



THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE



The Children's Quality of Care Study FY06-07: A Study of the Quality of Children's Mental Health Services within Florida's Medicaid Behavioral Health Care Plans

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within Florida’s Medicaid Behavioral Health Care Plans**

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The Children's Quality of Care Study FY06-07: A Study of the Quality of Children's Mental Health Services within Florida's Medicaid Behavioral Health Care Plans

Executive Summary

For the past three years, the Children's Quality of Care Study has examined the quality of Medicaid-funded mental health care provided to children with serious emotional disturbance (SED) enrolled in either a Prepaid Mental Health Plan (PMHP) or Health Maintenance Organization (HMO) and their families in various regions of Florida. This third and final year focused on examining the effectiveness of managed care organizations in providing quality mental health services to children with SED in AHCA Area 7 (Brevard, Orange, Osceola, and Seminole counties) and to ascertain any differences in quality of care among the four managed care organizations included in the study. A mail survey was sent to 400 caregivers (parents/guardians) of children with SED and 100 service providers to assess the quality of Medicaid-funded mental health care being provided in the following four domains of care: access, consumer engagement, appropriateness, and outcomes.

The vast majority of caregiver and provider survey questions were answered using a five-point scale ranging from 1=strongly disagree to 5=strongly agree. Mean scores for survey questions and domains were utilized to determine statistically significant differences in caregiver responses by MCO. To facilitate a meaningful interpretation of the data, mean scores for caregiver and provider data were translated and discussed as follows: 1-2.5=less than positive responses, 2.5 - 3.5 = neither positive nor less than positive responses (neutral), 3.5 - 5 = positive responses.

Clearly, there is room for improvement in the MCO service systems as evidenced by caregiver responses, which resulted in most domain mean scores falling within or below the neutral range. Further examination revealed consistent and significant differences across MCOs on three of the four domains (i.e., access, consumer engagement, and appropriateness). No significant differences across MCOs were found on the Outcomes domain. Amerigroup consistently received the highest ratings which were significantly better than United in each domain except Outcomes. FHP had a significantly higher rating compared to United in the Appropriateness domain. No other domain comparisons were significantly different.

Areas where caregiver ratings generally were within the positive range for mean scores include: providers identifying the mental health needs of children, cultural competence of providers, out-of-pocket expenses for the family, adequacy of provider locations and office hours, providers soliciting and incorporating family input in the child's treatment, client confidentiality, and determining mental health services based on the child's needs.

Caregiver data, however, suggest the need for further improvement in the following areas of Access to services: more consultation relevant to family customs

and traditions that may affect treatment, having an interpreter available for the family, availability of providers to see patients right away when needed, caregiver ability to obtain necessary medications, provision of assistance to families when dealing with multiple providers and/or service systems, availability of providers to talk with caregivers when called, assistance with caregiver childcare needs, and minimization of missed time from work or other activities when caregivers obtain mental health services for their child.

Caregiver responses in the Consumer Engagement domain revealed a specific need for providers to: better inform families about the child's condition, medication, and/or treatment; talk with caregivers about ways to manage their child's behavior and stress; discuss treatment options with families and offer a choice of treatments; and offer or provide a copy of the treatment plan to caregivers.

Areas needing attention in the Appropriateness domain include: improving services or consumer engagement to affect a positive change in caregiver views of the appropriateness of treatments being provided to children with SED, better individualization of treatment plans, further incorporation of child strengths in treatment plans, and improving communications between providers or agencies/systems to ensure continuity of care.

Mean scores of caregiver responses in the Outcomes domain suggest the need for the provision of services to assist families in mitigating the degree of stress in the family, greater collaboration with families and the school system to help improve school performance, and improved monitoring and tracking of child and family satisfaction with mental health services.

Provider respondents reported more positive opinions about the quality of mental health care provided to children with SED and their families than did caregivers, with the exception of the Access domain where caregivers reported slightly more positive perceptions than providers. Although 79% of mean scores for provider questions were greater than or equal to 3.5, the data suggest a need for attention to specific service areas. In the domain of Access to services, these areas include problems with: appointments being available right away when needed, getting necessary mental health medications, coordination with other providers or service systems, families having to pay for services or medication, family transportation and childcare, caregivers missing time from work or other activities when obtaining mental health services for their child. Even though all of the mean scores for provider questions in the Consumer Engagement and Appropriateness domains were greater than or equal to 3.5, the pursuit of further improvement is not an unreasonable expectation. In the Outcomes domain, provider responses also indicated a possible need for a review of outcome measurement tools used to track and monitor child progress and improved tracking and monitoring of provider satisfaction with the policies and procedures of the managed care organizations.

In addition to barriers arising from the areas already discussed, other potential barriers to effectively serving children with SED and their families arose from quantitative and qualitative data obtained in the study. Forty-five percent of

provider respondents and 30% of caregiver respondents reported experiencing problems with obtaining necessary mental health medications. Although providers generally reported experiencing medication challenges with all four of the MCOs included in this study, more specific comments were made relevant to the HMOs. These included problems with obtaining authorizations, dealing with MCO staff that were not trained in child psychiatric issues, and formularies covering different medications (which also caused children who had changed MCOs to try other medications before being approved for the previously proven medications). Other problematic issues included restrictions in service authorizations (HMOs) and burdensome paperwork (all MCOs).

Recommendations

Findings from the caregiver and provider surveys generated the following recommendations for stakeholders in the Medicaid-funded mental health system:

- The generally neutral caregiver ratings of MCOs suggest a need for further attention to improvement within all domains of quality care.
- Managed care organizations should consider soliciting feedback from service providers on satisfaction with MCO policies and procedures and seeking provider input on what works best in the MCOs and what needs improvement in order to serve children with SED and their families in a more collaborative manner.
- Managed care organizations and service providers may wish to consider re-examining their satisfaction questionnaires sent to families in order to obtain more detailed feedback from families relevant to their experiences with the service system and MCO policies. Questions could be structured to inquire about overall experience, as well as most recent provider contact to examine both overall experiences as well as emerging trends in care. If not already occurring, MCOs should share anonymous feedback with providers in order to improve care.
- Medication formularies and policies governing access to medications should be made consistent across managed care organizations, so all children receiving pharmacological treatment have equal access to necessary medications.
- Although service providers are not required by Medicaid to provide transportation and childcare assistance, these remain issues for families and should be addressed by the system of care serving them.

Introduction

Two managed care strategies to provide Medicaid-funded mental health services to children in Florida include the Prepaid Mental Health Plan (PMHP) and Health Maintenance Organization (HMO) models. Services in both plans are provided through managed care organizations (MCOs) and their contracted provider networks. For the past ten years, the Agency for Health Care Administration (AHCA) has contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) of the University of South Florida to perform an evaluation of the Medicaid managed mental/behavioral health care plans, a sub-study of which has been the Children's Quality of Care Study since FY04-05.

The Children's Quality of Care Study was conducted for the purpose of examining the quality of Medicaid-funded mental health care provided to children with serious emotional disturbance (SED) and their families in various regions of Florida. The first two years of the study consisted primarily of qualitative interviews with service providers and caregivers (parents/guardians of children with SED) in AHCA Area 1 (Santa Rosa and Escambia counties) (Vargo et al., 2005) and Area 5 (Pasco and Pinellas counties) (Vargo et al., 2006b). This third and final year of the study consisted of a mail survey of providers and caregivers in Brevard, Orange, Osceola, and Seminole counties (AHCA Area 7). The study included a measure development phase (Phase I) to develop and refine the evaluation instruments and a service system evaluation phase (Phase II) to assess the quality of care being provided to children with SED and their families in the following four domains: access, consumer engagement, appropriateness, and outcomes. A review of the literature relevant to serious emotional disturbance and the quality of mental health care for children was conducted and is presented below.

Serious Emotional Disturbance

Children and adolescents with serious emotional disturbance make up approximately five to nine percent of youth ages 9-17 years old in the United States (U.S. Department of Health and Human Services [USDHHS], 1999). Approximately 5%-13% of children with SED have substantial to extreme functional impairment (Friedman, Katz-Levy, Manderscheid, & Sondheimer, 1998). SED is not a diagnosis, rather, it is a classification term used to identify children with emotional, mental, or behavioral problems that limit their functioning in various arenas, such as school, home, or their community. The actual number of youth affected by SED varies depending on the definition being used (Narrow et al., 1998). School systems use the definition established by the Individuals with Disabilities Education Act (IDEA, 1997) and the Center for Mental Health Services relies on the diagnosis of a mental, behavioral, or emotional disorder specified in the Diagnostic and Statistical Manual of Mental Disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 1993). In Florida, where over 300,000 children have or are at risk for a serious emotional disturbance, a child can be classified as SED in a number

of ways, including having a diagnosable emotional, behavioral, or psychotic disorder, being classified by a school district as SED, or receiving SSI benefits for a psychiatric disability (Florida Department of Children & Families [DCF], 2007).

For this study, a definition of serious emotional disturbance was established by a subcommittee of clinicians and researchers serving on the FMHI-AHCA research team (Appendix A). Specifically, a child was considered to have SED when very specific criteria were met, including (1) having at least two claims on different days in the Medicaid claims data for a specific diagnosis category (bipolar disorder, schizophrenic disorder, major depressive disorder or personality disorder), or (2) having at least two claims on different days in at least two diagnosis (attention deficit-hyperactivity disorder, conduct/oppositional disorder, anxiety disorder, or depressive disorder), or medication (anti-psychotic, anti-depressant, or mood stabilizing medications) categories as indicated by Medicaid claims data.

Varying definitions of serious emotional disturbance may contribute to an under-identification of the number of children with SED (Reddy, 2001), and the varying terminologies associated with SED can make it difficult for providers to offer appropriate treatment (Vernberg et al., 2006). It has been estimated that only 20-25% of children with mental health issues receive the services necessary to meet their needs (Costello, Messer, Bird, Cohen, & Reinherz, 1998; Kataoka, Zhang, & Wells, 2002). Educational assistance, integrated treatment and case management services, family-centered services, support groups, recreational activities, after-school programs, mentoring services, and respite care are some of the specific needs identified in previous research (Kernan, Griswold, & Wagner, 2003; Marcenko, Keller, & Delaney, 2001). Children with SED need services that fully integrate them into the most normative activities possible while minimizing stress on their caregivers.

Needs that are not being met due to deficiencies at the system level include lack of child care for the family during service provision, extended waiting periods for appointments, failure of providers to accurately assess children in a timely manner, frequent changes in providers, lack of funds to cover service costs, lack of effective service coordination, lack of individualized services, and conflicting goals of different providers (Kernan et al., 2003; Koyanagi & Semansky, 2002, 2003). Because children with SED often have functional impairments in several settings, they require services from multiple systems and moreover, these services need to be flexible and coordinated (American Academy of Pediatrics, 2000; Stroul & Friedman, 1988).

Quality of Care

Quality care has been defined as the degree to which health services result in desired outcomes through the use of the current professional knowledge base (McGlynn, 1997). Donabedian's (1980) influential framework for assessing quality focuses on three key components: the structure of the service network, the process that occurs between providers and clients, and outcomes of the antecedent

care. This framework allows the unique health care perspectives of providers, caregivers, consumers, and society to be taken into account (Dickey, 2001). Specifically, the literature cites a number of domains and indicators as important to measuring the quality of children's mental health care. These include: access to services, assessment completeness, treatment outcomes, continuity and coordination of services, the nature of the population being served, individualized services, least restrictive and culturally competent services, early intervention and identification, family inclusion, respecting children's rights, the quality of the interactions and communications between clients and providers, the quality of the health plan, appropriate referrals, following basic treatment principles, appropriate psychosocial treatment, medication referral, and maintaining child safety (Burns, 1996; Eisen et al., 1999; Hermann, Leff, & Lagodmos, 2002; Stroul & Friedman, 1988; Zima et al., 2005).

Recognizing the importance of incorporating consumer input in the process of assessing the quality of mental health treatment, the Mental Health Statistics Improvement Program (MHSIP) Task Force developed a Consumer-Oriented Mental Health Report Card (USDHHS, 1996). The MHSIP Report Card is organized around the domains of prevention, access, appropriateness, and outcome with consumer satisfaction included under each domain. The American Academy of Child and Adolescent Psychiatry (1998), in its efforts to assist in the evaluation of effectiveness of Medicaid contractors, identified similar performance categories in their Best Principles for Measuring Outcomes in Managed Care Medicaid Programs.

In addition, the American Psychiatric Association (APA) created a separate Task Force on Quality Indicators for Children in order to address the particular needs of children's mental health (2002). The Task Force was charged with developing "clinically-based, patient-focused quality indicators" (p. 61) specifically for children and adolescents. What resulted was a quality framework with recommendations for each indicator of quality in each of the five domains of care (prevention, access, quality/process/appropriateness, satisfaction/perceptions of care, and outcomes/ effectiveness). It was intended that this framework serve as a tool for health care organizations and groups as well as researchers evaluating the quality of mental health care provided to children and adolescents.

During the first year of FMHI's Children's Quality of Care sub-study (2004-2005), interviews were conducted with providers of services and caregivers (parents/guardians) of children and adolescents with SED to obtain their definitions of quality of care (Vargo et al., 2005). A list of 36 commonly cited quality indicators was compiled from the literature and caregivers and providers were asked to rate the list using a 5-point Likert scale with 5 being "very important" and 1 being "not at all important". While there were some differences in rankings between providers and caregivers, the overwhelming majority of indicators were ranked by both groups as important to the quality of care provided to children with SED. Indicators were classified into the following four domains to create the Quality of Care Framework, which was used as the basis for examination in this study: access, appropriateness, consumer engagement,

and outcomes (Appendix B). The domains and indicators in the Quality of Care Framework reflect those found in the literature, including those recommended in the MHSIP Consumer-Oriented Mental Health Report Card (USDHHS, 1996) and the more youth-specific framework created by the APA's Task Force on Quality Indicators for Children (2002).

Access

Accessibility of services is the beginning of the journey of treatment for children with SED and their families and a critical step towards achieving quality outcomes and creating a healthy life (Burns, 1996). Those with SED are the population of children with the greatest need for care (Friedman et al., 1998), and consequently are predicted to benefit the most from involvement in multiple mental health care service sectors (USDHHS, 1999). Access to comprehensive community-based mental health services for children may prevent or lessen the number of admissions to in-patient mental health facilities (Brinkmeyer, Eyberg, Nguyen, & Adams, 2004). The following indicators specific to access of services are discussed below: timely evaluation, comprehensive evaluation, cultural competency, flexible system of care, communication between systems, and social and economic costs to the child and family.

Timely Evaluation

The importance in accurately identifying childhood mental disorders is clear as more children display co-morbid symptoms, and research suggests that mental disorders in childhood often persist into adulthood (Ringeisen, Oliver, & Menvielle, 2002). In order to properly address a child's emotional or behavioral problems, providers need to be accessible to families within a reasonable timeframe and a mental health assessment should be conducted in a timely manner (APA, 2002; American Academy of Pediatrics, 2000; Yanos, Garcia, Hansell, Rosato, & Minsky, 2003). The sooner a child's disturbance is identified, evaluated and treated, the more likely a positive outcome will result (Stroul & Friedman, 1988). In a 2002 focus group report, parents of children enrolled in Medicaid-funded mental health services waited anywhere from one to 15 years to receive an accurate assessment and diagnosis of their child's problem, and certainly within that time witnessed their child's problem worsen (Koyanagi & Semansky, 2002). Parents in a different region of the country similarly stressed the need for timely evaluations and accurate assessment, and the authors found that a delay in diagnosis ultimately led to situations where children had to enter the system through crisis services (Koyanagi & Semansky, 2003).

Comprehensive Evaluation

Tolan and Dodge (2005) point out that a provider's well-intentioned attempt at "best practice" for a client without proper evaluation is a signal of the shortcomings of the children's mental health system. Without timely and comprehensive assessments, children and their families can suffer tremendously (Koyanagi & Semansky, 2002, 2003). A comprehensive assessment conducted by an interdisciplinary treatment team

can also result in a more accurate assessment (Bickman, 1996). A proper evaluation should include an assessment of a child's problems, strengths, and special needs; family, school, and social dynamics; and an appropriate multi-axis DSM-IV-TR diagnosis (APA, 2002; Stroul & Friedman, 1988).

Cultural Competency

Cultural competency becomes more and more important as the cultural demographics in an area become more diverse. One definition of cultural competency set forth in the literature describes it as a set of attitudes, skills, behaviors, and policies that enable providers to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). To this end, mental health services should be aligned with the cultural and linguistic characteristics of the consumer and minimize cultural barriers by making available service providers who reflect the ethnicity and language of the consumer and offer continuing education in providing culturally competent services (APA, 2002; USDHHS, 1996). Clients in ethnic minorities are at risk for premature termination of services due to barriers such as language and differences in cultural norms about disease and treatment (Dixon, 2002).

Flexible System of Care

Providing a flexible system of care and a full range of services, particularly at system entry, is an important indicator of quality care. The literature suggests that a full range of mental health service options be made available to the consumer and recommends that children and their families have access to a coordinated continuum of care, including not only traditional forms of treatment (outpatient and inpatient therapy), but also alternative and community-based interventions (home-based treatment, case management, and family support) (APA, 2002; USDHHS, 1996). As their first principle for an optimal system of care, Stroul and Friedman (1988) state that children with SED "...need access to a comprehensive array of services addressing the child's physical, emotional, social, and educational needs" (p.11). Youth will benefit from a creative and thoughtful mix of mental health interventions provided in an integrated and coordinated manner (Burns, 1996; English, 2002, Shield et al., 2003).

Communication Between Systems

Fragmentation and gaps in mental health care systems for children have been cited as concerns about children receiving insufficient care (American Academy of Pediatrics, 2000; New Freedom Commission on Mental Health, 2003; Zima et al., 2005). The New Freedom Commission (2003) also noted that families can easily become overwhelmed in their attempts to access and navigate services across multiple, often disconnected programs. Children with SED often embody a mix of emotional, behavioral, and medical challenges (Reddy, 2001), necessitating not only multiple health care providers, but also an open line of communication among them for optimal care. The literature suggests that appropriate linkages between multiple service sectors should allow for coordinated movement through systems to provide effective and efficient treatment (Stroul & Friedman, 1988; Zima et al., 2005).

Social and Economic Costs to Child/Family

The APA (2002) recommends that efforts be made by providers to minimize social and economic costs related to a child's mental health treatment, including the minimization of missed work days for parents or guardians. Families of children with SED often report losing their social networks and becoming isolated, leading to possible anxiety and depression (Burns, 1996). Helping families build support networks external to their child's mental health care provider offers an avenue towards self-sufficiency as well as increased adequacy in parenting skills (Dawson & Berry, 2002; Gaudin, Wodarski, Arkinson, & Avery, 1991). Teachers can also assist in linking parents and caregivers of children with emotional disturbances with each other for support and information (Cheney, Osher, & Caeser, 2002). Flexible service dollars are helpful in assisting caregivers to not only pay for services, but also for other aspects of care for their children with SED, such as taxi fares, respite care, prescription medication, and family counseling (Dollard, Evans, Lubrecht, & Schaeffer, 1994).

Consumer Engagement

In the last twenty years, there has been a clear shift from viewing families as the primary contributors to a child's mental health problems towards allowing parents and caregivers to become an integral part of their children's treatment (Osher, van Kammen, & Zaro, 2001). The APA (2002) and the MHSIP Task Force (USDHHS, 1996) also recognize the importance of family engagement as an indicator of quality. In order to maintain family commitment in a child's treatment as well as maximize the probability of a successful treatment outcome, home-based interventions have been increasingly implemented for children with SED, where their families are taught practical skills and are able to develop trust with the health care provider (Berry, 1992). The following indicators of consumer engagement are discussed below: providing information to the family, giving the family a choice of interventions, soliciting and considering child and family input in treatment, and client confidentiality.

Providing Information on Child's Condition/Treatment to Child/Family

According to the MSHIP report card, mental health service consumers should always receive information about their condition, treatment, and medication that enables them to make an informed choice about their services (USDHHS, 1996). Although families of children with SED should be full participants in all areas of their child's treatment (Stroul & Friedman, 1988), this is contingent on having access to the information necessary for decision making. Power and colleagues (2005) suggest a link between how much a caregiver knows about a problem and how to effectively manage it, and the caregiver's willingness to seek appropriate treatment. When a provider openly discusses the child's diagnosis and treatment plan with the family, caregivers are more likely to feel a sense of control (Wallston, 1992), and believe that by working together, there can be improvement in the child's life (Power et al., 2005).

Offering a Choice of Interventions to Child/Family

Parent and guardian involvement in a child's mental health care treatment can be critical for a positive outcome, but a negative relationship between caregivers and providers often results in premature termination of a child's services (Noser & Bickman, 2000). A contributing factor to a poor relationship can be the absence of any explanation of the treatment goals by the provider. If a child's family does not understand or agree with the interventions proposed by the provider, the family is less likely to follow through with treatment recommendations (Ringeisen et al., 2002). It is recommended that mental health plans routinely assess the degree to which parents and caregivers are included in treatment planning for their child and that parents and guardians be asked how much they and their input were acknowledged by service providers (APA, 2002).

Considering and Incorporating Child/Family Input into Treatment

A clinical dilemma is presented when there is disagreement between a provider and caregiver about the manner in which a child's therapeutic treatment should proceed (Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004). For example, while research supports the efficacy and success of psycho-stimulant treatment for ADHD, families instead continue to prefer behavioral interventions that may not prove to be as effective (Ringeisen et al., 2002). In their final guidelines for practitioners, Power et al. (2005) reiterate the point of listening to the child's family, noting that providers need to move forward with evidence-based interventions only when the family is ready for them. While a disagreement between providers and families can be a frustrating process, continual involvement of families in making treatment choices will most likely result in a lower dropout rate and better outcomes for both the youth and their loved ones (Power et al., 2005).

Client Confidentiality

For both children and adults, the President's New Freedom Commission on Mental Health (2003) states, "The privacy of personal health information—especially in the case of mental illnesses—will be strongly protected and controlled..." (p.14). The APA (2002) also suggests that protecting adolescents' confidentiality should be of the utmost importance to providers, particularly when it comes to sharing information about emotional and behavioral symptoms with parents or guardians. In their look at the experiences of adolescents in foster care and their mental health services, Lee et al. (2006) found that a main complaint among youth who were unhappy with services stemmed from broken confidentiality on the provider's part.

Appropriateness

The core values put forth by Stroul and Friedman (1988) speak to the importance of providing services appropriate to each client, family, and situation. Their first core value states that “...the system must be driven by the needs of the child and his or her family” (p. 11) and encourages providers to adapt services to the client and caregiver, rather than conforming to pre-existing service models. The second core value holds that children’s mental health treatment should be appropriately community based and provide the least restrictive care possible. The following indicators of appropriate care are discussed below: appropriate treatment, individualized treatment plans, use of professionally accepted guidelines, maximizing service continuity, professionalization of staff, and training in best practice guidelines.

Appropriate Treatment

Appropriate and effective treatments promote the process of recovery while remaining considerate of benefits and risks, cultural factors, and patient preference (APA, 2002; USDHHS, 1996). In their interviews with managed care organizations, Vargo and colleagues (2006a) found appropriate treatments to include those that are the least invasive, least harmful, and take place in a safe environment. The APA also stresses that both psychosocial treatments and medication should be used where they have been shown to be effective and clinically indicated. The key to appropriate service utilization, then, is that service use is matched with the specific needs of a client and family, while balancing mental and physical health benefits as well as risks (Donabedian, 1980; Noser & Bickman, 2000).

Individualized Treatment Plans

The Final Report of the President’s New Freedom Commission on Mental Health (2003) recommends that an individualized plan be developed for every child with a serious emotional disturbance. Stroul and Friedman (1988) recommend that individualized services be provided, taking into account the unique needs and strengths of each client. Additionally, Burns (1996) warns that services need to be based on the specific needs of a child and his or her family, not on the ease or availability of a particular service. She notes that this kind of care requires considerable flexibility in services, possibly requiring a mix of therapies and treatments. In order to truly individualize services to children and their families, providers must access all available resources—formal and informal, traditional and non-traditional (Lourie, Katz-Levy, & Stroul, 1996).

Reflecting Professionally Accepted Guidelines in Treatment Plans

Children classified as having a serious emotional disturbance may have a variety of diagnoses. Treatment guidelines have been developed for these diagnoses, including attention-deficit/hyperactivity disorder (ADHD), conduct disorder, mood disorders (depressive and bipolar disorders), and schizophrenia. In addition to these specific professionally developed treatment guidelines, previous

research has yielded recommendations from managed care organizations in utilizing professionally accepted guidelines, including the practice of peer review of treatment plans, the management and signature of a qualified supervisor on treatment plans, and offering clinical training for staff in the development of treatment plans (Vargo et al., 2006a).

Prescribing Medications Based on Evidence/Guidelines

Psychiatric medication should be prescribed in appropriate doses and duration, and where clinically indicated, along with psychosocial treatments (APA, 2002). The APA further notes that new research and findings are constantly emerging about medications, calling for the continuous updating of a provider's knowledge and evidence base. Vargo et al., (2006a) found through their conversations with MCOs that sometimes medications are prescribed to children for their side effects rather than their intended, FDA-approved uses. This occurrence is problematic, and the MCOs recommended that medications only be prescribed for their intended effects. Michael English (2002) acknowledges that effective psychosocial and pharmacologic interventions exist for many childhood mental disorders and seems to take the position that medication should rarely, if ever, be the sole treatment for children's mental health problems; rather, a multi-systemic, integrated approach to treatment planning and delivery is more appropriate. Zima and colleagues (2005) cite much scientific research when they express apprehension over the fact that the use of psychotropic medications for children with psychiatric disorders has increased two to threefold in the last decade, a statistic which has outpaced the scientific evidence to support the efficacy and safety of such use.

Maximizing Continuity of Care

The term 'continuity of care' generally refers to the management and treatment of conditions without disruption between systems or providers (Ware, Tugenberg, Dickey, & McHorney, 1999; USDHHS, 1996). Stroul and Friedman (1988) stress the importance of the relationships between systems, for youth with SED often have multiple needs, and the more seamless their treatment across systems, the more effective the treatments. The APA (2002) suggests that continuity of care also include the consideration of a client's past treatment experiences and history as part of his or her current treatment plan. They point out research that demonstrates that the lack of continuity of mental health care has caused clients and families to be dissatisfied or drop out of treatment.

Professionalization of Staff

When examining the professionalization of service providers, factors to consider include the ability to perform job skills and assessments, the ability to relate to clients with effective communication and relationship building skills, and whether or not provider staff are licensed (Lee et al., 2006; Vargo et al., 2006a). In addition to being appropriately qualified, direct service staff should be supervised by a senior staff member, who will ensure that they are following appropriate treatment guidelines with their clients (Knauss, 2002). Continuing education is a practical

and important method for ensuring quality health care and research has shown a need for better and expanded in-service training that would improve the skills of providers and staff who offer community-based mental health services to children (Bryant-Comstock, Huff, & VanDenBerg, 1996; Pires, 1996).

Training in and Application of Best Practice Guidelines

In order to best serve youth with SED, it is imperative for providers to continuously update their knowledge base as well as modifying their practice as indicated by research (Tolan & Dodge, 2005; APA, 2002). Boothroyd, Stiles, Dhont and Beiler (2003) found a low level of provider adherence to published treatment guidelines for various mental health disorders, although there remains a disparity of professional opinions regarding the value of such guidelines (Smith, 2002). However, when possible, mental health services should be delivered in accordance with known and professionally accepted best practice guidelines (USDHHS, 1996).

Outcomes

Donabedian (1980) defines the term ‘outcome’ as “a change in a patient’s current and future health status that can be attributed to antecedent health care”, which also includes “improvement of social and psychological function” (p. 82-83). Similarly, the Quality of Care Framework developed from previous research (Vargo et al., 2006b) and utilized as the basis of the examination of quality of care for this study, represents the interrelatedness of the four domains of quality care: access, consumer engagement, appropriateness, and outcomes. For example, an indicator such as a comprehensive evaluation should lead to appropriate treatment developed in consultation with the family, which in turn should lead to outcomes for the child and family. Specific outcome indicators discussed below include: improvement in child and family functioning and stability, meeting the child’s needs, and child and family satisfaction.

Improvement in Child Functioning and Stability

Effective and quality mental health services should minimally interfere with and improve a child’s functioning in day-to-day activities in such arenas as home, school, and in the community while affecting a significant reduction in symptoms (APA, 2002; USDHHS, 1996). Rosenblatt, Wyman, Kingdon, and Ichinose (1998) also recognize the importance of promoting independent functioning in children. Since the effects of emotional and behavioral disturbances can disrupt a child’s functioning in the school setting, it is also important for school officials to be cognizant of children with potential problems and refer them for services (English, 2002). There are differences in opinion, however, as to whether or not improvement in school performance and attendance are valid indicators of quality care. The APA (2002) views a child’s improved attendance record to be an indicator that he or she has received quality mental health care. However, Vargo et al. (2006a) found at least one MCO reporting that improved school attendance was not necessarily a good measure of quality treatment, noting that a multitude of factors can affect a child’s attendance or performance at school and therefore

is not necessarily indicative of the quality of mental health care. The MSHIP report card (USDHHS, 1996) agrees with both conclusions when they note that attendance is a basic but minimal measure of school functioning.

Improvement in Overall Family Functioning and Stability

It is reasonable to assume that the more severe and persistent a child's emotional or behavioral problems, the more likely these difficulties will interfere with his or her home life. It is, therefore, important to monitor family functioning as well. One way of helping families to stay healthy is providing them with concrete services. Concrete services refer to economic and material needs, which very often directly affect the level of stress a family experiences (Dawson & Berry, 2002). Assisting families with finding housing, paying utilities, or receiving medical care can improve their ability to learn and to utilize the new skills associated with caring for their child with SED (Rittner & Wodarski, 1999). The Surgeon General's report (USDHHS, 1999) also stresses the need to support families who, along with raising a child with emotional difficulties, often face challenges such as poverty, joblessness, substance abuse, and victimization. Support services to families can include assistance with daily tasks and errands, support counseling, food stamps, or even respite care (USDHHS, 1999).

Meeting the Child's Needs

It has been estimated that nearly 80% of children in the U.S. do not receive the mental health services they need (Kataoka et al., 2002), and only one in four children with SED receive appropriate treatment (Costello et al., 1998). When outlining principles for systems of care for youth with SED, Stroul and Friedman (1988) stress that systems should be driven by the needs of the children and their families. The APA (2002) recognizes that a child's needs are being met when their quality of life has improved as a result of effective treatment. Results can include an increased enjoyment of life and more participation in age (or developmentally) appropriate activities. When clients feel that their needs are being met, particularly adolescents, they are more likely to be engaged in services, which may result in improved outcomes (Garland et al., 2004).

Child/Family Satisfaction

Client satisfaction is a multidimensional indicator of quality (Anderson, Rivera, & Kutash, 1998). A child and family who are satisfied with their care may be more likely to engage in care and follow treatment plans (Donabedian, 1980), thereby increasing the quality of the treatment process. The APA (2002) believes satisfaction to be so critical a measure of quality of mental health care that they treat the indicator as its own domain. A variety of dimensions of family satisfaction can be measured, specifically as it relates to access to services, cultural competence of services, the services themselves, family involvement in treatment planning, and discussion of treatment options (APA, 2002). In addition to soliciting perceptions of satisfaction from families, providers should be asked about their satisfaction with the mental health plan and how they impact service provision (APA, 2002).

Research Questions

The following question guided the overall direction of the study: How effective are the PMHP and HMO managed care plans at responding to the needs of and delivering quality mental health services to children with SED and their families in AHCA Area 7? Five additional questions were developed to facilitate specificity in the collection, analysis, and comparison of data.

Research Question 1: To what extent does the quality of behavioral health care provided to children with SED, as perceived by their caregivers, differ by managed care plan?

Research Question 2: What are providers' perceptions related to the provision of quality mental health services to children with SED?

Research Question 3: What are the similarities and differences between caregiver and provider perceptions of the quality of mental health services provided to children with SED?

Research Question 4: What are the facilitators and barriers to receiving mental health services as reported by caregivers and providers?

Research Question 5: What are the similarities and differences between caregiver and provider reports of facilitators and barriers to receiving mental health services and to what extent do they differ by managed care plan?

Methods

This study consisted of an evaluation of Medicaid-funded mental health services provided through managed care organizations (MCO) operating in AHCA Area 7 (Brevard, Orange, Osceola, and Seminole counties). Table 1 lists each MCO and the approved start dates for each corresponding county of operation in Area 7.

Table 1
AHCA Area 7 Managed Care Organization Approved Start Dates

Managed Care Organization	County of Operation	Approved Start Date
Amerigroup Florida (HMO)	Orange, Osceola, Seminole	03/01/05
	Brevard	07/01/05
Harmony-HealthEase/Staywell (HMO)	Orange, Osceola, Seminole	04/01/05
	Brevard	09/01/05
United Healthcare of Florida (HMO)	Brevard, Orange, Osceola, Seminole	09/01/05
Florida Health Partners (FHP - PMHP)	Brevard, Orange, Osceola, Seminole	08/01/05

Throughout this report, the terms “caregiver” and “provider” are used. “Caregiver” refers to the parent or guardian of a child with SED. “Provider” refers to individual staff members from the provider agencies who participated in the study. Study activities were conducted in two phases, Measure Development (Phase I) and Service System Evaluation (Phase II).

Phase I: Measure Development

During Phase I, distinct yet parallel surveys were developed for each stakeholder group (one for caregivers and one for providers) in an effort to capture the unique experiences of each respondent group while facilitating an appropriate comparison of responses between caregivers and providers. Survey questions were generally organized around each domain of study (i.e., access, consumer engagement, appropriateness, and outcomes). Each survey was developed by refining questions from the FY05-06 Children’s Quality of Care Study (Vargo et al., 2006b) interview protocols. Most questions were revised to fit into a quantitative, scaled format, with most offering a 5-point, Likert-type scale (strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree). Other questions offered a choice of answer options with instructions to either circle one answer or circle all answer options that applied. The provider survey also included several open-ended questions to elicit more descriptive responses related to various managed care system facilitators and barriers that providers may have experienced or observed.

The Pediatric Symptom Checklist (PSC) was incorporated into the caregiver survey to better inform the study of caregiver opinions of child functioning. The Pediatric Symptom Checklist (Jellinek, Murphy, & Burns, 1986) is a 35-

item caregiver self-report psychosocial screening measure. Caregivers report the frequency that their children exhibit specific behaviors such as “being irritable or angry”, “having trouble concentrating”, “feeling sad or unhappy”, “getting in fights with other children”, and “not listening to rules” on a three-point scale ranging from 0=“Never” to 2=“Often.” Studies have documented high levels of agreement between parents’ and professionals’ PSC ratings (Jellinek et al., 1988; Murphy, Jellinek, & Milinsky, 1989; Murphy, Reede, Jellinek, & Bishop, 1992), good internal consistency (.89) and test-retest reliability (.86) (Jellinek et al., 1988), and acceptable validity (Jellinek & Murphy, 1990). Normative data suggest that PSC scores of 28 or above reflect a need for further psychosocial evaluation and that 10% to 13% of children in a general pediatric sample exceed this threshold (Jellinek & Murphy, 1990; Jellinek et al., 1986; Jellinek et al., 1999).

The caregiver survey and cover letter describing the study were presented to caregiver participants in two focus groups to obtain their feedback on wording, applicability, flow of survey questions, and cover letter language. Participants were also asked if there were questions they thought should be added to the mail survey (see Appendix C for the focus group questioning route). Potential focus group participants were identified with the assistance of a local chapter of a national organization that provides advocacy and support for families with children with emotional/behavioral problems. Flyers were mailed to 40 parents and guardians served by this organization, notifying them of the focus groups and asking for their voluntary participation in their choice of one of two scheduled groups. At the beginning of each focus group, caregivers read and signed a consent form and confidentiality statement. A total of 12 caregivers participated in the two focus groups; each caregiver was paid \$25.00 cash for his or her participation. Feedback from focus group participants was reviewed by the study team and incorporated into the caregiver survey and cover letter as feasible and appropriate. In order to include participants whose primary language is Spanish, the finalized English version of the caregiver survey was translated into Spanish by bilingual staff at FMHI who have experience in translating written materials. Caregivers of children identified as having Hispanic surnames (n=120, 30% of the sample size) were mailed English and Spanish versions of the survey. Hispanic surnames were identified utilizing Medicaid administrative data and computer software designed for this purpose.

The provider survey was produced only in English since it was reasonably assumed that all providers would be able to read and understand English. The caregiver and provider surveys were also sent to AHCA for their review prior to finalization; their feedback was also incorporated as appropriate. Copies of the mail surveys may be requested from the principal author of this report.

The reliability and validity of the caregiver survey were examined and determined to be adequate. A detailed summary of these findings is provided below.

Reliability and Validity of the Caregiver Survey

Cronbach's alphas were computed for each domain to assess the internal consistency reliability of the caregiver survey. Within each domain, high levels of reliability were obtained supporting the utility of these scales. Cronbach's alphas for each domain were: Access .85, Consumer Engagement .91, Appropriateness .90, and Outcomes .94.

The validity of the caregiver survey domains was assessed by correlating each domain score with an external, single-item satisfaction question relevant to that domain. Higher positive correlations indicate that higher domain scores reflect greater caregiver satisfaction. Significant ($p < .01$), positive, correlations were found for each domain score and its corresponding satisfaction question, thus supporting the construct validity of the domain scales. (See Appendix D for more detail).

Caregivers' assessments on the Pediatric Symptom Checklist (PSC) were also validated against a satisfaction question related to how the child was doing as a result of the mental health services received. As anticipated, a significant negative correlation was found ($p < .01$), indicating that higher levels of symptomatology were associated with lower levels of caregiver satisfaction with their child's functioning.

In addition to determining the reliability and validity of the caregiver survey, the research team sought to verify the structure and organization of the Quality of Care Framework that was utilized as the model of examination in this study. A factor analysis of the Likert-scaled survey questions was performed to detect any structure in the relationship between survey items. This technique classifies variables (survey items) into any number of components or groups that can then be labeled by researchers depending on the meaningfulness of the resulting classification. In this case, the factor analysis revealed the existence of two meaningful component groups that the research team intuitively labeled as Service Quality and Outcomes. The Service Quality component contained survey questions inquiring about access, consumer engagement, and appropriateness of care, as well as questions to caregivers about their satisfaction within these domains. The second component group, Outcomes, contained all survey questions related to child and family outcomes and the two questions about caregiver satisfaction with how the child is doing as a result of receiving mental health services and how well medications are working.

As a result, the Quality of Care Framework was revised to reflect two larger components: Service Quality (which includes the domains of Access, Consumer Engagement, and Appropriateness) and Outcomes (Appendix E). These two component groups reflect the logic behind the Quality of Care Framework, i.e., quality services in the areas of access, consumer engagement, and appropriateness should lead to quality outcomes. Making the distinction between the three service domains within the Service Quality component facilitates examination of these domains by organizing the survey into a reasonable flow of questions and assists in identifying specific areas where services are working well or need improvement.

Phase II: Service System Evaluation

Phase II of the study consisted of an evaluation of the Medicaid mental health managed care service system through the use of a mail survey. Medicaid mental health claims data for children with SED were requested from each MCO for January through August 2006. MCOs were asked to use specific criteria in identifying children with SED (see Appendix A). These criteria included (1) existence of a specific diagnosis in Medicaid claims data (i.e., bipolar disorder, schizophrenic disorder, major depressive disorder, or personality disorder), or (2) existence of a specific diagnosis (i.e., attention deficit-hyperactivity disorder, conduct/oppositional disorder, anxiety disorder, or depressive disorder) in combination with treatment with anti-psychotic, anti-depressant, or mood stabilizing medications as indicated by Medicaid claims data. This definition was established in FY05-06 by a subcommittee of clinicians and researchers that were part of the FMHI-AHCA research team and was intended for use across AHCA-funded studies at FMHI related to children with SED.

Once claims data were received from each MCO, they were reviewed for fidelity to the request criteria and those cases not meeting the criteria were excluded from possible selection. Cases were then sorted by the date of the claim and 100 children with the most recent claims were selected for each MCO for a desired total of 400 children. In instances where there were multiple children with the same address, the first child listed was selected. United Healthcare of Florida (HMO) did not have 100 children in their claims data and therefore, all of the children in their claims data that met the request criteria were included in the study sample (n=87). In order to obtain a sample size of 400 cases and create more equity in the proportion of the sample size in relation to the number of cases in the claims data for the three remaining MCOs, 13 additional cases were chosen from the PMHP (FHP) claims data. Table 2 lists the sample size for each MCO.

Table 2
Sample Sizes for Caregiver Survey Mailings

Managed Care Organization	Sample Size
Amerigroup Florida (HMO)	100
Harmony - HealthEase/Staywell (HMO)	100
United Healthcare of Florida (HMO)	87
Florida Health Partners (FHP - PMHP)	113
Total	400

To initiate the provider sampling process, MCOs were asked for the names and contact information of agencies included in their provider networks. The following most frequently utilized provider agencies were then identified according to the claims data obtained from the MCOs and served as the pool from which provider survey recipients were selected:

- Behavioral Support Services
- Children's Home Society of Florida

- Circles of Care, Inc.
- Devereux Florida
- Intervention Services, Inc.
- Lakeside Alternatives
- Park Place Behavioral Health Care
- Seminole Community Mental Health Center

To identify specific individuals to include in the provider sample, these eight provider agencies were contacted by a research team member via telephone and email with an explanation of the study and a request for a list of their direct service staff in the relevant counties. After receiving staff information (names, titles, mailing addresses), follow-up calls were made to agencies to clarify any details that were unclear to the research team (e.g., to clarify services provided by individuals when it was not evident from position titles, to clarify if those in supervisory positions also provided direct services, etc.). Those deemed inappropriate for inclusion in the study (intake personnel, practicum students, anyone not providing direct service to children with SED) were eliminated from possible selection. The remaining staff lists for each agency were sorted by position title and first name of the participant. Since Seminole Community Mental Health Center had only nine staff members on their staff list (and all were appropriate for inclusion), all nine were included in the study sample. Thirteen staff members were then chosen from each of the remaining seven provider agencies by selecting the first person with each position title and then repeating until the desired number of individuals was chosen within each agency. This resulted in a provider sample of 100 individual staff members in the following service categories: 51 counseling/therapy, 18 psychiatry, 16 supervisory (also provided direct services), and 15 case management.

Based on published methods of conducting mail surveys (Boothroyd & Shern, 1998; Dillman, 1978; Salant & Dillman, 1994), provider and caregiver surveys were mailed using a five-wave mailing protocol over a two-month period in an effort to ensure a sufficient response rate. Caregivers and providers were mailed an initial pre-notification postcard explaining that the University of South Florida would be conducting a study examining the quality of Medicaid-funded mental health care for children with emotional and/or behavioral problems. The pre-notification postcard sent to caregivers included text in English and Spanish (survey materials sent to providers were produced only in English). One week later, a survey packet was mailed. The survey packet included a cover letter explaining the study, the survey, and a pre-addressed, stamped return envelope. Caregivers identified as having Hispanic surnames were sent a two-sided cover letter with the English version on one side and the Spanish version on the reverse side along with English and Spanish versions of the survey. All other caregivers were sent a cover letter in English with Spanish-translated instructions at the bottom of the letter on how they could request the Spanish version of survey materials. Two weeks later, a follow-up postcard was mailed and two weeks subsequent to that, another survey packet was mailed. Final survey packets were mailed one month later via certified mail.

All mailing materials (postcards, letters, and surveys) included a toll-free telephone number for caregivers and providers to call if they had questions, if they wanted another survey mailed to them, or if they wanted to be removed from the mailing database. A total of six phone calls were received from caregivers and providers to: request removal from the mailing list, request another survey, or notify researchers that the provider served only adults and would not be completing the survey. Each wave of mailings (postcards and survey packets) excluded: those who had already returned completed surveys, those for whom mailings were returned for insufficient addresses, or those who asked to be removed from the database. Caregivers were sent a \$10 money order after returning a completed survey; however, providers were not paid for their participation.

Data Analysis

Analyses of caregiver and respondent data were performed to coincide with the four quality of care domains examined in this study: access, consumer engagement, appropriateness, and outcomes. All Likert-scaled questions from caregiver and provider surveys were assigned to one of each of these domains. Mean scores were calculated for individual survey questions and for each quality of care domain. Domain scores were determined by summing the scores for questions within each domain and applying a mean substitution method for unanswered questions if the respondent answered at least two-thirds of the questions within each domain. In addition, an overall quality of care score was derived by aggregating responses across all four domains. The mean scores for each domain and overall quality of care were then converted to a 5-point scale to remain consistent with the original survey design and to facilitate ease in reporting and interpretation.

Since there were four managed care organizations included in this study, analysis of caregiver quantitative data was accomplished through the use of ANOVAs (analysis of variance) with Tukey's tests to identify any statistically significant differences among mean scores for quality of care domains and survey questions for MCOs. In order to generate further detail in caregiver responses (level of agreement or disagreement), cross-tabulations of quantitative data were performed and reported. Provider data were not analyzed or reported by MCO since provider respondents indicated that they served multiple MCOs for children's mental health services; therefore frequency distributions were utilized.

Qualitative data recorded on surveys by caregivers and providers were examined through the use of content analyses. Although the amount of qualitative data was somewhat limited by the quantitative nature of the surveys, common themes in the data were identified and reported accordingly.

Results

Caregiver Demographic Data

Of the original sample of 400 caregivers who were mailed surveys, 145 participated in the study, which equated to a response rate of 36%. Two additional caregivers indicated that their children had not received services within the last six months and although they were paid for their participation, their data were excluded from the analysis. There were 102 (25%) caregiver surveys returned as undeliverable by the post office for reasons such as: unable to forward and insufficient address. After deducting these from the original sample, the response rate adjusted to 49%. Of the 120 caregivers who were mailed Spanish and English versions of the survey, 17 (14%) caregivers completed the Spanish version and 38 were returned as undeliverable by the post office. The majority of caregiver respondents identified themselves as either the child's mother, adoptive mother, or grandmother (n=125), with the remainder (n=17) identifying themselves as father, aunt, great aunt, sister, or guardian.

Utilizing the Medicaid claims data obtained from MCOs, a comparison of age, gender, and diagnosis was made to illustrate the representativeness of the child sample and respondent groups to the population (Table 3). Since there were children in the population that had more than one diagnosis in the data, the diagnosis associated with the most recent claim was used for this comparison. This parallels the methodology utilized to select the original sample of 400 children. Not surprisingly, for children with SED, the majority of children in each group had diagnoses of mood/affective disorders or attention deficit disorders. A diagnosis of bipolar disorder was more common in all three groups than depressive disorder. A much smaller percentage had diagnoses of disruptive behavior disorders, schizophrenia and psychoses, or anxiety disorders.

Table 3
Diagnosis Comparison of Children Studied

Diagnosis Category	Population		Sample		Children of Respondents	
	Total	%	Total	%	Total	%
Mood/Affective Disorders	398 (Bipolar)	24%	128	32%	42	29%
	194 (Depression)	12%	70	18%	21	14%
	57 (Other)	4%	16	4%	8	6%
Sub-Total	649	40%	214	54%	71	49%
Attention Deficit Disorders	663	41%	114	29%	43	30%
Disruptive Behavior Disorders	220	14%	45	11%	21	14%
Schizophrenia & Psychoses	58	4%	20	5%	8	5%
Anxiety Disorders	19	1%	5	1%	1	1%
Other	17	1%	2	0%	1	1%
Total	1626	100%	400	100%	145	100%

Diagnosis categories were also examined for the respondent group by MCO. Table 4 illustrates the differences between the diagnoses associated with the most recent claim for children enrolled in each MCO.

Table 4
Diagnosis Comparison of Respondent Children by MCO

Diagnosis Category	Children of Respondents by MCO			
	Amerigroup n=41	Harmony n=27	United n=27	FHP n=50
Mood/Affective Disorders	25% (Bipolar)	59%	37%	12%
	7% (Depression)	34%	26%	4%
	7% (Other)	0%	0%	10%
Sub-Total	39%	93%	63%	26%
Attention Deficit Disorders	42%	0%	15%	45%
Disruptive Behavior Disorders	12%	0%	11%	27%
Schizophrenia & Psychoses	5%	7%	11%	2%
Anxiety Disorders	2%	0%	0%	0%
Total	100%	100%	100%	100%

While most respondent children enrolled in Harmony (93%) and United (63%) had a diagnosis of mood/affective disorder associated with the most recent Medicaid service claim, a smaller percentage of respondent children enrolled in Amerigroup (42%) and FHP (45%) had similar diagnoses. It should also be noted that the data in Table 4 present only the diagnosis associated with the most recent claim in the data received from the MCOs and does not speak to the possibility of children having multiple diagnoses.

Table 5 illustrates the similarity in age and gender between the child population, sample, and respondent groups. Over half of the children in each group were over the age of 12 and most were male.

Table 5
Age and Gender Comparison of Children Studied

Subject Group	Age				Gender				Total
	9 to 12	%	13 to 17	%	Female	%	Male	%	
Population	719	44%	907	56%	574	35%	1052	65%	1626
Sample	162	41%	238	60%	164	41%	236	59%	400
Respondents	70	48%	75	52%	53	37%	92	63%	145

Caregivers were asked to indicate whether or not their child was Hispanic (38% said yes) and then to identify all race categories that applied to their child (Table 6). It is interesting to note that in addition to identifying their children as Hispanic in the first question, caregivers also identified their children as Hispanic in the question regarding race.

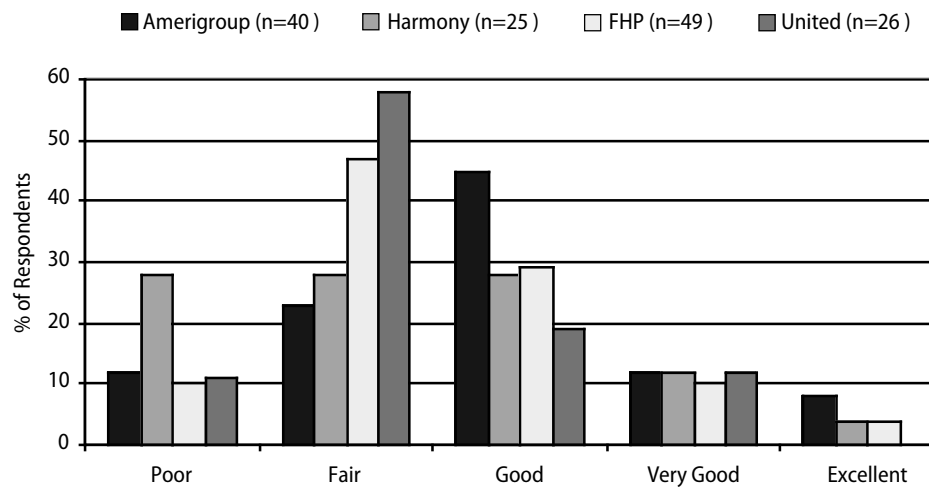
Table 6
Child Race as Identified by Caregivers

Race	n
White	73
Black or African American	40
American Indian or Alaska Native	1
Asian	0
Native Hawaiian or Other Pacific Islander	0
Other (Hispanic/Puerto Rican/Chicano/Spanish 29, Multiracial 4, Arabic 1, Unknown 1)	35

According to caregiver reports, the majority of children examined in the study were receiving the following mental health services (duplicated count): medications (85%); counseling/therapy in the provider’s office (58%), at home (32%), or at school (29%); and case management services (19%). Almost half (49%, n=71) of the children included in this study were receiving medication in conjunction with some form of therapy as reported by caregivers. A much smaller percentage of caregivers reported that their child was receiving only medication (11%) or therapy (13%).

Overall, 47% (n=66) of 140 caregivers rated their child’s current mental health status as good to excellent; the mental health status for the remaining children was rated as fair to poor. Figure 1 displays this data by MCO. Amerigroup had the highest percentage of caregivers rating their child’s mental health status as good to excellent (65%), followed by Harmony (44%), FHP (43%), and United (31%).

Figure 1
Child Mental Health Status by MCO as Reported by Caregivers



Provider Demographic Data

Forty-one providers returned completed surveys, for an initial response rate of 41%. This response rate adjusted to 45% when nine providers were omitted from the original sample of 100 (three no longer worked at the agency, five indicated that they did not treat children, and one asked to be removed from the mailing list). Responses were received from every provider agency included in the study. Of the 41 individual providers participating in this study, the majority identified position titles that were classified into the counseling/therapy and supervisory service categories (Table 7).

Table 7
Provider Respondents by Service Category

Service Category	Position Title	n	%
Counseling/Therapy	Therapist, Counselor, Behavior Analyst	19	47%
Supervisory	Clinical Director/Manager/Supervisor, Program Director/Manager/Supervisor	12	29%
Psychiatry	ARNP, Psychiatrist	5	12%
Case Management	Targeted Case Manager	5	12%
Total		41	100%

Fifty-nine percent (n=24) of responding providers indicated they had earned Master's degrees in counseling/therapy, social work, psychology, or psychiatric nursing. Eight (20%) reported earning Bachelor's degrees in psychology, social work, or exceptional education; and 7 (17%) completed post-Master's education (Ed.S., M.D., and Ph.D.). In addition to academic degrees, 22 providers reported holding some form of professional licensure (14 LCSW/LMFT/LMHC, 3 ARNP, 3 MD, 2 other).

Research Question 1:

To what extent does the quality of mental health care provided to children with SED, as perceived by their caregivers, differ by managed care plan?

Caregiver responses are summarized for each domain in the Quality of Care Framework (i.e., access, consumer engagement, appropriateness, outcomes) and are organized by the indicator areas within each domain with significant differences reported between MCOs ($p < .05$). In general, caregivers responded to the majority of questions using a five-point scale ranging from 1=strongly disagree to 5=strongly agree. To facilitate an overall comparison among MCOs, mean scores for survey questions and domains were calculated, along with an Overall Quality of Care score which was determined by aggregating responses across the four domains (Table 8). Mean scores throughout the report were interpreted and discussed as follows: 1-2.5=less than positive responses, 2.5-3.5=neither positive nor less than positive responses (neutral), and 3.5-5=positive responses.

Table 8
Mean Scale Scores for Quality of Care Domains by MCO as Reported by Caregivers

Quality of Care Domain	# of Items per Domain	Managed Care Organization				Statistical Significance
		Amerigroup	FHP	Harmony	United	
Access	19	3.77*	3.57	3.43	3.40*	* $p=.047$
Consumer Engagement	14	3.81*	3.53	3.53	3.12*	* $p=.003$
Appropriateness	8	3.54*	3.39**	3.32	2.83*, **	* $p=.006$ ** $p=.033$
Outcomes	23	3.28	3.26	3.01	2.89	NS
Overall Quality of Care	64	3.47*	3.28	3.26	3.01*	* $p=.036$

Overall, caregiver ratings in each domain fell in the 2.5-3.5 (neutral) range. Further examination revealed consistent and significant differences across MCOs on three of the four domains (i.e., access, consumer engagement, and appropriateness). No significant differences across MCOs were found on the outcomes domain. Amerigroup consistently received the highest ratings which were significantly better than United in each domain except outcomes. FHP had a significantly higher rating compared to United in the appropriateness domain. No other comparisons were significantly different.

The findings associated with each quality of care domain are summarized below. Information on various questions within each domain was examined to better understand the differences found across MCOs in domain scores. For readers interested in detailed information, Appendices F - I provide a comparison across MCOs on each question in the quality of care domains.

Access

Five indicators were assessed within the Access domain. They include timely and comprehensive evaluation, culturally competent services, a flexible system-of care, communication between systems, and costs to the family.

Timely and Comprehensive Evaluation

There were 26 caregivers reporting that their children began receiving mental services within the last six months. Of those, 20 also indicated that their child had received a complete mental health evaluation prior to receiving services, and 18 said that it was provided in a reasonable amount of time. When asked if their child's mental health needs were identified by the service provider, 59% of caregivers overall reported a positive experience.

Cultural Competency

Caregivers were generally positive in their responses about the cultural competence of the providers and mental health services their child received. Mean scores were highest for providers speaking and using signage in the caregiver's preferred language, using understandable words, and respecting the caregiver and child (mean scores ranged from 3.85 to 4.51). Scores were slightly lower for providers respecting the caregiver's beliefs about forms of treatment and receiving printed materials in the caregiver's preferred language (mean scores ranged from 3.15 to 3.97). The lowest mean scores (ranging from 2.58 to 3.25) resulted from caregiver ratings of whether or not an interpreter was provided when translation was needed.

Flexible System of Care

Caregivers' assessment of the flexibility of the system of care rendered mean scores ranging from 2.41 to 4.08. Approximately three-fourths of caregiver respondents across MCOs indicated that providers' office hours were adequate. Amerigroup had a significantly higher positive response (4.08) from caregivers regarding the convenience of provider locations than did Harmony (3.27). Sixty-three percent of caregivers reported the absence of problems in getting needed medications and 45% said they were able to obtain appointments right away when needed, with Amerigroup and FHP having significantly higher mean scores than United.

Of the 54 caregivers reporting specific problems with obtaining mental health services for their child, half indicated that certain medications were not covered by the mental health plan, 20% said they had to wait a long time to get the first appointment, 17% said they had to wait a long time to get services after the first appointment, and 13% indicated that their child did not qualify for in-home counseling.

Communication Between Systems

Less than half of caregivers had positive reports regarding communication with providers (mean scores ranged from 2.84 to 3.51). Forty-six percent indicated

that they were able to talk to their child's mental health care provider when they called and 43% said that their child's provider helped them deal with all of the people and systems they needed to work with to help their child.

Social and Economic Costs to Family

Caregivers were asked about problems with transportation and childcare, missing time from work and other activities, and paying for medication or other mental health services with their own money. Overall, only 12% of caregivers reported having out-of-pocket expenses for mental health services or medications for their children. However, caregivers with children enrolled in United reported a significantly less positive response (3.56) in comparison to Amerigroup (4.56) and FHP (4.42). Eighteen percent and 23% of caregivers, respectively, reported problems with transportation to needed services and obtaining childcare (mean scores ranged from 3.00 to 3.66). Almost half (49%) of caregivers indicated that they missed time from work or other activities in order to obtain mental health services for their child.

Consumer Engagement

The domain of Consumer Engagement includes discussion on the following quality of care indicator areas: offering information and treatment choices to families, consideration of family input in treatment, and client confidentiality.

Providing Information on Child/s Condition/Treatment to Family

Responses ranged from a mean of 2.96 to 4.08 for survey items in this area. Over half of caregiver respondents indicated that providers had given them information about their child's condition, medication, and/or treatment (53%), and talked with them about ways to manage their child's behavior, stress, etc. (58%). A higher percentage of caregivers (69%), however, indicated that providers had discussed the purpose of the child's medications with them.

Offering a Choice of Interventions to Family

Caregivers were asked if providers discussed treatment options with them and if they were offered a choice of treatments for their child (e.g., medication, counseling). Fifty-seven percent of caregivers had affirmative responses in both instances. Approximately one-fourth reported that these consumer engagement strategies had not occurred, however (mean scores ranged from 2.92 to 3.54).

Considering and Incorporating Child/Family Input into Treatment

There were seven questions for caregivers related to the degree to which family input was considered and incorporated in the child's treatment. Overall, caregiver responses ranged from a mean of 2.27 to 4.36. United had significantly lower mean scores in the areas of: providers asking about child strengths, providers soliciting and including caregiver input in treatment planning, and caregivers signing and being offered a copy of the treatment plan.

Overall, 72% of caregivers reported that providers asked them about their

child's strengths (mean range 2.81-4.03). Similarly, 80% of caregivers indicated that providers took their opinions into account when working with the family (mean range 3.69-4.34). Approximately two-thirds of caregivers reported that providers asked their opinion about their child's treatment and included caregiver input in planning the child's treatment (mean range 2.77-3.72, 3.04-3.87). Thirty caregivers (21%) indicated that their child did not receive the services the caregiver wanted (e.g., received medication instead of other services that the caregiver may have preferred). Over three-fourths of caregivers reported signing the child's treatment plan. Only 35% said that the provider offered or gave them a copy of the treatment plan.

Client Confidentiality

Nearly one-fourth (24%) of caregivers reported concerns related to their child's information being shared with others without permission. However, 83% indicated that their child's provider had respected their family's right to privacy, with United (3.63) having a significantly lower mean score than Amerigroup (4.39).

Appropriateness

Indicator areas discussed in the Appropriateness of Services domain include appropriateness of treatment, individualization of treatment plans, the use of professionally accepted guidelines, continuity of care, and the professionalization of staff.

Appropriate Treatment

Caregivers were asked whether they thought the treatment provided was right for their child. Only half answered affirmatively. Significant differences were revealed between mean scores for United (2.64) and the other three MCOs (Amerigroup 3.53, Harmony 3.50, FHP 3.42).

The survey also solicited caregivers' opinions on what they believed to be the right type of treatment for children with emotional/behavioral disorders. Table 9 provides a duplicated count of caregiver answers (respondents were asked to select all answer options they felt appropriate). Many believed that appropriate treatment should be based on the child's needs, that a combination of medication and therapy would be most effective, and that family counseling may also be helpful. Other treatment suggestions offered by caregivers included: trying therapy as an initial intervention prior to considering medication, respite and additional community services, additional school counseling services, and treating the entire family.

Table 9
Treatment Caregivers Believed to be Appropriate for Children with SED

Type of Treatment Appropriate for Children with SED	n=128	%
I think it should be a combination of medication and counseling/therapy for the child.	97	76%
I think it should be based on the child's condition and needs.	92	72%
I think counseling or therapy for the family can help.	83	65%
I think counseling or therapy for the child is the best way to treat these problems.	33	26%
I think medication for the child is the best way to treat these problems.	12	9%
Other	16	13%

Individualized Treatment Plans

Questions included in this indicator area inquired about the individualization of treatment plans, medications, and services (mean scores ranged from 2.64 to 3.85). Over half of caregivers across MCOs indicated that their child's treatment plan was created specifically for their child (53%) and that services were based on the child's needs (66%). A lower percentage of caregivers indicated that treatment plans included child strengths (49%), with significantly lower scores for United (2.64) than Amerigroup (3.43) and FHP (3.44). In addition, significant differences were found between Amerigroup (3.74) and United (2.87) for caregiver reports that their child received medications that were right for their child's emotional/behavioral problems (54% overall responded affirmatively).

Reflecting Professionally Accepted Guidelines in Treatment Plans

When asked if they agreed that their child's treatment plan was changed or updated on a regular or as needed basis, over half (58%) were in agreement. Nineteen percent disagreed and nearly one-fourth (23%) were neutral in their response.

Maximizing Continuity of Care

Caregiver perceptions of the continuity of mental health care were evaluated by asking if all of the people helping their child with mental health care services had talked to each other about the child's care. Mean responses ranged from 2.38 to 3.11. Twenty-seven percent answered affirmatively, 32% answered negatively, and 41% were neutral in their response (neither agree nor disagree).

Professionalization of Staff

Relevant to caregiver opinions about providers' being good at taking care of their child's emotional/behavioral problems, only half (50%) of caregivers indicated that they believed this to be true, with significant differences found between Amerigroup (3.68) and United (2.88).

Outcomes

Discussion related to the Outcomes domain included caregiver opinions on various aspects of child and family functioning, the degree to which the child's needs were met, and satisfaction with the mental health service system.

Improvement in Child Functioning and Stability

Questions relevant to child functioning focused on interactions with friends, interest in other activities, school, and overall functioning. Mean scores for child functioning questions ranged from 2.59 to 3.53. Positive functioning with friends and new/renewed interest in other activities was reported by less than half of caregivers (38% to 46%). Improved school functioning (including getting into less trouble at school, having more interest in school, and improved grades and attendance) was reported by 37% to 53% of caregivers. Caregivers were also asked if their child had gotten better overall and if things had been good for their child overall. Both items elicited relatively low affirmative responses (38% and 40% respectively). Findings for the latter item included a significantly higher mean score for FHP (3.40) than for United (2.70) and Harmony (2.67).

Pediatric Symptom Checklist

As stated in the methods section of this report, the Pediatric Symptom Checklist (PSC) was incorporated into the caregiver survey to better inform the study of caregiver perceptions of child functioning. A score of 28 or above indicates a higher level of impairment. Overall, 75% of caregiver responses on the PSC resulted in scores of 28 or above. There were no significant differences between MCOs.

Improvement in Overall Family Functioning and Stability

The range of mean scores for caregiver ratings of family functioning survey items (2.42 to 3.22) were slightly lower when compared to those for child functioning, although no significant differences were found among MCOs. Although only 25% of caregivers reported less stress in the family, a slightly greater percentage (35%) reported that family members had gotten along better and indicated that overall things were good for the family (38%).

Meeting the Child's Needs

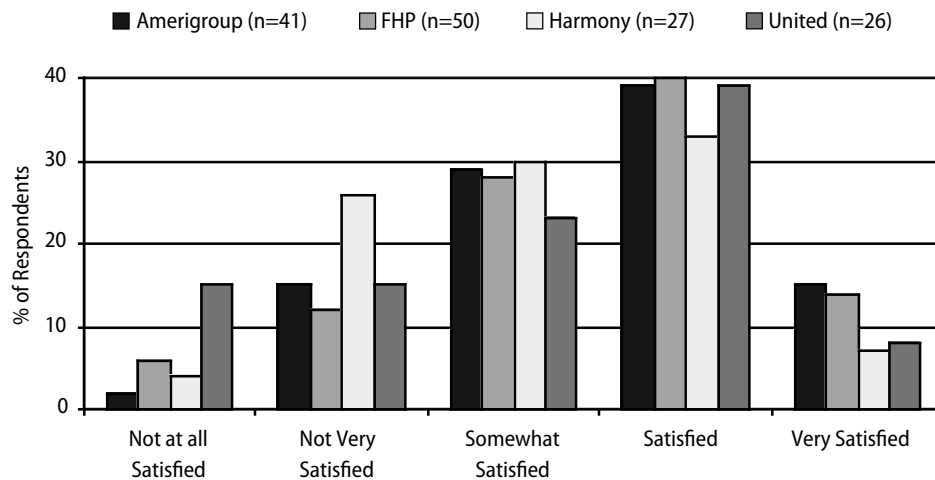
When reporting their perceptions of whether or not their child's needs were met, less than half of caregivers (43%) indicated that their child received all the services they needed, while approximately one-third (34%) believed that the mental health services received met all their child's needs. Fifty-six percent reported that medications helped with their child's emotional/behavioral problems. Overall mean scores ranged from 2.40 to 3.65.

Family Satisfaction

Survey items included in this indicator area focused on caregiver satisfaction related to the individual quality of care domains and child functioning. Mean

scores for these items ranged from 2.74 to 3.76. Significant differences were found for satisfaction with: access to services, caregiver involvement in treatment planning, and the kinds of mental health services received. All significant differences were between Amerigroup (3.63, 3.71, 3.43) and United (2.93, 2.92, 2.74) respectively. Caregivers rated their satisfaction according to the following scale: 1=not at all satisfied, 2=not very satisfied, 3=somewhat satisfied, 4=satisfied, 5=very satisfied. A greater percentage of caregivers (59%) reported higher levels of satisfaction (satisfied or very satisfied) with the people who provided mental health services to their child than any other satisfaction item in the survey. Conversely, caregiver satisfaction with how their child was doing as a result of receiving mental health services had the lowest percentage of caregivers (30%) reporting being satisfied or very satisfied. Figure 2 illustrates caregiver satisfaction with the quality of mental health services received. Amerigroup and FHP had a higher percentage (54%) of caregivers being satisfied or very satisfied. United had the lowest percentage of caregivers reporting that they were somewhat satisfied (23%), and also had the highest percentage (31%) of unsatisfied caregivers (not very satisfied or not at all satisfied).

Figure 2
Caregiver Satisfaction with the Quality of Mental Health Services by MCO



Summary of Caregiver Responses

Examination of mean scores for each of the quality of care domains revealed a clear pattern of caregiver responses among MCOs. More positive experiences with Amerigroup were conveyed through the quantitative data in relation to the other three MCOs; significantly less favorable responses emerged for United in all domains except Outcomes. The majority of caregiver ratings for survey questions (66%) fell within or below the neutral range (mean scores were less than 3.5). These results strongly suggest a need for improvement in all domains of quality of care among all MCOs.

Areas where caregiver ratings generally were within the positive range for mean scores include: providers identifying the mental health needs of children, cultural competence of providers, out-of-pocket expenses for the family, adequacy of provider locations and office hours, providers soliciting and incorporating family input in the child's treatment, client confidentiality, and basing mental health services on the child's needs.

More specifically, however, the data suggests the need for further improvement in the following areas of Access to Services: providers inquiring about family customs and traditions that may affect treatment, having an interpreter available for the family, providers seeing patients right away when needed, caregiver ability to obtain necessary medications, assistance provided to families when dealing with multiple providers and/or service systems, availability of providers to talk with caregivers when called, assistance with caregiver childcare needs, and minimization of missed time from work or other activities when caregivers obtain mental health services for their child.

Caregiver responses in the Consumer Engagement domain revealed a specific need for providers to: better inform families about the child's condition, medication, and/or treatment; talk with caregivers about ways to manage their child's behavior and stress; discuss treatment options with families and giving them a choice of treatments; and offer or provide a copy of the treatment plan to caregivers.

Areas needing attention in the Appropriateness domain include: improving services or consumer engagement to affect a positive change in caregiver views of the appropriateness of treatments being provided to children with SED, better individualization of treatment plans, further incorporation of child strengths in treatment plans, and improving communications between providers or agencies/systems to ensure continuity of care.

Caregiver responses were less positive for the Outcomes domain than for the other three domains of quality of care. While the theory behind the Quality of Care Framework is that quality services lead to quality outcomes, mean scores in the Outcomes domain suggest the need for the following additional services to support children with SED and their families: services to assist families in mitigating the degree of stress in the family, greater collaboration with families and the school system to help improve school performance, and improved monitoring and tracking of child and family satisfaction with mental health services.

Research Question 2:

What are providers' perceptions related to the provision of quality mental health services to children with SED?

Since provider agencies served children enrolled in each of the four PMHP and HMO managed care organizations included in this study, provider responses cannot be presented by MCO. Providers answered the vast majority of questions using the identical scale offered to caregivers: 1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree. Depending on the type of mental health service provided, some provider respondents may not have had knowledge of specific quality of care items included in the survey; therefore a “don't know” answer option was also offered in the provider survey. These answers were not included in the analysis. Using the 5-point answer scale, higher mean scores indicate a more positive response (3.5-5=positive, 2.5-3.5=neutral, 1-2.5=less than positive). Appendices J-M delineate mean scores for survey questions included in each domain.

Mean scale scores were computed for provider responses for each of the quality of care domains. Table 10 indicates a greater need for improvement in the Access domain as reported by provider respondents.

Table 10
Mean Scale Scores for Quality of Care Domains as Reported by Providers

Quality of Care Domain	# of Items per Domain	Mean Scale Score
Access	23	3.48
Consumer Engagement	16	4.33
Appropriateness	14	4.21
Outcomes	9	3.71
Overall Quality of Care	62	3.63

Access

Timely and Comprehensive Evaluation

Most provider respondents (88%) indicated that comprehensive evaluations were conducted in a timely manner within their agencies. The mean score for provider reports was 4.29.

Cultural Competency

Seven of the questions relating to cultural competence mirrored those asked of caregivers. Mean scores for cultural competence items ranged from 3.79 to 4.50. The lowest percentage of providers reporting a positive experience was 69% regarding the question whether the personnel in their agencies asked caregivers about family customs and traditions that may affect the child's treatment. Ninety-four percent of providers affirmed that the personnel in their agencies used words that are understandable to children and families.

Over half of provider respondents (55%) acknowledged that they had received materials and/or training on how to offer culturally competent services to children and families within the last 12 months. All but one reported that these materials or trainings were helpful.

Flexible System of Care

A flexible system of care includes having adequate hours of operation, access to a sufficient number of licensed professionals in a reasonable time frame, access to appropriate medications, and having established protocols for mental health emergencies. Ninety-two percent of providers indicated that their agencies had mental health emergency protocols in place and 76% offered client hours outside the regular 9am-5pm work week. All other questions for this indicator area had only 56% to 59% of positive responses (agree or strongly agree), with mean scores ranging from 3.35 to 3.51.

Communication Between Systems

Providers were asked if their agencies had an established process of consulting with primary care providers and an established mechanism to coordinate services with the school system and other agencies for children with SED. Eighty-five percent and 81% respectively responded affirmatively. However, 43% revealed that they had experienced problems with communication or coordination of services between providers or service systems (mean score 2.89).

Social and Economic Costs to Family

Mean scores for survey items in this indicator area ranged from 2.22 to 2.63. Approximately three-fourths (73%) of provider respondents indicated that caregivers sometimes had to pay for mental health medication or services for their child. Between 50% and 60% of providers reported that caregivers often encounter challenges with obtaining transportation and childcare in order to obtain mental health services for their child; while only 31% and 16% reported offering agency assistance with transportation or child care needs, respectively. Two-thirds (67%) revealed that caregivers often miss time from work to obtain mental health services for their child.

Consumer Engagement

Providing Information on Child/s Condition/Treatment to Family

Questions posed to providers regarding what information they provided to families yielded mean scores of 4.24 to 4.37. Ninety-seven percent of providers reported that they educated caregivers about their child's condition, treatments, and/or medications; and explained side effects or interactions of medications. Almost 90% indicated that they provided information to caregivers regarding behavior management techniques to use with their child and that they always explained the child's treatment plan to the caregiver.

Offering a Choice of Interventions to Family

Between 87% and 97% of providers, respectively, said they discussed available treatment options with caregivers and that caregivers were given a choice of different treatment options. Mean scores ranged from 4.20 to 4.43.

Considering and Incorporating Child/Family Input into Treatment

Ninety to one hundred percent of providers reported asking caregivers about their child's strengths, soliciting input from the child and family during the treatment planning process, taking child and family opinions into consideration when working with children with SED (and that caregivers shared their opinions), and incorporating caregiver suggestions/input into the child's treatment plan as much as possible. Fewer providers, however, indicated that caregivers always signed their child's treatment plan (88%) and that caregivers were always offered or given a copy of the treatment plan (69%). Mean scores for this indicator area ranged from 3.69 to 4.54.

Client Confidentiality

Mean scores for client confidentiality were positive (4.03 to 4.68). The vast majority of providers reported following HIPAA and other confidentiality requirements to ensure child/family confidentiality and privacy (97%), as well as carefully ensuring client confidentiality when collaborating with other providers or agencies (95%). Only eight providers (20%) reported experiencing any challenges with protecting client confidentiality.

Appropriateness

Appropriate Treatment

To get a sense of what providers' opinions were regarding what appropriate treatment for children with SED should include, they were given the same list of six treatment options as caregivers and asked to choose all treatment options they thought were appropriate. Table 11 lists the duplicated responses of 40 providers. Not surprisingly, most providers believed that a child's condition and needs should guide treatment and many believed that family counseling could be useful. A greater number thought that providing medication in conjunction with counseling was more appropriate than just medication or counseling alone.

Table 11
Treatment Providers Believed to be Appropriate for Children with SED

Type of Treatment Appropriate for Children with SED	n=40	%
I think it should be based on the child's condition and needs.	35	88%
I think counseling or therapy for the family can help.	26	65%
I think it should be a combination of medication and counseling/therapy for the child.	19	48%
I think medication for the child is the best way to treat these problems.	3	8%
I think counseling or therapy for the child is the best way to treat these problems.	3	8%
Other	6	15%

Additional treatment options suggested by providers included: applied behavior analysis is needed in most cases, interface with school staff should occur, medication should never be provided without counseling, some clients receiving stimulant medication may not need therapy, and therapy should be provided initially then medication offered if needed.

Providers were also asked to describe the protocol for offering psychosocial interventions and medication management to children with SED within their agencies; 29 providers responded. Over one-third (38%) indicated that, generally, therapy was offered as the initial intervention with the option of medication explored based on the child's needs and in consultation with the family. Thirty-four percent reported that psychosocial interventions and medication options were considered simultaneously, and 28% did not specify preferred initial interventions, but stated that treatment was based on the child's needs in consultation with the family.

Individualized Treatment Plans

Positive responses were received from providers on the individualization of treatment plans to each child's needs and strengths (94%) as well as the selection of services to meet individual needs (97%). A lower percentage of providers, however, reported integrating child strengths into treatment plans (87%). Mean scores were relatively high, ranging from 4.18 to 4.53.

Reflecting Professionally Accepted Guidelines in Treatment Plans

Between 92% and 100% of providers indicated that: professionally accepted guidelines were used when developing treatment plans and to guide their work with children with SED, protocols were in place to ensure that treatment plans reflect professionally accepted guidelines, and treatment plans were reviewed regularly or as needed. Mean scores were also in the positive range for these survey items (4.15-4.41).

Medications

Providers were asked if medications were monitored to ensure that prescriptions were appropriate for use with children with emotional/behavioral problems and if they were monitored to ensure that they were prescribed based on professionally accepted guidelines. Affirmative answers were received from 84% and 80% of provider respondents, respectively.

Maximizing Continuity of Care

Regarding continuity of care when children change provider agencies, only 68% of providers responded positively (mean score 3.65); while 88% indicated that efforts were made to ensure continuity of care when a child is served by multiple provider staff within an agency (mean score 4.05).

Professionalization of Staff

Providers were asked if they participated in any ongoing continuing education within the last 12 months and/or in-service training relevant to their position and if they had received training specific to working with children and adolescents with SED. Ninety-eight percent and 81%, respectively, answered yes to these questions. For provider respondents that did not hold some form of professional licensure, 75% of them indicated that they received supervision from a licensed professional on a regular basis.

Best Practice

When asked if they had been given or had access to any instructional materials (e.g., treatment guidelines) provided by the MCOs within the last 12 months, 12 of 39 providers answered affirmatively. Materials from all four MCOs were reported being received. Descriptions of these materials included: a variety of materials by MCO and from different organizations across the United States, clinical treatment guidelines and formularies, and online and telephone trainings (United Healthcare).

Thirteen of 38 providers (34%) reported having contact with MCOs related to their quality management processes (e.g., quality monitoring information/activities). This contact focused on treatment plan audits, communication regarding service denials or difficulties with service authorizations, quality monitoring of case files, or attendance at regular quality assurance and performance improvement meetings with FHP.

In addition, providers reported using standardized assessment tools with children (91%) and having a process in place to ensure that termination of services occurred in an appropriate manner (89%).

Outcomes

Because this study did not solicit child-specific data from providers, survey questions in the Outcomes domain inquired about the providers' monitoring of child and family outcomes and their opinions on satisfaction with the mental health service system.

Improvement in Child and Family Functioning and Stability

Eighty percent of provider respondents reported that they monitored and tracked the overall stability, functioning, and quality of life of children with SED that they served. Slightly fewer reported monitoring family functioning and stability. Seventy-seven percent reported the use of specific tools that were appropriate to measure child outcomes. Mean scores for these items ranged from 3.81 to 4.11.

Meeting the Child's Needs

Although 78% of providers indicated that in general, the children they served were getting their needs met through the mental health services being provided (mean score 3.97), only 49% reported that children received all the services they needed (mean score 3.32).

Family Satisfaction

Seventy-seven percent of provider respondents indicated that they thought families were satisfied with services (mean score 3.83). Less than half of providers (47%, mean score 3.28) reported that they were satisfied with the policies and procedures of the managed care organizations in which the children they served were enrolled.

Summary of Provider Responses

The majority (79%) of mean scores for provider questions fell within the positive range (greater than or equal to 3.5). However, the data suggest a need for attention to specific service areas. In the domain of Access to services, these areas include issues with: appointments being available right away when needed, getting necessary mental health medications, coordination with other providers or service systems, families having to pay for services or medication, family transportation and childcare, caregivers missing time from work or other activities when obtaining mental health services for their child, and provider agencies offering assistance with transportation and childcare needs of families. All of the mean scores for provider questions in the Consumer Engagement and Appropriateness domains were equal to or above the 3.5 mark, however, this does not preclude the pursuit of further improvement in these areas as well. In the Outcomes domain, provider responses also indicated a possible need for a review of outcome measurement tools used to track and monitor child progress and improved tracking and monitoring of provider satisfaction with the policies and procedures of the managed care organizations.

Research Question 3:

What are the similarities and differences between caregiver and provider perceptions of the quality of mental health services provided to children with SED?

Although the research team attempted to parallel as many survey questions as possible between caregivers and providers to facilitate comparison between the perceptions of these respondent groups, there were questions asked of providers that were not posed to caregivers and vice versa. For example, providers were asked if: there were enough licensed professionals in their agencies, they followed HIPAA guidelines, they utilized professionally accepted treatment guidelines, and the specific outcome measurement tools they used were appropriate. Caregivers, on the other hand, were asked if their child was not receiving services the caregiver wanted, if they thought their child's treatment was right for him or her, and questions about specific aspects of their child's functioning and satisfaction with mental health services. In spite of these differences, a comparison between caregiver and provider mean scale scores was conducted for each quality of care domain to gain an overall sense of the similarities and differences between the two respondent groups (Table 12).

Table 12
Mean Scale Scores for Quality of Care Domains by Respondent Group

Quality of Care Domain		Respondent Group	
		Caregivers	Providers
Access	# of Items	19	23
	Mean Scale Score	3.56	3.47
Consumer Engagement	# of Items	14	16
	Mean Scale Score	3.53	4.33
Appropriateness	# of Items	8	14
	Mean Scale Score	3.32	4.21
Outcomes	# of Items	23	9
	Mean Scale Score	3.15	3.71
Overall Quality of Care	# of Items	64	62
	Mean Scale Score	3.28	3.63

As may be expected, providers had more positive perceptions about the quality of mental health care provided to children with SED and their families than did caregivers, with the exception of the Access domain where caregivers reported slightly more positive perceptions than providers. The biggest differences between mean scores appeared in the Consumer Engagement and Appropriateness domains. Notable differences in mean scores between caregiver and provider responses to survey questions are discussed below.

Access

In general, responses between respondent groups were similar for survey items in the Access domain including most cultural competency items and problems with getting medications. Moderate differences were found in perceptions about providers asking about family customs and traditions that may affect treatment and the availability of interpreters when needed. In both instances, providers had more positive responses (3.91, 3.80) than caregivers (3.27, 2.73) respectively. The greatest differences, however, emerged in the area of cost to the family, although interestingly, caregivers had more positive responses than providers. Caregivers reported more positive experiences with not having out-of-pocket expenses related to mental health services or medications (4.20) than providers (2.45). This may be a result of overestimation by providers or possibly an over-conveyance of costs by caregivers in their conversations with providers. This cannot be known, however, without further investigation. Although both groups reported more issues with obtaining or assisting with childcare needs of caregivers, there was a greater difference between their reports related to transportation problems. Once again, providers had a less positive response (2.40) than caregivers (3.57).

Consumer Engagement

Survey items in the Consumer Engagement domain elicited more positive perceptions from providers than caregivers in the areas of providing information to families on the child's condition, medication, or treatment; offering behavior

management techniques to caregivers; discussing treatment options and giving families a choice of treatments; soliciting family input and incorporating family suggestions in treatment plans; and offering or giving the family a copy of the treatment plan. Mean scores for these areas ranged from 3.69 to 4.54 for providers and 3.28 to 3.62 for caregivers.

Appropriateness

Caregivers reported less positive responses than providers relevant to the development of individualized treatment plans, the selection of services based on the child’s needs, incorporation of child strengths in the treatment plan, updating treatment plans on a regular basis, and providers communicating with each other about a child’s mental health care. Provider mean scores ranged from 4.15 to 4.53 and caregiver mean scores ranged from 2.87 to 3.59.

However, providers and caregivers reported similar beliefs regarding the most appropriate treatments for children with SED (Table 13). A high percentage in both groups thought that treatments should be based on the child’s needs and that counseling can benefit the family. A greater percentage of caregivers than providers believed that treatment should include a combination of therapy and medication. A much smaller percentage in each group reported that medication or therapy alone was appropriate.

Table 13
Provider/Caregiver Comparison of Treatments Believed to be Appropriate for Children with SED

Type of Treatment Appropriate for Children with SED	Providers n=40	Caregivers n=128
	%	%
I think it should be based on the child’s condition and needs.	88%	72%
I think counseling or therapy for the family can help.	65%	65%
I think it should be a combination of medication and counseling/therapy for the child.	48%	76%
I think counseling or therapy for the child is the best way to treat these problems.	8%	26%
I think medication for the child is the best way to treat these problems.	8%	9%

Outcomes

There were fewer parallel survey items between respondent groups in the Outcomes domain, because caregivers were asked about specific aspects of child functioning and providers were not. There was one item, however, that showed a large difference between respondent group reports. Providers had a more positive perception (3.97) of services meeting the child’s needs than caregivers (2.94).

Research Questions 4 and 5: What are the facilitators and barriers to receiving mental health services as reported by caregivers and providers and what are the similarities and differences between the two respondent group reports?

When providers were asked if there was anything about the structure or policies and procedures of MCOs that facilitated or hindered their ability to effectively serve children with SED enrolled in those plans, 25% fewer providers reported facilitators than barriers. Table 14 details their quantitative answers.

Table 14
Providers Reporting Facilitators and Barriers to Services

Answer Option	Facilitators		Barriers	
	n=38	%	n=38	%
Yes	17	45%	23	60%
No	10	26%	6	16%
Don't Know	11	29%	9	24%

Facilitators to Services

Nine of 17 providers offered comments related to facilitative factors. General comments included: having a specific point of contact at the MCO (however, if that person was unavailable, others could not assist); receiving approval for an adequate amount of time for children to stabilize in a crisis unit; and not needing approval for every hour billed. More specifically, providers noted that Amerigroup seemed less restrictive in allowing medication approvals, had more medications for children in their formulary, and had improved in the area of approving prior authorization claims. FHP was mentioned as doing a “good job” at following up on enrolled children while also allowing providers to make good clinical decisions and provide needed services.

Barriers to Services

Twenty-one providers offered descriptive comments about the barriers presented by MCO structures or policies and procedures. General comments included: insufficient time allotments for services, denials of prior authorizations and reauthorizations for services and medications that children were already taking, problems with obtaining approval for adequate lengths of stay for more intensive services, and difficulty in obtaining Risperdal for children who are dangerously aggressive. The provider survey also yielded comments specific to individual MCOs. Amerigroup was mentioned as “rarely” approving therapeutic behavioral onsite services (TBOS). Providers noted the following challenges with Harmony: excessive paperwork for service authorization, not re-authorizing targeted case management services causing the provider to close the case prematurely, not offering all needed services, and not authorizing clinically appropriate medications. It was also suggested that United needed to make Adderall XR, Concerta, and Focalin XR available. One provider also indicated that the FHP’s requirements for documentation and service plans were a burden and that better training was needed.

In addition to specific questions regarding factors that facilitated and hindered effective service delivery, other challenges that may have impacted effective service provision were revealed throughout the survey data and are summarized below.

Challenges with Medications

Seventeen of 38 providers (45%) reported experiencing problems with medications being covered by MCOs and offered the following additional comments. Although providers generally reported experiencing medication challenges with all four of the MCOs included in the study (including hearing complaints from others/parents), more specific comments were made related to the HMOs. It was reported that prior authorizations (mainly Harmony) were a “hassle” to obtain, after which staff had to go back to the MCO when pharmacies indicated that claims were not being approved. In addition, it was reported that there were staff who were not educated or trained in child psychiatric issues handling prior authorizations. Providers also reported that HMOs covered different medications and when clients switched HMOs, they were forced to try different medications before being approved for the medications that had already proven effective (causing increased behavioral problems at home and school). This finding echoes what providers reported in the FY05-06 Children’s Quality of Care Study (Vargo et al., 2006b.) However, when stating that psychiatric medications for children with SED were being delayed or denied, one provider respondent stated that Amerigroup was “the only HMO that appears to be helpful to any degree.”

While not mentioning specific MCOs, providers reported problems getting Risperdal, Adderall, and Seroquel for their clients. Harmony and United Healthcare were mentioned specifically regarding problems in obtaining Risperdal, Strattera, Geodon, Zyprexa, Abilify, some antidepressants, and antipsychotics (Harmony only).

Compared to the 45% of providers reporting medication issues, 29% of caregiver respondents reported having problems with getting the medications their children needed for their emotional/behavioral issues.

Service Denials

Twenty of 38 providers (53%) reported that children had been denied needed services through the MCOs within the last six months. Table 15 lists the reasons for denial (a duplicated count is presented since providers were asked to indicate all reasons they had encountered).

Table 15
Reasons for Denial of Services through Managed Care Organizations

Reason for Denial as Reported by Providers	n=20	%
Service limit exceeded	11	55%
Service not covered under the managed care plan	10	50%
Child not eligible for service	8	40%
Provider not available	4	20%
Other	8	40%

Other reasons for service denial included: an inability to obtain psychological testing, the caregiver did not comply with HMO qualifications in a timely fashion, the managed care plan stated that the client had received services for too long a period of time, strict medication guidelines, the consumer did not have a social security number, and lapse of coverage.

Differences in MCOs that Impacted Treatment

Fifteen of 36 providers (42%) indicated that there were differences between the Medicaid MCOs that impacted their treatment of children enrolled in these plans. Two providers noted great challenges in obtaining approvals for certain medications, yet another stated that the addition of Strattera and Concerta to the Medicaid formulary was of “great benefit.” One provider stated that United did not include an extended release stimulant (12 hr.) on its formulary. The destructiveness of cuts in the number of allowable counseling sessions and the clinical difficulty caused by HMOs approving different amounts of therapy were also mentioned. One provider noted restrictions in service authorizations with Amerigroup and Harmony, while two others mentioned challenges in obtaining approvals and the paperwork involved in obtaining TBOS (therapeutic behavioral onsite services) from Amerigroup and Harmony.

Other Barriers

Other possible barriers to effective provision of Medicaid-funded mental health services discussed previously include those survey questions yielding low mean scores. Caregivers were not extremely positive in their responses about the availability of: interpreters for translations services, appointments to see providers right away if necessary, assistance from providers to deal with all of the people and systems necessary to serve the child appropriately, providers to talk to the caregiver when called, childcare services, and receiving information from providers on the child’s condition, behavior management techniques, and treatment options. Providers also noted issues with being able to see patients right away when needed, having enough licensed professionals to serve children with SED, effectively coordinating with other providers or systems, out-of-pocket expenses for caregivers, and caregiver transportation and childcare issues.

Conclusions

The vast majority of caregiver and provider survey questions were answered using a five-point scale ranging from 1=strongly disagree to 5=strongly agree. Mean scores for survey questions and domains were utilized to determine statistically significant differences in caregiver responses by MCO. To facilitate a meaningful interpretation of the data, mean scores for caregiver and provider data were translated and discussed as follows: 1-2.5=less than positive responses, 2.5-3.5=neither positive nor less than positive responses (neutral), 3.5-5=positive responses.

Clearly, there is room for improvement in the MCO service systems as evidenced by caregiver responses that resulted in most domain mean scores falling within or below the neutral range. Further examination revealed consistent and significant differences across MCOs on three of the four domains (i.e., access, consumer engagement, and appropriateness). No significant differences across MCOs were found on the Outcomes domain. Amerigroup consistently received the highest ratings which were significantly better than United in each domain except Outcomes. FHP had a significantly higher rating compared to United in the Appropriateness domain. No other domain comparisons were significantly different.

Areas where caregiver ratings generally were within the positive range for mean scores include: providers identifying the mental health needs of children, cultural competence of providers, out-of-pocket expenses for the family, adequacy of provider locations and office hours, providers soliciting and incorporating family input in the child's treatment, client confidentiality, and determining mental health services based on the child's needs.

Caregiver data, however, suggest the need for further improvement in the following areas of Access to services: more consultation relevant to family customs and traditions that may affect treatment, having an interpreter available for the family, availability of providers to see patients right away when needed, caregiver ability to obtain necessary medications, provision of assistance to families when dealing with multiple providers and/or service systems, availability of providers to talk with caregivers when called, assistance with caregiver childcare needs, and minimization of missed time from work or other activities when caregivers obtain mental health services for their child.

Caregiver responses in the Consumer Engagement domain revealed a specific need for providers to: better inform families about the child's condition, medication, and/or treatment; talk with caregivers about ways to manage their child's behavior and stress; discuss treatment options with families and offer a choice of treatments; and offer or provide a copy of the treatment plan to caregivers.

Areas needing attention in the Appropriateness domain include: improving services or consumer engagement to affect a positive change in caregiver views of the appropriateness of treatments being provided to children with SED, better

individualization of treatment plans, further incorporation of child strengths in treatment plans, and improving communications between providers or agencies/systems to ensure continuity of care.

Mean scores of caregiver responses in the Outcomes domain suggest the need to: provide services to assist families in mitigating the degree of stress in the family, better collaborate with families and the school system to help improve school performance, and improve monitoring and tracking of child and family satisfaction with mental health services.

Provider respondents reported more positive opinions about the quality of mental health care provided to children with SED and their families than did caregivers, with the exception of the Access domain where caregivers reported slightly more positive perceptions than providers. Although 79% of mean scores for provider questions were greater than or equal to 3.5, the data suggest a need for attention to specific service areas. In the domain of Access to services, these areas include problems with: appointments being available right away when needed, getting necessary mental health medications, coordination with other providers or service systems, families having to pay for services or medication, family transportation and childcare, caregivers missing time from work or other activities when obtaining mental health services for their child. Even though all of the mean scores for provider questions in the Consumer Engagement and Appropriateness domains were greater than or equal to 3.5, the pursuit of further improvement is not an unreasonable expectation. In the Outcomes domain, provider responses also indicated a possible need to review outcome measurement tools used to track and monitor child progress and improve tracking and monitoring of provider satisfaction with the policies and procedures of the managed care organizations.

In addition to barriers arising from the areas already discussed, other potential barriers to effectively serving children with SED and their families arose from quantitative and qualitative data obtained in the study. Forty-five percent of provider respondents and 30% of caregiver respondents reported experiencing problems with obtaining necessary mental health medications. Although providers generally reported experiencing medication challenges with all four of the MCOs included in this study, more specific comments were made relevant to the HMOs. These included problems with obtaining authorizations, dealing with MCO staff that were not trained in child psychiatric issues, and formularies covering different medications (which also caused children who had changed MCOs to try other medications before being approved for the previously proven medications). Other problematic issues included restrictions in service authorizations (HMOs) and burdensome paperwork (all MCOs).

Limitations

While the level of caregiver participation resulted in an adjusted response rate of 49%, one-fourth (n=102) of the original 400 caregiver surveys were returned as undeliverable by the post office. A higher response rate among caregivers may have been achieved had the percentage of undelivered surveys been lower.

The sample of children received from United had Medicaid claims from January to August 2006; all other MCO samples selected for inclusion in the study included most recent claims from August 2006. United was also one of the most recent MCOs to implement Medicaid managed care in Area 7 (September 2005). It is possible that these two factors may have contributed to lower scores being received for United.

Recommendations

Findings from the caregiver and provider surveys generated the following recommendations for stakeholders in the Medicaid-funded mental health system:

- The generally neutral caregiver ratings of MCOs suggest a need for further attention to improvement within all domains of quality care.
- Managed care organizations should consider soliciting feedback from service providers on satisfaction with MCO policies and procedures and seeking provider input on what works best and what needs improvement in the MCOs in order to serve children with SED and their families in a more collaborative manner.
- Managed care organizations and service providers may wish to consider re-examining their satisfaction questionnaires sent to families in order to obtain more detailed feedback from families relevant to their experiences with the service system and MCO policies. Questions could be structured to inquire about overall experience, as well as most recent provider contact to examine both overall experiences as well as emerging trends in care. If not already occurring, MCOs should share anonymous feedback with providers in order to improve care.
- Medication formularies and policies governing access to medications should be made consistent across managed care organizations, so all children receiving pharmacological treatment have equal access to necessary medications.
- Although service providers are not required by Medicaid to provide transportation and childcare assistance, these remain issues for families and should be addressed by the system of care serving them.

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Appendix A: SED Data Request Criteria

The Children's Quality of Care Study staff is requesting data (see variable list below) for children who meet the selection criteria on page 2. Please use claims data for January through August 2006 (inclusive) for Brevard, Orange, Osceola, and Seminole counties to select children.

VARIABLES

We are requesting the following variables for each child who meets the selection criteria on page 2:

- | | | |
|-----------------------------------|--------------------|--|
| a. Medicaid number of child | e. Phone number | j. Provider's name and contact information |
| b. Full name of child | f. Race of child | k. Diagnosis, Axes I & II |
| c. Name of parent/guardian | g. Gender of child | l. Claims/service receiving |
| d. Address, city, state, zip code | h. DOB of child | |
| | i. Provider agency | |

SELECTION CRITERIA

All children who meet the following criteria:

1. Age range: 9-17 inclusive. Age should be as of December 1, 2006.
2. Claims data that meets the following SED definition criteria (either A. or B. below):
 - A. Have at least 2 claims on different days in one of the following diagnostic categories:**
 1. Bipolar Disorder (Diagnosis code in range from 296.4-296.99 or 296-296.19)
 2. Schizophrenic Disorders (Diagnosis code in range from 295-295.99 or 297-298.99)
 3. Major Depressive Disorder (Diagnosis code in range from 296.-296.39)
 4. Personality Disorder (Diagnosis code in range from 301-301.99)

NOTE: At least one of the two required claims must occur in January through August, 2006.

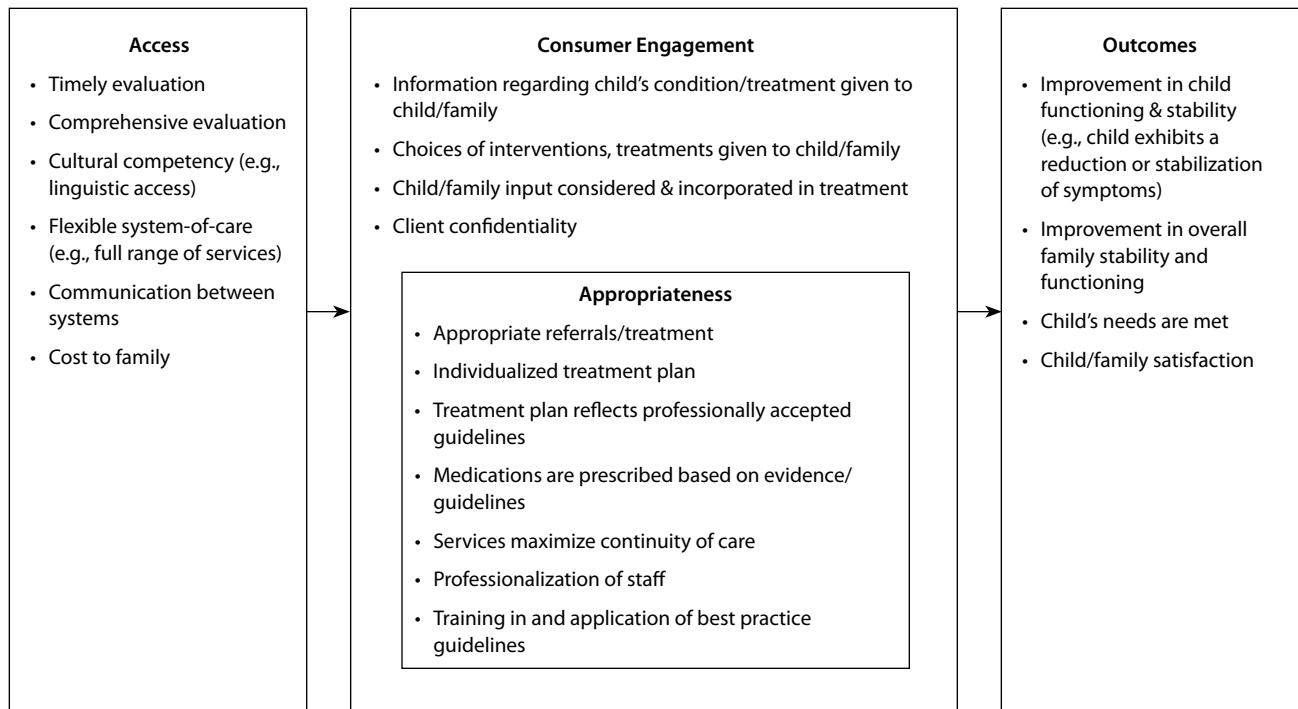
OR

- B. Not have diagnoses 1-4 above, but have at least 2 claims on different days in at least 2 of the following 7 conditions (there must be at least 2 claims for each condition met):**
 1. ADHD (Diagnosis code in range from 314-314.99)
 2. Conduct/Oppositional Disorder (Diagnosis code in range from 312-312.99 or 313.81)

3. Anxiety Disorder (Diagnosis code in range from 300-300.99, or 308-308.99, or 313-313.99 or in 309.81, 309.89, 309.21) but not in (300.40,300.15,300.16,300.19))
4. Depressive Disorder (Diagnosis code in range from 311-311.99 or in 300.40, 301.13)
5. Anti-Psychotic medication (total claims must total to at least a 60-day supply of medication, generic names for pharmaceuticals include: ARIPIPRAZOLE, CLOZAPINE, OLANZAPINE, QUETIAPINE FUMARATE, RISPERIDONE, ZIPRASIDONE HCL, CHLORPROMAZINE HCL, FLUPHENAZINE DECANOATE, FLUPHENAZINE HCL, HALOPERIDOL, HALOPERIDOL DECANOATE, HALOPERIDOL LACTATE, LOXAPINE SUCCINATE, MESORIDAZINE BESYLATE, MOLINDONE HCL, PERPHENAZINE, THIORIDAZINE HCL, THIOTHIXENE, TRIFLUOPERAZINE HCL).
6. Anti-Depressant medication (total claims must total to at least a 60-day supply of medication, generic names for pharmaceuticals include: CITALOPRAM HYDROBROMIDE, FLUOXETINE HCL, FLUVOXAMINE MALEATE, PAROXETINE HCL, SERTRALINE HCL, BUPROPION HCL, MIRTAZAPINE, NEFAZODONE HCL, TRAZODONE HCL, VENLAFAXINE HCL).
7. Mood Stabilizers (total claims must total to at least a 60-day supply of medication, generic names for pharmaceuticals include: CARBAMAZEPINE, CLONAZEPAM, DIVALPROEX SODIUM, GABAPENTIN, LAMOTRIGINE, LITHIUM CARBONATE, LITHIUM CITRATE, OXCARBAZEPINE, TOPIRAMATE, VALPROATE SODIUM, VALPROIC ACID).

NOTE: At least one of the two required claims must occur in January through August, 2006

Appendix B: Quality of Care Framework



Appendix C: Focus Group Questioning Route

Goal: To obtain caregivers' feedback/comments on a draft questionnaire and cover letter.

Process Notes: The group will begin by reading the consent form to prospective participants, answering any questions they have, having them sign the consent form and confidentiality statement and collecting these forms.

(10 – 15 minutes)

Participants will be asked to read a draft cover letter and complete a draft questionnaire at the start of the focus group

(10 – 15 minutes)

1. What are your reactions to the cover letter?
 - a. Is the purpose clearly stated?
 - b. Is it clear that participation is completely voluntary?
 - c. If you received a letter such as this do you think you would complete and return the survey? Why? Why not?
 - d. What suggestions do you have for improving the language in this cover letter?
2. What are your reactions to the survey? (15 – 20 minutes)
 - a. Do you think the questions in the survey do a good job at describing what you think of as quality of care?
 - b. What questions need to be added? Deleted?
 - c. Does the wording of any questions need to be changed?
 - d. What did you like or dislike about how the survey flowed, did the order of the questions make sense to you?

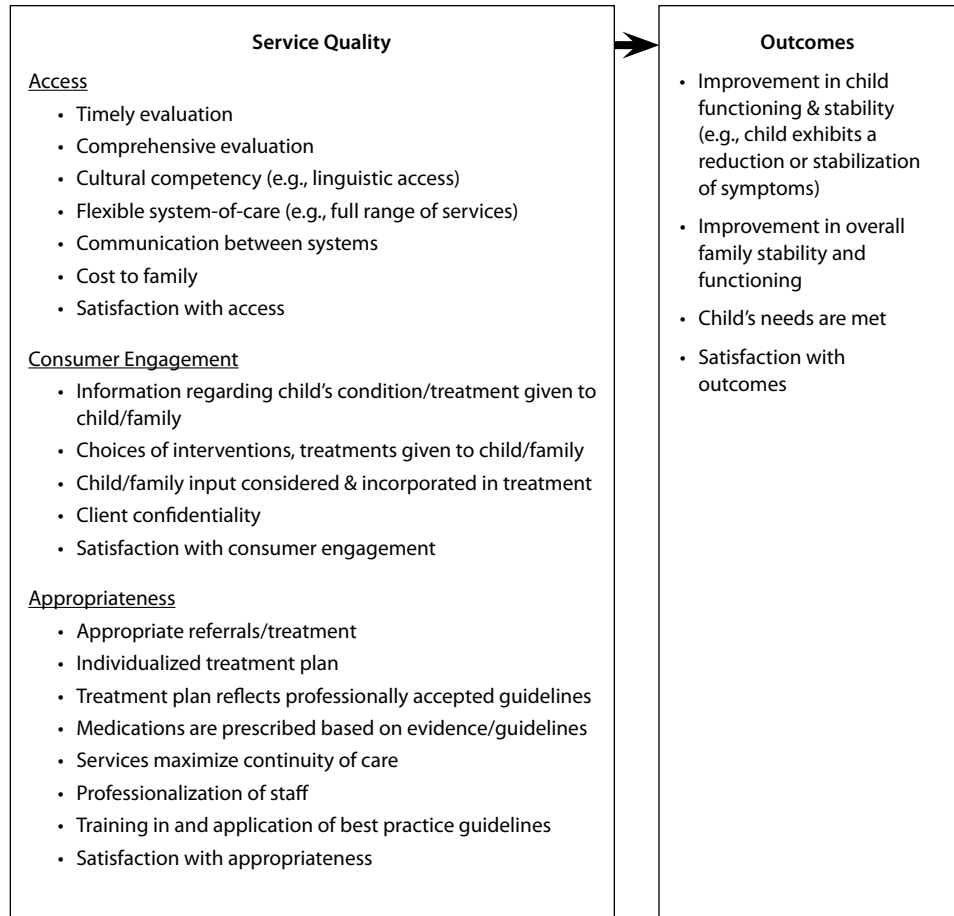
Process Notes: Summarize the major themes and get verification from the group that we have captured the major and important issues/topics
(5 – 10 minutes)

Pay group participants and have them sign payment receipts.

Appendix D: Correlational Analyses Between Domains and Corresponding Satisfaction Questions in the Caregiver Survey

Domain	Satisfaction Question Within the last six months, how satisfied were you with...	Pearson Correlation (r)	Sig. Level
Access	your ability to get mental health services for your child?	.685	0.01
Consumer Engagement	your involvement in planning for your child's mental health services?	.694	0.01
Appropriateness	the mental health services your child received?	.757	0.01
Outcomes	how your child is doing as result of the mental health services he/she received?	.790	0.01
Overall Quality of Care	the quality of mental health services your child received?	.686	0.01
Pediatric Symptom Checklist	how your child is doing as result of the mental health services he/she received?	-.408	0.01

Appendix E: Quality of Care Framework-Revised



Appendix F: Access Domain Mean Scores for Caregiver Responses

Survey Items in Access Domain	MCO Mean Scores				Sig. Level
	Amerigroup	FHP	Harmony	United	
Mental health needs identified by provider	3.54	3.54	3.38	3.32	NS
Asked about family customs	3.41	3.42	3.07	2.96	NS
Provider respected family beliefs about treatment	3.88	3.80	3.67	3.50	NS
Provider used words family understands	4.32	4.15	4.12	4.06	NS
Signs in language family understands	4.23	3.85	4.04	4.08	NS
Printed materials in language family understands	3.97*	3.15*	3.52	3.44	p=.025
Providers spoke in family's preferred language	4.48	4.23	4.23	4.12	NS
Interpreter available	2.58	2.63	3.25	2.60	NS
Providers respected child/family	4.51	4.14	4.12	4.15	NS
Appointments right away if needed	3.68*,**	2.77*	2.89	2.63**	*p=.006 **p=.007
No problems getting medication	3.81*	3.57**	3.23	2.41*,**	*p=.001 **p=.005
Adequate provider office hours	3.93	3.79	3.63	3.88	NS
Convenient provider locations	4.08*	3.81	3.27*	3.58	p=.032
Provider helped deal with different systems	3.51	3.24	2.89	2.84	NS
Able to talk to provider when called	3.35	2.92	2.96	3.11	NS
Didn't have to pay for services	4.56*	4.42**	3.89	3.56*,**	*p=.001 **p=.005
Transportation not a problem	3.65	3.66	3.42	3.44	NS
Childcare not a problem	3.46	3.00	3.19	3.00	NS
Missed time from work	2.63	2.98	2.46	2.62	NS
Overall Access Domain	3.77*	3.57	3.43	3.40*	*p=.047

Appendix G: Consumer Engagement Domain Mean Scores for Caregiver Responses

Survey Items in Consumer Engagement Domain	MCO Mean Scores				Sig. Level
	Amerigroup	FHP	Harmony	United	
Family informed about child's treatment	3.58	3.12	3.19	3.26	NS
Purpose of medication explained	4.08	3.52	3.54	3.42	NS
Offered ways to manage behavior, stress, etc.	3.67	3.35	3.35	2.96	NS
Providers discussed treatment options with family	3.51	3.41	3.27	2.96	NS
Providers gave family treatment choices	3.46	3.54	3.38	2.92	NS
Provider considered family opinions	4.34*	3.92	3.81	3.69*	p=.047
Provider asked about child's strengths	4.03*	3.78**	3.88***	2.81*,**,***	*p=.000 **p=.001 ***p=.002
Provider solicited family opinion about child's treatment	3.72*	3.44	3.62	2.77*	p=.012
Family opinions incorporated into treatment plan	3.87*	3.69	3.68	3.04*	p=.015
Family signed treatment plan	4.36*	3.91**	3.81	3.21*,**	*p=.000 **p=.026
Family offered or given copy of child's treatment plan.	3.39*,**	2.67*	2.81	2.27**	*p=.029 **p=.002
Child did not get services that family did not want	3.58	3.52	3.37	3.27	NS
Provider respected family's right to privacy	4.69*	4.08	3.93	3.63*	p=.007
Family did not have concerns about confidentiality	3.48	3.59	3.38	3.44	NS
Overall Consumer Engagement Domain	3.81*	3.53	3.53	3.12*	*p=.003

Appendix H: Appropriateness Domain Mean Scores for Caregiver Responses

Survey Items in Appropriateness Domain	MCO Mean Scores				Sig. Level
	Amerigroup	FHP	Harmony	United	
Family thought treatment was right for child	3.53*	3.42**	3.50***	2.64*, **, ***	*p=.013 **p=.028 ***p=.037
Individualized treatment plan	3.38	3.49	3.22	2.78	NS
Child's services based on needs	3.85	3.64	3.52	3.15	NS
Child received medications right for him/her	3.74*	3.52	3.19	2.87*	p=.010
Child's strengths incorporated into treatment plan	3.43*	3.44**	3.30	2.64*, **	*p=.029 **p=.018
Treatment plan updated regularly	3.78	3.44	3.28	3.15	NS
Providers talked to each other about child's care	2.98	2.90	3.11	2.38	NS
Provider was good at taking care of child	3.68*	3.44	3.30	2.88*	p=.027
Overall Appropriateness Domain	3.54*	3.39**	3.32	2.83*, **	*p=.006 **p=.033

Appendix I: Outcomes Domain Mean Scores for Caregiver Responses

Survey Items in Outcomes Domain	MCO Mean Scores				Sig. Level
	Amerigroup	FHP	Harmony	United	
Child made new friends	3.40	3.07	3.23	3.00	NS
Child getting along better with other children	3.15	3.13	3.04	3.04	NS
Child getting into less trouble at school	3.32	3.36	2.84	2.79	NS
Child more interested in school	3.00	3.13	2.92	2.59	NS
Child's grades improved	3.05	3.21	3.24	2.92	NS
Child's school attendance better	3.53	3.50	3.24	3.09	NS
Child new/renewed interest in hobby, sport, other activity	3.32	3.07	3.04	2.96	NS
Child is better overall	3.15	3.10	2.78	2.93	NS
Overall, things good for child	3.29	3.40**,**	2.67*	2.70**	*p=.027 **p=.040
Less stress in family	2.62	2.74	2.42	2.74	NS
Family members getting along better	2.97	3.02	3.08	3.15	NS
Overall, things good for family	3.22	3.22	2.78	2.81	NS
Medication helped with child's emotional/behavioral problem	3.50	3.65	3.00	3.09	NS
Child received all needed services	3.13	3.22	3.04	2.40	NS
Mental health services received met all child's needs	3.15	3.06	2.81	2.56	NS
Satisfied with ability to get services	3.63*	3.36	3.44	2.93*	p=.028
Satisfied with involvement in planning services	3.71*	3.51	3.44	2.92*	p=.010
Satisfied with kinds of mental health services received	3.43*	3.38	3.11	2.74*	p=.049
Satisfied with mental health services received	3.44	3.33	3.15	2.89	NS
Satisfied with people who provided services	3.76	3.66	3.22	3.44	NS
Satisfied with quality of mental health services received	3.49	3.44	3.15	3.08	NS
Satisfied with how child is doing	2.98	3.18	2.74	2.78	NS
Satisfied with how well medication worked	3.14	3.22	2.81	2.82	NS
Overall Outcomes Domain	3.28	3.26	3.01	2.89	NS

Appendix J: Access Domain Mean Scores for Provider Responses

Survey Items in the Access Domain	Mean Score
Evaluations were timely	4.29
Asked about family customs	3.91
Respected family beliefs about treatment	3.94
Used words family understands	4.50
Signs in language family understands	3.79
Printed materials in language family understands	3.80
Personnel speak in family's preferred language	3.91
Interpreter available	3.80
Appointments right away if needed	3.44
No problems getting medication	3.35
Enough licensed professionals	3.51
No waiting list	3.41
Offered extended hours	3.81
Protocol for mental health emergencies	4.24
Consultation with primary care	3.94
Coordinate with school	3.92
Problems coordinating with other providers	2.89
Family did not have to pay for services	2.45
Family did not have trouble with transportation	2.40
Family did not have trouble with childcare	2.63
Caregiver did not miss time from work	2.33
Agency offered transportation assistance	2.63
Agency offered childcare assistance	2.22
Overall Access Domain	3.48

Appendix K: Consumer Engagement Domain Mean Scores for Provider Responses

Survey Items in the Consumer Engagement Domain	Mean Score
Family informed about child's treatment	4.35
Side effects of medication explained	4.37
Family given information about behavior management	4.24
Treatment plan always explained to family	4.25
Discussed treatment options with family	4.43
Gave family treatment choices	4.20
Family input considered in treatment	4.26
Family asked about child strengths	4.45
Solicited family input in treatment planning	4.54
Family shared opinions in treatment planning	4.43
Family suggestions incorporated into treatment plan	4.51
Caregiver always signed treatment plan	4.24
Caregiver always given or offered copy of treatment plan	3.69
Followed HIPAA	4.68
Ensured client confidentiality when collaborating	4.65
No challenges with client confidentiality	4.03
Overall Consumer Engagement Domain	4.33

Appendix L: Appropriateness Domain Mean Scores for Provider Responses

Survey Items in the Appropriateness Domain	Mean Score
Individualized treatment plans	4.42
Services chosen to meet child needs	4.53
Child strengths incorporated into treatment plan	4.18
Used professional guidelines in treatment planning	4.45
Treatment plans regularly reviewed	4.15
Protocol to ensure treatment plans reflect guidelines	4.21
Used professional guidelines to guide work	4.41
Medications monitored for appropriate use with children	4.26
Medication monitored against professional guidelines	4.23
Continuity of care between provider agencies	3.65
Continuity of care within agency	4.05
Received regular supervision from licensed professional	4.06
Appropriate standardized assessment tools used	4.28
Established process for appropriate termination	4.11
Overall Appropriateness Domain	4.21

Appendix M: Outcomes Domain Mean Scores for Provider Responses

Survey Items in the Outcomes Domain	Mean Score
Monitored/tracked child functioning and stability	4.11
Used specific tools to measure outcomes	3.83
Outcome measurement tools were appropriate	3.87
Had no concern with measurement tools	3.45
Monitored/tracked family functioning and stability	3.81
Children received all needed services	3.32
Children's needs were generally met	3.97
Families satisfied with mental health services received	3.83
Providers satisfied with MCO policies	3.28
Overall Outcomes Domain	3.71