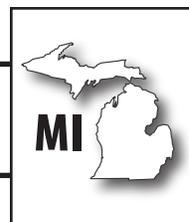## Michigan (**Group Two:** Existing Standardized Protocols)
• Child and Adolescent Functional Assessment Scale (CAFAS)

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).

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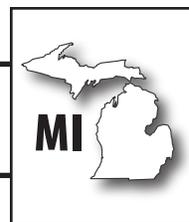
Background

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

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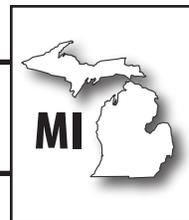
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52   Hodges, K. (2004). Using assessment in everyday practice for the benefit of families and practitioners.
Professional Psychology Research and Practice, 35 (5), 449-456.

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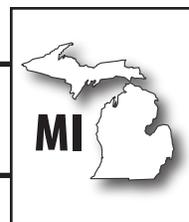
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53 Hodges, K. (2004). Using assessment in everyday practice for the benefit of families and practitioners. Professional Psychology Research and Practice, 35 (5), 449-456.

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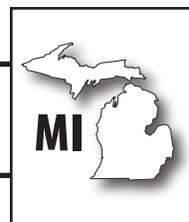
As noted earlier, the State and its external evaluator have modified the CAFAS over time in response to LME feedback and CAFAS data reviews. For example, they have strengthened the caregiver subscales and modified the CAFAS scoring threshold requirements for eligibility for home-based services to give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

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

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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.

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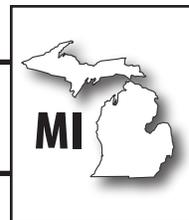
are actually doing the CAFAS ratings at the local level. As noted earlier, Michigan implements a "train the trainers" reliability training and maintains a list of those who have been trained. State-level stakeholders also stressed that both the State and localities need dedicated staff time to implement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