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.

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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).

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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.

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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

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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

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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

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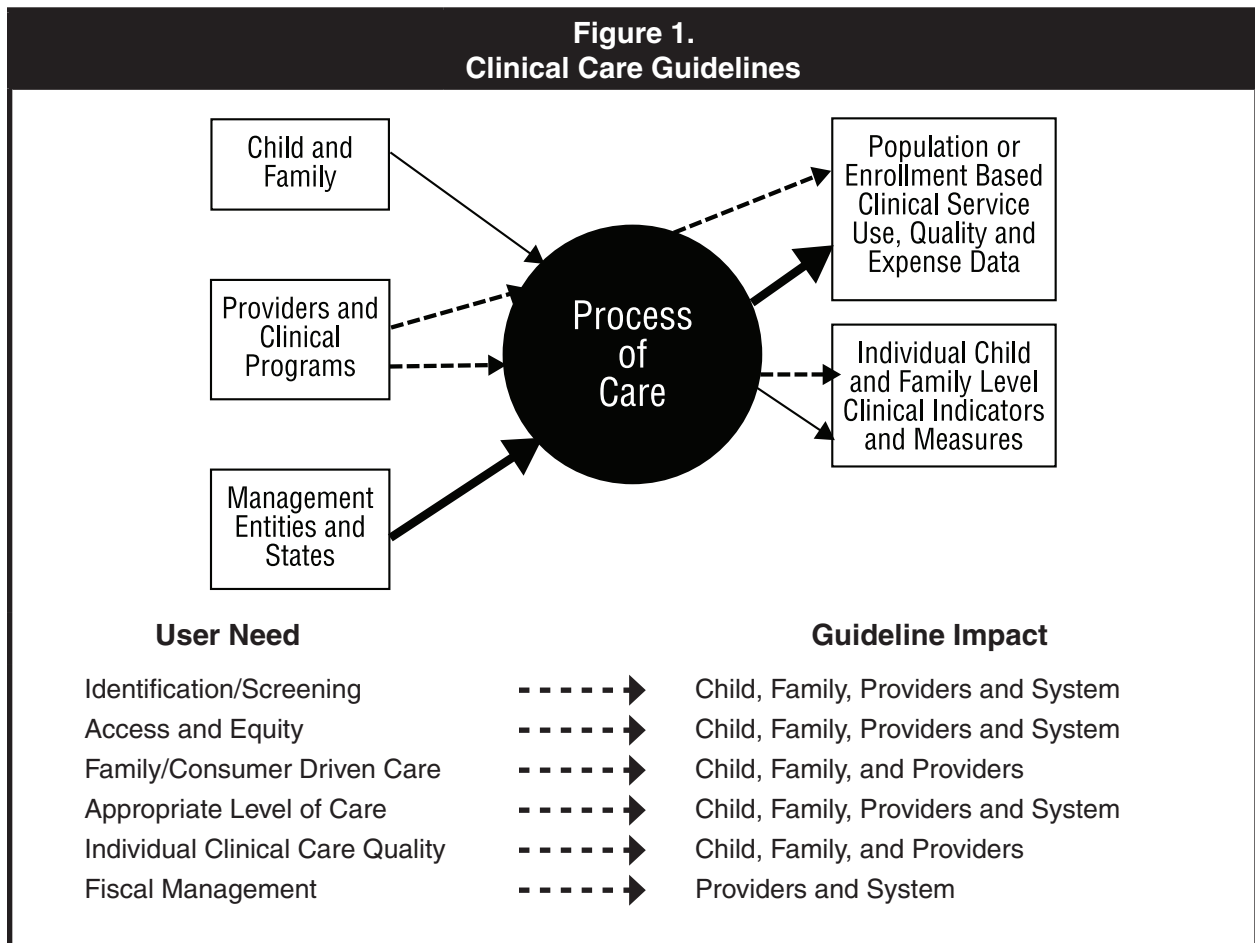
15 The National Wraparound Initiative (s.d.) Wraparound Fidelity Index 3.0. Available http://depts.washington. edu/wrapeval/WFI.html. [University of Washington, The Research and Training Center on Family Support and Children's Mental Health at Portland State University, and the national Federation of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

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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.