment include:

(1) presenting concerns,

(2) behavioral health and medical history,

(3) criminal justice,

(4) substance related disorders,

(5) abuse/sexual risk behavior,

(6) risk assessment,

20 Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS/DBHS Revised Assessment Process. Available http://www.azdhs.gov/bhs/assess_process <http://www.azdhs.gov/bhs/assess_process>.

(7) mental status exam,

(8) clinical formulation and diagnoses,

(9) next steps/interim service plan.

In essence, the Core Assessment serves as a triage tool, ensuring that the most appropriate next steps are identified, with the youth's immediate needs provided for until a comprehensive assessment, required within 45 days, can be completed.

All completed assessments include documentation of the living environment, employment or educational/vocational status, strengths, social/cultural features, and developmental history. When "triggered" by the information collected, additional aspects documented are the presence of criminal justice involvement, eligibility for determination of Serious Mental Illness (SMI), or special services provided within 24 hours to children removed from their homes by Child Protective Service activities. All SMI determinations are reviewed by either a psychiatrist or a psychologist.

The Clinical Formulation and Diagnoses section within the Core Assessment was developed to define a preliminary construct of the nature of the individual's strengths and weaknesses, and the relative contribution of all assessed areas (developmental, health and social history, family relationships, family functioning and cultural patterns, family psychosocial and medical history and personal traits, etc.) to these strengths and weaknesses. In a succinct paragraph, the assessor is expected to provide a descriptive picture of the individual by summarizing, not repeating, accumulated data collected and most importantly, making sense of it. If done correctly, this section ties together disconnected details, historical facts and observations that have been collected to this point, organized to create a clinically pertinent conceptual portrait of the child for use in service plan development. A diagnostic summary, based on the multi-axial system and including Global Assessment of Functioning (GAF) or Child Global Assessment scores (CGAS), is included.

The Interim Service Plan stemming from the Core Assessment is made up of recommended next steps, including the core team's suggested response to immediate risks. There is also room to note recommended additional team members and the person to contact for immediate assistance. Additional service goals may be added or completed at follow-up meeting(s). Goals are drawn from an examination of life domains, with further identification of strengths and additional supports to build "a complete picture."

The Core Assessment is built on the premise that the assessment process must be an ongoing one, and that the information necessary to develop a meaningful, comprehensive, clinically sound and family focused service plan must be developed over time and in the context of a Child and Family or Adult Team. Thus, a first step in the interim service plan is the development of these teams. Following the Core Assessment, an individualized ongoing Service Plan is established based on continuing assessment. The Service Plan is documented on a standardized form that involves the youth, the family and the team. The form captures identified objectives, outcome measures and target dates for achievement. Progress is regularly

reviewed and objectives revised if necessary. At a minimum, annual updates are done using a standardized form for addressing a services and treatment summary, current clinical status including diagnosis, and all recommendations.[21]

Individualized, Culturally Competent Family Focus

Stakeholders in the state's reform process felt that the old state guidelines were overwhelmingly diagnosis-driven and not family-driven. This did not fit the Arizona Vision, so new guidelines were created to better respond to the new model of care and the expectations set by the Twelve Principles. The Child and Family Teams are built upon the premise of care delivery that is individualized based on need and family culture. A professional "Clinical Liaison" is assigned to each Child and Family Team with the goal of creating a link between the Team's objectives and identified needs and the providers or other available resources. The Clinical Liaison also contributes clinical expertise and recommendations to help guide comprehensive team decision-making.

Impact of Service Availability

As a result of the federal EPSDT based lawsuit, Arizona Medicaid has significantly broadened the array of covered services, and clinical guidelines have been set with an expectation of increased access. Some providers reportedly still limit care, however, due to provisions in their managed care contracts with the RBHAs. However, if a service is not readily available, the state guidelines require the child and family team to either try elsewhere to find the service or create an alternative.

Training, Fidelity and Oversight

An instruction manual for the assessment and planning instruments is provided to all practitioners (i.e., clinical supervisors, assessors and/or clinical liaisons). It provides an in-depth understanding of how to effectively and efficiently put the tools to use. The guide addresses the purpose of each component of the tools, along with the intent behind the individual questions. For assessment-related questions, examples of additional probes are provided that assessors may choose to use to solicit information.

There was extensive statewide training for providers on the assessment tool both in-person and via videotapes. The implementation plan was to phase-in use of the tool after the initial trainings, with full implementation by March 2004. A second wave of training moved beyond basic assessment skills to enhanced assessment training, and provided follow-up technical assistance. ADHS worked collaboratively with the Arizona Office of Behavioral Health Licensing to define credentialing and privileging criteria, based in part on these additional trainings, to expand the types of practitioners qualified to do assessments. Specific Practice Improvement Protocols were created as part of another statewide training effort. Newly developed Technical

21 Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS-DBHS behavioral health assessment and service plan checklist. Available http://www.azdhs.gov/bhs/assessment/assess_tool.doc <http://www.azdhs.gov/bhs/assessment/assess_tool.doc> .

Assistance Documents, planned to complement Practice Improvement Protocols, addressed administrative and operational issues confronting providers.

Some monitoring and supervision about use of the guidelines was built into contracts with the RBHAs and T/RBHAs. RBHAs undergo annual clinical and administrative reviews of their work. They are also monitored via chart reviews, audits, independent case reviews, bi-annual consumer satisfaction surveys, and ongoing quality management oversight. A quality management workgroup is in the process of developing clinical supervision standards for Child and Family Teams, fidelity measures for Child and Family Team process, and process outcome indicators. The Wraparound Fidelity Index (WFI)[22] is currently being used in some of the settings to measure fidelity to the Child and Family Team process (the wraparound model consistent with Arizona's Twelve Principles.)

Experience to Date

The clinical guidelines used in Arizona were developed to support the Twelve Principles, facilitate quality management and encourage consistency of service provision. They were not written to capture or manage cost, and the cost implications of implementing the Vision have yet to be measured.

With the new system in place, work has begun to try to monitor adherence to Practice Improvement Protocols (e.g. measurement of compliance with the "urgent response" protocol required when children are removed from their homes by child welfare).
An independent auditor is using performance measures to evaluate:

(1) child and family team development,

(2) cultural competency,

(3) member and family care experience,

(4) appropriateness of care and

(5) access.

The Arizona Department of Health Services Policy Office, with oversight by the Medical Director's Office and input from behavioral health consumers, family members, and providers, reviews guidelines on a regular and as-needed basis.

Participants in developing the "Arizona Vision" report that the experience taught them it was crucial to communicate clearly from the outset how the guidelines are intended to be used. Are they "recommendations" or are they "mandates"? Will there be monitoring against them? They also found it valuable to consider existing "best practices" located elsewhere. This led Arizona policy makers to recognize that need and strengths driven care, tied to the wisdom of families, was what would help the state system the most. The ADHS Policy Office is now working with the Medical Directors office and Clinical Bureaus to revise service planning guidelines and Practice

22 Bruns, E., Suter, J., Burchard, J., Force, M. & Leverentz-Brady, K. (2004). Assessing fidelity to community-based treatment for youth: the Wraparound Fidelity Index. Journal of Emotional and Behavioral Disorders. 12, 69-79. The Wraparound Fidelity Index also may be downloaded from the following website: http://depts.washington.edu/wrapeval/WFI.html

Improvement Protocols to more carefully outline the Department's expectations as well as its requirements.

Major Benefits, Concerns and Lessons Learned

Arizona stakeholders described a number of **benefits** associated with the use of the new guidelines, including:

- They promote and extend the "Vision" of how the state's children and families should be served
- They instill core values (the Arizona Principles) into all components of service delivery
- They have changed the paradigm of care delivery in the state
- Treatment planning is less of a "random act" and instead can be supported to become more consistent
- Structured guidelines promote development of quality improvement processes and outcomes measurement

Stakeholders also identified the **challenges** of implementing the new guidelines, including:

- Analyzing, understanding and addressing the cost of discarding the old procedures and putting new ones in place
- The effort involved in training, re-training and coaching providers and administrators on the new practice approach.
- Intrinsic resistance to the "team" approach and partnering with families
- Previous paradigm of "experts" deeply entrenched
- Adjusting the quality management system and supervision protocols in order to monitor and reinforce adherence and fidelity after the training phase is over

Additional issues surfacing from early audits and chart reviews include finding that the new Assessment and Service Planning processes are not being uniformly used in all geographic service areas. It appears that, despite intensive training, the new assessment tool is not yet being fully used as intended regarding both cultural competency and service planning. An unrelated concern post-implementation has arisen during a review of authorizations. This review suggests that some providers themselves are using prior authorization processes in a manner that creates barriers to full access to care, even though the state has tried to remove such barriers. The issue is multi-textured. Part of it may stem from the difficulty, in general, of moving a provider system to a new service paradigm. Part may also be related to the fact that the RBHAs are capitated systems; the amount they pay providers (or that the state pays RBHAs) may not be sufficient to fully implement the new guidelines and practice expectations. State-level stakeholders indicated that further efforts to partner with the RBHAs and providers will be required to address this issue.

Delaware (**Group One:** State-Developed Guidelines)

- Clinical Services Management Criteria

Overview

The Division of Child Mental Health Services (DCMHS) within the Delaware Department of Services for Children, Youth and Their Families operates as a JCAHO-accredited managed behavioral health care organization providing services through a statewide network of public and private providers. Clinical Services Management Teams, currently seven located throughout the state, manage the care of each child in the system by working directly with children and families to plan, authorize, monitor and coordinate care. The Division created its own clinical care guidelines for every level of care in its system, including both mental health and adolescent substance abuse treatment services. The guidelines are used by Clinical Services Management Team Leaders, who are licensed mental health professionals, and their care managers to determine appropriate levels of care. They also are used as referral guidelines for providers in the system. The guidelines are used qualitatively, rather than to create a quantitative score linked to service level.

Delaware's public mental health system is a partnership between commercial managed care organizations (MCOs) under contract to the State Medicaid agency and the Division of Children's Mental Health Services. The MCOs manage physical health care and a basic behavioral health benefit, which is defined as the equivalent of 30 hours of mental health and/or substance abuse outpatient services or its equivalent, renewable annually. The Division's clinical care guidelines apply only to children served by the Division, who essentially are Medicaid-eligible children who need more than 30 hours of outpatient services, as well as children who are without insurance.

Goals

The Delaware Clinical Services Management Criteria are described by State-level stakeholders as "reasonably broad" by intent, to allow their clinicians a degree of latitude. Exceptions are the criteria for hospitalization, which are fairly strict, and the criteria for partial hospitalization/day treatment, which make clear the Division's policy not to provide these services as an alternative to a public education program. There is some intentional overlap among the criteria for different levels of care, again by intent to create latitude for Clinical Team Leaders. The Division intentionally has made the guidelines very public, uses them as talking points with providers and families, and keeps them published on the Division website.[23] State-level stakeholders indicated that a primary goal of the guidelines is to create equity and fairness in the system by establishing uniform criteria for use statewide.

Background

DCMHS has used clinical care guidelines for nearly 15 years in its system but established a more rigorous, formalized set of guidelines with the advent of managed care in 1996. When DCMHS first established guidelines, most of the existing examples came from the commercial sector, which covered only brief hospitalization and outpatient services, and state-level

23 Delaware's clinical care guidelines can be found at: http://www.state.de.us/kids/default.shtml <http://www.state.de.us/kids/default.shtml> .

stakeholders reportedly rejected these as not reflective of their broader array of services or public sector mission. DCMHS stakeholders also reported that they have looked at numerous proprietary instruments over the years, such as the CALOCUS (now CASII), but ultimately decided to develop and stay with their own guidelines to best reflect their array of services and their system. Their current set of guidelines is based loosely on American Psychiatric Association (APA) and National Institute on Drug Abuse guidelines, the latter of which were based loosely on those of the American Society of Addiction Medicine (ASAM). The guidelines also are based on input from Clinical Team Leaders' experience and a general review of the literature.

As the Division has developed new services within its system of care, it also has had to develop new guidelines. In addition, State-level stakeholders indicated that they maintain an ongoing dialogue with their provider network, which operates as an "early warning system" to bring to the Division's attention problems with the guidelines.

Description

Clinical care criteria for mental health and substance abuse services have been established for the following levels of care:

- Crisis Intervention Services
- Outpatient Services
- Clinical Care Management
- Intensive Outpatient Service (home-based)
- Aide Service (Wraparound)
- Evening After-School Program
- Day Treatment
- Partial/Day Hospital
- Individual Residential Treatment (e.g., family treatment home)
- Residential Treatment Center (facility-based)
- Psychiatric Hospital

Each set of criteria includes a brief definition of the service and a list of "primary and other" considerations to guide determination of the appropriateness of the service. For example, self harm is one primary consideration in the case of hospitalization, and an example of "other considerations" in the case of hospitalization is "intellectual limitations, such as mental retardation, which are a primary factor in the client's behavioral problems (that) render the youth incapable of benefiting from interventions offered." [24]

24 State of Delaware, Department of Services for Children, Youth and Their Families Division of Child Mental Health Services (March 2004). Mental health criteria for hospitalization. Available www.state.de.us/kids/pdfs/cmh_crit_mh_2003.pdf <http://www.state.de.us/kids/pdfs/cmh_crit_mh_2003.pdf>.

Delaware (**Group One:** State-Developed Guidelines)

- Clinical Services Management Criteria

State-level stakeholders indicated that the criteria are intended to screen children into appropriate services, not keep them out. State-level stakeholders believe that the clinical guidelines help clinicians to do a risk analysis, to review more systematically what has and has not been tried, and to answer the basic question of how to reduce risk. The criteria are not based on a logarithm and do not specify discharge criteria; clinicians use their own judgment regarding absence of the problem that placed a child in a service to begin with, or stabilization, to determine discharge. However, the Division does use peer review monitoring for utilization management. In addition, the Division's management information system, utilized both by Clinical Teams and Division managers, tracks the levels of care in which children are enrolled and provides automatic reminders to care managers about due dates for clinical necessity reviews. Clinical Team leaders can make the decision to go outside of the guidelines (unless it involves a bed). Exceptions to guidelines may be reviewed by senior Division management. In addition, some exceptions end up being reviewed by the utilization review committee retrospectively. For example, at one point, the system experienced an over-use of outpatient combined with behavioral aides for the same children, which led to implementation of additional authorization steps for this combination of levels of care.

Individualized, Culturally Competent Family Focus

DCMHS indicated that there is a formalized process for involving families in clinical decision-making, and that Clinical Team Leaders can implement a wraparound team approach with families. State-level stakeholders pointed out that one of the limitations to the guidelines is that they only cover services available in the network and that some services needed by culturally diverse children and families, for example, children with hearing impairments and Spanish-speaking families, are not available, rendering the guidelines less effective. They also noted limitations with respect to youth who are involved in Delaware's drug court. State-level stakeholders believe that most of the challenges in serving these youth have to do with creating a "drug recovery environment" within the drug culture in which many of these youth live. The clinical care guidelines do not address recovery issues.

DCMHS stakeholders believe that their guidelines do support an individualized approach to care with families because they do not have specific time limits or discharge criteria, and there is no benefit limit. Also, they reported that Team Leaders develop, in effect, strategic plans with families regarding service delivery and that these plans are unique to each child and family.

Impact of Service Availability

As noted above, the clinical guidelines are pegged to available services, that is, to services that the Division provides within its network. Even so, clinicians still identify the need for services that are not available because of capacity limits, or because the service is not available within a certain geographic area, or is not within the Division's network (for example, some services for youth with co-occurring emotional and developmental disorders.) The Division uses a consulting child and adolescent psychiatrist to consult on both program and case-specific needs, which is one resource that Clinical Team Leaders can utilize when a needed service is not available.

The Division's MIS system actually has a "services gaps" indicator so that the Division can track gaps systematically. The Division uses this MIS data, as well as periodic surveys of Clinical Teams, to identify and try to address gaps. Recently, for example, gaps were addressed with respect to treatment services for youth with sexual offenses.

Among the new services that the state has developed in response to identified gaps are: Individual Residential Treatment (i.e., family treatment homes) as a step down based on an analysis showing that children were remaining too long in facility-based residential treatment; Intensive Outpatient Services (i.e., home-based) for children with mild-moderate mental retardation/developmental delays based on an analysis indicating that these children do not fare well in traditional, office-based settings; and, Intensive Outpatient Services (i.e., home-based) based on an analysis that too many children were being admitted to residential treatment who could be served in the community if in-home services were available.

Training, Fidelity and Oversight

The Division trained Clinical Team Leaders and has conducted training for providers on the clinical guidelines. It relies on Team Leaders (i.e. clinical supervisors) to conduct ongoing training of their care managers. State-level stakeholders indicate that the criteria are very basic to their system and are very much integrated into system operations at this stage. Thus, there is no ongoing, formalized training on the guidelines at this point. However, new Clinical Team Leaders serve an apprenticeship six-month period, in which they are learning the entire system, including the clinical care guidelines.

The Division does not have a formal process to monitor the use of the guidelines or their impact. As noted earlier, they rely on provider input, formalized through a quarterly providers' forum, and regular input from Clinical Management teams. In addition, they track impact on access (primarily to outpatient), family satisfaction, appeals and grievances, and cost -- data that they feel gives them some indication of the impact of the guidelines. State-level stakeholders noted that the system has few appeals that go beyond a level-one stage and that consumer satisfaction surveys indicate that 80% of families (out of 2,000 served) are satisfied, particularly with services provided by clinical care managers. Stakeholders also pointed out that their clinical care managers carry caseloads of 1:28-30 compared to the much smaller caseloads in some systems of care (1:10) serving children with intensive needs, yet satisfaction levels with their care managers is high.

State-level stakeholders indicated that they formally review and revise the clinical care guidelines every three years. They review the literature and try to bring a knowledge base into Delaware on an ongoing basis through, for example, quarterly workshops for clinicians. They noted that, to date, the guidelines for mental health and substance abuse have been parallel, but they are re-visiting their assumptions based on their experience with youth involved in drug court and in light of more research in recent years on adolescent substance abuse treatment and recovery issues.

Delaware (**Group One:** State-Developed Guidelines)

- Clinical Services Management Criteria

Experience To Date

State-level stakeholders indicated that they did not experience a great deal of resistance to the clinical care guidelines by providers. However, they did describe some resistance on the part of child welfare and juvenile justice stakeholders, who view the criteria as a mechanism to reduce access, particularly to beds. DCMHS stakeholders noted that their data show that they are not rejecting youth involved in child welfare and juvenile justice if they are referred for service, and they believe part of the problem is that these systems are not screening and referring youth for behavioral health services. DCMHS feels that the behavioral health system actually has a fairly low threshold for admitting youth, and that they should be getting more referrals from child welfare and juvenile justice. DCMHS argues that the major issue is a lack of a systemic approach and shared responsibility for screening and referring these children and adolescents. DCMHS also points to use of the guidelines as one key reason why they have few instances of judges ordering youth into particular levels of care.

Major Benefits, Concerns and Lessons Learned

State-level stakeholders believe that the major benefit to using clinical care guidelines is that they support rational decision-making and greater equity in the system. In the past, DCMHS was open to criticism that, when dollars were short, treatment decisions were made based on available dollars. They believe that the guidelines make it more difficult to levy that criticism. State-level stakeholders also pointed out that the guidelines serve to satisfy State Medicaid agency requirements that services provided by DCMHS, which is acting as a managed care entity, are clinically necessary.

DCMHS stakeholders believe that a benefit to these particular guidelines is that they are broad, thereby allowing their Clinical Team Leaders some latitude in decision-making. By the same token, they pointed out that because the guidelines are broad, Team Leaders can make different decisions using the same criteria—a complaint sometimes voiced by providers. State-level stakeholders also pointed out that clinical decision-making is affected as well by availability of services and by Team Leaders' knowledge about which providers are providing quality care.

DCMHS stakeholders indicated that they are still wrestling with what the clinical care criteria ought to be. They struggle, for example, with what the criteria ought to be for youth involved in the foster care system who remain in residential treatment because of lack of a placement in foster care, or what the criteria ought to be for residential treatment in general in light of data questioning its effectiveness. In the substance abuse arena, they struggle over what the criteria should be for youth who are using substances and refusing to show up for treatment; for example, they pose the question as to whether a youth using marijuana, who erratically attends community services, should be considered a "failure" and in need of a more restrictive level of care.

Delaware (**Group One:** State-Developed Guidelines)

- Clinical Services Management Criteria

DCMHS stakeholders offered several "lessons learned" to other states who are interested in implementing clinical care guidelines, which include:

- Make the guidelines transparent and very public (unlike, for example, the clinical care guidelines used in the private managed care world, which are proprietary, shared only with an MCO's network of providers and care authorizers and not with families and other system stakeholders)
- Maintain very open channels of communication with providers whose experience and knowledge base is important to incorporate into the guidelines
- Be clear what the system is and is not—for example, in the case of Delaware, DCMHS believes it is important to emphasize that they are a mental health and substance abuse treatment system, not, for example, a mental retardation system.[25]

25 DCMHS stakeholders noted that they do struggle with children and adolescents who have co-occurring disorders of mental retardation and behavioral health disorders as there is no one system designated to serve this population.

Pennsylvania (**Group One:** State-Developed Guidelines)

- Guidelines for Mental Health Necessity Criteria ("Appendix T") and
- Guidelines for Best Practice in Child and Adolescent Mental Health Services

Overview

Child and adolescent behavioral health services in Pennsylvania are administered through a managed care behavioral health carve out arrangement, called HealthChoices, in which Pennsylvania's counties have risk-based contracts with the State and may act as their own managed care organizations (MCOs) or contract for MCO functions with commercial or non profit entities. As a result of the strong county role in the delivery of behavioral health services, there is wide variation across the State in the types of managed care entities used, with some counties using government entities, some using commercial managed care companies, and some using non profit or hybrid arrangements.

With the implementation of managed care eight years ago, the State developed Guidelines for Medical Necessity Criteria for both adult and child and adolescent services; the guidelines are known as "Appendix T" as they are incorporated as an appendix within the HealthChoices manual. The purpose of Appendix T is to provide decision-making criteria for the admission, continuing stay, and discharge of children and adolescents in various treatment environments under regulation by the State Medicaid and mental health agencies. Appendix T states that " this document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse…and Office of Medical Assistance…payment regulations, for deciding when to treat, continue or discontinue treatment."[26] Appendix T covers mental health necessity criteria for the following services: psychiatric inpatient hospitalization; residential treatment; psychiatric partial hospitalization; outpatient treatment; behavioral health rehabilitation services under EPSDT—home and community-based services; Family-Based Mental Health Services Program; and targeted case management. The State uses the adolescent patient placement criteria of the American Society of Addictions Medicine (ASAM) for adolescent substance abuse treatment services.

The Appendix T criteria are broad, qualitative guidelines that are nested within an overall philosophy of system of care principles, including individualized care. While MCOs and providers are required to use the criteria, the state also allows MCOs to develop "similar but equal" criteria; State-level stakeholders indicated that, to date, no one has put forward an alternative. Any changes have to be approved by the State Department of Public Welfare. On an individual basis, a member may grieve a denial based on the application of medical necessity criteria; the second-level grievance includes a county-level person. At this level, the application of medical necessity for a particular child may be changed.

In addition to Appendix T, the State also developed "Guidelines for Best Practice in Child and Adolescent Mental Health Services." The Guidelines describe protocols and discuss issues related to a broad range of clinical practice issues organized in three main sections: Assessment, Practice, and Behavioral Health Submissions. Like Appendix T, these are broad guidelines, and State-level stakeholders noted that MCOs and their providers typically are using

26 State of Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (04/01/2004). Appendix T: Guidelines for mental health necessity criteria. Available http://www.dpw.state.pa.us/omap/rfp/hlthchcrfp/HlthChBHappdxTpartB.asp.

additional assessment and clinical decision making tools. For example, the Philadelphia County behavioral health organization is utilizing a version of the Child and Adolescent Needs and Strengths (CANS) tool to assess and guide clinical dispositions for youth involved in the juvenile justice system.

Goals

State-level stakeholders indicated that a major goal in their development of the Appendix T criteria was to ensure that the State's system of care values would be reflected in medical necessity criteria to establish a framework for managed care companies. There was concern within the State about medical necessity criteria historically promulgated by managed care companies which was perceived to restrict access to services and require consumers to "fail first" in one level of care before being eligible to access a higher level of care. Thus, a major goal of Appendix T was to send a message and provide guidance to the MCOs. State-level stakeholders indicated that the criteria also are intended to promote consistency in clinical decision-making statewide and across diverse MCOs.

With respect to the State's Best Practice Guidelines, the intention was to promote high quality care and provide a framework for "systematic, conscientious clinical pursuit."[27] The Guidelines enable the State to articulate its "CASSP" (i.e., system of care) philosophy of care and to offer guidance to MCOs and providers on how these principles translate into practice.[28]

Background

The Appendix T criteria were developed initially during the development phases of HealthChoices through a process supported by a national foundation grant. The State drew on the expertise of psychiatric consultants, families and others to formulate the criteria and piloted them in one county. State-level stakeholders indicated that the criteria were "out for years for review" before becoming final and that counties, through this process, are quite familiar with them.

Description

The Appendix T Mental Health Necessity Criteria are organized into four parts:

- **Part B.1** governing psychiatric inpatient hospitalization, residential treatment, psychiatric partial hospitalization, and outpatient treatment;
- **Part B.2** governing behavioral health rehabilitation services under EPSDT: home and community-based services;

27 State of Pennsylvania, Department of Public Welfare (February 18, 2005). Guidelines for Best Practice in Child and Adolescent Mental Health Services. Available http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/ <http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/> .

28 CASSP stands for Child and Adolescent Service System Program, a federal initiative that promoted the development of systems of care for children, adolescents and their families that are coordinated across child-serving systems, strengths-based, culturally competent, provide services in the least restrictive setting, and create meaningful partnerships with families and youth in policy, management and service delivery.

- **Part B.3** governing the Family Based Mental Health Services Program; and
- **Part B.4** governing targeted case management services.

Each Part is generally organized to include: an introduction; a description of the service type, its function and philosophy, and rationale for its inclusion within the continuum of care; a discussion of CASSP principles governing service provision; relevance of severity of symptoms and intensity of treatment; admission guidelines; continued care guidelines; discharge and service transition guidelines; and, documentation requirements. Admission, continuing stay and discharge criteria incorporate diagnostic criteria (e.g., presence of a DSM IV diagnosis), level of functional impairment, assessment of severity, and caregiver strengths and needs. As noted earlier, the Appendix T criteria are very broad and qualitative, covering a relatively broad array of services within a State-articulated philosophy of strengths-based, individualized service provision.

The State's Best Practice Guidelines incorporate guidance related to assessment, practice and documentation. The Guidelines cover a lengthy list of nearly 50 subject areas including such topics as: "An Effective Interagency Team Meeting; Building Blocks of the Clinical Interview; Engaging Minority Children and Adolescents Through Respect; Expectations for All Individualized, Community-based, Enhanced Mental Health Services; Expected Practices with Wraparound Services; In Support of Genuine Parent-Professional Collaboration; Possible Clinical Indicators for Psychotropic Medication for Children and Adolescents; Strengths-Based Treatment of Children: What It Is and What It Isn't; The Role of Natural Supports in Behavioral Health Treatment for Children; Working with Children and Adolescents Who Are Defiant; Principles of Effective Home-Based Treatment."[29]

Individualized, Culturally Competent Family Focus

The Appendix T Mental Health Necessity Criteria and the Best Practice Guidelines were developed intentionally to reflect the State's commitment to a strengths-based, culturally competent, individualized approach to care that views families and youth as partners in decision-making. Also, the criteria and guidelines were developed and refined with the input of families and many other stakeholders. Throughout both documents, the State emphasizes the importance of an individualized approach to care, and specific issues related to serving racial and ethnic minority families and to partnering with families are addressed in the Best Practice Guidelines. The criteria and guidelines require an individualized service planning team (ISPT) for every child receiving residential treatment or behavioral health rehabilitation services, although the extensiveness of the teaming process will vary depending upon the intensity needs of the child/family. It also should be noted again that the criteria and guidelines are so broad that they readily accommodate an individualized approach to clinical decision-making.

29 For a complete listing of topics and description of the guidelines, see: www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines

Pennsylvania (**Group One:** State-Developed Guidelines)

- Guidelines for Mental Health Necessity Criteria ("Appendix T") and
- Guidelines for Best Practice in Child and Adolescent Mental Health Services

The State monitors service utilization by age, race/ethnicity and has implemented an Early Warning System, in which one of the indicators is access to services by minority populations, recognizing that, historically, racial and ethnic minority families have experienced disparities in accessing services, particularly within managed care environments. The State also has funded efforts to improve the cultural competence of the delivery system.

Impact of Service Availability

State-level stakeholders indicated that, theoretically, it is not permitted to have "unavailable service capacity" in that counties must look for alternatives when a particular type of service is not available. The State also monitors the service capacity provided in MCO networks. However, State-level stakeholders also expressed concern that too many of the service dollars go to residential treatment and to therapeutic support staff (a type of behavioral health aide that has become synonymous, unintentionally, with the provision of wraparound services). As a result, there are few incentives for the development of different types of home and community-based services.

Training, Fidelity and Oversight

The State does not conduct training per se on the mental health necessity criteria; however, it works closely with the counties to prepare them for managed care implementation, instituting a "readiness review" process in which there is orientation and preparedness training for all of the managed care requirements, including the criteria. The State charges the counties with conducting training for MCOs on the criteria and guidelines. However, State-level stakeholders also pointed out that the State developed the criteria through a very open process and that MCOs were familiar with the criteria even before the Request for Proposals process to select MCOs. Also, Appendix T incorporates principles and a philosophy that were part of the system even prior to managed care. State-level stakeholders reported that the mental health necessity criteria are "very much part of our culture" at this point.

The State conducts extensive monitoring of the managed care system in general. It utilizes independent reviewers to do annual reviews of the MCOs, including extensive chart reviews of all MCOs. They also interview case managers, look at cost and quality issues, cost trends, and management capacity. There are quality monitoring teams for each of the MCOs, who are themselves required to develop yearly quality management plans. In addition, one of the agreements the State made in response to a lawsuit involving children's services several years ago was to collect data on every child receiving Behavioral Health Rehabilitation Services, which include Therapeutic Support Staff, Mobile Therapy, and Behavioral Specialist Consultant. (Interestingly, State-level stakeholders believe that this requirement has led to a disproportionate emphasis on prescriber intentions—i.e., whether provider intentions are followed or not -- as a proxy for quality instead of looking at other quality criteria.)

Pennsylvania (**Group One:** State-Developed Guidelines)

- Guidelines for Mental Health Necessity Criteria ("Appendix T") and
- Guidelines for Best Practice in Child and Adolescent Mental Health Services

Experience To Date

As noted earlier, Appendix T Mental Health Necessity Criteria were intentionally crafted as broad criteria partly because of concerns in the State about managed care's tendency to implement narrow, restrictive criteria that would impede access and partly in response to strong advocacy and a history of litigation that argued for broad criteria. In the early stages of behavioral health managed care implementation, State-level stakeholders indicated that they were cautious, unsure of how managed care entities would try to control access; the State, at this early stage, required that every denial of a service, full or partial, had to come to the State for independent review. Two years ago, the State eliminated that requirement; however, denials are still reported, and the State conducts random reviews and monitors outliers. Indeed, as the State has developed experience with managed care and the Appendix T criteria, concerns have developed that the criteria are so broad that they end up being costly, in effect. However, efforts by managed care entities to tighten up the criteria have been resisted strongly by advocates. State-level stakeholders noted that providers tend to "err " on the side of maximum rather than minimum service thresholds, and Appendix T does not establish minimum thresholds; instead, the criteria encourage individualized care. Appendix T does not incorporate formal, quantitative assessment measures, although the State more recently has encouraged managed care entities to use standardized tools. Although the State is interested in seeing MCOs use standardized tools, it also remains very committed to an individualized approach to care, and State-level stakeholders expressed the concern that, in their experience, certain tools are not as appropriate with particular populations of children. For example, they feel that the CALOCUS (now CASII) is not appropriate to use with children who have autism, and that the CAFAS does not apply as well to young children.

State-level stakeholders reported that, after eight years of experience with Appendix T, managed care entities are doing a good job of applying the criteria as the State intended. There is some concern that in continuing stay reviews, there is too much emphasis on reauthorizing rather than good clinical care management and examination of how the child is actually doing in care. State-level stakeholders expressed concern that there is too much of a bias in the system to keep children in high levels of care if they are doing well, rather than to step them down and link them to supports. Similarly, they believe there is too great a tendency in the system to "increase the dose" of a particular service if a child is not doing well rather than considering the appropriateness of the service in the first place; they noted this as an issue particularly with therapeutic support staff (i.e., TSS workers, a type of behavioral aide)—a service in which the State has experienced rising costs for several years.

State-level stakeholders believe there remains a tendency in the system to "maintain" children in treatment settings, rather than to focus on the issue of recovery. They believe this is partly because the notion of recovery and resiliency for children is relatively new and because the culture among providers and families, also supported by lawsuits over the years, is biased toward maintenance. However, State-level stakeholders also reported that they are seeing greater development of family-based programs throughout the State, which incorporate the concept of recovery and resilience and can serve as a viable alternative to TSS workers.

Pennsylvania (**Group One:** State-Developed Guidelines)

- Guidelines for Mental Health Necessity Criteria ("Appendix T") and
- Guidelines for Best Practice in Child and Adolescent Mental Health Services

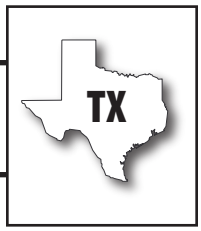
The Appendix T guidelines have not been updated to date. However, State-level stakeholders reported that, currently, there are two task forces, one focusing on behavioral health services for youth and the other focusing on services for children with autism, and that changes in the criteria may result from the work of these groups.

Major Benefits, Concerns and Lessons Learned

State-level stakeholders indicated that the major benefit of their mental health necessity criteria is that they have led to, in their view, the highest levels of access to services for children in the country. On the other hand, State-level stakeholders expressed concern as to whether they can sustain the level of growth in access that they have seen over the past eight years and also whether children are receiving the appropriate level of care and types of services and supports that they need. State-level stakeholders pointed out that 80% of the State's population is now covered by HealthChoices, and that children represent 60% of HealthChoices' costs. They also noted that the HealthChoices behavioral health managed care carve out covers populations such as children with autism whose numbers have grown considerably over the past few years and that HealthChoices also covers children and youth who meet the definition of disability under the Supplemental Security Income (SSI) program, regardless of family income. State-level stakeholders did note, however, that particularly among the more mature MCOs, they are seeing some leveling off of costs as the MCOs become more experienced in developing new home and community-based service types. Nonetheless, the State remains concerned over high costs associated with use of residential treatment.

Texas (**Group One:** State-Developed Guidelines)

- Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)



Overview

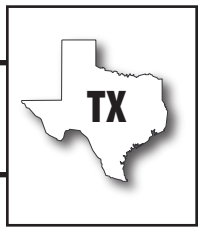
For many years, the Texas public mental health system used the Child Behavior Checklist (CBCL) and the Community Functioning and Problem Behavior Rating Scale to measure child outcomes and evaluate system performance, but not for clinical decision making. Presently, the public mental health system is in the midst of implementing a far-ranging new initiative, the Resiliency and Disease Management Initiative, the overall aim of which is to define a service package and financing methodology for community mental health services for both adults and children. The Initiative is intended to better define the following: who is eligible for community mental health services; what services will be provided; methods for managing utilization; consistency regarding the cost and pricing of services; and expected outcomes of services. As part of this Initiative, the State developed its own set of clinical decision making guidelines for required use by local mental health authorities and their providers. The guidelines for children are known as the Child and Adolescent Texas Recommended Assessment Guidelines, or CA-TRAG. The CA-TRAG is used by clinicians at Local Mental Health Authorities (LMHA) and by LMHA providers to assess service needs and to recommend a level of care for children and adolescents, ages 3-17, in the public mental health system. It yields quantitative scores that determine eligibility for services and level of care. The guidelines are fundamental to utilization management in the system. In addition, the CA-TRAG forms the basis of the mental health system's Child and Adolescent Evaluation Assessment, which is the instrument the State uses to assess system outcomes.

Goals

The State's User Manual for the CA-TRAG describes the goals of the CA-TRAG as two-fold: "first, to develop a systematic assessment process for measuring mental health service needs among children and adolescents based on their principal diagnosis and ten domains; and, second… to propose a methodology for quantifying the assessment of service needs to allow reliable recommendations for authorization into the various levels of care with specified types and amounts of services."[30] The manual notes that the CA-TRAG was developed in response to concerns expressed both by clinicians and system administrators about the need for a common framework across the State for making decisions on level of care placement and outcomes related to the treatment of children and adolescents in the public mental health system. In addition, the manual describes a history in children's mental health of: "inequities in care" and "great variability in the types and amounts of services provided to children and adolescents that cannot be explained by differences in specific needs for care (e.g., diagnosis, intensity of symptoms, level of functioning)." [31] It notes that, "in a system constrained by limited resources, it is critically important to distribute treatments and services in accordance with identified needs

30 State of Texas, Department of State Health Services (November, 2005).User's manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf>.

31 Ibid.



and appropriateness of the service modality."[32] The State's goals in developing the CA-TRAG had both to do with consistency and equity in service provision and a desire to move the system toward evidence-based, best practice service delivery consistent with principles of resiliency, disease management, and recovery.

Background

Before making the decision to develop its own set of guidelines, the State looked at numerous existing guidelines, including some developed by clinical researchers, some developed by managed care companies, and some developed by other states. These were rejected for a variety of reasons. With over 40,000 children and adolescents involved in the public mental health system, the State wanted to promulgate use of guidelines that would be relatively easy for many providers to use, and, based on its experience with using the CBCL, the State reportedly was not particularly interested in using another proprietary instrument or in having providers use multiple instruments. For example, the State found that several other states use proprietary instruments, such as the Child and Adolescent Functional Assessment Scale (CAFAS), for subsets of children, but Texas was interested in using only one instrument for all children. In addition, philosophically, some State stakeholders felt that models developed with public funds should be in the public domain and that states should not have to use limited dollars to purchase them. As another example, the State decided not to use the CALOCUS (now CASII) because, according to Texas stakeholders, it encompassed levels of care that Texas did not have and thus would need adaptation. Other instruments were rejected as too costly to train clinicians in their use, too complicated or long for clinicians to use, or not sufficiently attentive to the needs of children and adolescents or to issues of poverty or to co-occurring disorders in children.

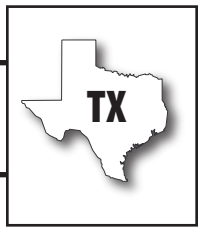
The State developed a set of principles to guide development of its own clinical guidelines. These principles included:

- The instrument should be easy to understand and use by clinicians
- The domains assessed should be quantifiable and should promote consistent clinical judgment
- Level of care or service package descriptions should be brief and clear to ensure uniformity and efficiency
- Level of care recommendations should be made appropriately to ensure correct responses to the needs of children and adolescents.[33]

32 Ibid.
33 Ibid.

Texas (**Group One:** State-Developed Guidelines)

- Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)



The process the State used to develop the CA-TRAG included holding a Consensus Conference with national experts and Texas stakeholders, including family members, review of the literature and state of the science, and a small workgroup that included representatives from the State, the local mental health authorities, and family members.[34]
In addition to the principles and goals noted earlier, the workgroup reportedly was guided by the very real concern of using extremely limited dollars wisely. State-level stakeholders thus wanted to ensure that the clinical decision making process would encourage provision of services shown to be effective in the literature. State-level stakeholders believe that the CA-TRAG does allow for an individualized approach to care but within parameters that promote certain proven treatment approaches. Some family members, however, have expressed concern that, by choosing specific treatment models, the CA-TRAG moves away from an individualized, wraparound approach to service planning.

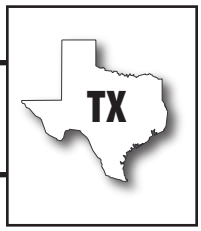
The State developed an initial version of the CA-TRAG, which it tested for reliability and validity in the summer of 2003, and then issued a second version in the fall of 2003. The State began implementation in four pilot sites but went statewide with implementation in the fall of 2004 in accordance with Texas House Bill 2292. The State Medicaid Plan was changed in order to encompass the service packages described in the CA-TRAG.

State-level stakeholders reported that as they began implementation with the first four pilot sites, they did meet initial resistance, particularly from licensed clinicians, and that certain decisions made with respect to evidence-based practices were controversial. For example, the State's review of effective practices indicated mixed evidence of efficacy for day treatment and so, ultimately, it was not included within Resiliency and Disease Management levels of care, creating concerns among day treatment providers. On the other hand, families reportedly were more supportive of dropping day treatment as they preferred having their children remain in regular classroom settings with appropriate supports and were sensitive to the expense of day treatment within the context of resource limitations. As another example, cognitive behavioral therapy, an evidence-based practice, is not practiced by all licensed clinicians and thus requires a change in practice not necessarily easy or possible for all clinicians to make. Family preservation programs, around which evidence was mixed, are not included in CA-TRAG while Multisystemic Therapy (MST), is. On the other hand, stakeholders noted that for some providers, for example BA-level staff that can provide skills training, the guidelines and manualized approach of CA-TRAG create greater confidence and consistency for service delivery.

Description

The CA-TRAG includes diagnostic categories and ten domains for assessment purposes. Diagnosis is organized under three large categories: Externalizing Disorders; Internalizing Disorders; and Bipolar, Schizophrenia, Major Depressive Disorder with Psychosis and Other Psychotic Disorders. Diagnosis is considered one key factor for determining the level and type of service that may be needed, and each level of care includes diagnosis-specific interventions

34 Papers from the Consensus Conference are available on the Texas website: www.dshs..state.tx.us/mhprograms/RDM.shtm



documented in the literature. For example, cognitive behavioral therapy is a recommended treatment associated with diagnoses under the Internalizing Disorders category. The User Manual acknowledges that sometimes children have multiple diagnoses or do not fit clearly into any one major category. The manual provides guidance that, in those instances, three factors should be considered: (1) what problem is causing the most impairment; (2) what issue is the most amenable to treatment; and (3) what services do the child or family see as being most beneficial.[35]

In addition to diagnostic category, the CA-TRAG requires assessment across ten domains, which are associated with intensity of services needed. The ten domains include:

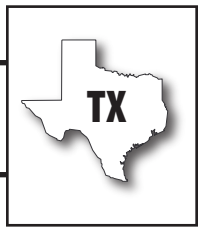
1. Ohio Youth Problem Severity Scale (OYPSS; Ogles et. al., 1999)
2. Ohio Youth Functioning Scale (OYFS; Ogles et. al., 1999)
3. Risk of Self-Harm
4. Severe Disruptive or Aggressive Behavior
5. Family Resources
6. History of Psychiatric Treatment
7. Co-Occurring Substance Use
8. Juvenile Justice Involvement
9. School Behavior
10. Psychoactive Medication Treatment.

Texas stakeholders noted that they incorporated the Ohio Scales in order to support family and youth input as the best source of information on problem severity and functioning. In most instances, multiple criteria are listed under each domain, although only one criterion is needed to assign a rating within a domain. For the most part, domains are rated on a scale of one (e.g., no notable limitations) to five (e.g., extreme limitations).[36]

The CA-TRAG is used as part of the clinical intake interview for children and adolescents involved in the public mental health system. The CA-TRAG score determines eligibility for services and determines assignment to one of four levels of care. It also is used for outcome measurement and must be completed at intake, every 90 days, and at termination of services. Finally, the CA-TRAG scores also are used for purposes of re-authorizing service provision. While the CA-TRAG may be administered by a case manager, the diagnosis (which is part of the level of care determination) must be made by a licensed professional. Clinicians are not allowed to use other instruments to make level of care recommendations, which essentially are approved through the public mental health system's utilization management process. For children who were already involved in the system prior to implementation of CA-TRAG, there

35 Ibid

36 State of Texas, Department of State Health Services (November, 2005).User's manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf> .



was a retroactive assessment process using the CA-TRAG. In addition, the old assessment system was "turned off," and CA-TRAG was fully automated such that the computer assigns level of care based on the clinician's data. Providers are not reimbursed for services if they fail to use the CA-TRAG for initial evaluations and 90-day re-evaluations (re-evaluations can occur at any time but no less than 90 days).

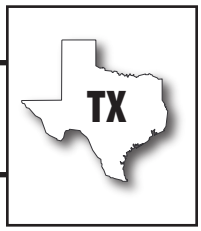
The four levels of care associated with the CA-TRAG include the following:

- **Crisis Services**
- **Level of Care 1**: Brief Outpatient
  - Service Package 1.1: Brief Outpatient (Externalizing Disorders)
  - Service Package 1.2: Brief Outpatient (Internalizing Disorders)
- **Level of Care 2**: Intensive Outpatient
  - Service Package 2.1: Intensive Outpatient (Externalizing Disorders—Multi-Systemic Therapy [MST])
  - Service Package 2.2: Intensive Outpatient (Externalizing Disorders)
  - Service Package 2.3: Intensive Outpatient (Internalizing Disorders)
  - Service Package 2.4: Intensive Outpatient (Bipolar Disorder, Schizophrenia, Major Depressive Disorder with Psychosis or other psychotic disorders)
- **Level of Care 3**: Treatment Foster Care
- **Level of Care 4**: After Care, which essentially is medication maintenance and case coordination.

Each level of care describes particular packages of services. The User's Manual encourages clinicians to recommend the level of care that is most effective while also the least restrictive.[37] The packages of services associated with each level of care include:

- **Crisis Services**: 24-hour triage; crisis assessment; case coordination; physician services; inpatient hospitalization, crisis respite (if available); and 23-hour observation.
- Brief Outpatient (**Level 1**) (Externalizing Disorders): psychosocial skill development; parenting skills; behavior management skills; support group; may also include medication management. This service package is considered to be relatively short-term, usually terminated within 90 days, for youth who do not have serious emotional disorders.
- Brief Outpatient (**Level 1**) (Internalizing Disorders): cognitive behavioral therapy; case coordination; family support, parent education. This service package is considered to be relatively short-term, usually terminated within 90 days, for youth who do not have serious emotional disorders.
- Intensive Outpatient (**Level 2**): This service package essentially includes four service clusters: For youth with externalizing behaviors: (a) Multi-systemic Therapy (MST), which

37 Again, readers are encouraged to read the User's Manual for a full description of the levels of care associated with the CA-TRAG.



the mental health system is funding in partnership with the juvenile justice system, at present funding four teams in the Fort Worth area; (b) in areas without MST, intensive case management, skill-building, family peer mentors, wraparound service planning with some flexible support dollars. For youth with internalizing disorders: (c) cognitive behavioral therapy plus intensive case management, family peer support, wraparound service planning with flexible support dollars. For youth with Bipolar Disorders, Schizophrenia, Major Depressive Disorder with Psychosis or other psychotic disorders: medication management and stabilization, cognitive behavioral therapy, skill training, intensive case management, family peer mentors, wraparound service planning with flexible support dollars.

- Treatment Foster Care (**Level 3**): This level of care is available to children and adolescents at imminent risk of residential treatment due to severe aggressive or disruptive behavior. State-level stakeholders noted that, originally, they intended to use the Oregon Social Learning Model of Multidimensional Treatment Foster Care but were deterred by the cost and noted that they are still wrestling with how to build in sufficient training and supervision that is affordable.
- Aftercare (**Level 4**): Intended for children who have stabilized, includes medication maintenance and case coordination.

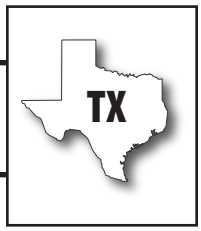
Individualized, Culturally Competent Family-Focus

One national expert reportedly advised the State during planning that particularly because of its severe resource limitations, the State should consider trying to have a "trans-generational impact" and reduce long term dependency on the system by incorporating strong supports for children, parents, grandparents, and extended family networks, and build child and family resiliency. In terms of CA-TRAG, all parents have access to family support groups, regardless of level of care, and all services can be provided out of the office (e.g., in home, at school etc.). In addition, all local mental health authorities are required by the State to employ or contract with family partners, and the State provides funding to the statewide family organization. The State is trying to support creation of family-run chapters in every locality but acknowledges this as a difficult effort, and has not yet been able to change Medicaid to support coverage of family peer mentors. As noted earlier, while State-level stakeholders believe that the CA-TRAG has sufficient flexibility to support an individualized approach to care, some family members argue that, by definition, level of care criteria create a certain rigidity around service decision-making.

The Ohio Youth Scales, an instrument that forms a part of the CA-TRAG, has been translated into Spanish. As discussed more fully below, State-level stakeholders expressed concerns that translation issues with some of the instruments—how they translate from English to Spanish—may be affecting accurate assessment of functional impairment issues among Hispanic children.

Texas (**Group One:** State-Developed Guidelines)

- Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)



Impact of Service Availability

State-level stakeholders noted that service capacity is basically unchanged since implementation of the CA-TRAG and is limited. There is recognition that children and adolescents who are assessed using the CA-TRAG may be recommended for service packages that are not available. State-level stakeholders noted that they expect to find, over time, that the CA-TRAG is assessing for higher levels of care than are available. That is a major reason why the State's evaluation is documenting outcomes with respect to children who do receive recommended levels of care as compared to those who do not.

The User Manual, for example, discusses the possibility of "clinical over-ride" of CA-TRAG as primarily driven by resource limitations and suggests that clinicians indicate the appropriate CA-TRAG level of care recommendation even if they know the services are not available. The manual notes that "only then will it be possible to understand the real needs of children and adolescents as part of the evaluation…"[38] State-level stakeholders indicated their intention to use data from CA-TRAG to promote changes in the service array with the State legislature and executive budget staff. In the meantime, they believe CA-TRAG is being used to drive practice change.

Training, Fidelity, and Oversight

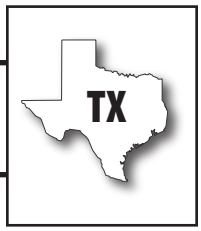
The State conducts its own one-day training on the CA-TRAG instrument and has contracted for training in some of the key effective practices encouraged by the CA-TRAG, including cognitive behavioral therapy, intensive case management, and a wraparound approach to service planning. The State has adopted a "train-the-trainers" approach in order to extend the reach of limited training resources and indicated that it has taken a lot of time to train providers.

The State has developed written fidelity measures for each level of care within the CA-TRAG, and has put in place performance contracts with all of its local mental health authorities. These contracts mandate the use of CA-TRAG and utilization of training that is available, in addition to program measures, such as that 85% of the Ohio Scales have to be reported by parents and a certain number of hours of skills training has to be provided.

The Resiliency and Disease Management Initiative, of which the CA-TRAG is a part, incorporates a major evaluation component, which includes three elements:

- **Fidelity Toolkit and Quality Management**—includes both State oversight, using a small, internal research and evaluation staff working with program staff, who, in turn, are supported by the data warehouse Texas has created, and self-evaluation and reporting by the local mental health authorities
- **Individual Outcome Monitoring**—tracked by providers

38 State of Texas, Department of State Health Services (November, 2005).User's manual for the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG), Version 3.0. Available http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf <http://www.dshs.state.tx.us/mhprograms/UsersManualCATRAG_1105_V3.0.pdf> .



- **Resiliency and Disease Management Examiner**—reports semi-annually on overall system-wide progress, using aggregated individual data.

There are specific evaluation criteria for both adult and child and adolescent service provision to assess system outcome objectives. The Children's Criteria include: access; time between authorization and first encounter; appropriateness of service; adherence to clinical guidelines; juvenile justice involvement; functioning; problem severity; school behavior; family re-unification; Medicaid enrollment status; and, youth/parental perception of services.[39]

In its first six-month evaluation report on the four pilot sites, the State described the following promising results: high access to services following assessment; high percentage of children who were appropriately served (i.e., percentage where authorized levels of care matched recommended levels of care, compared to children who were either under-served or over-served, that is, level of care authorizations did not match level of care recommendations); more children who were appropriately served rather than under-served experienced improvement in functioning, problem severity, and school behavior. The report also noted two areas of concern: too big a time gap between authorization for service and commencement of services; and, a need for greater adherence and fidelity to the clinical guidelines to achieve recommended average monthly hours of service.[40]

Experience To Date

One hundred percent of local mental health authority clinicians and providers in the pilot sites reportedly are using CA-TRAG. In addition to the first six-month evaluation results described above, State-level stakeholders shared a number of observations based on their experience to date…

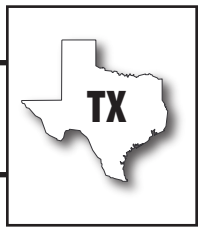
- Stakeholders have noted some problems with use of the Ohio Scales in representing accurately levels of functional impairment among Hispanic children and adolescents. The State is finding that Hispanic families may be under-reporting the level of functional impairment in such areas as school behavior, due apparently to the way that the Ohio Scales translate into Spanish. State-level stakeholders noted that they experienced similar problems with the CBCL in the past.
- Stakeholders also are finding that the Ohio Scales may lack sufficient sophistication to pick up internalizing disorders and may under-represent the severity of these disorders
- State representatives are hearing anecdotal reports that they may have to create a different range to better distinguish between Levels 1 and 2 of the CA-TRAG. Currently, Level 2 includes a wraparound approach and case management, but use of the Ohio Scales is suggesting that Level 2 does not always indicate a need for wraparound and case management.
- Some of the other child-serving systems, juvenile justice for example, are critical because they want more intensive services covered.

39 A full description of these criteria can be found on the above cited website.

40 A complete summary of the evaluation report can be found on the Texas website.

Texas (**Group One:** State-Developed Guidelines)

- Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)



State-level stakeholders view the CA-TRAG as inevitably a work in progress given the evolving nature of efficacy studies of children's mental health practice. They indicated that changes will be made over time just as they are being made in the adult guidelines, which is in its third iteration. Texas has set aside dollars from its mental health block grant to support additional Consensus Conferences to identify new practices that should be incorporated into the CA-TRAG. What State-level stakeholders do not see changing, however, is the State's focus on holding clinicians to a set of guidelines that supports effective practice.

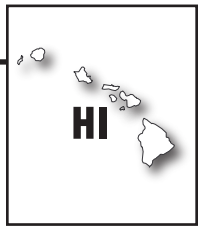
Major Benefits, Concerns and Lessons Learned

State-level stakeholders believe that a major benefit of the CA-TRAG is that it provides a uniform, objective instrument that can serve multiple purposes (i.e., assessment, service authorization and re-authorization, outcomes monitoring) and that it encompasses a family/youth perspective by incorporating the Ohio Scales. They do not view the CA-TRAG as a "Cadillac," but one that still accomplishes key system goals. They believe that the CA-TRAG creates consistency in clinicians' approaches to evaluating children and adolescents and a "standard of care," and ensures that re-evaluations will occur so that children are not "stuck" in inappropriate or too restrictive settings. Also, these stakeholders feel that the instrument ensures that the State has data on children in care and supports the State's outcomes monitoring efforts.

State-level stakeholders consider the CA-TRAG as a first step in an evolving process. They have concerns over the cultural sensitivity of the instrument with respect to the Spanish version in particular. Some clinicians and some families have been critical that the CA-TRAG is too prescriptive, but the State argues that, with limited resources, the State should be linking resources to evidence-based and best practices. In addition, State-level stakeholders believe that the CA-TRAG does lend itself to an individualized approach to service planning and delivery far more than some of its critics understand. State-level stakeholders noted, for example, that the CA-TRAG is not based just on a numerical value, that wraparound flexible dollars are incorporated into the levels of care (though the dollars are limited), and that clinicians can exercise "clinical override." However, they also have concerns that, whenever guidelines are used, clinicians may have a tendency to use them too rigidly, and that there is an inherent tension in their system between a desire for clinical flexibility and a need to manage scarce dollars. One of the major pieces of advice that the State-level stakeholders offered to other states is to build protections and training into the clinical guidelines process as they have done and continue to try to strengthen in the Texas system.

State and Local Descriptions (continued)

II. Sample Sites Using Existing Standardized Protocols (Including Proprietary and Open Domain)



Hawaii (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)
- Child and Adolescent Service Intensity Instrument (CASII)
- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)

Overview

Hawaii provides an extensive and well-documented example of statewide reform in the delivery of children's public mental health services. The health system infrastructure for Hawaii includes the State Department of Health (DOH), which oversees three separate administrations: Behavioral Health Services, Health Resources, and Environmental Health. The Behavioral Health Services Administration holds the statutory responsibility to provide "preventive, diagnostic, treatment and rehabilitative services for emotionally disturbed and mentally ill children and youth,"[41] which it dispenses via its Child and Adolescent Mental Health Division (CAMHD). The Behavioral Health Services Administration also includes the Adult Mental Health Division and the Alcohol and Drug Abuse Division, while the Developmental Disabilities Division resides separately within the Health Resources Administration. The Child and Adolescent Mental Health Division is well acquainted with the CASSP[42] principles, having been the recipient of multi-year, federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding. In redesigning the behavioral health care delivery system for children and youth in Hawaii, policy makers integrated the concepts underlying CASSP into their official philosophy. The impetus to redesign the delivery system was generated by several factors, which created a force for change, including: increased population, demographic shifts, and a consent decree related to the Individuals with Disabilities Education Act (IDEA), relating specifically to behavioral health services for children in special education.

Hawaii's child and adolescent mental health system has grown in capacity in the last ten years so that it now serves over one thousand children and youth with emotional and behavioral challenges. Accommodation to this need for service system growth has been greatly facilitated by collaboration between the Child and Adolescent Mental Health Division and the Department of Education, including statewide implementation of School-Based Behavioral Health (SBBH) programs, and partnership with the statewide family organization, Hawaii Families As Allies.

41 Hawaii Revised Statues, §321-171

42 Stroul, B. A. & Friedman, R. M. (1994, rev. ed.). A system of care for children and youth with severe emotional disturbances. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

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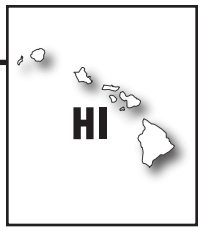

Goals

The CAMHD and its provider agencies, including satellite clinics, have identified five distinct goals regarding Hawaii's children and youth and their families:

(1) CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives and achieved outcomes.

(2) CAMHD and its providers will consistently adhere to the Hawaii Child and Adolescent Service System Program Principles[43]

(3) CAMHD and its service providers will consistently apply the current knowledge of evidence based services (EBS) in the development of individualized plans. The design of the mental health system will facilitate the application of these services.

(4) CAMHD and its provider agencies will routinely evaluate performance data and apply the findings to guide management decisions and practice development.

(5) The business principles implemented throughout CAMHD and its provider agencies will insure high quality and accountable operations.[44]

An evidence-based task force was convened in 1999 and "practice guidelines" were issued with quarterly updates and a biennial comprehensive review. Gradually, these guidelines have begun to shape practice within the CAMHD network of providers; one of the evidence-based practices, Multi-Systemic Therapy (MST), is now a major initiative with manualized training provided to several contracted providers. Intensive case management or "mental health care coordination," which has been found effective in assuring the provision of needed mental health services, is available to families within the family guidance centers.

The current initiative by CAMHD uses formal instruments and clinical guidelines to ensure that every child who meets criteria for more intensive services is fully assessed and appropriate treatment selected[45]. Youth with intensive services needs also continue to be identified in public schools under the Individuals with Disabilities in Education Act (IDEA)[46] and the juvenile courts. Hawaii utilizes the Child and Adolescent Functional Assessment Scale (CAFAS) to determine eligibility for intensive services provided by CAMHD and its satellite clinics. The threshold for

43 Hawaii Task Force (1993). State of Hawaii Child and Adolescent Service System Program (CASSP) Principles. Available http://www.hawaii.gov/health/mental-health/camhd/library/pdf/cassp.pdf.

44 State of Hawaii State Department of Health [Website]. http://www.hawaii.gov/health/mental-health/camhd/

45 Daleiden, E. L. (2003). Child Status Measurement: Operating Characteristics of the CALOCUS and CAFAS For the Period of July 1, 2000 to June 30, 2003; Version 2-24-04. Hawaii: Department of Health, Child and Adolescent Mental Health Division. Available http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/mr/mr001.pdf <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/mr/mr001.pdf>

46 The Individuals with Disabilities Education Act (IDEA), Public Law 94-142 (formerly Education of All Handicapped Children Act). For an overview of the Act, see Apling, R. & Jones, N. L. The Individuals with Disabilities Education Act (IDEA): Overview of major provisions (CRS Report for Congress, RS20366). Washington, DC: Congressional Research Service. Available http://usinfo.state.gov/usa/infousa/educ/files/ideaover.pdf <http://usinfo.state.gov/usa/infousa/educ/files/ideaover.pdf>.

Hawaii (**Group Two:** Existing Standardized Protocols)

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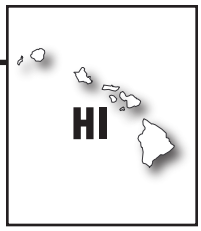


intensive services for youth under Hawaii's managed Medicaid program is a score of > 80 on the CAFAS[47] and a DSM-IV qualifying diagnosis. Such youth become eligible for intensive services, called the Support for Emotional and Behavioral Development program (SEBD)[48]and are served as part of CAMHD's behavioral health plan under Medicaid. The clinical instruments used in the Hawaii system—CAFAS, CALOCUS (now CASII),[49] and Achenbach[50] profiles—are used concurrently both for evaluation purposes and to support appropriate decision making, but they are not used in isolation. All scores are combined with clinical judgment by the array of trained staff at the family guidance centers so that levels of care are reviewed in an individual context.

Background

Hawaii's children and families benefited significantly from a federal Reduction of Seclusion and Restraint grant, which provided resources for supporting delivery system change. Formal functional measures, such as the CAFAS and the Achenbach System of Evidence-Based Assessment (ASEBA), including the parent and school CBCL reports and the YSR, had been used for several years within CAMHD. In 2000, the CALOCUS (now known as the CASII) was also added. These three main instruments are tracked and reported quarterly, then summarized annually in the CAMHD Annual Report. Standardized use of the measures is a major component of the accountability systems of CAMHD. The effectiveness of schools and Family Guidance Centers is also monitored by a sampling of intensive case reviews annually (formerly referred to as "service testing"), looking for qualitative information to add to the quantitative data generated by use of the clinical instruments. Additional measures are used with some of the subgroups within the child and adolescent population, such as juvenile sex offenders. As the result of the judicial consent decree, CAMHD was able to combine efforts with the Hawaii educational authority to respond to the emotional and mental health needs aspects of the requirements of the IDEA. This double authority created a new environment within which significant changes could be made in the overall way that agencies related to each other and the process of clinical decision making. The state of Hawaii has mandated a goal for all child treatment to be related to the use of the selected clinical guidelines, recognizing that this is difficult to enforce. These guidelines and standards are known as the Interagency Performance Standards and Practices Guidelines (IPSPG); components are updated regularly and a major revision occurs when new contracts are issued. Staff members from the Department of Health

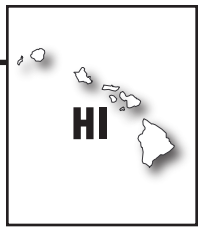
47 Hodges, K. (1998) Child and Adolescent Functional Assessment Scale (CAFAS). Ann Arbor, MI: Functional Assessment Systems

48 Readers are encouraged…criteria. See State of Hawaii, Child and Adolescent Mental Health Division (6 July 2005). Support for emotional and behavioral development (SEBD) referral process. Available http://www.hawaii.gov/health/mental-health/camhd/library/pdf/sebd/a7393.pdf <http://www.hawaii.gov/health/mental-health/camhd/library/pdf/sebd/a7393.pdf> .

49 American Academy of Child & Adolescent Psychiatry (s.d.). CASII: Child and Adolescent Service Intensity Instrument. Available http://www.aacap.org/clinical/CASII/index.htm <http://www.aacap.org/clinical/CASII/index.htm>

50 Achenbach, T.M. (1991). Integrative Guide for the 1991 CBCL/4-18. YSR, and TRF profiles. Burlington, VT: University of Vermont, Department of Psychiatry.

Hawaii (**Group Two:** Existing Standardized Protocols)



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collaborate with Department of Education staff to update the performance standards, along with family organizations, providers, university faculty, and state policy makers. All clinical staff in delivery sites have been trained in administration of the CAFAS, the CALOCUS (CASII) and the CBCL and YSR. Some of the data elements may be collected by phone interview. The scores for each child are put together with clinical information to create a mental health treatment plan and a coordinated service plan.

Description

Selection of which instruments to use was initially based on expert technical assistance from SAMHSA, the federal court monitor, and the University of South Florida Research and Training Center for Children's Mental Health. Leadership by the state child mental health director and the medical director within CAMHD helped move the assessment model adoption process. In trying to "help the most people" within the overall population, the state's systematic plan involving functional measures at six month intervals and clinical guidelines to identify and treat high-need youth has two purposes: (1) to track individual clinical status and contribute to level of care determinations, (2) to monitor overall system performance. There are three ways to be identified as high-risk and enter the system; one is via the school, with mental health services that are mandated by the child's 504 plan or IDEA plan. Another way is to have treatment mandated by the judge in juvenile court, and the third is via mental health SEBD eligibility, based on a CAFAS score of > 80. A child with a CAFAS score of 60 or above can be considered "provisionally qualified" for SEBD and be eligible for services but must be reviewed at six month intervals rather than annually.

Individualized, Culturally Competent Family Focus

Hawaii, which has an "amalgam" culture of diverse heritages, has been committed to implementing the assessment model with maximum congruence to the CASSP principles. As a result, a range of interpreters and multi-cultural, multi-lingual staff have been involved in the process. Family members have participated in local committees and management teams, as well as in planning, policy-making and performance measurement activities. Families and other stakeholders (schools, child welfare,, mental health, developmental disabilities, juvenile justice) share decision-making at the level of the individual child. The CAMHD attempts to maintain fidelity to family-focused care. Once a child is determined to be eligible for services, assessment tools are used only to inform clinical judgment, and final care delivery decisions are made in the treatment team, on which families and youth are key members.

Impact of Service Availability

Use of the guidelines themselves is not seen as impacting access, but the new assessment model is co-managed and, therefore, hospital and clinic staff, i.e., mental health care coordinators collaborating with intensive case managers, are required to be responsive to each other and do whatever is necessary to move the child to the appropriate level-of-care in a timely

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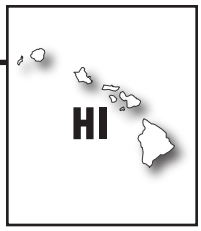

fashion. If services are not available, the care coordinator can go outside the network (through the use of flexible funds), or a child can remain where he/she is, with bridge/supplemental services added to bring the level-of-care as close as possible to the one for which they are waiting. The active partnership of school personnel in the shared goal of keeping children in the community has aided the ability of the system to individualize services.

Training, Fidelity and Oversight

Interagency Performance Standards and Practice Guidelines (IPSPG) were created by the Department of Education and the Department of Mental Health together, and the state is bound to uphold these standards, which are posted publicly on their website. Guidelines are updated, based on a best-practice system in place, which reviews current research and reports changes. Training takes place in three ways:

- Face-to-face, practice development meetings with “stand-up” trainings
- “Mentoring” of selected agencies as needed (“focused consultation/training”) on request
- CME credit and/or supervision credits for the individual who completes training

Practitioners, mostly located within satellite public clinics, are re-qualified annually based on refresher courses in measurement tool administration. External contracts with provider agencies also require use of the measures, which is outlined in the IPSPG manual or “green book.

The CAMHD Central Office monitors compliance with guideline adherence, and each clinic has a quality assurance specialist and a fiscal specialist who report relevant data to track clinic participation in the process. Care Coordinators report to supervisors who oversee timeliness of completion of necessary measures at required intervals. Achenbach measures (CBCL, YSR and TRF) are most challenging to gather due to responsibility lying outside of CAMHD administration. The CBCL is to be done by parents, YSR is completed by the youth, and the TRF is designed for teachers. The CAFAS and CALOCUS (CASII) can be completed by the “active clinician” for each case and do not require added face-to-face contact with the family or child.

Experience to Date

Because Hawaii is a small state, it has been able to access key players relatively easily. This has also meant that working relationships have been created among top and mid-level managers. CAMHD leaders stress that it is necessary to have substantial public, professional (across all mental health disciplines) and consumer buy-in in order to implement major changes such as these in a state system. Hawaii found it helpful to gather interest groups and diverse stakeholders at the beginning in order to devise a collaborative strategic design. The parent organization, “Families as Allies,” helped at every level of planning and implementation. Unlike many system of care settings, Hawaii reports that of all the professional interfaces, collaboration with schools has run the most smoothly. They credit the now ten-year relationship of shared

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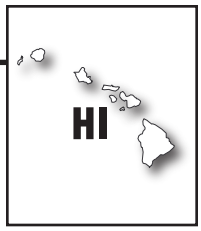


ownership at the service level for facilitating the level of school participation and support. Individual school personnel seeking to have children placed out of the community have learned that collaboration with mental health staff can work well to maintain challenged students in their local schools.

As early results are being analyzed, it appears that better outcomes are being reported, with increased rates of high-school graduation and decreased juvenile justice involvement compared to 1999, as well as decreased consumer complaints. Mental health costs, while not the primary focus, have also decreased since the introduction of system guidelines for service selection, although community-based vendors have begun to ask for increased rates to handle their new, more complex caseloads. With the SEBD population included in the CAMHD system of care, the federal match contribution through various programs of state Medicaid has increased significantly.

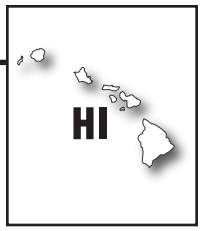
Collaboration with the University of Hawaii medical school has led to resident rotations in the family clinics. The residents gain experience in administration and see the value of evaluation instruments and guidelines for level of care, which has helped disseminate the goals and the skills necessary for integration of these concepts into future practice. The eight child psychiatrists employed by CAMHD are all clinical faculty of the medical school Department of Psychiatry; most supervise residents, some conduct seminars and lectures in specialized community psychiatry topics, and others conduct research with resident involvement. Social Work and Psychology trainees from the University of Hawaii also benefit from opportunities for internships and practicum experiences as well as the chance to participate in clinical research. CAMHD participation in the provision of graduate mental health training supports the development and sustainability of a mental health workforce trained in the CASSP principles.

Major Benefits, Concerns and Lessons Learned

Challenges related to implementation of statewide clinical guidelines include financial and personnel investment for initial training and ongoing education and the need for increased written production by staff, as documentation is required to support reliable use. Notable strengths of the instruments selected are: CAFAS and Achenbach tools support assessment and long-term planning, with trends observed over time. CALOCUS (or CASII) provides minute to minute acuity monitoring and also takes clinicians out of the conventional “step-wise” movement in level of care selection, instead using intensity of need to guide treatment decisions. Major benefits are the improved quality of mental health services to the state’s children and families, as well as an increased evidence-base that is now contributing to clinical treatment decisions.

The greater evidence base underlying decision-making has been supported by the highly structured accountability throughout the system. This comprehensive accountability has led to a resulting increase in available data for analysis. The Child and Adolescent Mental Health Division reports that the average entry level CAFAS score is 120, with the average exit score

Hawaii (**Group Two:** Existing Standardized Protocols)



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around 70. Utilization of out-of-state placements has dropped significantly from 80 youth to less than 10. Similar decreases are noted in residential hospitalization rates and length of treatment in community residential programs. Despite these gains, the CAMHD remains concerned about the numbers of youth for whom out-of-home treatment, particularly at the community-based residential level of care, is recommended by treatment teams. The greater level of information now captured regarding these youth, as well as the greater availability of community based interventions, will help in the pursuit of ongoing improvements aimed at minimizing the need for residential care.

Michigan (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)

Overview

Michigan's child behavioral health system encompasses Health Maintenance Organizations (HMOs) that manage an acute care benefit (equivalent to 20 outpatient visits) and Community Mental Health Centers (CMHCs) that operate as Local Management Entities (LMEs) responsible for managing more intensive, extended care (e.g., Rehabilitation Services Option under Medicaid). The State requires the LMEs to use the Child and Adolescent Functional Assessment Scale (CAFAS) for determining eligibility for certain services, specifically, home-based services, including in-home services, therapeutic case management, and crisis services. In addition, the State uses the CAFAS data generated by the LMEs to monitor treatment outcomes across the LMEs and to strengthen the knowledge base regarding fit between various treatment approaches and different populations of children served. Some of the LMEs use the CAFAS for ongoing treatment monitoring at the program level to inform continuous quality improvement efforts both at the individual child/family level as well as across the total child population served. The HMOs utilize their own clinical decision-making criteria, although there is interest in the State in using the CAFAS to help manage the boundary between the HMOs and the LMEs. The CAFAS score thresholds and parameters for home-based services and therapeutic case management are incorporated into the State Medicaid manual.

The State does not use the CAFAS for initial entry into the system but only for eligibility for certain types of services. State-level stakeholders noted that use of the CAFAS is needed at the front end, but also expressed concern that if the system is under-funded, use of a tool like CAFAS can lead to rationing care and restricting access to any type of service. At present, State-level stakeholders do not feel that use of the CAFAS is restricting access, and they pointed out that improvement in the CAFAS score does not mean that a child loses his/her eligibility for services. They stressed that, while the CAFAS is a quantitatively-based assessment tool, Michigan's use of the CAFAS emphasizes the importance of considering the entire profile created by the assessment and not simply a total score.

Goals

State-level stakeholders indicated that use of the CAFAS is intended to support a more uniform approach to service delivery across the State and to help ensure that children receive the appropriate amount and type of service. The State also is interested in having the LMEs use the CAFAS as a tool for ongoing treatment outcome monitoring to improve quality of care and to be able to compare performance across LMEs in the State. The State itself uses the CAFAS data to monitor treatment outcomes system-wide, to learn about effectiveness with different types of children, and to assist the LMEs in assessing their performance. In addition, use of the CAFAS is intended as a tool to ensure appropriate access to (and discourage inappropriate use of) a bundled package of what are fairly expensive services (i.e., home-based services).

Michigan (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)

Background

Michigan began statewide use of the CAFAS with the implementation of managed care in 1998. State-level stakeholders indicated that they started fairly simply and have made modifications over time. For example, they added a caregiver scale to strengthen family input into the clinical decision-making process. Initially, use of the CAFAS was intended to strengthen monitoring at the system level, a requirement of the new managed care system. Use of the CAFAS has evolved to encompass treatment outcome monitoring and program evaluation, as well as to support treatment planning at the individual child/family level.

State-level stakeholders reported that, currently, about half of the 48 LMEs (i.e., Community Mental Health Centers) in Michigan are using the CAFAS clinical decision-making/outcomes monitoring system as intended. These LMEs are participating in the State's Level of Functioning (LOF) project, in which the State has teamed with a university-based evaluator to monitor treatment outcomes. The LOF project provides monthly feedback to the participating LMEs regarding youth who are making poor progress in treatment. Additional reports are used to ensure record compliance, monitor at-risk youth, and assist in reviewing the adequacy of treatment plans. The project also generates outcome data for children with different types of presenting issues.

Description

The CAFAS is described by its developer[51] as follows:

> The **CAFAS**…assesses impairment in day-to-day functioning that is due to emotional, behavioral, psychiatric, psychological, or substance abuse problems. The CAFAS consists of a list of behavioral descriptions (e.g., expelled from school) grouped by levels of impairment (i.e., severe, moderate, mild, no impairment) within domains of functioning (subscales). The CAFAS subscales assess the youth's functioning in the following domains: School/Work, Home, Community (reflects on delinquent behavior), Behavior Toward Others, Moods/Emotions (reflects on depression and anxiety primarily), Self-Harmful Behavior, Substance Use, and Thinking (reflects on major thought problems or severe communication problems).
>
> The clinician reads through the items in a subscale (e.g., School), starting with the most severe level of impairment, until an item that has been true for the client during the rating period (e.g., last three months) is found. Each item is associated with an impairment level (e.g., expelled appears at the severe impairment level), with the impairment levels having numeric values that serve as subscale scores as follows: 30 = severe, 20 = moderate, 10 = mild, and 0 = no or minimal impairment. Although only one endorsed item is needed

51 The CAFAS was developed in 1989 by Dr. Kay Hodges, Professor of Psychology at Eastern Michigan University, who holds copyright ownership of the instrument.

> to determine a youth's level of impairment in each subscale, additional items can be selected for the purpose of identifying problems to be addressed. The scores for the eight subscales are summed to generate a total score for the youth, with a higher score indicating greater impairment…

In addition, there are two subscales for caregivers: Material Needs (i.e., the extent to which the caregivers can provide for the youth's material needs without the youth's development being impeded) and Family/Social Support (i.e., the extent to which the caregivers can meet the youth's needs for nurturance, guidance, and protection without exposing the youth to harm, violence, or excessive discord)…

Each CAFAS subscale also has an associated list of positive items that can be considered either a goal or a strength, depending on the youth. By choosing goals and strengths for each of the CAFAS subscales, the treatment steps to be taken to address each domain can be specified.[52]

As noted earlier, the State requires its LMEs to use the CAFAS to determine eligibility and continuing need for home-based services and for therapeutic case management. To access home-based services, for example, there are three scoring options: (1) a total CAFAS score of 80 or greater; (2) a CAFAS score of 20 or greater on two or more subscales; or (3) a CAFAS score of 20 or greater on one subscale and 20 or greater on the caregiver/resources subscale. LMEs are required by the State to use the CAFAS with all children served by the LMEs and to administer it at intake, at exit, and annually if the child remains in care a year or longer. LMEs participating in the Level of Functioning project described earlier also administer the CAFAS quarterly.

The system currently in place allows the State (and LMEs) to capture demographic data, risk factors, and services received across populations served. Thus, the State is able to identify, for example, statewide, or within a given LME catchment area, what percentage of the population served comes from single family households or exhibits poor school functioning, etc. It also captures data by eight different "client types," for example, children with conduct disorders, with thought disorders, with substance abuse problems, etc. so that system-wide or by LME, the system generates knowledge about outcomes by type of child served. This information can help to inform appropriateness of different service approaches for children presenting different types of issues. At a program evaluation level, the data generated by use of the CAFAS statewide can help to identify strengths or shortcomings of given LMEs with particular types of children. So, for example, one LME may be achieving improvements in CAFAS scores with children with conduct disorders but not having the same success with children with depression. As another example, an LME may show differences in improvements on CAFAS scores by racial or ethnic group. The data also can be aggregated to show, for example, types of children with poorer outcomes

52 Hodges, K. (2004). Using assessment in everyday practice for the benefit of families and practitioners. Professional Psychology Research and Practice, 35 (5), 449-456.

across the LMEs. These data have implications both for the State and for individual LMEs on training that may be needed and on introduction of evidence-based and effective practices for subgroups of children that are not responding well to current service interventions.

State-level stakeholders have written about the reasons underlying the State's selection of the CAFAS, which include:

- It is relevant to youth who present with a variety of problems
- It is useful in assessing impairment across life domains
- It is relatively simple and teachable
- It incorporates concrete examples for each level of the measure
- It allows for input from multiple informants
- It has sound psychometric properties
- It is useful to clinicians as well as state administrators
- It is not too labor intensive
- It facilitates communication between families and practitioners.[53]

Individualized, Culturally Competent Family Focus

State-level stakeholders believe that the way in which they intend the CAFAS to be used supports better, more individualized treatment planning and more family-focused care. They pointed out that the focus of the CAFAS on level of functioning across multiple domains, rather than presence of a diagnosis, leads to addressing the problems that parents view as most important and that are most frequently observed in school, among peers and at home. State-level stakeholders also noted that the caregiver subscales enable a focus on the important issue of caregiver stress, and that Michigan's use of the CAFAS includes a specific form related to "Parents' Goals for Their Child" to facilitate family voice in articulating parents' goals, priorities and what caregivers view as the strengths of their children. Stakeholders pointed out that parents tend to know the history of their children's CAFAS scores and become very goal-directed to see the scores reduced. State-level stakeholders also noted that because their use of the CAFAS captures demographic, racial and ethnic data, they are able to analyze systemically treatment outcome issues related to different racial and ethnic groups. State-level stakeholders noted that the key to use of the CAFAS is to embed it within an individualized approach to care that prevents rigidity.

53 Hodges, K. (2004). Using assessment in everyday practice for the benefit of families and practitioners. Professional Psychology Research and Practice, 35 (5), 449-456.

Michigan (**Group Two:** Existing Standardized Protocols)
- Child and Adolescent Functional Assessment Scale (CAFAS)

Impact of Service Availability

State-level stakeholders noted that lack of service availability also "informs triage," that is it influences treatment planning, even with use of a quantitative, manualized assessment tool like the CAFAS. They noted that even the LMEs that are most committed to use of the CAFAS within an individualized approach to care end up providing services that are "substitutes," for example, therapeutic case management, because of the shortage of other specified services, such as in-home services. State-level stakeholders also pointed out that, even with statewide use of the CAFAS, there are still too many children in basic outpatient treatment that should be receiving more intensive services if the services were available.

Training, Fidelity and Oversight

The State uses a "training of trainers" approach to conduct reliability training for the LMEs on use of the CAFAS. The training is conducted annually by the developer of the CAFAS, and LMEs are expected to continue to conduct reliability training over time. State-level stakeholders indicated that commitment and leadership at the LME level is critical to whether the CAFAS is used as intended to guide treatment planning and monitor treatment outcomes for continuous quality monitoring purposes.

The State and its evaluator also review CAFAS data on a regular basis and make revisions based on their review. State-level stakeholders indicated that use of the CAFAS data helps to ensure that decisions are data-driven, rather than derived from often competing opinions among providers and LMEs. They believe that the data-based decision-making that is facilitated by use of the CAFAS helps to break down resistance to change. State-level stakeholders also expressed a desire for more resources (staff and time) to be able to monitor the LMEs' use of the CAFAS more closely to analyze issues related to treatment consistency and cost of care.

Experience to Date

With the adoption of managed care in 1998, Michigan policy more clearly articulated that the LMEs would serve children with more serious disorders while the HMOs served those with less serious issues. State-level stakeholders indicated that use of the CAFAS allows the State and the LMEs to see which children they are serving and whether they are, in fact, children with serious disorders. The CAFAS data to date reportedly indicate that the LMEs are serving children with serious disorders. State-level stakeholders also noted that the CAFAS data allow other child-serving systems (e.g., child welfare and juvenile justice) to track services to children involved in those systems. Indeed, the children's mental health staff are trying to get the child welfare system to use the CAFAS within their own system and not only for children referred to the LMEs. State-level stakeholders do not believe that use of the CAFAS has impeded access to home-based services, but rather is serving to ensure appropriate use of these services.

As noted earlier, the State and its external evaluator have modified the CAFAS over time in response to LME feedback and CAFAS data reviews. For example, they have strengthened the caregiver subscales and modified the CAFAS scoring threshold requirements for eligibility for home-based services to give more weight to family risk factors.

Michigan (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Functional Assessment Scale (CAFAS)

The State's goal is to have 75% of the 48 LMEs in Michigan participating in full use of the CAFAS (i.e., for treatment outcome monitoring, treatment planning, program evaluation, as well as eligibility determination). State-level stakeholders indicated that they have taken steps to respond to LMEs concerns to try to improve use of the system. For example, in response to LME feedback about the need for data to support individual treatment planning, the reports generated by the university evaluator on a monthly basis (via the LOF Project) were modified to generate individual child/family level data (rather than only aggregate). The LOF project now produces clinical management reports and flags children whose CAFAS scores are not improving. State-level stakeholders noted that as the State and individual LMEs increasingly are able to utilize the CAFAS data to guide treatment planning and treatment outcome monitoring, there is increased interest among non-participating LMEs to become more engaged.

The State and its evaluator also have begun to utilize the CAFAS data to conduct cluster analyses of subgroups of children with different presenting issues to determine which seem to be improving with existing services (i.e., customary care) and which are not making comparable gains. The intention is that this type of analysis will lead to provision of targeted interventions known to be more effective for certain subgroups. For example, an analysis of CAFAS data on 4,777 children and youth served by the LMEs allowed evaluators and the State to describe and compare five clusters of children, their relative degree of impairment across the CAFAS subscales and their relative degree of improvement on the CAFAS scores. The analysis enabled evaluators to identify potential, targeted treatment interventions for various clusters of children that might help to improve level of functioning.[54] Additionally, analysis of the CAFAS data has enabled evaluators and the State to identify predictors of poorer outcomes with customary care; these predictors include: pervasiveness of problems across settings (e.g., home, school); impaired caregiving environment; previous hospitalization for substance abuse or psychiatric disorder; and, placement out-of-home. Again, the State and its evaluator are using these data to promote targeted interventions that show evidence of efficacy when these predictors are in place.[55] Their efforts to bring knowledge to the localities about effective interventions for various subgroups of children with whom the LMEs are struggling also creates incentives for the LMEs to use the CAFAS system.

Major Benefits, Concerns and Lessons Learned

State-level stakeholders indicated that, in general, it is a challenge to collect data systemically statewide as so much depends on local interest, leadership, integrity with respect to the process, and capacity. Some of the LMEs, for example, simply do not have the technical capacity to implement the CAFAS system fully, or they do not have a strong understanding of how to utilize technology and data to support frontline practice. To minimize "scamming" of the system and improve fidelity, the State stresses the importance of quality control over those who

54 Hodges K., Xue Y., & Wotring J. (2004). Outcomes for children with problematic behavior in school and at home served by public mental health. Journal of Emotional and Behavioral Disorders, 12(2),109-119.

55 Xue Y, Hodges K, Wotring J. (2004). Predictors of outcome for children with behavior problems served in public mental health. Journal of Clinical Child and Adolescent Psychology, 33(3), 516-523.

are actually doing the CAFAS ratings at the local level. As noted earlier, Michigan implements a "train the trainers" reliability training and maintains a list of those who have been trained. State-level stakeholders also stressed that both the State and localities need dedicated staff time to implement this type of system.

State-level stakeholders believe that the way in which they use the CAFAS data to delineate clusters of children with different presenting issues and then offer guidance for targeted treatment interventions is a major strength of the system, and one that incorporates far more flexibility than mandating use of particular evidence-based practices. The State indicated that they could grow this capacity of the system faster if they had additional research and knowledge development resources. As noted earlier, the State also stressed the importance of utilizing the CAFAS to consider the child/family profile and not just a total score and to make use of its capacity for cluster analyses. They indicated that their analysis of the CAFAS data supports this view. For example, as noted earlier, in their ability to analyze different clusters of children, they found that there are certain predictors of poorer outcomes with care as usual even when total CAFAS scores at intake are the same. State-level stakeholders emphasized the importance of using the CAFAS within a systemic context—to guide individual treatment planning and to monitor treatment outcomes for continuous quality improvement. They also stressed that the CAFAS should be used to help guide provision of effective interventions and not to "beat up on" providers for failing to attain CAFAS score improvements. They believe that, in any event, when the CAFAS is used as a punitive monitoring device, providers simply may try to scam the system. The State intentionally requires that data on the CAFAS be input at the level of the individual item endorsements, rather than subscale scores, to minimize possible efforts to trick the system. State-level stakeholders also pointed out that use of the CAFAS within the context of continuous quality improvement means that families fare better as quality and consistency of care improve.

One other major benefit that state-level stakeholders noted about Michigan's use of the CAFAS is that it provides statewide data to guide decision-making. The data are transparent and help to mitigate chaos and reactivity among stakeholders at state and local levels when system changes are required.

Community Mental Health Authority
of Clinton, Eaton, and Ingham Counties (MI)

(**Group Two:** Existing Standardized Protocols)

- **Local Level**: Implementing CAFAS Within an Individualized Approach to Care

Overview

Clinton Eaton Ingham (CEI) is a community mental health center that operates as a capitated local management entity for the delivery of child/adolescent behavioral health care in three counties in the Lansing, Michigan area. CEI both manages and provides care for children in the Lansing catchment area and their families. Perhaps more than any other local management entity (LME) in Michigan, CEI has incorporated the State's mandated use of the CAFAS into its ongoing, day-to-day assessment, service planning and treatment outcome monitoring activities.

CEI administers the CAFAS at intake, again within the first month of service provision, at 4-6 months, and annually for children who remain in care more than a year. This is far more than is required by the State, which mandates administration of the CAFAS at intake and exit. CEI uses the tool to triage youngsters into appropriate levels of care, i.e., outpatient versus the package of services known as home-based (which include in-home services, therapeutic case management, and crisis services).

Background

CEI has used the CAFAS since the state mandated its use in 1998. Initially, there was resistance among CEI clinicians to using it because CAFAS was viewed as "problem-oriented" whereas the culture at CEI is "solution-focused." CEI leadership made a decision to integrate use of the CAFAS systemically, that is, not to train just one "CAFAS expert" as some of the other LMEs were doing, but to incorporate the CAFAS into everyday practice by training all of its clinicians (using a "train-the-trainers" approach) and revamping agency forms so that CAFAS requirements were embedded into day-to-day documentation. In this way, use of the CAFAS did not require additional paperwork but could become part of everyday practice. CEI stakeholders indicated that it took about a year to a year and a half to incorporate use of the CAFAS into the CEI culture and that, currently, there is a 97% compliance rate with use of the tool. CEI stakeholders also noted that while there was an initial perception that the CAFAS was problem-oriented, clinicians in time came to see the tool as very functional and now use it as, in effect, a "common language" within the agency. Similar to Michigan State-level stakeholders, CEI interviewees expressed a desire to get their counterparts in the child welfare system and within the courts to use the CAFAS to broaden this common language across child-serving systems and create better placement decisions.

Individualized, Culturally Competent Family Focus

CEI as an agency is committed to partnering with families and was in the forefront of flagging some of the issues with the CAFAS initially that led to strengthening the caregiver subscales of the CAFAS. CEI currently is piloting an additional caregiver scale to accompany the CAFAS, which assesses parenting skills (i.e., the Advance Child Management Skills Scale for Caregivers, Hodges, 2002).

Community Mental Health Authority
of Clinton, Eaton, and Ingham Counties (MI)

(**Group Two:** Existing Standardized Protocols)

- **Local Level**: Implementing CAFAS Within an Individualized Approach to Care

CEI stakeholders believe that, initially, it can be difficult to administer the CAFAS with families with multiple problems who are in serious crisis, which characterizes many of the families with whom CEI works. However, CEI's experience is that families become receptive over time as they see improvements in CAFAS scores, which become a kind of tangible benchmark for progress. CEI stakeholders also emphasized that the CAFAS makes treatment decision more transparent for families because decisions are tied to functional status across many domains that are understandable and important to families, such as school functioning. It is not, in the words of one CEI stakeholder, "mystical" or absorbed with diagnostic jargon, and it allows families to "see their own progress." CEI stakeholders believe that use of the CAFAS supports their overall aim to help families become more self-reliant.

CEI stakeholders indicated that use of the CAFAS allows them to report actual data to families and to the larger community on progress made. It reportedly has helped to take their work out of the anecdotal realm and gives both families and the community measurable results.

CEI stakeholders also feel that their use of the CAFAS supports what has long been an individualized approach to care at the agency, at the same time it reduces subjectivity in the assessment and treatment planning process. CEI clinicians use the CAFAS as a guide within an individualized approach to care. In addition, CEI reportedly provides a fairly broad range of services and treatment interventions and, as a result, is able to craft "finely tuned" care plans.

About 10% of the population in Lansing is comprised of racial and ethnic minority families, and the area also encompasses both urban and rural populations. CEI stakeholders did not identify any particular issues related to use of the CAFAS with respect to racial and ethnic minority children.

Fidelity and Oversight

Because they are implementing a continuum of care, more than one clinician typically is involved in a child's care at CEI. Thus, the agency has a built-in inter-rater reliability system with respect to use of the CAFAS.

CEI described the State's "oversight" role as more supportive than regulatory. CEI stakeholders have found the State and its evaluator to be highly responsive to issues raised by the agency both with respect to the CAFAS instrument itself and regarding assistance in analyzing data on different subgroups of children served. For example, feedback contributed by CEI reportedly led to changes in the language of the CAFAS to be more strengths-based, and, as noted earlier, CEI is piloting the extended caregiver guidelines.

Community Mental Health Authority
of Clinton, Eaton, and Ingham Counties (MI)

(**Group Two:** Existing Standardized Protocols)

- **Local Level**: Implementing CAFAS Within an Individualized Approach to Care

Experience To Date

To date, CEI reportedly has used the CAFAS primarily at the service planning level; however, it is very interested in using it more at a systemic level but lacks the management information system (MIS) capacity at present. It finds the data generated by the State and its evaluator to be very helpful in understanding macro (i.e., population level) issues and would like to be able to do more of that kind of data analysis within the agency if resources were available.

CEI stakeholders pointed out that they very much are serving children with the most serious disorders (as the State intends) and that the CAFAS allows them to document that; the average total CAFAS score of children served by CEI at intake is 130 (compared to an average statewide total score of 80). CEI has adopted a solution-focused treatment approach and does not believe it is helpful to families for the agency to "hang onto" children indefinitely. In general, they consider a total CAFAS score of 70-80 to be sufficient for discharge, for example. As noted earlier, the CAFAS has removed much of the subjectivity around when a child should be discharged (and discharge could be to a step-down service). CEI stakeholders also noted that use of the CAFAS supports moving children more readily out of service so that more children can get in. As a result, the agency does not have waiting lists, and stakeholders noted that families can always return for services if needed.

CEI has worked closely with the State and its university evaluator to identify weaknesses in the CAFAS, such as in the caregiver scales noted earlier, and is assisting in piloting a new parent management skills scale. CEI also works with the State and its evaluator to analyze subgroups of children and youth it serves to identify areas needing more targeted interventions. For example, they found that youth with delinquent behaviors made improvements while often their families did not so the agency began to look at targeted interventions they could do with the families of these youth. As a result, CEI reportedly is having better results with delinquent youth than LMEs statewide.

CEI stakeholders also reported that one subgroup of children with whom they are finding that the CAFAS is not the best tool to identify strengths and weaknesses is those with developmental disabilities.

CEI stakeholders indicated that, occasionally, they get criticized for using only one tool, and they are aware that, in some other states, multiple tools are used. However, they feel that use of multiple tools has more to do with the system's needs than with what families want and need. Their basic attitude and practice is to use the CAFAS as a guide and not let it dominate practice; as one stakeholder said, "we do not let ourselves become prisoners of the CAFAS."

Major Benefits, Concerns, and Lessons Learned

CEI stakeholders offered a number of "lessons learned" from their use of the CAFAS, including the following:

- It is essential to integrate the CAFAS into everyday documentation and make it part of the "language" of the agency.
- Use of the CAFAS works best when it is embedded into a system that is strengths-based, solution-focused and committed to the principle of individualized care. CEI emphasized that its priority in hiring clinicians is to select those who understand and can practice this philosophy, rather than those wedded to an "expert mentality."
- While CEI stakeholders acknowledge that CAFAS scores could be used to "rate" clinicians, they strongly advise against it. They pointed out that in their system, they take a team approach to care and that every family is different, making comparisons about clinician competencies based on CAFAS scores problematic. They stressed instead using the CAFAS as an "accountability measure" for their program as a whole. Similarly, CEI stakeholders caution against tying rewards or penalties to reliability in use of the CAFAS.
- Based on their experience with the CAFAS, CEI stakeholders reported that they are heading increasingly toward an outcome-driven practice model rather than doing lots of assessments. They have found the CAFAS to be a tool that supports an outcome orientation, reduction in paperwork, and partnerships between families and clinicians in assessing strengths and needs and developing solution-focused treatment approaches. [56]

56 Hodges, K & Grunwald, H. (2005). The use of propensity scores to evaluate outcomes for community clinics: identification of an exceptional home-based program. The Journal of Behavioral Health Services & Research, 32(3), 294-305.

New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

Overview

The New Jersey Division of Child Behavioral Health Services (DCBHS) is implementing a behavioral health carve out, formerly called the New Jersey Partnership, serving a statewide, total population of children and adolescents with emotional and behavioral disturbances and their families. The population includes both Medicaid and non-Medicaid eligible children and those with both acute and extended care needs. The DCBHS reform creates a single statewide integrated system of behavioral health care to replace the previously fragmented system in which multiple child-serving systems (e.g., child welfare, juvenile justice, child mental health, and Medicaid) provided their own behavioral health services. System components include: a statewide Contracted Systems Administrator (an Administrative Services Organization, in effect); at the county level, Care Management Organizations (CMOs) charged with managing care for children with the most intensive needs and their families, as well as Family Support Organizations (FSOs), which are family-run organizations that work in partnership with the CMOs to provide peer mentors, family education and support and advocacy. In addition, the reform includes Youth Case Management, which is a distinct level of case management services for youngsters with less intensive needs than those served by the CMOs. The New Jersey Department of Human Services, Office of Children's Services, is the state purchaser, and the Partnership is being rolled out by county over a five-year period, with all counties participating by January 2006. The goals of the Partnership are to: increase funding for children's behavioral health care; provide a broader array of services and supports; organize and manage services; and provide care that is based on core values of individualized service planning, family/professional partnership, culturally competent services, and a strengths-based approach to care.

A key feature of the NJ system of care is the use of the Child and Adolescent Needs and Strengths (CANS) tool by all system partners across child-serving systems. The CANS is a standardized assessment instrument that incorporates a quantitative rating system within an individualized assessment process. The State worked with Dr. John Lyons of Northwestern University, the developer of the CANS, to adapt the instrument, leading to development of three versions of the CANS—one for crisis assessment, one for initial screening and assessment, and one for use by care management organizations to guide service planning for youth with the most intensive service needs.[57] The State mandates that the Crisis Assessment tool be used by the State's Mobile Response and Stabilization Services providers. The Needs Assessment instrument is mandated for use by the Contracted Systems Administrator, system partners, such as child welfare workers, and providers, at entry to screen for eligibility and level of intensity of service need. The comprehensive Strengths and Needs Assessment tool is mandated for use by the Care Management Organizations, by Youth Case Management providers[58] and by residential treatment providers for individualized service planning. The three instruments, which encompass similar domains, are designed to build on and inform one another. The State mandates their use

57 New Jersey's name for the CANS is the Strengths and Needs Assessment.

58 Youth Case Management is a distinct type of service separate from intensive care management provided by the CMOs. Youth Case Management is designed for youth at very high risk for out of home placement but not yet involved with a CMO.

as Information Management and Decision Support tools to guide and inform the process of care. New Jersey reportedly is the only State using the CANS statewide and the only State using a web-based certification process to support its use.

Goals

The State was interested in utilizing a standardized clinical decision making tool statewide for several reasons, not the least of which was to convey the sense of meaningful change intended by the Partnership initiative. The State's goal is to ensure that the issues of most importance to each child/family are considered in the assessment process and are embedded in service planning and outcomes management. This integration helps to ensure that quality improvement efforts stay focused on child and family issues. State-level stakeholders believe that use of the CANS keeps providers focused on the individual needs and strengths of each child and family and gives them a tool and a process to monitor and manage outcomes. They also indicated that they were interested in a tool that could be readily modified and adapted to meet their system needs, and they reported that they have found the CANS easy to modify. State-level stakeholders also noted that they were interested in use of a set of tools that would support programmatic and system wide practice change and give providers, families and youth a sense of change over time. For example, the CANS clearly identifies youth and family strengths; in this respect, the CANS, according to State-level stakeholders, supports the concept of resiliency.

Background

The Comprehensive Needs and Strengths Assessment and Crisis Assessment tools were developed in 2002 and the Needs Assessment tool in 2003. During planning for the Partnership, State-level stakeholders reviewed what other states were using in connection with EPSDT screening processes. Reportedly, they found primarily "long checklists" that did not meet New Jersey's interest in tying assessments to outcomes. They were interested in assessment instruments that could be used as information management and decision support tools to support the process of care and that could be used throughout the system at all levels, following children and families as they moved throughout the system. As State-level stakeholders noted, they were interested in finding or developing a "family of tools" that were relatively simple to administer and understandable to both providers and families. Use of the tools is increasingly embedded within all of the child-serving systems and is mandated for use by the management entities and providers within the NJ system of care.

New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

Description

All three of the CANS instruments used by New Jersey track child behavioral and emotional needs, child risk behaviors, child strengths, life domain functioning, and caregiver needs and strengths.[59] All three lead to assessment data that translate into four pathways related to how intense the service response should be. These can be summarized as including: "0-no response;" "1-watchful monitoring;" "2-action;" "3-'red flag,' immediate response." Each of the three instruments is discussed more specifically below.

The State's information material describes the Crisis Assessment instrument as follows: "This (instrument) is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by the individuals who are directly involved with the crisis assessment. The form serves as a template to consistently integrate information about the needs of the child and family to support decision making at the time of the crisis. This tool is designed from a communication theory perspective. As such, the indicators are selected to represent the key information needed in order to decide the best intervention strategy for a child during a time of crisis."[60]

The **Crisis Assessment tool** addresses the following areas:

- Risk Behaviors, including: suicide risk; self-mutilation; other self harm (e.g., risk-taking behavior); danger to others; sexual aggression; runaway; judgment (e.g., poor decision making); fire setting; social behavior.
- Behavioral/Emotional Symptoms, including: psychosis; impulse/hyperactivity; depression; anxiety; oppositional; conduct; adjustment to trauma; anger control; substance use.
- Functioning Problems, including: living situation; community; school; peer functioning; developmental.
- Juvenile Justice, including: juvenile justice status; community safety; delinquency.
- Child Protection, including: abuse or neglect; domestic violence.
- Caregiver Needs and Strengths, including: health; supervision; involvement; social resources; residential stability.

The **Needs Assessment tool** is described by the State's informational material as follows:

> "The (instrument) is a referral tool to support decision making about level of need… It supports the rapid and consistent communication of the needs of children…It is intended to be completed by the individuals who are directly involved with the referral. The assessment tool serves as a template to consistently integrate information about the needs of the child and family to support decision making in order to ensure the child

59 For complete versions of the CANS instruments used by the NJ Partnership, see the following websites: www.njkidsoc.org and www.njmhi.org.

60 Children's Initiative Crisis Assessment Manual, Version 2.0. 2003. Division of children's behavioral health services. New jersey department of human services

and family receive the appropriate services."[61] The tool recognizes that in some areas information may not be known about a child and his/her family; it allows for these areas to be marked as "Unknown," and these become priority areas for assessment by the entity receiving the referral (i.e., by the Contracted Systems Administrator and Care Management Organizations that receive referrals).

The **Needs Assessment tool** incorporates all of the areas in the Crisis Assessment tool and adds additional items, including:

- Under Life Domain Functioning, the following areas are added: family (which has to do with relationships with family members); social development; recreation; vocational; legal; medical; physical; sexuality; relationship permanence (e.g., stability of relationships).
- Caregiver Needs and Strengths are separated into two fuller categories, including, under Caregiver Needs: physical; mental health; substance use; developmental; safety. Under Caregiver Strengths: supervision; involvement; knowledge; organization; social resources; residential stability.

The comprehensive Strengths and Needs Assessment tool is defined by State materials as follows: "The (instrument) is a comprehensive service planning assessment for use with children and families receiving the most intensive services…Care Management Organizations, Youth Case Managers, and Children's Residential Providers will utilize (the instrument) as their primary service planning assessment at initiation of services and subsequently as a monitor for outcomes."[62]

The **Strengths and Needs Assessment tool** incorporates all of the areas within the Crisis and Needs Assessment tools and adds additional items, including:

- Under Life Domain Functioning, adds: school behavior; school achievement; school attendance.
- Adds a specific Child Strengths category that includes: family; interpersonal; optimism; educational; vocational; talents/interest; spiritual/religious; community life; relationship permanence.
- Adds a new category called Acculturation, which includes: language; identity; ritual.

In addition to the above, the comprehensive Strengths and Needs Assessment tool builds on the Needs Assessment tool by providing more in-depth information on key issues and also incorporates several new modules, including:

- **Developmental Disability Module**, including: cognitive; communication; developmental; self-care daily living skills

61 Division of child behavioral health services needs assessment manual, Version 2.0. 2003. Division of child behavioral health services. New jersey department of human services

62 Partnership for children strengths and needs assessment manual. 2003. Partnership for children. New jersey department of human services.

- **Sexuality Module**, including: Under Sex Related Problems: promiscuity; masturbation; reactive sexual behavior; knowledge of sex; choice of relationships; sexual identity; Under Sexual Deviance: voyeurism; frotteurism; exhibitionism; fetishism; pedophilia; sexual masochism; sexual sadism; transvestic fetishism.
- T**rauma Module**, including: Under "characteristics of the trauma experience": sexual abuse; physical abuse; emotional abuse; medical trauma; natural disaster; witness to family violence; witness to community violence; witness/victim to criminal activity; Under "if child has been sexually abused": emotional closeness to perpetrator; frequency of abuse; duration; force; reaction to disclosure; Under "adjustment": affect regulation; intrusions (e.g., intrusive thoughts of trauma); attachment; dissociation; time before treatment.
- **Substance Use Module**, including: severity of use; duration of use; stage of recovery; peer influences; parental influences; environmental influences.
- **Sexually Abusive Behavior Module**, including: relationship; physical force/threat; planning; age differential; type of sex act; response to accusation; temporal consistency; history of sexually abusive behavior; severity of sexual abuse; prior treatment.
- **Juvenile Justice Module**, including: seriousness; history; planning; community safety; peer influences; parental criminal behavior; environmental influences.
- **Fire Setting Module**, including: seriousness; history; planning; use of accelerants; intention to harm; community safety; response to accusation; remorse; likelihood of future fire setting.
- **Psychotropic Medication Module**, including long list of medications and opportunity to check current or past use and allergic/adverse reactions.

In all three assessment tools, the CANS incorporates the same rating system across all items covered in each. The scoring system includes:

- **0** indicates no evidence or no reason to believe that the rated item requires any action
- **1** indicates a need for watchful waiting, monitoring or possibly preventive action
- **2** indicates a need for action; some strategy is needed to address the problem/need
- **3** indicates a need for immediate or intensive action; this level indicates an immediate safety concern or a priority for intervention.

The CANS allows "some clinical judgment to determine the rating when no clear choice is obvious."[63] Also, State information materials make it clear that a "primary goal of the (tools) is to further communication with both the individual child and family and integrate information for the ..system of care."[64] As discussed more fully below, the State mandates formal training in the use of the tools and ongoing certification.

63 Ibid.
64 Ibid.

New Jersey (**Group Two:** Existing Standardized Protocols)
- Child and Adolescent Needs and Strengths (CANS)

Individualized, Culturally Competent Family Focus

As noted earlier, the CANS tools incorporate many items related to caregiver needs and strengths, and the comprehensive Strengths and Needs Assessment tool addresses issues related to culture, race and ethnicity. In addition, the values and organizational elements of the NJ system of care reflect a strong commitment to partnering with families and youth and to individualizing care, particularly for youth with serious disorders. State-level stakeholders feel that no other assessment tool they considered is as flexible as the CANS or as compatible with an individualized approach to care. Having said that, they also reported that they still get some criticism that the CANS is not sufficiently culturally competent or family-friendly, but the State's analysis of these concerns suggests that the problems lie not with the instruments themselves but with the users of the instrument. If a user is not sensitive to issues of partnering with families or is not culturally competent, his/her use of the CANS will reflect that.

State-level stakeholders also reported that they have modified certain aspects of the tools in response to concerns voiced by families. For example, the State pulled together a group of families and youth to review the language in the original comprehensive Strengths and Needs Assessment tool to make it more family and youth friendly.

Impact of Service Availability

State-level stakeholders noted that some of the resistance among practitioners to using the CANS initially was that it would lead to identification of problems for which no services were available. The State reportedly is trying to use the CANS to help identify service gaps when this occurs. State-level stakeholders also noted, however, that in most cases, the available array of services and supports can be individualized to match a level of need even if the plan is an interim one.

State-level stakeholders believe that use of the CANS is helping to support broadened access to services because the CANS promotes a common language and a shared vision. They pointed to, for example, youth involved in the juvenile justice system for whom the CANS is providing a "common language" between the behavioral health and juvenile corrections communities that is increasing access for this population.

Training, Fidelity and Oversight

As noted earlier, the State mandates formal training in use of the tools and ongoing certification. It has contracted with the University of Medicine and Dentistry of New Jersey to provide training and technical assistance to support system of care implementation, including training related to the CANS. The training is free and meets social work continuing education requirements. In addition, much of the training material is in a distance-learning format -- online, web-based and on compact disc. There is an active website with training schedules, with training offered frequently. The State and its technical assistance providers have built a web-based certification system for use of the CANS so that the State can maintain a database of everyone who is trained in the CANS. They also have in place an online "help desk" both for content and technical support related to the CANS certification process.

New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

State-level stakeholders noted that they did not take an "expert model" view of training but instead opted to "train everyone" in order to create shared values and consistency throughout the State. They pointed out that, to date, they have mandated training in the CANS for juvenile corrections staff, child welfare workers, staff in secure facilities, youth case managers, mental health providers, care management organizations, and mobile response and stabilization staff, and trainings are open to parents at any time. To date, there are over 1500 users of the CANS who have been trained by the State.

The State also developed a second level of training in the CANS to create a group of "super users" who are at a supervisory level within programs and agencies. These users receive two additional days of training on the science behind the instruments and to become more comfortable with the tools so that they can exercise a level of quality control over other users at their locales.

As noted earlier, the State is interested in utilizing the CANS outcomes management process for quality monitoring. Their goal is to have both care management staff and quality assurance staff in the Care Management Organizations, for example, thinking about how to use the CANS to monitor the quality of care plans and access to appropriate services and supports. They are hoping that the "super users" described earlier will be influential in this process; the goal is to have super users in the CMOs, in child welfare, juvenile corrections, and in Youth Case Management. The State is planning to set up quarterly "super user" meetings to foster peer-to-peer exchange and support for using the CANS with fidelity and to support quality monitoring. State-level stakeholders noted that they are trying to break down the attitude that use of the CANS is "the case manager's responsibility," and instead help supervisors and administrators to see the CANS as a vehicle for quality monitoring and systems management.

Experience To Date

State-level stakeholders believe that use of the CANS is helping to build a true system of care with a shared vision and a shared "language" for clinical and other service decision-making. However, they also reported that there has been and continues to be resistance to use of the tools in some quarters. For example, at first, juvenile justice staff expressed concern that use of the tools would require more work. State-level stakeholders reported that, over time, as these staff have used the tools, they find the CANS to be helpful because it keeps the focus on the child, and as noted earlier, creates a common language between behavioral health and juvenile justice that can support increased access to services for youth involved in juvenile justice. Mental health clinicians also expressed reservations and, according to State-level stakeholders, were among the most resistant. Some clinicians reportedly did not see how a quantitative tool with "little bubbles that had to be checked" could begin to capture all the nuances of their work with children and families. Also, clinicians tended to be skeptical that the reform effort would endure and were inclined to adopt the attitude of "this too shall pass." Other clinicians did respond to the idea that the CANS could help to ensure that their recommendations would be translated into action.

New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

State-level stakeholders noted that clinicians often have the most difficulty at first in completing the CANS because they reportedly tend to "over-think" responses when the tool is really asking for common sense responses. State-level stakeholders reported that even their Contracted Systems Administrator (a commercial behavioral health managed care company) was at first resistant to use of the CANS because they felt they had their own "level of care" criteria. However, the CSA now reportedly embraces the CANS as a tool to create a common language throughout the system, and the CSA is using the CANS to help identify populations of children who are in inappropriate levels of care, for example, "low needs" children in out-of-home treatment settings.

State-level stakeholders reported that as clinicians and others who are at first resistant to use of the CANS gain experience with it, they realize its utility as a decision support tool. Also, the fact that the DCBHS reform seems to be enduring along with its mandated use of the CANS is a factor in counteracting resistance. State-level stakeholders also reported that one of the errors they made initially was to roll out the CANS in a top-down manner that was resisted by practitioners at the local level. In response, the State's technical assistance providers and Dr. Lyons met with every CMO, which helped to break down the resistance and promote state-local partnership.

To provide an alternative to direct on-line entry for child welfare workers, the CSA has provided an auto-fax system that allows workers to fax the assessment forms to the CSA.

Major Benefits, Concerns, and Lessons Learned

State-level stakeholders described the major strengths of their use of the CANS as creating a common language across child-serving systems. Also, the tools support the values and goals of the system reform and the "action-oriented" intention of the reform's service planning processes. State-level stakeholders also noted as a strength the fact that the tools build off one another to support an integrated care planning and management process. They stressed as strengths the fact that the tools address both needs and strengths of children and caregivers and keep the focus foremost on the child. They view the CANS as very adaptable so that there can be ongoing quality improvement and adaptation as needed, and they pointed out that the tool is in the public domain so "it is free." They also noted that the CANS is adaptable to different child-serving systems; for example, they noted that New Jersey's child welfare system is being required to have in place an integrated assessment process for every child and that the CANS will enable them to do that from prevention to early intervention to treatment. State-level stakeholders also reported as a strength that use of the CANS helps to create a transparency and accountability in the system; the basis on which clinical and other service decisions are made is no longer a mystery to families and others. These stakeholders also indicated that use of the CANS lends itself to a team approach involving families, supporting the notion that everyone involved in a child's life has expertise to bring to the table and that expertise is not the sole domain of clinical experts. They feel that the strength of the CANS is that it is a communications theory-based tool that anyone can use.

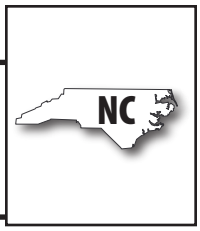
New Jersey (**Group Two:** Existing Standardized Protocols)

- Child and Adolescent Needs and Strengths (CANS)

State-level stakeholders described the major challenge as one of "scaling up." They began with providers and systems serving the most intensive-needs children and families and are just now turning to the broader outpatient community. In addition, they noted as a challenge getting managers and clinical supervisors to take full advantage of the CANS for quality monitoring and system management purposes.

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria



Overview

The North Carolina public behavioral health system is organized by Area Offices, which operate as local management entities (LMEs). The LMEs are charged by the State with many of the functions of managed care organizations, including organization of the provider network, service authorization, and utilization management, and they bear financial risk for service provision within their catchment areas. Managed care functions are relatively new to North Carolina's Area Offices. Historically, the Area Offices provided direct services. In an effort to improve quality and consistency of care across the State and to control costs, the State is now in the process of transitioning its Area Offices from their historic role as service providers to one of managed care entities.

North Carolina has identified several target populations for priority service provision, including: "seriously emotionally disturbed child with out-of-home placement;" "seriously emotionally disturbed child;" and, "homeless child." The State mandates the use of the Child and Adolescent Functional Assessment Scale (CAFAS) by LMEs and their contracted providers to determine whether a child meets eligibility under one of these categories as well as the child's eligibility for different service clusters (or levels of care). Once a child is determined eligible for service provision by virtue of his/her CAFAS score, then the LMEs and their contracted providers must use Child Level of Care (LOC) Criteria and Initial and Continuing Authorization Criteria, developed by the State, to guide clinical decision making and for initial and continuing service authorization. State informational material indicates that, "together, the Levels of Care Criteria and the Initial and Continuing Authorization Criteria create a protocol to guide the decision-making process for making initial authorization, continuing authorizations, and facilitating appropriate care management."[65] The guidelines are for use qualitatively, rather than to create an overall quantitative score, although they do incorporate the quantitative scoring associated with the CAFAS.

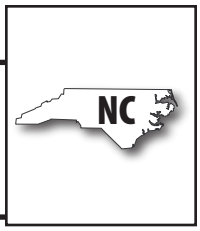
Goals

The State utilizes its Child Level of Care Criteria to support its movement toward use of managed care technologies in the provision of behavioral health services. Its goals are to improve consistency across the State in access to services and to contain costs. State informational materials describe several reasons for utilizing level of care criteria in a managed care environment, including: providing tools for supporting decisions about placing consumers in different levels of mental health care; increasing the predictability of level-of-care decisions;

65 For more information about North Carolina's Child Level of Care Criteria and their larger systems change reform, see the State's website at: http://www.dhhs.state.nc.us/mhddsas/childmentalhalth

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria



reducing wide variability of services provided to consumers with similar needs; providing justification for authorization decisions; helping ensure that consumers are assigned to services in an equitable manner; and allowing for authorization of services based upon a consumer's individual needs.[66]

Background

The State has used Level of Care Criteria for some time, which it has revised several times primarily in response to system changes, such as conversion to the Rehabilitation Services Option in Medicaid and, more recently, movement to managed care implementation. State informational material indicates that the criteria were developed through an extensive committee and consumer feedback process.

State-level stakeholders described their current status as "having a foot in two worlds." They are transitioning to a system in which local area offices bear risk for ensuring services to a designated population, must divest themselves of direct services, and have to learn how to implement the functions of a managed care entity. At the same time, the State is developing or refining statewide tools, such as the Child Level of Care Criteria, monitoring protocols, and technical assistance approaches to support and oversee the Area Offices in this transition. The most recent version of the Child Level of Care Criteria are those revised in March 2002, although the State is in the process of further refining the criteria for issuance in July 2005.

Description

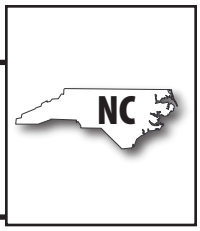
The State's informational material describes the following key characteristics of the Child Levels of Care Criteria:

- "Provide a framework for making initial and continuing authorization decisions about medically necessary services for the treatment of MH/SA disorders
- Describe the clinical indicators which should exist in order for authorization to occur at each level of care
- Provide guidelines for determining the level of care a child needs and the services appropriate for each level
- Consist of five levels ranging from mild to severe dysfunction
- Each level requires a CAFAS score within a corresponding range of overall dysfunction
- A child is eligible for the assessed LOC and less intensive services when appropriate
- Some services can be accessed at several different levels of care
- Each level of care has a recommended review period and criteria for reauthorization."[67]

66 Ibid.
67 Ibid.

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria



State informational material further describes that "initial authorization decisions are based upon the determination that:

- There is a reasonable expectation of improvement in condition
- The level authorized is necessary and appropriate to the child's present condition
- The child is at-risk of requiring more restrictive levels of care if the appropriate treatment is not provided
- There is not an equally effective service that is less restrictive or substantially less costly."[68]

According to the State literature, reauthorization (continuing authorization) decisions are based upon:

- "The persistence of severe symptomatology or problem behaviors
- The initial treatment goals not reached
- The treatment plan needs to be modified to introduce new treatment interventions
- New symptoms or behaviors have arisen
- There is a reasonable expectation that the child's condition will improve
- There is evidence of relapse if treatment is discontinued."[69]

The Child Levels of Care Criteria include medical necessity criteria (including discharge criteria) for a range of services. These include core services, which do not require pre-authorization up to specified limits, as well as services that do require pre-authorization. Core services include: case consultation; screening (up to six visits); evaluation; case management (up to 90 days); outpatient treatment (up to 24 visits); facility-based crisis intervention (up to 72 hours). Services requiring pre-authorization include: community-based services (e.g., behavioral aide services); day treatment/partial hospitalization; assertive community treatment team; and, five levels of residential treatment, ranging from family treatment homes to secure residential treatment facilities. The State also has developed definitions of each of these service types, which are available on the State's website. Currently, the State is developing definitions for a number of new services planned for July 2005, including community support, intensive in-home services, and Multisystemic Therapy. These new services will be included in the State's revised Child Levels of Care Criteria as well.

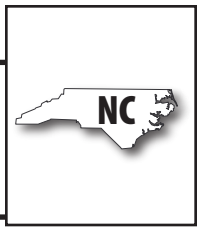
The current Child Levels of Care Criteria encompass four levels:

- **Level A**—encompasses case management, outpatient treatment (group), or community-based services (group), with total CAFAS score equal to or greater than 10 and other factors.

68 Ibid.
69 Ibid.

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria



- **Level B**—encompasses case management, outpatient treatment (group or individual), community-based services (group or individual), residential treatment (family type), with total CAFAS score equal to or greater than 30 or other factors present (such as suicide attempt) and other factors
- **Level C**—encompasses case management, outpatient treatment (group or individual), community-based services (group or individual), day treatment/partial hospitalization; residential treatment (family or program type), with total CAFAS score equal to or greater than 60 or other factors present and other factors
- **Level D**—encompasses assertive community treatment team; facility-based crisis intervention; residential treatment (highest level or secure RTC), with total CAFAS score equal to or greater than 90 or other factors present and other factors.[70]

State informational material indicates that, when disagreements arise about level of care decisions, resolution can be pursued by obtaining a second opinion, peer to peer review, or negotiating with the state.

Individualized, Culturally Competent Family Focus

State-level stakeholders indicated that the Child Levels of Care Criteria as currently formulated do not address issues related to culture and are not designed specifically for an individualized, family-focused approach to care. While providers in the State are familiar with and often utilize a Child and Family Team (i.e., individualized) approach to service planning, the LOC criteria determine whether a child gets to a Child and Family Team in the first place. State-level stakeholders indicated that they are trying to figure out how to adapt the current criteria to support system of care practice goals, something they want to see reflected in the revised Levels of Care Criteria slated for July 2005. In addition, efforts also are underway to develop protocols for Person-Centered Planning for individuals with developmental disabilities, and the State is interested in ensuring consistency between the LOC criteria and the Person-Centered Planning protocols. In effect, the State is trying to develop and reconcile system of care practice guidelines for children's behavioral health, person-centered planning protocols for children with developmental disabilities and the existing Levels of Care Criteria for eligibility and service authorization purposes.

Impact of Service Availability

State-level stakeholders indicated that service capacity issues are huge. Over time, waiting lists for different types of services have changed. Two years ago, stakeholders indicated that the major demand was for residential treatment and special needs, such as treatment for sexual offenders. Today, demand (and wait lists) is for community-based services, such as behavioral aides. There are not supposed to be waiting lists for Medicaid-eligible children (who thus receive a priority for service provision).

70 For a full description of the Child Levels of Care Criteria and the Initial and Continuing Authorization Criteria, see: Child levels of care criteria for mental health and substance abuse treatment services. Revised edition, March 2002. North Carolina division of mental health.

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria

Training, Fidelity and Oversight

The State conducted an initial round of training for the LMEs on the Levels of Care Criteria, and the LMEs are charged with conducting ongoing training of new staff and providers. State-level stakeholders believe there has not been sufficient training on the criteria or on system of care practice. However, there is widespread use of the Levels of Care Criteria nonetheless because the criteria drive service authorization and utilization management. State-level stakeholders believe additional training of LMEs and providers would help to break down some of the rigidity that has developed around use of the criteria. The State is in the process of developing new technical assistance materials related to utilization management and the LOC criteria and system of care practice—for implementation in July 2005.

The State has invested with a Child Mental Health Implementation Team the responsibility for revision, training and monitoring activities related to LMEs' use of the LOC criteria. Essentially, the LMEs have a contract with the State, which currently is focused on broadening access to services for populations of children (as well as adults) with serious disorders. Recently, a child psychiatrist with experience in systems of care was hired to serve as clinical policy director for the children's system, and he is now chairing the Implementation Team. State-level stakeholders noted that, while the Team is charged with monitoring implementation at the LME level and has conducted some on-site audits, much of the monitoring approach is still under development. They stressed that conversion of the old Area Offices to LMEs constitutes a major systems change that is still very new.

Experience To Date

At present, the Child Levels of Care Criteria are being used primarily for eligibility determination and service authorization purposes by care coordinators in the Local Management Entities. Noting that the LMEs essentially are at risk for paying for services that are found in hindsight to not be medically necessary, State-level stakeholders believe that the criteria are being applied fairly rigidly at this stage at the LME level. They are hoping that the revised criteria slated for July 2005, including several new services, and the technical assistance materials from the State will help to promote use of the criteria within a "system of care" practice model (e.g., individualized, strengths-based).

With respect to their impact on access to services, State-level stakeholders reported that the criteria serve both to keep children in and out of services. For example, use of the CAFAS reportedly has helped to improve access for children who need them the most, that is, children with serious behavioral health disorders, those who are in or at risk for out of home placement, and children who are hearing impaired or homeless. On the other hand, LMEs reportedly complain that the LOC criteria frustrate access to certain types of services, such as Community-Based Services (e.g., in-home).

North Carolina (**Group Two:** Existing Standardized Protocols)

- Child Levels of Care Criteria with CAFAS/Initial and Continuing Authorization Criteria

Major Benefits, Concerns and Lessons Learned

State-level stakeholders described the major strength of their Child Levels of Care Criteria as creation of some level of statewide consistency in child behavioral health service delivery. At the same time, however, they noted that there is still variance across the LMEs in their interpretations about medical necessity, and that the criteria as presently written may not incorporate sufficient flexibility at the clinical decision-making level to support individualized care. State-level stakeholders emphasized the importance of training to ensure consistency and prevent rigidity in use of the criteria. Based on their experience to date, they stressed that ongoing training and technical assistance to the localities and their providers is critical.

State and Local Descriptions (continued)

III. Sample Sites Using Formalized Individualized Wraparound Approaches

DAWN Project, Marion County (IN)

(**Group Three:** Formalized Wraparound Process)

Overview

The DAWN Project is a behavioral health carve out serving a subset of children in Marion County, Indiana (Indianapolis), who have serious behavioral health problems and are in or at risk for residential or other out of home placement. Indiana Behavioral Health Choices (Choices), a private nonprofit care management agency, acts as the managed care entity. Indiana, in partnership with Choices, began the planning process for the DAWN Project[71] in 1995 and began working with children in 1997. Funding for the planning phase (1995-1997) came from the Robert Wood Johnson (RWJ) Foundation, which was looking to replicate earlier successes in creating organized systems of care for children and adolescents, ages 5-17, with serious behavioral or emotional problems and their families. DAWN's continued funding occurred through a case rate paid per enrollee by state and local child welfare, probation and education agencies. The dollars used came from existing budgets for what would be been spent on these children if they required out of home placement. In 1999, the project received a federal children's system of care grant for $7 million, which provided resources to build upon the RWJ pilot. The DAWN Project is now funded primarily by city, county, and State funding through the case rate approach noted above. As a private care management organization, Choices provides administration, clinical and fiscal management of the DAWN Project and has recently launched replication projects in Ohio and Maryland. Choices uses practice process indicators selected by their stakeholders for performance measurement, such as cost and service utilization. Clinical instruments, such as clinical guidelines or functional measures, are used to assess individual clinical progress and for quality improvement purposes at the program level.

Goals

Prior to Indiana's application to launch the DAWN Project, state and local officials formed a consortium whose mission was to improve support to Marion County children and youth with serious emotional and behavioral problems and their families. The consortium sought to create an organized "system-of-care" for these children. Consistent with CASSP principles[72], the focus of the system is to be strength-based and engage the people closest to a child in developing and carrying out a comprehensive plan for the child. Clinical care guidelines are used to represent minimum thresholds of service to be provided but never maximums. Standardized measures inform service planning and practice via outcome data that could alter the treatment plan, but it is the child and family team process that drives care provision.

71 More information on the origin and design of the DAWN Project can be found on its website: www.kidwrap.org

72 Stroul, B. A. & Friedman, R. M. (1994). A system of care for children and youth with severe emotional disturbances. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

DAWN Project, Marion County (IN)

(**Group Three:** Formalized Wraparound Process)

Background

The local child welfare, juvenile probation and education systems refer children who are at risk of or already in out of home care to the DAWN Project to work with the agencies on their various mandates (permanency, community safety, education, reunification). The DAWN Project is run by a non-profit care management organization (Choices) that is value driven, consistent with the principles behind the system-of-care movement. These values include strength-based, family-focused, individualized, and culturally competent care, with an emphasis on keeping children and youth with their families and in the community whenever possible. The project contracts for staff with the community mental health centers in Marion County to access the Medicaid benefit; the care coordinators are employees of the centers but are housed in the project offices. The care coordinators serve a maximum of ten families at any time. They authorize the care monthly, and work to coordinate the services provided with the other personnel working with that family, for example, the child welfare case manager. A supervisor oversees teams of five care coordinators; several case managers support the teams by providing specific services to children and families, such as supervising parent visitation, crisis intervention and transportation. Choices also provides a broad array of services and supports through a contracted Provider Network of over 500 vendors, which provides many different types of services and supports, including clinical treatment services, in-home services, care coordination, mentoring, respite, parent support, informal supports, as well as residential treatment and foster care.

Description

The DAWN Project began as a county-based program using agreed upon eligibility criteria (rather than a clinical guideline or screening instrument) based on the original RWJ pilot funding goals, which were aimed at youth who met the federal definition of serious emotional disturbance (SED).

DAWN eligibility criteria are:

- functional impairment in two life domains
- involved in two or more systems: child welfare, juvenile justice, mental health or special education
- at-risk of or already in residential treatment
- resident of Marion county
- between five and 17 years of age
- DSM IV diagnosis or Special Education category
- duration of impairment lasting at least six months

Choices reports that using these types of standardized and mostly quantifiable eligibility determinants, rather than a potentially subjective instrument, helps them avoid “clinical drift” in terms of who is enrolled. Another protection, which supports the reliability of the eligibility criteria, is that feedback is given to the referral systems monthly for review.

DAWN Project, Marion County (IN)

(**Group Three:** Formalized Wraparound Process)

Once a child is enrolled in the DAWN Project, the Child and Adolescent Functional Assessment Scale (CAFAS)[73] is used to measure change in functional status from baseline, to six and 12 months. Care coordinators perform the CAFAS as part of their routine work. The DAWN Project also includes an evaluation component, and researchers also perform the CAFAS at the same time intervals as Choices care coordinators. Reportedly, the results trend together, although Choices stakeholders noted that the researcher-administered scores are higher than are those done by program staff.

Recently, via the national evaluation of federally funded system of care sites that is being conducted by ORC MACRO,[74] the Wraparound Fidelity Index (WFI)[75] has been added to DAWN's list of measures. Also, the State of Indiana has required Choices to use the Hoosier Assurance Plan Instrument—Child (HAPI-C).[76] However, the HAPI-C data feed into a state database that, reportedly, does not return information, so complying with its required use does not inform practice.

The DAWN Management team looks to its stakeholder-informed performance measures to help "run the business." Guidelines exist for: cost containment (such as, all services must be mapped to measurable goals and reauthorized every 30 days); quality management (e.g., CAFAS scores and program completion rate); and consistency (WFI).

Individualized, Culturally Competent, Family Focus

In keeping with the CASSP principles, DAWN emphasizes individualized, flexible care planning as "what we do" and is attentive to diversity within families and the need for creativity in clinical decision-making based upon strengths. Caregivers and youth sit on a monthly Child & Family Team, along with other stakeholders, such as child welfare and school personnel. The degree of successful program completion is one of the indicators used by DAWN to make sure that the family voice is being heard along with the WFI measure of family voice.

73 Hodges, K., Wong, M. M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. Journal of Behavioral Health Services and Research, 25 (3), 325-336.

74 Macro International, an opinion research corporation, is involved in designing and conducting a national evaluation of the Comprehensive Community Mental Health Services for Children and Families Program. More information on this evaluation can be found on Macro's website: www.orcmacro.com/ProgramAreas/Health/mentalhealth.aspx

75 Bruns, E.J., Suter, J.C., Burchard, J.D., Force, M., & Leverentz-Brady, K. (2004). Assessing fidelity to a community-based treatment for youth: The Wraparound Fidelity Index. Journal of Emotional and Behavioral Disorders, 12(2), 69-79. An electronic review copy of the WFI may be requested from the authours at http://depts.washington.edu/wrapeval/WFI.html <http://depts.washington.edu/wrapeval/WFI.html>.

76 The HAPI-C may be downloaded from Indiana's official state website at: www.in.gov/fssa/servicemental/pdf/Hapi-C.pdf Instructions for scoring may also be found at: www.in.gov/fssa/servicemenatl/pdf/Hapi-Cmanual.pdf

DAWN Project, Marion County (IN)

(**Group Three:** Formalized Wraparound Process)

Impact of Service Availability

DAWN Project stakeholders noted that, once children are enrolled in DAWN, there is an open network for access to services for any youth within DAWN: "if they (the kids and family) need it, we can go get it." However, only youth in the public system can access the DAWN Project, and the public systems that are paying for the services (i.e., child welfare, juvenile justice, education) decide who is referred.

Training, Fidelity and Oversight

Choices has contracted with the Indiana Consortium for Mental Health Services Research to conduct a comprehensive local and national (in conjunction with the evaluators of the Federal grant project) evaluation of the DAWN Project. One training outgrowth of DAWN has been the creation by the state in partnership with Choices of the Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families, which now supports 30 grant sites across 45 Indiana communities. Intensive coaching is provided to communities as they develop their local systems of care.

Within DAWN itself, care coordinators follow program guidelines using information from clinical and fiscal data run twice a month (this does not include those measures done by MACRO). This bi-weekly information is conveyed to the supervisor and weekly feedback provided in supervision. Fidelity is enhanced via supervisory oversight, weekly staff training and development, monthly care planning team meetings that check on progress toward goals and monthly review of existing services. Choices does a separate weekly review of levels-of-care and service utilization, particularly monitoring the number of youth in out-of-home care and residential care and their lengths of stay.

Training is done at orientation for all new staff. The Director of Outcomes and Evaluation works on inter-rater reliability for the CAFAS. Supervisors work on the link between clinical events and CAFAS scores in supervision meetings. Exploration of identifiable CAFAS trends that predict the 80% of youth with "successful completion" of the program is underway.

Experience to Date

DAWN Project management staff believes that guidelines that are used correctly and consistently are necessary to prevent dilution of mission integrity. However, DAWN Project leaders have found that one tool alone cannot cover all needs. The recommendation from the DAWN experience is to think through all the elements that you have to keep track of for practice management and program sustainability and select a limited number of instruments or guidelines that support those elements. Evidence drawn from measurement of service use and clinical improvement is critical in providing information back to stakeholders regarding whether the program is meeting its goals and should continue and is, therefore, directly related to sustainability.

DAWN Project, Marion County (IN)

(**Group Three:** Formalized Wraparound Process)

Major Benefits, Concerns and Lessons Learned

DAWN Project stakeholders shared a number of observations regarding the various clinical decision-making and measurement tools they are using, including:

- Use of the CAFAS gives DAWN a benchmark within the field for the sake of comparison with other programs. It is also fast and relatively simple to use. However, stakeholders also reported that the CAFAS does not flow well into treatment planning and its every six-month collection does not offer concurrent information to the clinical decision-making process.
- The WFI is very quick to use (20 minutes) and very relevant to ongoing quality improvement activities. However, it is designed to provide a program or system report, and is not useful on an individual basis.
- Real time cost data help flag the need for increased clinical and/or administrative oversight and intervention. Linked datasets allow care coordinators and supervisors to see cost in the context of clinical information, which is more useful to them than getting separate reports.

Although the CAFAS was the "hot tool" and the only one that was easy to learn to use at the time that DAWN was beginning, they are currently leaning toward using the CANS[77] for the following reasons:

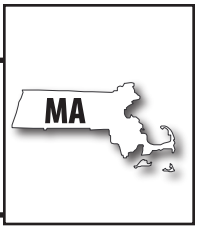
- Belief that it works better as a practice tool—allowing immediate communication (i.e. three areas to work on that can be built directly into the treatment plan)
- CANS includes the DSM-IV—is multi-dimensional and includes education, child welfare and juvenile justice system questions
- Good experience using it in the state of New Jersey for non-clinically sophisticated staff to gain insight into the relevant issues
- Being pragmatically oriented, it "levels the playing field" among team members from disparate backgrounds
- It offers information sharing and communication strategy while maintaining the clinical sensitivity of the CAFAS
- Includes the concept of "strengths" in the model
- It is dynamic; it can be used every week if needed
- Allows for clinical and fiscal outcomes to be integrated.

The DAWN Project's report on its use of clinical guidelines, based on seven years of experience, is particularly valuable since one of the contributions the project makes in the field is that it strives to represent an efficient blend of clinical and business knowledge and is, therefore, more transferable than a more purely academic model.

77 Lyons, J. S., Griffin, E., Fazio, M., & Lyons, M. B. (Revised 2003; c1999). Child & adolescent needs & strengths: An information integration tool for children and adolescents with mental health challenges: CANS-MH manual. Winnetka, IL: Buddin Praed Foundation. Available http://www.dcf.state.fl.us/mentalhealth/publications/cans4.pdf <http://www.dcf.state.fl.us/mentalhealth/publications/cans4.pdf>.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Overview

The Mental Health Services Program for Youth (MHSPY) in Massachusetts is an interagency collaboration aimed at demonstrating the effectiveness of an intensive combination of mental health, pediatric and substance abuse services for children and youth with serious emotional disorders who would otherwise risk placement out of their homes and communities. The MHSPY program grew out of broad stakeholder recognition that legislatively defined "categorical funding" created gaps and ambiguities in the mandates of the state's main child serving agencies (Medicaid, mental health, juvenile justice, child welfare and education), which contributed to the difficulty of caring for children and families with complex needs. During two years of consensus building and planning, child mental health clinicians, policy experts, parents, administrators, state agency staff, and community representatives came together to form the MHSPY Steering Committee.

The Massachusetts MHSPY program was a recipient for one of twelve Robert Wood Johnson (RWJ) Foundation and Washington Business Group on Health (WBGH) replication grants awarded in 1997, which supported development of the model. Now using blended public agency funding, the program provides traditional and non-traditional services through Neighborhood Health Plan, a private, not-for-profit, managed care organization.

From its inception, MHSPY has straddled identities as a research and demonstration project for an integrated clinical care intervention, a state Medicaid contracted service for a special population, and an innovative financial and shared governance model. Special population screening instruments and eligibility criteria, clinical quality guidelines and program performance measures were selected by the MHSPY Steering Committee to address all of these program identities and their unique customers. Performance measures needed to be located within the four overarching outcome domains of: level of clinical functioning, service intensity and utilization, program cost, and family, youth and referring agency satisfaction.

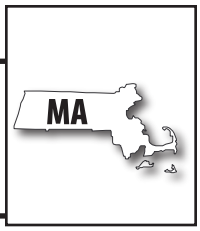
Goals

The MHSPY program aims specifically to address the fragmentation of care that surrounds youth with psychiatric illnesses and their families. For these children, access barriers to appropriate clinical screening and treatment, as well as lack of coordinated decision-making across state agencies (e.g. mental health and child welfare), frequently cause them to be placed in residential facilities, group or foster homes far away from their relatives, neighborhood schools, and communities.

The MHSPY Steering Committee, representing the major child serving agencies in the state, as well as community and family representatives, created a state pilot to investigate whether allowing greater flexibility within available resources, and using an individualized, child-specific care planning team, would work better than "usual care." The RWJ Foundation MHSPY model, as replicated in Massachusetts, was intended to decrease reliance on expensive, out-of-home placements and to stretch limited mental health resources by developing an extensive support service system for children with severe emotional disturbance and their parents.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



The MHSPY design was greatly influenced by the federal Child and Adolescent Service System Program (CASSP) principles. Children and their parents were placed at the center of a system of care involving mental health services, the schools, child welfare, and juvenile justice. The Massachusetts MHSPY replication is unique in that physical health care also is included in the benefit. A better-integrated system of care, as defined by the RWJ Foundation, was expected to envelop the child and his/her family and thereby promote continuity of care and improved outcomes. The MHSPY Replication grant sites, including Massachusetts, additionally were required to be accountable for outcomes, able to maximize funding sources and be designed to take place within a managed care context. This accountability has been highly beneficial in establishing the legitimacy of guidelines and required training and fidelity enhancement activities. Massachusetts MHSPY adapted the systems of care model in order to maintain the strengths of financially accountable, intensively clinically managed care, while combining that with a family-driven, collaborative approach consistent with the CASSP principles.

Background

MHSPY is a clinically intensive home and community-based intervention that uniquely combines medical, substance abuse and psychiatric care, as well as "wraparound" support resources, for Medicaid youth and their families. The program is administered through a three-tiered shared governance structure that requires: (1) collaboration and communication about policy across separate state agencies and between the public (EOHHS) and private sectors (Neighborhood Health Plan) at the state level; (2) shared decision-making about resource use, referrals and disenrollments at the area agency operations level; and (3), active participation in all service decisions by the involved local agency staff at the service delivery level.

Program funding is based on blended public agency funds from multiple state agencies, including: Medicaid, Department of Social Services (child welfare), Mental Health, Department of Youth Services (juvenile justice), and Education. These funds are used to purchase all medical, mental health, substance abuse and social services, including "wraparound" [78] resources, based on clinical criteria and in the context of family-based care planning teams[79]. This highly specialized health care delivery system, which combines public and private dollars, has multiple sources of accountability, and requires transparency in both financial and clinical decision-making (see **Figure 1)**.

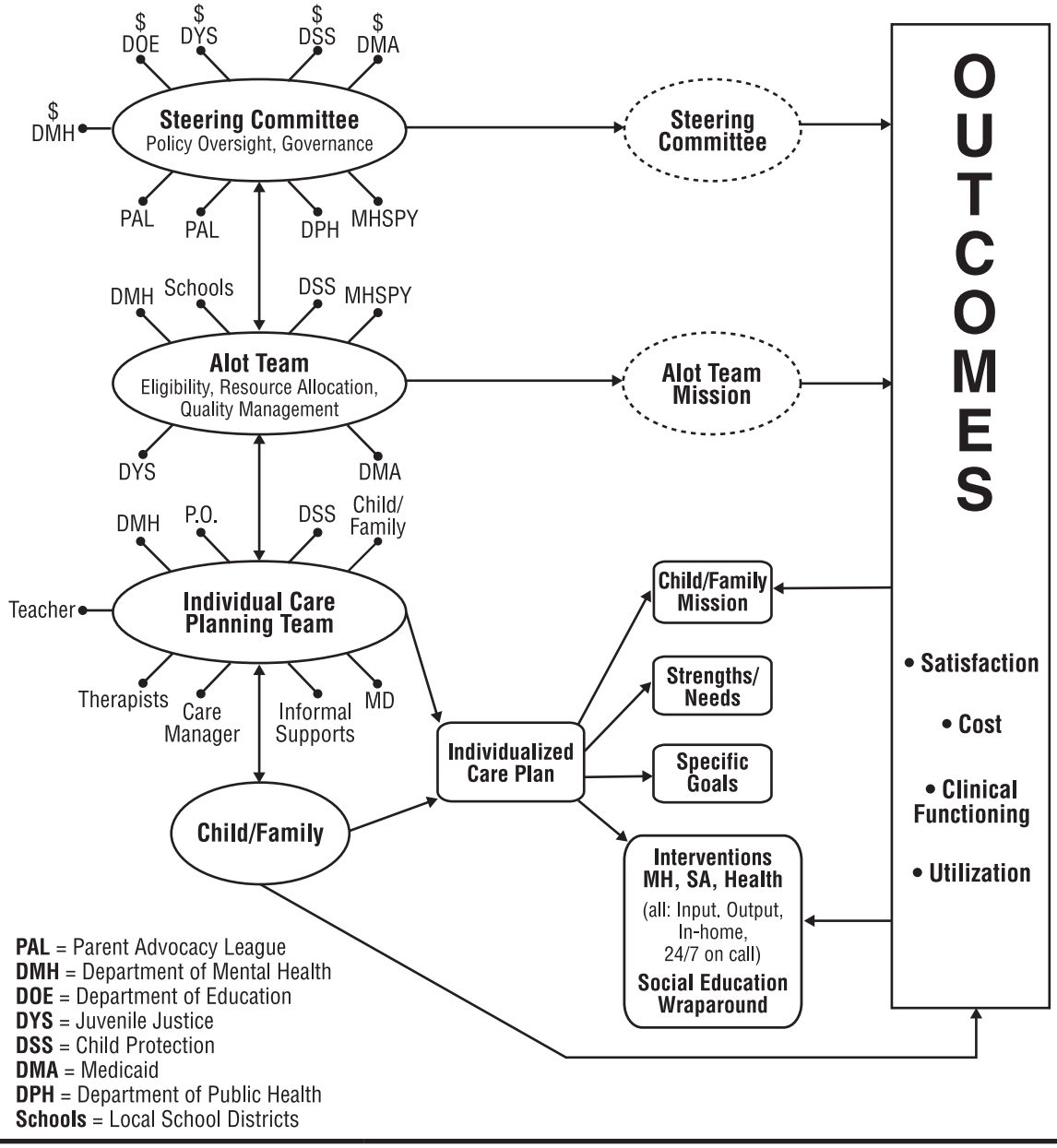
78 VanDenBerg, J., & Grealish, E. M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. Journal of Child and Family Studies, 5(1), 7-21.

79 Pires, S.A (2002). Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 1: Managed care design & financing (FMHI Publication #211-1). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)

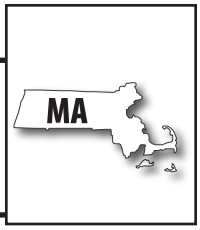
Figure 2.
MHSPY Model Design and Infrastructure



PAL = Parent Advocacy League
DMH = Department of Mental Health
DOE = Department of Education
DYS = Juvenile Justice
DSS = Child Protection
DMA = Medicaid
DPH = Department of Public Health
Schools = Local School Districts

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



The overlapping mandates allow the delivery of highly coordinated clinical care and other supports, but bring with them complex reporting expectations that address unique state agency obligations, as well as those needed for the purpose of clinical quality management and pilot evaluation. This results in multiple instruments being used in order to address information needs at various levels of the program.

When the group of stakeholders that became the MHSPY Steering Committee achieved consensus regarding the MHSPY program mission, there was recognition that "usual care" left many youth under-diagnosed or misdiagnosed and that the nature of child mental health conditions was that clinical presentation sometimes evolved over time. Therefore, there was a focus on intensity of service need, rather than diagnosis for selection of youth to enroll. At the same time, the public sector agency purchasers were wary of losing managerial oversight over such a broadly flexible benefit and wanted to make sure that appropriately complex youth were enrolled. A single screening instrument score was felt to be insufficient to this purpose. Ultimately, the following combined criteria for enrollment eligibility were determined:

MHSPY Eligibility Criteria

- children three through 18 years of age
- residents of the pilot communities
- eligible for services from Medicaid and at least one other state agency and/or receiving special education services
- demonstrably impaired for greater than six months and either already out of the home or at-risk of out of home placement
- Child and Adolescent Functional Assessment Score (CAFAS)[80] greater than 40
- a parent or guardian willing to consent to child's treatment and to participate in the care planning process.

The Steering Committee agreed on a definition of the expanded Medicaid and multi-agency "benefit" which included a continuum of care from least (home-based) to most restrictive (hospital and residential) settings. In addition, the MHSPY intervention was to draw upon the "wraparound philosophy" and included flexible funding to support individualized, strength-based service planning for each child, facilitated by a MHSPY Care Manager and the Care Planning Team.

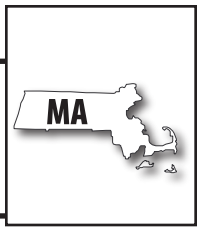
Description

MHSPY enrollees are referred by local representatives from the Massachusetts Departments of Mental Health, Social Services (Child Welfare), Youth Services (Juvenile Justice), and local special education departments. MHSPY offers an integrated care model for youth with significant mental health needs; referring agencies often select youth for whom previous

80 Hodges, K., Wong, M. M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. Journal of Behavioral Health Services and Research, 25 (3), 325-336.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



interventions have failed. Each youth is assigned a Care Manager to work with the youth and his/her family and help them articulate their needs and goals via a strength-based process. MHSPY Care Managers are responsible for a caseload of eight youth and their families.

The intensive treatment approach involves creation of a Care Planning Team, made up of the family, a MHSPY Care Manager (a Master's level clinician who chairs the team), and all providers or informal supports identified by the family as involved in their child's care. The team defines the "mission" for the youth and the individualized interventions (physical, social, mental health, educational, wraparound, etc.) based on understanding of family culture, strengths and needs, including immediate and long-term concerns, and the establishment of trust among team members. MHSPY Care Managers are responsible for direct clinical intervention (face-to-face home-based care for the child), care coordination (linkage with professional and non-professional community resources), and case administration (authorization of services and documentation).

The intervention process and culture is reinforced via multiple layers of training and concurrent supervision. A Clinical Supervisor oversees five Care Managers. The MHSPY care planning processes, which combine to create the impact of the overall intervention, include: (1) the Care Planning Team; (2) the resulting Individual Care Plan, which specifies all interventions and wraparound resources to facilitate implementation; (3) measurable goals for each intervention with concurrent monitoring of results; and, (4) shared accountability among all members of the Care Planning Team regarding outcomes.

In addition to the Care Management services, MHSPY includes: a standard Medicaid physical health benefit, including inpatient and outpatient medical, surgical, and pharmacy; standard Medicaid covered mental health and substance abuse services, including inpatient and outpatient treatment, neuropsychology assessment and medications; non-traditional services, including parent partners, therapeutic after-school program, and respite; and, wraparound services, such as transportation and camp.

The community based, interagency referral and clinical review team, known as the MHSPY Area Level Operations Team (ALOT), contributes clinical expertise, along with a depth of individual case knowledge, to supplement the screening process that accompanies application of the eligibility criteria, including administration of the CAFAS, at the time of referral. Youth who do not meet eligibility criteria are referred to alternate resources outside of MHSPY. For those who do meet eligibility criteria and are enrolled, a battery of baseline assessments are done to establish youth functioning and overall parent or family status at the time of enrollment. In order to best interpret results in both baseline and repeated measures of functional status, information is collected from multiple sources, including parent and teacher reports, youth self-report, Care Manager assessment, and administrative data. Details of the overall methodology for the collection of individual clinical information in MHSPY are provided in **Table 4**.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)

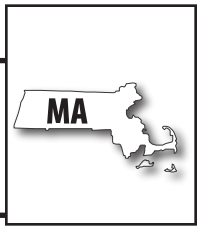


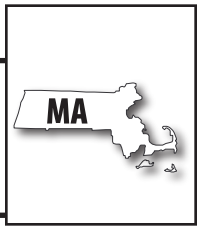
Table 4.
Massachusetts Mental Health Services Program for Youth Evaluation Methodology

Outcome	Perameter	Source	Measure	Frequency
I. Level of Functioning	Home	Caregiver	CAFAS[1]	Baseline, Every 6 Months; Disenrollment
		Caregiver	CBCL[2]	Baseline, Every 6 Months; Disenrollment
		Child	YSR[3]	Baseline, Every 6 Months; Disenrollment
		Caregiver	FCBS4	Baseline, Every 6 Months; Disenrollment
	School	Teacher or Counselor	CAFAS	Baseline, Every 6 Months; Disenrollment
		Teacher or Counselor	TRF6	Baseline, Every 6 Months; Disenrollment
		Office of Special Education	IEP6 (if applicable)	Baseline, Upon Revision
	Community Mental Health	Caregiver	CAFAS	Baseline, Every 6 Months; Disenrollment
		Care Manager	PAT7, CGAS8	Baseline, Every 6 Months; Disenrollment
		Care Manager	CAFAS	Baseline, Every 6 Months; Disenrollment
	Physical Health	Pediatrician	Medical Record	Baseline
II. Service Utilization	Referring Agency	Special Education via five participating school districts,	IEP Service Plan, Treatment Plan, Court Records	Baseline
		Child Welfare (Dept. of Social Serives),		
		Mental Health (Dept. of Mental Health),		
		Juvenile Justice (Dept. of Youth Services)		
	Mental Health	Neighborhood Health Plan, MHSPY Clinical Records	Utilization Reports	Baseline, Monthly; Disenrollment
	Wraparound	MHSPY Clinical Records	Suthoriztion Data; Chart Records	Baseline, Monthly; Disenrollmen
	Physical Health	Neighborhood health Plan, Primary Care Physician	Medical Records; Claims, Authoriztions	Baseline, Monthly; Disenrollment
III. Cost	Captitated Claims	Neighborhood Health Plan	Financial Reports	Baseline, Monthly; Disenrollment
	Fee for Service Claims	Neighborhood Health Plan	Claims	Monthly
	Non-MHSPY Services	Referring Agencies	Agency Data	Baseline
IV. Satisfaction	Home	Youth, Caregiver	Questionnaire	Disenrollment
	Stakeholder	Referring Agency	Questionnaire	Disenrollment

1. CAFAS: Child and Adolescent Functional Assessment Scale (Hodges, 1998).
2. CBCL: Child Behavior Checklist (Achenbach, 1991).
3. YSR: Youth Self-Report (Achenbach, 1991).
4. FCBS: Family Centered Behavior Scale (Allen, Peir, & Brown, 1995).
5. TRF: Teacher Rating Form (Achenbach, 1991).
6. IEP: Individualized Education Program
7. PAT: Mental Healh Patient Assessment Tool (Grimes, 1990).
8. CGAS: Children's Global Assessment Scale (Shaffer, Gould, Brasic, Ambrosini, Fisher, Bird, Aluwahlia, 1983).

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Measurement of level of functioning is collected at baseline, every six months, and at discharge using the following standardized instruments: the Child and Adolescent Functional Assessment Scale (CAFAS),[81] the Child Behavior Checklist (CBCL), Youth Self Report (YSR), the Teacher Report Form (TRF),[82] and the Family Centered Behavior Scale (FCBS).[83]

These measures are administered by the MHSPY Enrollment Manager at baseline and by the Clinical Outcomes Coordinator at subsequent intervals. Additionally, two instruments are administered by MHSPY clinicians: the Child Global Assessment Scale (CGAS)[84], and the child Patient Assessment Tool (PAT).[85] These clinician-rated instruments are intended to be used to inform the care planning process. Finally, satisfaction surveys are administered by the Clinical Outcomes Coordinator to the youth, the family, and the leading agency involved when a child is discharged. Findings from these various instruments are used concurrently as part of the clinical quality management conducted by Senior Clinical Managers and supervisory staff, as well as combined semi-annually for aggregate analysis at the program level.

Individualized, Culturally Competent Family-Focus

Consistent with the historic link to the CASSP principles in the organized system of care model, the MHSPY program stresses individualized, comprehensive and culturally appropriate care. This care is strengths-based, designed and implemented in partnership with families and youth. Caregiver involvement is crucial to the care planning process. The Care Planning Team (CPT) is a family-based team that develops and monitors the child's care plan; a meeting cannot be held without a parent or guardian present. Each child's individualized care plan is created in partnership with the family and youth who must agree with the plan and help select the interventions, which need to fit the family's culture. The CPT creates a mission, a "picture of how they want things to look" for the child, stated in the family's words, and then works actively together to build a sustainable plan to accomplish that mission. The degree to which this has happened determines the family team's assessment of when a youth is ready to "graduate" from MHSPY.

81 The CAFAS was developed in 1989 by Kay Hodges, Professor of Psychology at Eastern Michigan University, who holds copyright ownership of the instrument. For more information regarding CAFAS, readers should refer to the Michigan section in this publication.

82 Achenbach, T. M. (1991). Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles. Burlington, VT: Department of Psychiatry, University of Vermont.

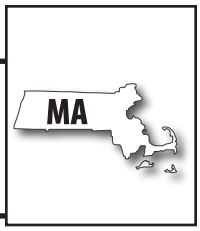
83 Allen, R., Petr, C., & Brown, B. (1995). Family Centered Behavior Scale. Lawrence, KA: Beach Center on Families and Disability, University of Kansas.

84 Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). Archives of General Psychiatry, 40(11):1228-1231.

85 Grimes, K.E. (1990). Child Patient Assessment Tool. Boston, MA: Harvard Pilgrim Health Care. See also Abrams, H. S. (1993). Harvard community health plan's mental health redesign project: A managerial and clinical partnership. Psychiatric Quarterly, 64(1), 13-31 and Grimes, K. E. (1997) Seen and not heard: planning for children's mental health in managed care. Journal of the Association for Academic Minority Physicians, 8(4):74-77..

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Impact of Service Availability

MHSPY purchases services for MHSPY enrollees based on the needs identified in real time by the Care Planning Team. Individualized interventions, using both standard mental health treatment categories, such as psychotherapy or medication, and non-traditional services, such as transportation to a specialized after-school program, are matched to the goals (supported by the known strengths) and authorized directly by the MHSPY Care Manager. There are no external review committees or remote administrative processes to interfere with bringing appropriate resources to meet the need. However, there are times when the desired service can be difficult to find and creating capacity is challenging when demand is intermittent.

In Massachusetts, MHSPY has operated as a "pilot" under a Medicaid waiver, which allowed access to MHSPY for some communities only. While an EPSDT lawsuit seeking greater access to home and community-based services is in process in Massachusetts, at the present time, most parts of the state have only "usual care" available for children with serious emotional disturbance. The fact that only a relatively small number of families in total can access the non-traditional services that MHSPY is able to develop and purchase through flexible funds means that the provider community does not widely offer such services. Therefore, while clinical guidelines do not restrict service availability for MHSPY members, there can be challenges in locating convenient respite resources, for example, or Spanish speaking in-home family therapists, when the overall purchasing power and program capacity is too small to generate significant provider response.

Training, Fidelity and Oversight

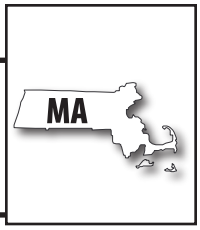
Intensive supervision to ensure fidelity to the model is a key element in the conceptual framework of shared purpose or "continuity of intent" that underlies the MHSPY program. This includes the assumption that higher degrees of morbidity require greater attention to detail on the part of all providers, with specified processes to facilitate coordination and integration across interventions. While health care recipients with low or moderate levels of severity may be able to advocate for themselves in order to get what they need, youth and families with high levels of severity and barriers to accessing care appear to benefit from highly specified, intensely supervised clinical interventions.[86][87] Therefore, MHSPY Care Managers use the manualized MHSPY clinical intervention process to: (1) assess the strengths and needs of each child, (2) to facilitate the creation of a dedicated team of individuals (teachers, friends, relatives, state agency staff, pediatricians and other clinicians) identified by the family to participate as their Care Planning Team and (3) to monitor treatment efficacy so that appropriate changes in the intervention plan can be made in real time for the youth and family as needed.

86 Schoenwald, S. K; Henggeler, S. W; Brondino, M.J; & Rowland, M. D. Multisystemic therapy: Monitoring treatment fidelity. Family Process, 39(1), 83-103.

87 Schoenwald, S. K; Brown, T. L; Henggeler, S. W. (2000). Inside multisystemic therapy: Therapist, supervisory, and program practices. Journal of Emotional and Behavioral Disorders, 8(2), 113-127.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Care Managers directly work with the MHSPY youth and their families, so this allows them to use their own clinical training, for example, to recognize safety or crisis circumstances that require adjustments of the plan on an urgent basis. This shift in treatment strategy might occur between Care Planning Team meetings, but team members would be either consulted or notified, depending on the need. The Crisis/Safety plan for each child is reviewed weekly by the clinical staff. Care Managers also use the Child-Patient Assessment Tool (PAT), a clinician assessment, to establish functional status of child and family at baseline or program entry. This measure, along with the CGAS, is repeated by the Care Manager every six months. Training on the PAT is done during orientation for all new clinical staff and at periodic intervals to ensure inter-rater reliability. Clinical Supervisors and the Medical Director review PAT scores and other formal instrument results in their regular supervision meetings with the Care Managers.

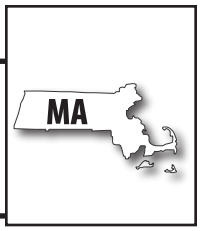
In addition to information gathered from documentation by Care Managers, formal data collection via standard instruments is conducted through the Research Department. The Clinical Evaluation and Enrollment Manager first administers the CAFAS, CBCL, YSR, TRF and FCBS at enrollment (baseline) for all new program enrollees. Follow-up data collection using each of these measures at 6 month intervals is conducted by the Clinical Outcomes Coordinator. The Outcomes Coordinator receives training and supervision, which includes inter-rater reliability checks with the Clinical Evaluation and Enrollment Manager. MHSPY staff who are responsible for administering the instruments keep up with any suggested protocols to enhance reliability and validity, such as the CAFAS training protocols, which include refresher testing every 6 months and yearly vignette write-ups.[88] Follow up CAFAS scores are determined using multiple sources to help ensure accurate scoring in adherence with the CAFAS guidelines for administration. Families are interviewed for the follow-up Child Behavior Check List and Family Centered Behavior Scale measurement, teachers are asked to complete the Teacher Rating Form on a six-month basis, and adolescents are given the Youth Self-Report every six months. The persons administering the instruments are not involved in the youth's care. Interest in participation by families in the data collection is high, which increases confidence in the reliability of the findings.

Part of the MHSPY process is for Care Managers and Clinical Supervisors to train "system partners" (i.e. child protective service workers, teachers) in the model so that expectations among care planning team members are congruent, and so that a shared culture, such as using a strength-based approach, can be developed. As MHSPY staff have the opportunity to work again with someone they know from a previous case, it is clear that the prior experience helps a great deal with establishing ground rules about participation and team process. Frequently, these relationships and skills built around one child's Care Planning Team contribute directly to referrals of other youth in need and/or to improvements in service delivery for similar children.

88 Hodges, K., Wong, M. M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. Journal of Behavioral Health Services and Research, 25 (3), 325-336.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Experience to Date

MHSPY uses multiple instruments and clinical decision-making supports throughout the program. This occurs at the level of the individual youth, from the CAFAS score to assist with screening and eligibility at baseline, to multiple measures of functional status or clinical improvement over standard intervals to assess the degree of treatment effectiveness and to note if treatment changes are needed. Such information also contributes to the determination of overall family readiness for "graduation" from the program. No tools or guidelines are used for the purpose of limiting or restricting care. A MHSPY member does not need to reach a certain "score" on an instrument to make them eligible for a greater level of service intensity. Nor do improved scores create a risk of being disenrolled from the program. Both kinds of decisions are made at the level of the Care Planning Team and are based on expressed needs and associated strengths.

Major Benefits, Concerns and Lessons Learned

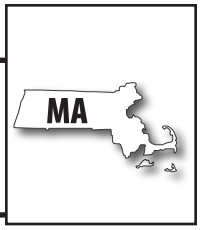
Benefits to the instruments and assessments in use now by MHSPY include that all of the individual child measures also "roll up" in aggregate for purposes of evaluation of program effectiveness. These aggregate reports provide longitudinal information about trends in clinical, cost, level of restrictiveness and other programmatic results, which have directly impacted the knowledge base among policy makers regarding the quality of program outcomes, which, in turn, has aided sustainability. Familiarity with the performance measures has also helped in communicating with state level decision makers regarding the degree of reliability in MHSPY outcomes, including the fact that the results from a second MHSPY site have replicated the first regarding level of restrictiveness and success in keeping enrolled youth in their homes and communities.

MHSPY has found that no one instrument provides all the information necessary to determine care decisions, track outcomes and provide data for quality improvement efforts, but that combining information from several sources allows useful secondary analyses to be done. For example, to address the important stakeholder question of who is best served by access to MHSPY, program analysts are reviewing characteristics of youth most likely to respond to MHSPY versus those least likely to respond. Upon completion, MHSPY will be able to use information from the standardized measures to inform purchaser/stakeholders regarding future referral policies and procedures within their own agencies. Information from clinical instruments is most helpful to such stakeholders when presented in conjunction with data on service use and cost, as well as in the context of family and youth satisfaction reports.

Another benefit to the use of standardized measures is that there is information available for many of the instruments, such as the CAFAS, regarding the meaning of certain percentage points of change. Also, since the tools are widely used, it is possible for clinicians, program administrators and policy makers to compare results with other programs across the country.

Mental Health Services Program For Youth (MHSPY) (MA)

(**Group Three:** Formalized Wraparound Process)



Concerns include the fact that intensive training and quality monitoring, such as that done by MHSPY, require staff time and resources that standard state agency contracts generally do not support. Thus, program administrators risk being expected to provide detailed reports based on "evidence based" interventions, without any additional funding being provided to support such activities. Additionally, many instruments require licensing agreements and/or the purchase of software applications for scoring, which brings additional expense, not to mention that any such data collection requires staffing both for the collection efforts and entry of the resultant data, even before analytic time is considered. Another concern is that, except in cases where states or programs have obtained generous federal Center for Mental Health Services (CMHS) grant awards, there is no funding for "follow up" post enrollment data to assess the degree to which improvements are sustained and what helps sustain them.

Lessons learned, in addition to the fact that information is not free, include that the training of clinical care managers is unlikely to be heavily research based and that it is more difficult than might be imagined to bridge the two cultures – research and clinical - when integrated program results. Therefore, even when the data are captured reliably and transferred expeditiously to care managers, it is not necessarily transparent or obvious to care delivery staff how to integrate the information into the clinical decision-making process taking place within the Care Planning Team. Further challenges occur when either an existing instrument loses favor, and the protocol for collection needs to be modified, giving all prior longitudinal data trends an artificial endpoint, or when a new instrument acquires a following that make it necessary to add it (plus training, collection and reporting expenses) to the program's procedures. There is an inherent tension between information processing needs that value stability of data definitions and reporting methods and the realities of a field such as child psychiatry where the science base is evolving, bringing with it new instruments and new strategies for analysis. Sometimes, it is external policy changes that create the need for modifications in the use of guidelines and instruments. A recent example of this involves the potential addition of the Child and Adolescent Needs and Strengths (CANS)[89] to the MHSPY instrument panel in the near future because the state of Massachusetts child welfare agency (DSS) has chosen the CANS as a required tool for private organizations under contract with the agency. While there are some overlaps in the two instruments, MHSPY does not currently intend to replace the CAFAS with CANS but rather will add the administration of the CANS to the instrument protocol. Although information gatherers will potentially be facing redundancy regarding some of the items, using both makes it possible to be in compliance with policy directives from a major purchaser, while continuing to report established data elements from a standard instrument on a longitudinal basis.

89 CANS, the Child and Adolescent Needs and Strengths, is an instrument developed by John S. Lyons, Ph.D., at Northwestern University.

Wraparound Milwaukee, Milwaukee County (WI)

(**Group Three:** Formalized Wraparound Process)

Overview

The "Wraparound Milwaukee" program, which began in 1995, is a multi-stakeholder, public system of care for high risk youth and families organized around risk-based, blended funding that pays for a broad range of services and supports provided through an individualized, wraparound approach to service planning and provision. Wraparound Milwaukee is managed by the Milwaukee County Division of Child Mental Health Services, which functions as a management services organization (or managed care entity). Initially based upon a six year, $15 million federal grant from the Center for Mental Health Services (CMHS) to Milwaukee County, it was one of the first ten such sites funded throughout the country. The intent of the federal grants was to "foster the development of more comprehensive, community-based care for children with serious emotional needs and their families,"[90] Milwaukee Wraparound is designed to be accountable and at risk for service use, dollars spent, and clinical results achieved, and its administrators are fluent in managing care and reporting outcomes. It has both far more information about individual children served than most public mental health systems and far more flexibility as to what can be provided, largely as a result of blended funding and case rate and captitation financing arrangements. It is built on a foundation of CASSP principles.[91] In the ten years since it started, Wraparound Milwaukee has repeatedly demonstrated improvements in areas such as community safety and school attendance. There have also been significant improvements in the program's ability to maintain youth at home who were otherwise likely to be placed in hospital or residential care.

Goals

As previously documented in the Health Care Reform Tracking Project's Promising Approaches series.[92] Wraparound Milwaukee was designed to reduce the use of institutional-based care, such as residential treatment centers and inpatient psychiatric hospitals, while providing more home and community-based services. CMHS grant support was targeted to ensure greater family inclusion in treatment programs, along with collaboration among child welfare, education, juvenile justice, and mental health in the delivery of services.[93] Therefore, many of Wraparound Milwaukee's measurement points and data collection activities relate to items of importance to the program's stakeholders/purchasers, such as: the number of youth in placement, service dollars broken out by offender type, recidivism, school attendance, and level of functional impairment.

90 alt.samhsa.gov/samhsa_news/VolumeXII_5/article2

91 Stroul, B. A. & Friedman, R. M. (1994, rev. ed.). A system of care for children and youth with severe emotional disturbances. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

92 Pires, S.A (2002). Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems, 1: Managed care design & financing (FMHI Publication #211-1). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

93 More information on the origin and design of Wraparound Milwaukee can be found on their website: www.milwaukeecounty.org/service

Wraparound Milwaukee, Milwaukee County (WI)

(**Group Three:** Formalized Wraparound Process)

Background

Wraparound Milwaukee uses formal instruments to monitor clinical progress, such as the Child Behavior Checklist (CBCL),[94] Youth Self Report (YSR),[95] and the Child and Adolescent Functional Assessment Scale (CAFAS)[96] (five scales), as determined by the original CMHS grant evaluation protocols. They do not use any pre-admission "assessment tools" because they are required to accept any court-ordered child who matches eligibility. However, the eligibility definition itself is based on level-of-care criteria described within their contract with the State Medicaid agency. These include:

(a) the federal definition of "serious emotional disturbance" (SED)

(b) must have clinical symptoms consistent with SED within the last six months and having persisted over the past year

(c) presence of a DSM-IV diagnosis

(d) functional impairment in any of the following areas: psychosis, dangerous to self or others, lack of self-care, personal grooming, lack of age-appropriate decision making, social relationships, peers and adults, family, disruptive behavior, violence, school/work

(e) involved with two or more service systems

(f) at risk of immediate placement in psychiatric hospital, residential care or correctional system.

The eligible population is therefore a special population, determined by the referring agencies within the county, as well as (initially) the federal government, to require highly intensive services. Wraparound Milwaukee does not represent either a floor or a ceiling for services within the county, but is instead an alternative to usual care. The program increases access to clinically appropriate services for those youth who are able to remain at home as a result of the individualized, community-based services, but administration of the eligibility guideline is done before the referral is generated.

Initial treatment decisions, ongoing care and treatment monitoring are done within the context of the "Child and Family Team" concept. The team determines "medical necessity;" all care is signed off on by either a psychologist, or if medication is involved, a psychiatrist. This person may be either a treating clinician on the team or a consultant to the team.

94 Achenbach, T. M. & Rescorla, L. A. (2001). Manual for the ASEBA school-age forms & profiles: an integrated system of multi-informant assessment. Burlington, VT: ASEBA

95 Ibid.

96 Hodges, K., Wong, M. M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. Journal of Behavioral Health Services and Research, 25 (3), 325-336.

Wraparound Milwaukee, Milwaukee County (WI)

(**Group Three:** Formalized Wraparound Process)

Selection of treatment goals and appropriate interventions is guided by the use of structured "Life Domain" documents. These are updated and reviewed to measure clinical improvement and for quality management purposes. Clinical tools are also used to measure improvement, but not to drive immediate service decisions. Analysis of trends in functional measures does ultimately provide input for changes in program treatment strategies.

Description

The instruments and guidelines used by Wraparound Milwaukee are not mandated by the state nor are they widely in use within the state. They are a combination of formal measures defined by SAMHSA as part of the federal grant participation, along with additional measures chosen by the program for the purposes of following and reporting results. An example of the latter is the collection of data regarding juvenile offenses for the periods six months prior to the program, during the program, and up to three years post program involvement.

Care Coordinators collect: a) CAFAS scores and b) school attendance and related records. Family members and youth periodically provide: (a) CBCL and YSR data, (b) Updated Life Domain information. Juvenile justice staff provides information on offense records, past and present. There are audits regarding missing or completed data, but the need for monitoring of the way that guidelines are being used is up to individual supervisors to determine.

Individualized, Culturally Competent Family Focus

Wraparound Milwaukee is a model of family-driven, individualized care, and Care Coordinators are instructed to share all instruments and results with the families. The Child and Family team process supports flexible care planning, consistent with the wraparound philosophy, and also supports caregiver/youth decision-making roles.

The Care Coordinator makes edits to the care plan on a regular basis in response to informal and formal feedback regarding the youth's progress toward his goals. Individual factors, such as strengths, needs, culture, language and ethnicity are integral to the definition of appropriate interventions and services within the care planning done by the Child and Family Team.

Impact of Service Availability

If selected services are not immediately available, the team works to create alternatives, either temporary or sustainable, that can address the needs driving the initial service selection.

Training, Fidelity and Oversight

Training and certification on the use of the formal instruments is performed by the Program Evaluator, who also submits reports to stakeholders, following the standard set by CMHS, and monitors contractual compliance.

Wraparound Milwaukee, Milwaukee County (WI)

(**Group Three:** Formalized Wraparound Process)

Experience to Date

Wraparound Milwaukee stakeholders shared the following from their experience with use of standardized instruments within a wraparound process:

(a) Optimal use of clinical care guidelines requires a process that includes systematic training

(b) It is important to select indicators that are meaningful to stakeholders

(c) "Be careful what you collect"—all items require resources to collect and report

(d) Clinical tools are not a substitute for an effective Child and Family Team process but a guide for monitoring progress.

Major Benefits, Concerns and Lessons Learned

Wraparound Milwaukee identifies its most valuable indicators as: school attendance reports and rates of recidivism. Stakeholders indicated that the major benefit of an organized protocol to capture and compare this information is that it supports program sustainability. The non-traditional strategies, such as the wraparound approach, gain credibility when the evidence of a reduced level of need is presented to external stakeholders. Internal to the program, guidelines that require clinical instruments to be used offer support to ongoing quality improvement processes.

Wraparound Milwaukee stakeholders identified several challenges associated with use of standardized instruments. Specifically, they noted that clinical information at the individual level is difficult to collect. It costs money both to collect and to analyze individual level data. Furthermore, staff must be trained to use the formal instruments and how to interpret results, and much of the work still relies on manual processes, which also requires supervisory resources and quality control.

Appendix A

Glossary

Clinical assessment: A standardized procedure, with appropriate investigations or tests, to determine the individual physical, mental, or social well-being of a child. Performed at the request of a family or youth and includes a complete record of any findings and advice to the child/youth and family.

Clinical guidelines: Systematically developed process flow charts, which assist in decision making about appropriate health or behavioral health care for specific clinical conditions.

Criteria: An agreed-upon set of indicators to be used to assess eligibility for service access or change in level of care.

Evidence-based: Conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. This practice integrates individual clinical expertise with the best available external clinical evidence from systematic research, preferably involving randomized controlled trials.

Functional measures: Measurement of role performance or capacity in various areas; for youth, these areas include functional capacity within school, home and community, as well as ability to think or perceive surroundings accurately and interact appropriately with others.

Indicators: Items that flag particular events, processes or outcomes. Provide a quantitative basis for quality improvement, or sentinel, identifying incidents of care that may trigger further investigation. These indicators may address aspects of the process or outcome of health or behavioral health care delivery.

Instrument: Standardized tool whose use is validated and transferable from one trained user to another.

Measure: May be a "process" or "outcome" measure; should be reliable and reproducible for item being measured. Sometimes used synonymously with "instrument" – technically an instrument is used to measure something.

Medical Necessity: Despite its name, this term derives from insurance and regulatory origins and is not used in the medical community.

Outcome: The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement.

Outcome domain: The area or sector in which an outcome is located: health, expense, satisfaction, etc.

Outcome indicators: A specific item of information that serves as an incremental measurement that can be used to track a process over time. These items of information describe observable and measurable characteristics or changes that represent achievement of an outcome.

Outcomes management: Solutions that begin to 'close the loop' between infusing knowledge into the care process and generating new knowledge from empirical data gathered and analyzed as a by-product of evidence based care.

Outcome research: Studies that measure the effects of care or service delivery.

Wrap-around approach: A philosophical approach which promotes a process of strengths-based, needs-driven care in order to develop individualized responses to children and families in their own communities.

Appendix B

Resource Contact List

More detailed information about the experience using clinical guidelines of each of the sites described in this study can be obtained by contacting the following individuals:

Arizona

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Division of Behavioral Health Services
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Fax: 602-364-4560
Email: frider@dhs.state.az.us

Delaware

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Managed Care System Administrator
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Delaware Department of Services for Children, Youth and Families
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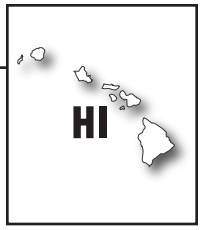
Hawaii



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Division of Mental Health
Department of Health and Human Services
1333 Mountain Shadows Drive
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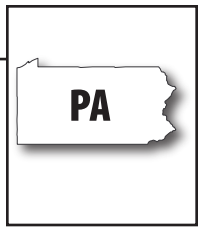
Pennsylvania



Julie Barley
Office of Mental Health and
Substance Abuse Services
Pennsylvania Department of
Public Welfare
DPW Complex #2
Shamrock Hall, Building 31
Harrisburg, PA 17105
Tel. 717 772-6427
Email: jbarley@state.pa.us

Texas

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Community Mental Health
Program Services
Texas Department of
State Health Services
Mail Code 2018
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Community Mental Health Authority

of Clinton, Eaton, Ingham Counties (MI)

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Children's Services
812 E. Jolly Road
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Dawn Project

Marion County (IN)

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Wraparound Milwaukee

Milwaukee County (WI)

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Publications of the HCRTP

Publications of the Health Care Reform Tracking Project (HCRTP) are available on-line as viewable/printable Adobe Acrobat PDF files:

http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/index or
http://pubs.fmhi.usf.edu click Online Publications (By Subject)

Reports of the Health Care Reform Tracking Project (HCRTP) are also available in print from the Research and Training Center for Children's Mental Health, at the Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271.

HCRTP Promising Approaches Series

Pires, S. A., & Grimes, K. E, (2005). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 8: Clinical decision making approaches for child/adolescent behavioral health care in public sector managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-8**)

Armstrong, M. I., (2005). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 7: Care Management in public sector managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-7**)

Wood, G. M., (2004). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 6: Family involvement in managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-6**)

Stroul, B. A., (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 5: Serving youth with serious and complex behavioral health needs in managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-5**)

Armstrong, M. I., (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 4: Accountability and quality assurance in managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-4**)

Hepburn, K. & McCarthy, J. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 3: Making interagency initiatives work for the children and families in the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (**Georgetown University Publication #211-3**)

McCarthy, J. & McCullough, C. (2003). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 2: A view from the child welfare system.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (**Georgetown University Publication #211-2**)

Pires, S.A (2002). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 1: Managed care design & financing.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211-1**)

HCRTP Consensus Conference 2003

Stroul, B.A., Pires, S.A, & Armstrong, M.I. (2003). *Health care reform tracking project: Using research to move forward: A consensus conference on publicly funded managed care for children and adolescents with behavioral health disorders and their families — September 29–30, 2003.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #215**)

HCRTP State Surveys

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HCRTP Impact Analyses

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Clinical Decision Making Approaches…in Public Sector Managed Care Systems

By:

Sheila A. Pires, M.P.A.
Katherine E. Grimes, M.D., M.P.H.

Produced in Cooperation with:

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