Understanding the Impact of Regulatory Changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach

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Understanding the Impact of Regulatory Changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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B.S.W Virginia Commonwealth University, 2003
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Acknowledgements

I owe a great deal of gratitude to the individuals who supported me during this long educational journey. There were many times, too many to count actually, that I did not think I would complete this journey. The support of those around me propelled me to complete my dissertation. Thank you to my husband Derrick who supported me through all phases of the doctoral program. Your love and support allowed me to complete this journey. To my family and friends, thank you for your love, support, and encouragement along the way.

I am so grateful for the mentorship that I received during my time at Virginia Commonwealth University. First and foremost, thank you to my chair, Dr. Mary Secret, who supported me along the way. It has been a long journey…one that I would not have finished without you! Thank you for “keeping your foot in my back”…this kept me moving forward. Thank you to the member of my committee, Dr. Melissa Abell, Dr. Rosemary Farmer, and Dr. Barbara Myers for your willingness to be on my committee and offer insight and support along the way. Dr. Delores Dungee-Anderson, I appreciate your mentorship during coursework, comprehensive exams, and the early phase of my dissertation work. Thank you to Dr. Kia Bentley for creating a community in the doctoral program…what a gift you gave to all of us. Dr. Mary Katherine O’Connor, thank you for pushing me intellectually and challenging me to think more critically…I am forever changed. Thank you to Dr. Ellen Netting, Dr. Sarah Kye Price, and Dr. Pam Kovacs for modeling what social workers do in the academy; you all demonstrated how to live and breathe the values of our profession as well as the Code of Ethics in a climate that can make it challenging to do so. Thank you to Dr. Humberto Fabelo for playing such an
integral role in all stages of my educational journey. Thank you to Dr. Tim Davey who pushed me to realize my intellectual capacity as an undergraduate student while also reminding me as a doctoral student that completing a doctoral program was more about your determination to finish than your intellectual capacity.

Thank you to my friends who supported me during this long journey. Nathan Perkins, our friendship is one of the greatest gifts from my time in the doctoral program. Your support over the past six years has been unwavering. You kept me grounded and reminded me that no matter what I owed it to myself to finish. Jenny Shadik, you are a wonderful person and friend. I appreciate our vent sessions and I am so grateful that we finished this journey together. Thank you to Crystal Coles for your guidance early on when my focus turned to mental health policy. Thank you to my cohort: Nathan Perkins, Jenny Shadik, Jimmy Young, Shane Brady, Carmen Monico, Jason Sawyer, Neal Masri, and Mariette Klein…the community we built and continue to have is one I will cherish forever.
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Dedication

To my husband and children. Derrick, thank you for reading every word of my dissertation. To Blyden, Isla, and Emery for being the motivation to finish my dissertation and for being a shining light in my life.
Abstract

UNDERSTANDING THE IMPACT OF REGULATORY CHANGES ON THE IMPLEMENTATION OF THERAPEUTIC DAY TREATMENT: A CASE STUDY APPROACH

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2014

Chair: Mary C. Secret, Ph.D.
Associate Professor
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Therapeutic Day Treatment (TDT) is a community-based mental health treatment program regulated and funded by the Department of Medical Assistance Services (DMAS) in the Commonwealth of Virginia. This case study sought to understand how DMAS regulatory changes impacted the implementation of the TDT program in the Commonwealth between fiscal years 2004 and 2011. In an effort to respond to this question, sources of qualitative and quantitative data were collected including: TDT fee-for-service data, regulations in the Community Mental Health and Rehabilitative Services manual guiding the implementation of the TDT program, and structured interviews with eight key stakeholders who interface with the TDT program. The fee-for-services analysis found that there was a 269% increase in fee-for-service expenditures between fiscal years 2007 and 2011. The analysis of the regulations found DMAS added language to provide greater clarity to the existing regulators. Some of these changes include the implementation of the PA process with KePRO as well as the VICAP process.
Additionally, staff requirements changed and paraprofessionals were no longer able to provide TDT programming. Caseload limits were also set for TDT programming. Four themes emerged through the analysis of the structured interviews. These themes include: 1) fraudulent practices and misuse of TDT services, 2) regulatory oversight, 3) cost containment, and 4) evaluation. Implications focused on the areas of policy, practice, and research by suggesting further research studies focusing on TDT and policy, offering the foundation of a more comprehensive theory focusing on policy implementation, and lastly the researcher provided a logic model for the TDT program in an effort to propel evaluation research forward.
Change isn’t easy and it doesn’t happen overnight, but the people writing mental health laws need to know what is broken before we can even begin to start down a path to fixing it.

--Virginia State Senator Creigh Deeds
CHAPTER ONE

Introduction

The focus of this dissertation is therapeutic day treatment (TDT), a unique community-based mental health treatment program, hosted primarily in public school settings, for children and adolescents in the Commonwealth of Virginia. Anchored in the principles of Systems of Care, TDT bridges the current dichotomized treatment modalities -- community-based treatment and school-based treatment -- for children and adolescents diagnosed with behavioral and/or emotional disorders (Christner, Mannuti, & Whitaker, 2009; Kutash, Duchnowski, Robbins, Kennan, & Stroul, 2008; Pumariega & Vance, 1999; and Whitson, Bernard, & Kaufman, 2013). However, despite the many advantages of TDT, several fiscal and programmatic challenges are inherent in delivering mental health services in a host setting where regulatory or funding oversight has been either limited or contradictory. This dissertation examines the fiscal and programmatic challenges of implementing TDT in a non-mental health setting with the intent of informing scholars and practitioners of ways to replicate the best of this model of treatment and avoid the pitfalls experienced by the Commonwealth of Virginia.

Chapter 1 provides the context and rationale for this study and is divided into the following sections: (a) child and adolescents emotional or behavioral disorders: extent of the problem; (b) Medicaid coverage for children and adolescents experiencing emotional or behavioral disorders; (c) Therapeutic Day Treatment: Virginia’s policy response; (d) framework and programs that inform TDT; (e) community-based mental health policy and programming (f) school-based mental health service delivery system; (g) research
Child and Adolescents Emotional or Behavioral Disorders: Extent of the Problem

According to the United States Department of Health and Human Services (2009), one in five children ages 9-17 experienced a diagnosable mental health disorder over the course of one year. In addition, approximately one in ten experienced a serious behavioral or emotional disorder during the developmental stages of childhood and adolescence (U.S. Department of Health and Human Services). In Virginia, the child advocacy group Voices of Children estimated that between 85,129 and 104,046 children and adolescents had experienced an emotional or behavioral disorder in the year 2010 (Voices of Virginia’s Children, 2011).

Prevalence rates vary according to children's socio-demographic characteristics. Among low-income children and youth between the ages of 6 and 17, over one-fifth (21%) have mental health problems (NCCP, 2010). Children from poor or low-income families are disproportionately likely to suffer from mental illness, with children in poor families having a higher rate of mental health problems than their ‘near-poor’ and ‘non-poor’ counterparts (Howell, 2004). In fact, low socioeconomic status is the strongest predictor of early childhood emotional problems and accounts for much of the racial/ethnic disparities in children's social–emotional and behavioral problems (Werner & Smith, 1992). These socio-demographic characteristics are particularly important in light of the fact that Medicaid, an insurance covering children and adolescents who fall
within or below the federal poverty line, funds many community-based mental health treatment programs, including TDT.

**Medicaid Coverage for Children and Adolescents Experiencing Emotional or Behavioral Disorders**

Operating under the U. S. Department of Health and Human Services, Federal Centers for Medicare and Medicaid Services, Medicaid is a joint federal and state program that finances mental health services for low-income and vulnerable individuals; it is the largest insurer of children’s health care at the state level (Newacheck, Pearl, Hughes, & Halfon, 1998; Yudkowsky & Tang, 1997). In Virginia, enrollment of low-income children in Medicaid has grown rapidly in the past several years. For example, in fiscal year 2004, 429,081 children were enrolled in Medicaid; in 2010, the number had climbed to 563,370, an increase of 31%. Thus, it is not surprising that the total claim expenditures for all medical services, including mental health services for low-income children during this same period, have increased 109% -- from roughly $637 million to $1.3 billion in state and federal funds (Virginia Voices for Children, 2011, p. 7).

**Therapeutic Day Treatment: Virginia’s Policy Response**

In the Commonwealth of Virginia, a wide array of mental health programs for children and adolescents are provided through the Department of Medical Assistance Services (DMAS), the state organization that administers Medicaid. DMAS dichotomizes the mental and behavioral health programming into two categories: traditional and non-traditional. Traditional programming includes inpatient mental health, outpatient therapy, medication management services through a primary care physician or psychiatrist, and

Established in the Commonwealth of Virginia in 1997 and licensed through Virginia’s Department of Behavioral Health and Developmental Services (DBHDS), TDT is unique to Virginia in the sense that it is completely community-based and is considered a less restrictive program compared to traditional partial hospitalization day treatment programs. The emergence of the TDT program was one of DMAS’ responses to the nationwide shift that moved mental health services from institutions to the community. As a community-based program, TDT provides individual counseling, group counseling, crisis intervention, medication education, family support and counseling, and behavior. In contrast, “day treatment” in other states is commonly referred to as partial hospitalization, offering similar services for individuals with severe behavioral and/or emotional disorders in a hospital setting (Rogers Memorial Hospital, 2014). Partial hospitalization day treatment is an intensive structured program to meet the needs of individuals with severe behavioral and/or emotional disorders as a step down service from inpatient or residential treatment. Both TDT programs and partial hospitalization programs offer individual and group counseling, crisis intervention, and medication education. While both programs are intensive in nature, key distinctions include the severity of the problem of the program participants and the location of services as previously described.

TDT in Virginia is funded solely through Medicaid and is not available to individuals who are not Medicaid eligible. Children and adolescents who experience behavioral and emotional disorders in the school setting and do not have Medicaid may
receive mental health support through their school system in what is known as school-based mental health programs. These programs are discussed in the section below, which addresses school-based mental health services.

Community Service Boards (CSB), the public agencies that provide mandated mental health services, and private for-profit and non-profit agencies are the providers of TDT programs and services in the Commonwealth of Virginia. From 1997-2004, these providers offered services primarily in after-school or center-based sites across the Commonwealth. In 2004, a shift occurred and providers began delivering TDT in public schools. Since that time, there have been significant changes in the policies guiding the implementation of TDT programs, with the most significant and rapid changes occurring since 2009.

Despite, and perhaps because of, the innovative nature of TDT programming, numerous challenges emerged in TDT programs across the Commonwealth with the expansion into the public school setting. DMAS’s Deputy Director of Complex Care noted questionable provider qualifications, questionable practices by providers, and limited utilization review practices that could jeopardize the integrity of the program and led to concerns about whether TDT was being implemented as DMAS intended (Personal communication, December 17, 2013). While it is to be anticipated that programmatic regulations would indeed impact service delivery, an understanding of what led to the regulation revisions and the extent to which the various regulations subsequently refined and/or limited service provision hold important lessons for other programs or state organizations who might be considering similar innovative programs as the Commonwealth of Virginia’s TDT program.
Framework and Programs that Inform TDT

In the 1980’s, the Systems of Care framework was introduced to address a fragmented service delivery system that accompanied the shift to community-based mental health. Subsequently, Medicaid programs, including the Virginia TDT program, have been providing services with this framework in mind (Behar, 1996; Meyers, 1994). Systems of Care is a service delivery framework that requires services to include the following components: (a) inclusion of families in planning services for their children; (b) integration of cultural competence into children’s services; (c) encouragement of cross-system efforts to meet the range of needs experienced in children (Stroul & Friedman, 1986). Embracing the Systems of Care framework, community-based mental health treatment programs are typically based on a flexible and individualized approach to service delivery for the child and family. Programming is provided within the context of his/her home and community as an alternative to treatment in out-of-home settings. Family and systems issues, such as access, utilization, child and family empowerment, financing, and clinical and cost-effectiveness of mental health services, which impact the localized and individualized care provided to children and adolescents, are also included in Systems of Care framework (Pumariega, Winters, & Huffine, 2003).

Child and adolescent mental health scholars and practitioners concur that the operationalized principles of the Systems of Care framework are imperative in implementing children’s mental health programming and that they should be considered in mental health programming (Foster, Kelsch, Kamradt, Sosna, & Yang, 2001; Liao, Muntuffel, Paulic, & Sondheimer, 2001; Lourie, Stroul, & Friedman, R. 1998; Quinn & Epstein, 1998; and Walrath, Sharp, Zuber, & Leaf, 2001). Thus, although Systems of
Care has not been formally institutionalized in Virginia, it serves as a policy guideline for the Commonwealth and many of its principles are operationalized in the regulations that guide several community-based mental health treatment programs, including TDT (Stroul & Friedman and Department of Medical Assistance Services, 2011).

Similar to TDT, there are programs nationwide that are informed by Systems of Care and that can provide some insight into the Commonwealth of Virginia TDT programs. Noteworthy are the Fort Bragg Project, which provides a wide array of community-based services, including outpatient psychotherapy, crisis response, home-based counseling, and partial hospitalization day treatment and the federal Comprehensive Community Mental Health Services for Children and Their Families program, which developed a comprehensive array of community-based services and supports with an emphasis on individualized, strengths-based services planning, intensive care management, partnerships with families, and cultural and linguistic competence (United States Department of Health and Human Services, 2014). The progress that has been made on a national level during the past two decades in the development, implementation and financing of community-based mental health treatment for children and adolescents with serious emotional disturbances and their families is illustrated by these programs (Cole, 1996; Cole & Poe, 1993; Davis, Yelton, & Katz-Leavy, 1993; Lourie, Katz-Leavy, De Carolis, & Quinlan, 1996; Stroul, 1996b) and provides the context for TDT in Virginia.

**Community-based Mental Health Policy and Programming**

Scholarship on community-based mental health services and policy change has focused on policy implementation (Glunta, 2010; Goggin, 1990; O’Toole & Meier, 2004;
Styles, 1981; Whitford, 2007), resource allocation in community mental health (Glover, 2000; Munro, 2004; Pulice, 1986; Saario & Stepney, 2009; & Wells, 1997), and evaluation research of community-based mental health programs for children and adolescents (Jackson, Frederico, Tanti, & Black, 2009 and Vernberg et al., 2008). A synthesis of this scholarship revealed how policy level decisions by political officials and policy makers dictated how funds were allocated to community-based mental health programming for children and adolescents and how the allocation of these funds needed to be linked to evaluation research to support programmatic efficacy (Green, Sommers, & Cohen, 2005). The emphasis on program efficacy is particularly important in the delivery of mental health services within Systems of Care as there is an emphasis placed on evaluation and quality improvement. For programs guided by Systems of Care, evaluation is a management mechanism to track progress, measure quality, and make adjustments as needed (Technical Assistance Partnership for Child and Family Mental Health, 2014).

**School-Based Mental Health Service Delivery System**

School-based mental health programs refer to any form of mental health interventions or support offered within the school environment that is directly funded by or contracted out by the school system under the Individuals Disabilities Education Act (IDEA) and section 504 of the Rehabilitation Act of 1973. Hunter (2004) acknowledged that schools are an ideal place to provide mental health services to children and adolescents, often because school environments are more convenient to children and families and therefore are more likely to be utilized than community-based programs. Schools provide a setting for identifying behavioral and/or emotional disorders.
There are vast array of treatment interventions, which fall under the umbrella of school-based mental health programming. Most of these programs allow children with behavioral and emotional disorders access to specialized interventions within the school facility and satisfy federal mandates regarding the education of children with disabilities (Hendrickson, Gable, Conroy, Fox, & Smith, 1999). School-based programs are often multidisciplinary and involve parents or primary caregivers. Components within school-based programs include: adopting token economy systems (Musser et al., 2001), providing training for teachers, parents or community members (Kutash, Duchnowski, Sumi, Rudo, & Harris, 2002) conducting behavioral assessments for each child (Hendrickson et al.), providing special summer programs for students and family advocates (Briar-Lawson, Lawson, Collier, & Joseph, 1997) or comprehensive mental health services such as individual, group, or family counseling, support groups, and referrals for medication (Weist, Nabors, Myers, Armbruster, 2000).

Many of the interventions embedded in school-based mental health programs are also implemented within TDT programs. TDT staff performs a comprehensive assessment on all children and adolescents, who are enrolled in the program. Additionally, TDT and school-based mental health programs may both provide individual and group counseling.

However, there are important distinctions between school-based mental health programs and TDT. First, TDT is funded by Medicaid and school-based mental health programs are funded by various other sources, including the school system and the Family Assessment Planning Team (FAPT) operating under the Individuals with IDEA and section 504 of the Rehabilitation Act of 1973. Second, the regulations guiding
school-based mental health programming are found within the IDEA and section 504 of the Rehabilitative Services Act whereas Virginia’s DMAS, under the Federal Centers for Medicaid and Medicare Services, develops all regulations that guide the implementation of TDT program.

Neither the community-based mental health nor the school-based mental health literatures address the phenomenon of having a community-based mental health program provide services in a school, whereby both entities have distinctly different regulations that guide how mental health services are to be rendered. Research indicates that school-based mental health programs have higher utilization rates than do community-based mental health programs (Virginia’s Commission on Youth, 2013). Higher utilization rates are a result of children and adolescents having greater access to school-based mental health programs, which is one of the greatest assets of school-based programs. Exploring TDT as a community-based mental health program, situated in the school setting, will encourage scholars and practitioners to consider this innovative community-based mental health program that increases access to mental health services for children and adolescents.

**Research Gaps on Therapeutic Day Treatment in Virginia**

Despite the literature that exists on community-based mental health treatment and school-based mental health treatment nationally, minimal research has been conducted around TDT programming in Virginia. To date, TDT-related data that DMAS has available includes fiscal data on fee-for-service billings and expenditures (monthly and fiscal year totals), diagnostic data (i.e. top diagnoses of children and adolescents receiving services), and counts of the number of children receiving services in the
Commonwealth (Karen Kimsey, Personal Communication, December 17, 2013). Voices for Virginia’s Children (2011), a non-partisan policy research and advocacy organization for children, stated that “finding meaningful state-level data about children’s mental health services, including Medicaid funded programming, is challenging. (p.1).” And, as with any human service endeavor, without such data it is difficult to plan for, implement, and continually improve effective services for children and adolescents with serious emotional and behavioral problems.

**Role of Social Work in Implementation Research**

The preamble of the National Association of Social Workers (2008) states, social workers promote social justice and social change with and on behalf of clients by engaging in select activities. These activities may be in the form of policy development and implementation and research and evaluation. Social work is an applied profession, emphasizing the connection between research, practice, and policy (Thyer, 2001). The aim of this dissertation research is to understand the how DMAS regulatory changes impacted the implementation of TDT services in the Commonwealth of Virginia. Given the lack of policy implementation research focused on the TDT program, this dissertation addresses the key areas in social work: research, policy, and practice. The nature of policy implementation research blends the areas of research and policy. From a program standpoint, practitioners and scholars who want to implement a program similar to TDT can use findings from this study. This study also takes a lesson’s learned approach whereby many of the challenges DMAS experienced are brought to light. This is particularly important given the vulnerable nature of many of the children and adolescents who participate in the TDT program or other similar community-based...
mental health programs. By understanding some of the pitfalls experienced in the implementation process, scholars and practitioners will be better equipped to successfully implement the program and meet the needs of the children and adolescents receiving services.

**Research Focus**

**Aim of the Dissertation Research**

The aim of this dissertation was to understand how DMAS regulations have impacted the implementation of TDT services. The researcher used a case study approach, where multiple units of analysis were triangulated to understand this phenomenon. Understanding how DMAS regulations have impacted TDT implementation allowed the researcher to begin to fill a gap within the scant literature that existed for TDT services within the Commonwealth of Virginia.

**Chapter Two: Literature Review**

Chapter two begins with a reiteration of the aim of the research being conducted. Subsequently, the first section presents a review of the literature on the children’s mental health movement section, which includes a discussion on the role of the Joint Commission on Mental Health and the Joint Commission’s work. Next, there is a discussion of school-based mental health programs, which provides a context to understand TDT as a community-based mental health treatment program based primarily in schools. The following section introduces TDT as a program by discussing the program’s history, funding source, and initial regulations. Policy implementation and implementation theory are introduced and discussed at length. These sections of the
literature review inform the research question within this study. Seven propositional questions derived from the literature review are then presented.

**Chapter Three: Methodology**

Chapter three begins with a brief history of case study research and its historical roots in social work research. A case study design was selected given that the case required extensive and in-depth description of a TDT services. Furthermore, “how” and “why” research questions are well suited for case study research, which is well documented in the case study literature (Creswell, 2013; Leonard-Barton, 1990; Yin, 2009). Given that the research question for this study sought to understand “how” regulatory changes impacted the implementation of therapeutic day treatment, the use of a case study method was appropriate. A thorough discussion of case study research and its alignment with the research question is provided. Guided by the literature presented in chapter two, seven propositional questions were developed and are discussed in detail within chapter three. Chapter three introduces the multiple units of analysis, including DMAS fee-for-service data for TDT, structured interviews with key stakeholders, and DMAS regulations guiding the implementation of TDT services. The data analysis plan includes both quantitative and qualitative analysis strategies. Chapter three concludes with strategies to establish and maintain research rigor while implementing this proposed research study.

**Chapter Four: Results**

Chapter four presents the findings from the analysis of the fee-for-service, regulatory, and structured interview data. The findings for the fee-for-service analysis
are presented in a chart and discussed. Findings from the regulatory analysis are divided by chapters in the Community Mental Health and Rehabilitative Manual, which guide the implementation of the TDT program. The structured interview analysis is presented based upon the themes that emerged in the thematic analysis. Lastly, these findings are triangulated to respond the study’s propositional questions.

Chapter Five: Discussion

Chapter five discusses the findings and implications from this case study. Through the technique of explanation building, the triangulated findings from chapter four related to each propositional question are grounded in the literature presented in chapter two of this dissertation. The limitations and strengths of this case study are discussed. The last section of this chapter outlines the implications of this study in the areas of policy, practice, and research.

Summary

This research study was designed to understand how DMAS regulatory changes have impacted the implementation of TDT services in the Commonwealth of Virginia. Due to the limited research on TDT services in Virginia, examining the posed research question was warranted. By responding to the posed research questions, this study allowed the researcher to understand the driving force of regulatory changes, how program efficacy is determined, how regulatory changes have impacted who provides TDT services, how services are rendered, and how the severity of clinical presenting symptoms changed between 2004 and 2011. An increased awareness of how DMAS regulatory changes impacted the implementation of TDT has implications for
community-based mental health treatment in Virginia, policy development, and policy implementation.
CHAPTER TWO

Literature Review

This study examined the impact of the regulatory changes of the Department of Medical Assistance Services (DMAS) on the implementation of therapeutic day treatment (TDT) services in the Commonwealth of Virginia. This chapter presents a review of the literature that informs the study’s focus. The literature review is divided into the following six primary sections: (a) children’s mental health movement; (b) school-based mental health programs; (c) Therapeutic Day Treatment in Virginia; (d) policy and policy implementation; (e) implementation theory and policy implementation; (f) implementation holon; (g) a discussion of the gaps in the literature, including a brief overview of how this study will fill these gaps, and (h) an introduction of the study’s propositional questions.

Children’s Mental Health Movement

Historically in the United States, addressing the needs of children, including those experiencing behavioral and/or emotional disorders, was left to the private sector of charity and faith-based services (Jimenez, 2010). The first orphanage was not established until 1729 and the first mental health hospital was established in Virginia in 1773 (Ritter, 2012). Although some attention to the mental health needs of children and adolescents was undertaken by local government, primarily through institutionalization, it was not until the mid-20th century that child welfare advocates, such as Dorothea Dix, Robert Hartley, and Mary Richmond pushed for more humane and government mandated policies and programs (Barker, 1995). These policies and programs aimed to provide
services for children experiencing behavioral and/or emotional disorders. While advocates struggled to improve conditions and provide resources to children and those with mental illness, it was not until the mid to late part of the 20th century that the specific mental and emotional health needs of children and adolescents was addressed through policy reform at a national level.

A report issued in 1969 by the Joint Commission on the Mental Health of Children (Commission) called attention to the mental health needs of children. Historically, the Commission was groundbreaking as it was the first national effort to address children’s mental health in a comprehensive manner. Informed by both federal and state reports that questioned the adequacy of mental health services for children with behavioral and emotional disorders, the Commission reported that nearly a million children needing psychiatric care in 1966 did not receive treatment. The Commission highlighted how children’s mental health services were provided in restrictive settings, such as inpatient psychiatric hospitals, due to the lack of community-based services (Friedman, Kutash, & Duchnowski (1996). Furthermore, when services were provided to children, they were often provided in a fragmented manner (Lourie & Stroul, 1998). Most importantly, the Commission identified that mental health services were provided only to one-third of children who were in need. The Commission’s final report included a discussion of surveys done in schools from across the United States. Unfortunately, the Commission’s report did not indicate the methodology used to create or analyze the school surveys, but identified only the study conclusion that seven to ten percent of school-aged children needed mental health services (Joint Commission on the Mental Health of Children, 1969). The Commission’s report, which also included contributions
by leading scholars and practitioners in the areas of early childhood, adolescents, and young adulthood, made the first significant statement of the problem of unmet mental health needs in children (Joint Commission on the Mental Health of Children, 1969). As a result of the Commission’s findings, there was a call for a coordinated response across health, social services, and mental health systems and a nationwide system of child advocacy aimed at meeting the multifaceted needs of children (Lourie, Stroul, & Friedman, 1998). Unfortunately, the Commission’s report and the advocacy call did not result in a substantive mental health services policy mandate for children (Lourie & Hernandez, 2003). According to Knitzer (1982), the Commission did not probe deeply enough into the fiscal, administrative, and statutory policies that determined whether and how children with mental health needs were served (p. 905) to provide clear directives for service provision. Thus, it was not surprising that there was little improvement in children’s mental health services. In 1979, a subsequent commission, the President’s Commission on Mental Health (1979), reiterated the concerns of the original Commission in that children in need of mental health services were often not receiving them; that those who received services were receiving more restrictive services than deemed clinically appropriate; that services were limited to in-patient, outpatient, and residential treatment, with few community-based treatment options being offered; and that the coordination among systems providing mental health services to children was weak and fragmented.

The findings of the President’s Commission were supported by the landmark study Unclaimed Children by Knitzer and Olson (1982) that increased public and professional awareness and concern regarding children’s mental health needs to the point
where governmental action was taken. Knitzer and Olson found that nearly three million children in the United States of America had significant mental health needs and two-thirds either received no services or inappropriate services to address these needs. In addition, Knitzer and Olson found that fewer than half the states in the U.S. had even one professional service provider solely devoted to meeting the mental health needs of children.

**Children and Adolescent Services Systems Project**

Prompted by Knitzer and Olson’s study, Congress enacted the Children and Adolescent Service Systems Project (CASSP) and appropriated $1.5 million to the National Institute of Mental Health (NIMH) to implement it (Day & Roberts, 1991). The goal of CASSP was to create system change within the children’s mental health system in an effort to improve service delivery. Subsequently, in 1985, NIMH initiated a request for applications for CASSP funding with the intent of awarding state mental health agencies grant money to develop and/or improve their mental health service delivery system for children with behavior and/or emotional disorders. The goals for CASSP included: (a) improve the availability and access to appropriate services across service systems for children with behavioral and/or emotional disorders; (b) develop leadership capacity and increase the allocation of resources for children’s mental health services; (c) establish coordination mechanisms and thereby increase levels of collaboration and efficiency among service delivery systems; (d) develop a mechanism for including family input in the planning and development of service systems, treatment options, and individual service planning; (e) develop capacity and provide technical assistance for CASSP implementation; and (f) evaluate the principles and practices of CASSP (Lourie,
Katz-Leavy, & Jacobs, 1986, p. 2). The funds were to be used solely for system
development activities; neither oversight of programs nor provision of direct services was
included in the project (Lourie et. al, 1990).

The first CASSP grants were awarded to states in 1985. Of the CASSP grant
applications received, 10 states received grant funding (Day & Roberts, 1991). In
addition to these state level grants, funding was provided to 3 research and training
centers to support the development and implementation of CASSP (Georgetown
University’s Child Development Center, University of South Florida, and Portland State
University).

In the late 1980’s, the Commonwealth of Virginia also received funding to
implement CASSP. One of the state-specified goals of CASSP in this state was to
develop a mechanism for including family input in the planning and development of
service systems, treatment options, and individual service planning. Stakeholders in
Virginia learned of the activities of Portland State University, one of the CASSP
Technical Centers through a series of parent-professional conferences in regions of the
country under the rubric “families as allies” (Lourie et. al, 1990). Subsequently, Virginia,
through the efforts of the National Alliance for the Mentally Ill (NAMI) and the Virginia
Treatment Center for Children, partnered with Portland State University to orchestrate a
national meeting for parents of children and adolescents with behavioral and emotional
disorders. This conference, held in Virginia in 1987, (Lourie et. al.), represented the most
significant effort to actualize CASSP in Virginia. Unfortunately, these efforts were met
with little success as localities were unable to mount the resources to create local
networks of care (Lourie, 1998).
While the CASSP did not continue in Virginia after the early 1990’s, important aspects of the project are apparent in Virginia and across the United States. For example, the inclusion of children’s services is required in the planning process of state departments of mental health for each state’s mental health plan under Public Law (PL) 99-660 (Day & Roberts, 1991). Services such as intensive case management, intensive outpatient, and family-based counseling were created or expanded for children and adolescents that were previously unavailable. This was a significant achievement as these newer services tended to be less restrictive and community-based services (Schlenger et al., 1995). Most importantly, CASSP was the genesis for the Systems of Care framework that now serves as a guide for most programs in the Commonwealth of Virginia, including TDT, that address the complex needs of children with mental health issues (Lourie, Stroul, & Friedman, 1998; Neill, 1997; Stroul, 1996).

**Systems of Care**

The Systems of Care Framework is built on a set of three core values and ten principles. The core values of Systems of Care are: (a) inclusion of families in planning services for their children; (b) integration of cultural competence into children’s services; (c) encouragement of cross-system efforts to meet the range of needs experienced in children (Stroul & Friedman, 1986). The principles of the framework include:

1. Children with behavioral and/or emotional disorders should have access to services that address their individual physical, social, and emotional needs;
2. Each child should receive individualized services.
3. Services should be the least restrictive available.
4. Family’s participation in service planning is vital.
5. Services should be integrated and coordinated between child-serving agencies.

6. Case management is fundamental to service coordination and integration of services.

7. Systems of Care should promote early identification to maximize the likelihood of positive outcomes.

8. Children with behavioral and emotional disorders should be ensured smooth transition to the adult service system.

9. The rights of children with behavioral and/or emotional disorders should be promoted and protected.

10. Children with behavioral and emotional disorders should receive services regardless of gender, ethnicity, race, religion, physical ability, or other characteristic (Lourie, Stroul, & Friedman, 1998; Stroul & Friedman, 1986).

Although Systems of Care is commonly referred to as a model in the literature, there are reasons to consider it as a framework rather than a model. Mullaly’s (2007) definition of a model is a detailed structure used for understanding a problem and developing a response, and assessing outcomes. Based upon Mullaly’s definition, Systems of Care lacks one of the basic components inherent a model -- a mechanism to assess outcomes. A framework, however, is a structure used to corral assumptions, goals, and principles (Netting, 2010). The Systems of Care framework is built on a set of three core values and ten principles. Embedded in the values and principles of the framework, are assumptions about the structure of a comprehensive service delivery system as well as the manner in which services should be delivered to children and adolescents with a variety of presenting needs.
System of Care is a framework intended to guide the implementation of a wide array of programs for children and adolescents through the set of core values and principles noted above; the framework is not connected to a funding stream as it is a guideline rather than a service delivery mechanism. Based upon the child centered and family focused principles, the Systems of Care framework is conceptualized with the child and family as the focus of service delivery, with needed services surrounding them within a coordinated service delivery system.

Consistent with a framework terminology, a basic feature of Systems of Care is that it does not require or identify a specific outcome for assembling a network of programs. Similar to CASSP, the System of Care framework is promoted by the CMHS of the Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services and is embedded in the mission statement of SAMSHA’s Child, Adolescent, and Family Branch:

“Systems of Care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around these principles: child centered, family-driven, strength-based, and culturally competent with interagency collaboration. The Child, Adolescent, and Family Branch embraces and promotes the core principles of Systems of Care.” (SAMSHA’s Child, Adolescent, and Family Branch).

**Systems of Care in Virginia.** In 2003 and 2004, the General Assembly’s Family Behavioral Health Policy and Planning Committee budgeted Items 329-G and 330-F to improve access to mental health services for children and their families. Specifically, this
budgetary and legislative mandate called for the Commonwealth of Virginia to initiate and improve access for mental health and intellectual disability services for children and adolescents, with case management serving as the coordinating component for those services. According to the Family Behavioral Health Policy and Planning Committee, “continuum of care” was defined as an array of services for children and adolescents to meet their individual needs. Additionally, the Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families was a plan developed in 2002 by the DBHDS to address access issues around children’s mental health in the Commonwealth. The plan asserted that developing community-based services would allow localities to shift monies from high-cost, highly restrictive treatments like residential treatment and move them toward lower costs, effective services like day treatment and wraparound services, thereby allowing more children to be served and in settings that are either at home or close to their home community (Department of Behavioral Health and Developmental Services, 2005). Using the Systems of Care framework, the plan identified services that fall within the recommended continuum of care for meeting the mental health, developmental, and substance abuse needs of the children, adolescents and families of Virginia. TDT was identified as one of the community-based mental health programs that fall within the mental health services portion of the System of Care. This is graphically depicted in Figure 2.1.
Figure 2.1. The System of Care Framework. From *A System of Care for Children and Adolescents with Severe Emotional Disturbances* (p. xxvi) by B. Stroul and M. Friedman, 1986. Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health.

*TDT services falls within “Mental Health Services” in Systems of Care.*
**Mental Health Programming and Systems of Care.** Mental Health programs guided by Systems of Care have been implemented in localities across the United States since the early 1990’s and some of them provide context and understanding of how the Systems of Care framework is operationalized at the community level. Many of the components within these programs were early versions of the services implemented later on in TDT’s program of community-based mental health treatment. Specific program examples are the Fort Bragg project and the federal Comprehensive Community Mental Health Services for Children and Their Families program.

**Fort Bragg Project.** Using the core values and principles of the Systems of Care framework, a demonstration was established in Fort Bragg, North Carolina in the early 1990’s. While System of Care projects are typically funded by SAMHSA, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funded the Fort Bragg Project (Bickman, Bryant, & Summerfelt, 1993). To support the principles of the framework, clinicians and agencies were recruited by CHAMPUS to provide a wide array of community-based services, including outpatient psychotherapy, crisis response, home-based counseling, and partial hospitalization day treatment. More restrictive services were provided for children and adolescents who presented with more intense behavioral and/or emotional disorders (Bickman, 1996). These services included specialized group homes, therapeutic homes, and inpatient mental health treatment. Clinicians and families collaborated to determine the most appropriate course of treatment for children in need of mental health services (Bickman, Bryant, & Summerfelt; Bickman et al., 1995). Fort Bragg’s ability to build a wide array of services was one of the first examples of how to organize and implement the Systems of Care framework. While the Fort Bragg project
increased access to services, a guiding principle of Systems of Care, it did not lead to improved clinical outcomes in children. Due to increased costs, the Fort Bragg project ended after it was evaluated in the late 1990’s (Bickman, Smith, Lambert, & Andrade, 2003). Despite ending in the late 1990’s, the principal investigator (PI) noted the benefits of increasing access to services and coordinating care embedded in the project, which are principles within Systems of Care. The PI called for more resources to be allocated to improving child and adolescent mental health programs rather than focusing on system level issues (Brickman & Fitzpatrick, 2002). Some of the programs that were offered in the Fort Bragg project, including the community-based and home-based counseling services, continues to be offered for children who need mental health support. Specifically, the Fort Bragg project included a partial hospitalization day treatment program, which had similar interventions as Virginia’s TDT program.

**Comprehensive Community Mental Health Services for Children and Their Families Program.** Within the Systems of Care framework, the federal Comprehensive Community Mental Health Services for Children and Their Families program, developed and implemented in localities nationwide in 1992 (Holden, De Carolis, & Huff, 2007), specifically informs Virginia TDT programming and regulatory guidelines. The federal Comprehensive Community Mental Health Services For Children and Their Families Program developed a comprehensive array of community-based services and supports with an emphasis on individualized, strengths-based services planning, intensive care management, partnerships with families, and cultural and linguistic competence (United States Department of Health and Human Services, 2014). Federal investments through the Department of Health and Human Services created change in community-based
mental health services for children, whereby prevention and intervention programs were
delivered systematically with the child and family as the focal point of program
implementation. Local level resources sustained this change in an effort to create Systems
of Care. Many localities were able to develop mental health programs that were child-
centered, ensured services were provided in the least restrictive environment, promoted
care coordination, and involved parents and/or guardians and treatment, which is aligned
with the principles guiding Systems of Care (Koyanagi & Feres-Merchant, 2000).

The national evaluation of the Comprehensive Community Mental Health
Services for Children and Their Families Program, conducted in 1997, had a goal of
generating information to inform policy decision-making at multiple levels. Findings
from the comprehensive program evaluation were used to determine program efficacy,
inform clinical practice for children and families, policy impact, and future policy
development and implementation (Holden, De Carolis, & Huff, 2007; Rosenblatt &
Rosenblatt, 2000; Rosenblatt, Wyman, Kingdon, & Ichinose, 1998; Rosenblatt &
Furlong, 1998; Rosenblatt et al., 1998; Rosenblatt & Rosenblatt, 1999; Walrath et al.,
2001; Walrath, Nickerson, Crowel, & Leaf, 1998; & Wood, Furlong, Casas, & Sosna,
1998). Findings from the evaluation research also indicated that facilitating sustainable
change in local mental health programming required impacting policy at the federal and
state as well as local community levels (Holden, De Carolis, & Huff). Findings also
indicated that local level policymakers, who are typically associated with agency
administrators, were key individuals to influence. Such stakeholders influence policies
for local child mental health agencies and can be effective partners in sustaining the
momentum necessary to produce community-level programmatic change (Holden, De Carolis, & Huff).

School-based Mental Health Programs

Several scholars have suggested that schools are an ideal place to provide mental health services to children because mental health counselors within schools have greater access to the children with behavioral and/or emotional disorders than do community-based clinicians (Hunter, 2009; Leaf, Schultz, Kiser, & Pruitt, 2003). Furthermore, the school setting has an inherent capacity to support children and adolescent mental health and development once mental health problems are identified. (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008). Service delivery in schools is also consistent with the guiding principle of the Systems of Care framework specifying that children should receive services within the least restrictive, most normative environment that is clinically appropriate (Lourie, Stroul, & Friedman, 1998). Furthermore, research indicates that school-based mental health treatment services tend to be less stigmatizing (Hunter, 2009). Research also supports the integration of mental health counselors into schools to work directly with students, their families, and members of the school faculty and administration (Adelman & Taylor, 1998; Hoagwood & Erwin, 1997; & Weist & Evans, 2005).

Currently, in the United States, school-based mental health services are the primary method of delivering mental health services to children and adolescents. In fact, schools are commonly regarded as the de facto providers of mental health services for children and youth (Burns, Schoenwald, Burchard, Faw, & Santos, 1995 and Farmer, Burns, Phillips, Angold, & Costello, 2003), providing an estimated 70–80% of
psychosocial services to those children who receive them (Rones & Hoagwood, 2000). However, little is known about the quality or type of services offered in school-based programs, in part because few school-based mental health programs have been evaluated empirically (Rones & Hoagwood, 2007).

There are numerous forms of school-based mental health. Individual counseling is a widely used therapeutic modality in most school-based mental health programs, in part due to the easy access to children (Armbruster & Lichtman, 1999; Brindis et al., 2003; Catron, Harris, & Weiss, 1998; Flaherty et al., 1996; Friedrich, 1999). Other school-based mental health programs, such as Peer Assistance Leadership and Service (PALS) program are designed to promote children’s learning and positive behavior through supporting teachers and encouraging parental involvement in school.

In general, community and school-based mental health programs operate unilaterally and exclusively in an effort to avoid duplication of services. Thus, community and school-based mental health programs are not likely to co-exist within a specific school (Catron, Harris, & Weiss, 1998).

**Therapeutic Day Treatment in Virginia**

**History**

In the early 1990’s, TDT began as a partial hospitalized day treatment program at Virginia Treatment Center for Children in Richmond, Virginia. In an effort to create a less restrictive community-based program, the services transitioned to the community. Richmond Behavioral Health Authority (RBHA) and Richmond City Public Schools (RPS), in partnership, piloted an after-school day treatment program. This program, which served 10 City of Richmond children seen by a child psychiatrist at RBHA,
included many of the interventions implemented in the partial hospitalization day
treatment program but was less restrictive in nature, due in part to the fact that services
were rendered in a school in the community closer to where the child lived. Considered a
success by RBHA and RPS, the pilot program grew into a full after-school program and
also went into two center-based schools for children with behavioral and emotional
disorders in RPS, Richmond Educational Alternative for Learning (REAL) School and
Thirteen Acres in the mid-1990’s. RBHA collaborated with DMAS to develop and fund
the TDT program (J. Coleman, personal communication, March 15, 2010).

Subsequently, DMAS submitted a State plan amendment (SPA) transmittal number (TN)
97-02 to secure Medicaid funds to and establish TDT as a Medicaid program and expand
community mental health and substance abuse services effective January 1997. In July
1998, DMAS received approval from the Department of Health and Human Services’
Centers for Medicare and Medicaid to fund an expansion of community-mental health
programs in the Commonwealth of Virginia, including TDT (Division of Medicaid and
State Operations, 1998). From 1997 – June 2004, the TDT program continued to be
provided in center-based schools and as an after-school program. In 2004, meetings were
held between DMAS, DBHDS, and RBHA stakeholders regarding expanding TDT
services into public schools. These meeting coincided with the General Assembly’s
Family Behavioral Health Policy and Planning Committee legislative mandate to improve
access to mental health services for children that was described above. These collective
activities by DMAS, RBHA, and the General Assembly led to the expansion of TDT
program to public schools thereby increasing access to an intensive community-based
mental health treatment program. (J. Coleman, personal communication, March 15,
The TDT program continues to be provided in public and center-based schools across the Commonwealth of Virginia, particularly in the southwest, central, and tidewater regions where there are no other school-based mental health programs provided.

**TDT Program Overview**

DMAS (2004) defines TDT as an intensive community-based treatment program that provides a range of psychotherapeutic interventions combined with medication education. Psychotherapeutic interventions include, but are not limited to, individual counseling, group counseling, crisis intervention, medication education, family support and counseling, and behavior management. These interventions are required by DMAS and are outlined in the “Required Activities” section of the Covered Services and Limitations chapter of the Community Mental Health and Rehabilitation manual and are the essence of the program. Guided by an Individualized Service Plan (ISP), a document required by DMAS, the TDT program provides individual counseling to address the specific mental health needs of each child or adolescent in the program. In addition to individual counseling, individualized medication education is also provided to any child or adolescent who has been prescribed psychotropic medication. Social skills groups are facilitated by day treatment staff and address areas such as managing anger, understanding feelings, decision-making, healthy relationships, etc. TDT is an intensive mental health program; many of the children and adolescents in the program require crisis intervention and support to de-escalate mental health crises that may arise during the school day or that they bring to school from home. Case management services, provided inside and outside of the classroom, include: (a) collaboration with other
professionals working with the children in the program, (b) making referrals for other services and supports needed by the children (or their families) in the program, and (c) provision of one-on-one behavioral support in the classroom. Collaboration with other providers and parents/guardians and interventions individualized to meet the presenting needs of children in the program further demonstrate how TDT is aligned with Systems of Care. Table 2.1 provides an exemplar of a school day for a child receiving TDT.
Table 2.1

*Therapeutic Day Treatment Exemplar of a School Day for a Child Receiving TDT*

<table>
<thead>
<tr>
<th>School Activities for Children Receiving TDT</th>
<th>TDT Program Interventions Provided During the School Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrive to school/breakfast</td>
<td>Group counseling</td>
</tr>
<tr>
<td></td>
<td>(Approximately 20-30 minutes daily)</td>
</tr>
<tr>
<td>English</td>
<td>Case management/crisis intervention services available to student</td>
</tr>
<tr>
<td></td>
<td>(Provided in the classroom)</td>
</tr>
<tr>
<td>Elective – 1 time per week</td>
<td>Individual counseling</td>
</tr>
<tr>
<td></td>
<td>(30 minutes – 1 time per week provided outside of the classroom)</td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>Math</td>
<td>Case management/crisis intervention services available to student</td>
</tr>
<tr>
<td></td>
<td>(Provided in the classroom)</td>
</tr>
<tr>
<td>Social Studies</td>
<td></td>
</tr>
<tr>
<td>Science</td>
<td></td>
</tr>
<tr>
<td>Personal Enrichment</td>
<td>Group counseling</td>
</tr>
<tr>
<td></td>
<td>(Approximately 30 minutes daily provided outside of the classroom)</td>
</tr>
</tbody>
</table>

**Funding.** DMAS, the agency that administers Medicaid in Virginia, is the sole funding source of TDT services; private insurance providers such as Cigna, Anthem, and Aetna do not provide funding for TDT services. TDT services are designed for children and adolescents who have insurance through DMAS and present with a significant
behavioral and/or emotional disorder classified as an Axis I diagnosis in the DSM-IV-TR. Axis I diagnoses include, but are not limited to Attention Deficit Hyperactivity Disorder, Disruptive Behavior Disorder NOS, Oppositional Defiant Disorder, Conduct Disorder, Asperger’s Disorder, Depressive Disorder NOS, Bipolar Disorder, Mood Disorder NOS, Anxiety Disorder, Schizoaffective Disorder, Schizophrenia, Post Traumatic Stress Disorder, and Adjustment Disorder. DMAS regulations authorize children and adolescents who are between the ages of four and seventeen to receive TDT services.

TDT services were and continue to be fee-for-service programs funded by DMAS and licensed through Virginia’s Department of Behavioral Health and Developmental Services (DBHDS), formally known as the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). The Centers for Medicaid and Medicare Services (CMS) (2012) defines fee-for-service as a system where Medicaid approved providers are paid for each service delivered. As of 2011, the TDT fee-for-service rate was $36.54 per unit; providers were able to bill for a maximum of 5 units per day. Units are calculated based upon the amount of hours TDT services are provided per day. TDT services must be provided at a minimum of two hours per billable day. For example, an agency providing TDT services to a child for 5 or more hours per day would be reimbursed $109.62 by DMAS.

**TDT Regulations.** In 1998, The Department of Health and Human Services’ Centers for Medicare and Medicaid approved the State plan amendment (SPA) dated January 22, 1997. The SPA proposed expanding community mental health and substance abuse services, including the TDT program into the community. A transmittal and notice
of approval of state plan material was developed by the Department of Health and Human Services Health Care Financing Administration. The TDT program regulations where outlined in the state plan materials. The TDT regulations, which outlined the amount, duration, and scope of the program, limited fee-for-service units to a total of 780 per fiscal year, and required therapeutic interventions to last at least two hours per day. The scope of interventions within the TDT regulations required TDT programs to provide clinical assessments, living skills and enhance social and interpersonal skills (i.e. problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group and family psychotherapy (Department of Health and Human Services, 1998). These specifications from the original regulations remain in the current regulations.

The original iteration of the regulations approved by The Department of Health and Human Services’ Centers for Medicare and Medicaid did not include sections addressing clinical presentation and criteria for children and adolescents to be enrolled in the TDT program. The aforementioned regulations from 1998 included a brief overview of required interventions; however, the regulations did not require providers to evaluate their programs nor did TDT providers have to obtain prior authorization to enroll children and adolescents into the program. Significant regulatory changes have occurred since the original iteration was published in 1998. Changes between 2004, when TDT transitioned into the public school system in Virginia, and 2011 is the focus of this dissertation.
**Policy and Policy Implementation**

Kahn (1969) defines policy as “the general guide to action, the cluster of overall decisions relevant to the achievement of the goal, the guiding principles, and the standing plan” (p. 131). Spanning the entire range of public activity, broad general categories of policy include some of the following areas: defense, aid to communities, education, social, health, and justice (Blechman, Gramlich, & Hartman, 1975). Titmuss (1986) and Schorr and Baumheier (1971) suggest that social policy consists of acts of government undertaken to provide a range of solutions to social problems such as poverty and mental illness that present within the larger population.

Titmuss’s understanding of social policy is an apt frame of reference for the Virginia General Assembly’s response to the social problem of mental illness in children and adolescents in the Commonwealth. Broad policy statements from the General Assembly guided specific operations of DMAS, which in turn developed its own policy statements outlining the operations of TDT programs which in turn then developed a narrower band of policy regulations that guided the implementation of the TDT program in the community. Thus, TDT program policies and larger governmental policies are nested within each other and together outline who does what and who gets paid for what services delivered within the TDT mental health delivery system.

**A Policy Response to the Mental Health Needs of Children in Virginia.**

One of Virginia’s policy responses' to children in need of mental health services lies within Section 30-174 of the Code of Virginia, which established the Virginia Commission on Youth and directed the Commission to "... study and provide recommendations addressing the needs of and services to the Commonwealth's youth and
their families." This section also directed the Commission to "...encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services." The 2002 General Assembly, through Senate Joint Resolution 99, directed the Virginia Commission on Youth to coordinate the collection of empirically based information to identify the treatments recognized as effective for the treatment of children, including juvenile offenders, with mental health treatment needs, symptoms and disorders. The Commission on Youth, along with the assistance of an advisory group, published the Collection of Evidence-based Treatments for Children and Adolescents with Mental Health Treatment Needs. The Collection was published in House Document 9 and presented to the Governor and the 2003 General Assembly. To ensure that this information remained current and reached the intended audience, the 2003 General Assembly passed Senate Joint Resolution 358, which required the Commission to update the Collection biennially. The Secretaries of Health and Human Resources, Public Safety and Education, along with the Advisory Group, were requested to assist the Commission in updating the Collection, as were various state and local agencies.

According to the Commission on Youth, DMAS functions as a funding source for children’s mental health services in the Commonwealth. DMAS, under the direction of the Centers for Medicaid and Medicare and the General Assembly generates its own set of policies and policy guidelines for the programs they fund. TDT is one of the programs through which DMAS implements its mandate to provide high quality and cost effective mental health, within the least restrictive setting, to qualifying Virginia children. According to the Commission on Youth, DMAS regulates and funds three evidence-
based programs, including: intensive in-home counseling, medication management, and functional family therapy. TDT is not identified as an evidence-based treatment; therefore, despite being provided and funded in Virginia it is not included in the Commission’s collection. The lack of evidence-base status is not surprising, as little data exists addressing the overall efficacy of the program as well as the reach of the program being limited to Virginia; this study is a necessary step forward to understand TDT and begin to fill this research gap. For the purposes of this study, TDT is a statewide program embedded in the Systems of Care framework and operationalized as delivering children’s mental health programs to the community in an effort to better address the mental health needs of children.

Implementation Theory and Policy Implementation

Implementation theory is used to understand and explain the policy implementation process (Hill & Hupe, 2006; O’Toole, 2003; Paudel, 2009; and Winter, 2003a); as such, it provides a critical lens to help understand the fiscal and programmatic challenges of implementing TDT in a non-mental health setting. The founding fathers of implementation theory, Pressman and Wildavsky (1984) define implementation theory in terms of a relationship to policy (i.e. policy implementation) as outlined in official documents. Pressman and Wildavsky’s definition of implementation theory, within the context of policy implementation, continues to be supported by scholars (In this sense, the State plan amendment (SPA) transmittal number 97-02 represents the children’s mental health policy statement for the Commonwealth of Virginia and encompasses DMAS’s goal of high quality, consumer-focused, recovery-based, and appropriate programs to address the mental health needs of children in the Commonwealth. This
policy is operationalized through the various programs that DMAS administers, including TDT services. In other words, this DMAS policy is implemented by the interventions of the TDT program and the program is guided by the TDT regulations.

**Effective Policy Implementation**

Elmore (1978) identified four main components needed for effective implementation of social policy:

1. Specific objectives and detailed guidance that reflect the intent of the policy.
2. Allocation of tasks and standards aligned with the intent of the policy.
3. An objective means of measuring the objectives, tasks, and standards within the policy.
4. A system of quality assurance and oversight control to hold those who are following the policy accountable for the enactment of the policy in practice.

Elmore’s four main components of effective policy implementation continued to be supported by policy implementation scholars such as Anderson and Sotir-Hussey (2006). Anderson and Sotir-Hussey identified three major activities in the policy implementation process, including:

1. Interpretation: Translation of policy into administrative directives.
2. Organization: Establishment regulations necessary to implement the program.
3. Application: Implementation of the program.

Integrated in the policy implementation process are inputs and outputs by key policy decision makers. Easton (1968) stated “policy is the output of processes involving inputs and outputs of decisions by key stakeholders and the implementation of such decisions” (p. 428). In other words, policy is perceived as the output of a governing system, with the input being the presenting needs or targeted problem of the population. Fixsen,
Naoom, Blase, Friedman, & Wallace’s (2005) stage two: planning and resourcing and stage three: implementing and operationalizing illustrated and expanded upon Easton’s concepts of inputs and outputs. Stage two: planning and resourcing focused on activities created to ensure effective implementation of the policy (Fixen et al., 2005). Stage three: implementing and operationalizing outlined the implementation plan and the output (i.e. policy) of the implementation plan.

**Policy Implementation Studies: First Wave**

Research on policy implementation has shifted focus over the past few decades and can be understood as occurring in three waves. The first wave of implementation studies, from 1973 to 1978, focused on describing and explaining failures to implement policy (Goggin et al., 1990). For example, in a case study of the Economic Development Agency’s employment programs in Oakland, California, Pressman and Wildavsky (1973) demonstrated how unsuccessful implementation of public policy frustrated governmental action attempts to address unemployment. Their analysis revealed the problems with how the policy was implemented. Specifically, their study found a disconnect between the policy that was developed to address unemployment and the manner in which the policy was implemented (Paudel, 2009). Overall, the first generation research was largely atheoretical and case-specific (Googin et al., 1990) as illustrated by Pressman & Wildavsky’s (1973) study. No policy implementation studies on children’s mental health were located in the first wave. The lack of policy implementation studies about children’s mental health during the wave is not surprising, because attention to children’s mental health policy was only beginning to emerge during this time period.
**Policy Implementation Studies: Second Wave**

The second wave of implementation studies, from 1979 to 1985, built on the studies of the first wave to posit more comprehensive theoretical models and perspectives that explained policy implementation. Implementation researchers generated a number of important findings from the research that was conducted during the second wave (Goggin, et al., 1990; Hogwood & Gunn, 1980; McLaughlin; and Van Meter & Van Horn, 1987). Such findings suggested that: federal and state policy cannot always mandate what matters at the local level; individual beliefs are central to the interpretation and implementation of policies; and effective implementation requires a strategic balance of pressure and support (Berman, 1980; Elmore, 1979; Goggin, 1986; Hogwood & Gunn, 1990; McLaughlin, 1987, and Van Meter & Van Horn, 1987). The findings from these studies generated the development of analytical frameworks, perspectives, and strategies (Goggin et al.), leading to an explication of differences between the top-down and bottom-up policy makers. The “top-down and bottom up perspectives” were formally developed as a result of this explication (Paudel, 2009 and Winter, 2003a) and are embedded perspectives in implementation theory. Thus, while the first wave of policy implementation studies were primarily atheoretical, research findings from the second wave of research lead to the development of two interrelated perspectives to explain policy implementation: the top-down perspective that represents the macro level, where central policy makers create a program, and the bottom-up perspective, where local service providers interact with target populations to deliver that program at the micro level.
The bottom-up perspective targets the relationships, both formal and informal, that are used to develop and implement policy based upon a recognized problem within a community, city, state, or at a societal level (Paudel, 2009 and Howllet & Ramesh, 2003). These relationships, often referred to as such street level bureaucratic relationships, are considered to be stronger and more equipped to understand the presenting problem and possible solution. Bottom-up theorists such as Berman (1978) argued that the most serious implementation problems occurred at the micro level as a result of significant differences in local contexts not taken into consideration when central policy makers developed the policy. Accordingly, street-level bureaucrats, not central policy developers, were seen as key to successful implementation as they adapted or failed to adapt policies to fit local contexts (Lipsky, 1978 and Paudel, 2009). In other words, top-down policies would be implemented only to the extent that street-level bureaucrats deemed them – the policies – as appropriate responses to the problems as experienced “on the street”. This is not to say that top-down policies are not able to address problems at the local level but rather, that policies have a better chance of being implemented successfully if the policy makers seek and attend to the insights of street-level bureaucrats as they create policies.

Top-down theorists identified policy developers as central actors who focused on the development and implementation of the policy. Top-down theorists sought to find methods to ensure that central policy designs would be faithfully implemented within the targeted system or program. The top-down perspective assumed that policy goals can be specified by policy developers and that implementation of the policy can be carried out successfully by controlling the implementation of the policy through oversight mechanisms outlined within the policy (Palumbo & Calista, 1990; Paudel, 2009; and
Therefore, according to top-down policy theorists, successful implementation occurs when policy makers tightly maintain control and oversight. From a top-down perspective, Van Meter and Van Horn (1975) developed generalized recommendations for successful implementation of policy across system and program contexts. They recommended that maintaining administrative capacity (i.e. policy administrators ability to manage policies according their own set rules) and resources was necessary to achieve successful policy implementation.

Table 2.2 provides a visual depiction of the differences between top-down and bottom-up implementation perspectives as outlined by Paudel (2009).
Table 2.2

*Differences between Top-down and Bottom-up Implementation Perspectives*

<table>
<thead>
<tr>
<th>Key Factors</th>
<th>Top-down Perspective</th>
<th>Bottom-up Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy decision-maker</td>
<td>Policymakers within larger systems</td>
<td>Street-level bureaucrats</td>
</tr>
<tr>
<td>Structure of policy implementation</td>
<td>Formal</td>
<td>Both formal and informal</td>
</tr>
<tr>
<td>Process of policy implementation</td>
<td>Purely administrative</td>
<td>Networking</td>
</tr>
<tr>
<td>Authority</td>
<td>Centralized</td>
<td>Decentralized</td>
</tr>
<tr>
<td>Outputs/outcomes</td>
<td>Prescriptive</td>
<td>Descriptive</td>
</tr>
<tr>
<td>Holder of discretionary policy power</td>
<td>Top-level bureaucrats</td>
<td>Bottom-level bureaucrats</td>
</tr>
</tbody>
</table>

Adapted from Paudel, N. (2009)

Based upon the assumptions associated with the top-down and bottom-up perspectives, DMAS operates from a top-down perspective in terms policy implementation for the TDT program. As discussed in the regulations guiding service delivery of TDT services of this literature review, DMAS develops the regulations that guide the implementation of TDT services based upon legislative mandates from the General Assembly. TDT regulations are presented as a formal document, with the regulatory manual being the final product of DMAS’s regulatory development process. DMAS authority related to the development and distribution of TDT regulations is
centralized and facilitated by key policymakers within the Department. The language within the TDT regulations is prescriptive in nature. For example, DMAS specifically states the criteria for admission into TDT, program requirement, staff requirements, and program components. Additionally, the auditing process reflects the top-down perspective.

**Policy Implementation Studies: Third Wave**

The third generation wave of implementation research, from 1986-present, was two-fold by drawing attention to policy delivery, not only as an organizational phenomenon, but also as an extension of policy politics (Brodkin, 1992; Meyers, Glaser, and Mac Donald, 1998; and Sandifort, 1998). In other words, attention is directed to how conflict over the terms and scope of social policy are reconfigured and advanced within the context of implementing institutions. In addition, the third wave incorporated the theoretical nature of the second wave and placed greater emphasis on examining the policy development and implementation processes.

A case study by Brodkin (1997) that examined the policy implementation process related to the Job Opportunities and Basic Skills (JOBS) program in Chicago, Illinois provides an example of third wave research. Despite the persistent hopes and preferences of both local policymakers and managers of the JOBS program, street-level bureaucratic research revealed that "JOBS caseworkers...do not do just what they want or just what they are told to want. They do what they can" (Brodkin, p. 24). Management strategies based on imposing rules and regulations produced undesirable effects, which illustrated a lack of awareness on the part of central policy makers in the policy implementation
process. Brodkin’s finding illustrated how the top level and street level bureaucrats negatively impacted the policy’s capacity to be implemented.

Friedman (2003) developed a framework for developing and implementing effective policy in children’s mental health. Freidman’s work incorporated the theoretical nature of the second wave and placed greater emphasis on examining the policy development and implementation processes, which were key characteristics within the third wave of policy implementation research. Friedman’s framework focused on four dimensions:

1. “The stages of policy development and implementation,
2. The levels at which policy is developed and the interrelationships among the levels,
3. The service sectors or systems affected by policy and the interrelationships among policy in different sectors, and
4. The variables that are likely to affect the level of impact of a policy.”

(p. 12)

One key distinction between Friedman’s work and second wave theorist was Friedman’s emphasis on the importance of the relationship between policy stakeholders, which is not emphasized with the top-down and bottom-up perspectives. He stated, the “most important issue may not be the level at which the policy is established but the relationships among the different levels of stakeholders in the implementation process” (Freidman, p. 12). Friedman also noted the importance of giving as much thought to policy implementation strategies as is given to the content of the policy itself.
Implementation Holon

A holon is a nested structure of embedded interrelated structures, theories, propositions, and concepts and is simultaneously a whole and a part (Luhmann, 1995). For this study, an implementation holon (see Figure 2.2) was created that incorporated Pressman and Widlavsky’s (1984) implementation theory, the Paudel’s (2009) bottom-up and top-down perspective and components of Elmore’s (1978) effective policy implementation. The development of this holon offered a more comprehensive and holistic understanding of implementation theory and processes, which was critical for this study given the complexities associated with policy implementation. The implementation holon informed the development of some of the propositional questions for this study, which are outlined in the next section of this chapter. Furthermore, this researcher utilized specific parts (i.e. theory, perspective, and/or components) of the holon as well as the entire holon to guide the discussion and implications of the findings in chapter five of this dissertation.
Chapter Two Summary

Implementation studies have been conducted for several years and are well established in the policy implementation literature (Brodkin, 1997; Goggin et al., 1990; Matland, 1995; Mazmanian & Sabatier, 1983; Pressman & Wildavsky, 1973; Saetren,
While implementation studies have been conducted on a broad range of social policies, there have been no studies conducted on TDT program policy implementation. The lack of policy implementation research illustrates a critical gap in the literature, particularly given Friedman’s emphasis on the importance of policy implementation in children’s mental health. Additionally, the need for such research has been recognized by the Behavioral Health Policy Department at DMAS as well as other policy advocacy organizations including Voices for Virginia’s Children. This study aims to begin to fill this gap within the literature.

Introduction of Propositional Questions

Guided by this literature review and theoretical tenets of implementation theory (Elmore, 1978; Friedman, 2003; and Paudel, 2009), this study seeks to understand how DMAS regulatory changes impacted the implementation of TDT in the Commonwealth of Virginia from 2004-2011 using a case study methodology. A fundamental aspect of case study methodology is the use of theory, such as implementation theory (Yin, 2009). Seven propositional questions have been developed based upon the literature presented in chapter one and chapter two of this dissertation and are thoroughly discussed in chapter three. The propositional questions for this study include:

1. An increase in the fee-for-service expenditures for TDT services led to DMAS contracting with a third party authorizer.
2. The top-down structure of TDT regulation development and implementation has created tension between DMAS and providers of TDT.
3. Budgetary expenditures of TDT were a driving force in creating regulatory changes by DMAS.

4. The lack of evaluation research data by providers of TDT in Virginia may be the result of DMAS not requiring such data be collected to receive funding.

5. Since 2004, regulatory changes have impacted who is able to provide TDT services.

6. Since 2004, regulatory changes have impacted how services are rendered.

7. Since 2004, regulatory changes have impacted the severity of presenting clinical symptoms related to specific behavioral and emotional disorders.
CHAPTER THREE

Methodology

Using a single case study design, this study sought to understand how the Department of Medical Assistance Services’ (DMAS) regulatory changes impacted the implementation of therapeutic day treatment (TDT) services in the Commonwealth of Virginia. This chapter outlines the methodology used to respond to this study’s research question. This chapter is divided into seven primary sections: (a) case study research; (b) propositional questions of the study; (c) data collection; (d) sources; (e) data analysis; (f) rigor; and (g) a summary of chapter three.

Case Study Research

A case study design, situated within the functionalist paradigm, was used for this study. The functionalist paradigm emphasizes objective regulation and objectivity and is the primary paradigm for the study of formal organizations (Burrell & Morgan, 1979). The functionalist paradigm assumes rational action on the part of organizations related to policy development and implementation and emphasizes the importance of hypothesis testing (Burrell & Morgan). While case study methodologies can be used in multiple paradigms, including social constructivist and critical paradigms, the functionalist paradigm was most applicable in this study as the goal was to examine the impact of policy change (Baxter & Jack, 2008). While this case study seeks to determine how the Department of Medical Assistance Services’ (DMAS) regulatory changes impacted the implementation of therapeutic day treatment (TDT) services in the Commonwealth of Virginia, the final results of the study are contextually bound to the parameters of this specific case, policy, and state and therefore meet the criteria of a suitable case study.
This research study was guided by Yin’s (2009) case study design. According to Yin, a case study is an empirical inquiry that:

1. Investigates a contemporary phenomenon within a real life context when the boundaries between phenomenon and context are not clearly evident. In this study, the phenomenon is therapeutic day treatment and the context is Medicaid funded child and adolescent mental health in the Commonwealth of Virginia.

2. Relies on multiple units of analysis, with data needing to converge in a triangulating fashion. In this study, the multiple units of analysis are TDT regulations, DMAS fee-for-service data for fiscal years 2004-2011, and structured interviews with key stakeholders. Triangulation occurs in response to the propositional questions.

3. Benefits from the prior development and use of theory to guide the case study (p. 18). The theory that guides this case study is implementation theory. As outlined in chapter two, the bottom-up and top down perspectives of policy implementation (Paudel, 2009) and the components of effective policy implementation (Elmore, 1978) are embedded in implementation theory (Pressman & Wildavsky, 1984), which collectively guide and inform this case study.

TDT is a contemporary phenomenon that exists within the context of Medicaid funded child and adolescent mental health services in the Commonwealth of Virginia. According to Yin (2009), the phenomenon under investigation in a case study is the case. For the purposes of this study, the case is the TDT program. Yin’s definition of a case study states that the boundaries between the case and context are not clearly evident. This definition is indicative of the fluid boundaries between the case of TDT services and the context of Medicaid funded child and adolescent mental health services.
in the Commonwealth of Virginia. TDT services are embedded within Medicaid funded child and adolescent mental health services.

Yin (2009) also noted that case studies must rely on multiple units of analysis to fully answer the research question. The multiple units of analysis in this case study are: structured interviews with key stakeholders who interface with TDT, TDT regulations from 2004-2011, and the total fee-for-service expense paid by DMAS to providers of TDT for each fiscal year from 2007-2011. All of this data was analyzed and subsequently triangulated, which reflects Yin’s definition. Lastly, Yin identified the benefits of using theory to guide the case study. Within the policy implementation literature, implementation theory is used to understand and explain the policy implementation process (Hill & Hupe, 2006; O’Toole, 2003; Paudel, 2009; and Winter, 2003a). The use of implementation theory guided this case study focusing on DMAS’s regulatory changes, through regulatory implementation, have impacted service delivery.

The case study method is well suited for research questions that seek to explain a present case. Furthermore, this method is relevant when a case requires extensive and in-depth description of a social phenomenon -- when “how” and “why” research questions are posed (Creswell, 2013; Leonard-Barton, 1990; Yin, 2009). Given that the research question for this study sought to understand “how” regulatory changes impacted therapeutic day treatment services, the use of a case study method was appropriate for the research question.

The case study literature indicates that research focused on policy implementation is well suited to case study research (Cook & Reichardt, 1979; Gilgun, 1990; and Smith & Robbins, 1982). Furthermore, Yin (1994) states that case study research is beneficial
when the existing literature about a case is limited. As discussed in Chapters 1 and 2, there is very little research that has been conducted on TDT in Virginia. This further illustrates that appropriateness of the case study methodology for this study.

**Historical Foundation of Case Study Research**

Historically, the origin of case study research is grounded in social work casework. Thomas & Znaniecki (1918) and Cavan (1928) used data from social workers case histories and casework notes to write textbooks discussing the case study tradition (Platt, 1992). These textbooks were intended to build the knowledge base around case study research. Early case studies that emerged from the University of Chicago focused on understanding the life histories of individuals experiencing various phenomena (Platt). In 1935, a public dispute emerged between Columbia University and the University of Chicago regarding the efficacy of case study methods for research purposes. Research conducted at Columbia University was strictly based upon the experimental scientific method. As a result, Columbia researchers challenged any research that included a non-experimental design – a challenge that resulted in the decline of the use of the case study method for a period of time (Tellis, 1997). The 1960’s brought a renewed interest in case study research. During this time, researchers became concerned about the limits of purely quantitative experimental research. Since the surge in the 1960’s of case study research, many prominent scholars such as Yin, Lincoln and Guba, Creswell, and Gilgun have contributed to the knowledge base of case study research (Creswell, 2013; Gilgun, 1994; George & Bennett, 2004; Gerring, 2004; Lincoln & Guba, 1985; Patton, 1990; Randolph & Eronen, 2007; and Yin, 1994, 2009). Scholars such as Yin (2009) bounded case studies in a research context by identifying a specific approach to the design of case
studies, defining the principles of data collection, and specifying strategies for data analysis and dissemination.

**Context and Case within Case Study Research**

The context for this study was Medicaid funded child and adolescent mental health services in Virginia. The case was therapeutic day treatment for children and adolescents in Virginia. Units of analysis are data that are collected for the study and naturally embedded in the case (Yin, 2009). In case study research, embedded units of analysis were different foci that inform the researcher’s capacity to answer research questions. These units were considered embedded because they existed within the case. Embedded units of analysis fit within the case and context of the case study. The embedded units of analysis that were collected and analyzed were structured interviews with key stakeholders who interface with TDT, TDT regulations from 2004-2011, and the total fee-for-service expense paid by DMAS to providers of TDT for each fiscal year from 2007-2011. This span of time was selected because 2004 is the year when the service delivery system transitioned from solely being provided in center-based schools/programs and after school programs to also being provided in public schools (Department of Medical Assistance Services, 2004). As discussed in Chapter 2, the extension of the service delivery system into the school setting represented a fundamental shift in the implementation of this program and was a critical aspect of this study. Yin (1994; 2009) provides a figure to illustrate the context, case, and units of analysis within a case study. Figure 3.1 mirrors Yin’s illustration and depicted the context, case, and units of analysis specific to this study. Yin’s illustration is a depiction of a holon, which is a nested structure of embedded interrelated structures (Luhmann, 1995). As
such, Figure 3.1 is a holon that illustrated how the case (TDT) is embedded within the context Medicaid funded child and adolescent mental health treatment in the Commonwealth of Virginia. Further embedded within the case (TDT) are the units of analysis.
Figure 3.1.

*Single-Case Study Design: Context, Case, and Units of Analysis*

Adapted from Yin, R. (2009)
Theory and Case Study Research

Yin (2009) emphasized the use of theory in case study research. According to Yin, theory provided a framework for engaging in the case study and also provided a guide for analyzing the data. Furthermore, using theory within case study research allowed the researcher to use analytic generalization where the findings of the study are linked back to the theory, perspective, and literature, which informed the study (Yin).

This study used implementation theory to guide the inquiry focusing on how DMAS regulatory changes impacted the service delivery of TDT in the Commonwealth of Virginia. Lee, Mishna, & Brennenstuhl (2010) emphasized the importance of selecting the theory or theories used within the case study during the initial phase of the research process. By doing so, the researcher was able to connect implementation theory (i.e. Elmore, 1978; Paudel, 2009; and Pressman & Wildavsky, 1984) to the methodology and subsequently the findings of the case study (Gilgun, 1994; Yin, 2009). The propositional questions and structured interview questions that were developed were guided by elements of the literature review, including implementation theory. For example, the top-down perspective (Paudel, 2009), embedded in implementation theory, informed the following propositional question: “The top-down structure of TDT regulation development and implementation created tension between DMAS and providers of TDT”.

Gummerson (1998) asserted that the detailed observations entailed in a case study enable us to study many different aspects, examine them in relation to each other, and view the process within its environment. For this study, examining different units of analysis such as structured interviews with key stakeholders who interface with TDT,
TDT regulations from 2004-2011, and the total fee-for-service expense paid by DMAS to providers of TDT for each fiscal year from 2007-2011 were analyzed and triangulated to understand relationships that existed between all of these data units within the context of the TDT program. Such examination provided a deeper understanding of the context of TDT in the Commonwealth of Virginia. Methodological steps of the case study included: (a) identifying the research question, (b) identifying propositional questions or objectives, (c) outlining the data collection process, (d) analyzing the data, (e) linking the analyzed data back to the propositional questions, and (f) interpreting the data in the context of the relevant literature and theory, related to the phenomenon being studied (David, 2007).

**Propositional Questions of the Study**

Propositional questions were developed based upon content within the literature review, including but not limited to therapeutic day treatment, specifically regulations guiding TDT service delivery in Virginia that were presented in chapter two (see Table 3.1).
Table 3.1

Propositional Questions for the Case Study

<table>
<thead>
<tr>
<th>Propositional Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An increase in the fee-for-service expenditures for TDT services between fiscal years</td>
</tr>
<tr>
<td>2004 and 2009 led to DMAS contracting with a third party authorizer.</td>
</tr>
<tr>
<td>2. The top-down structure of TDT regulation development and implementation created</td>
</tr>
<tr>
<td>tension between DMAS and providers of TDT.</td>
</tr>
<tr>
<td>3. Budgetary expenditures of TDT were a driving force in creating regulatory changes by</td>
</tr>
<tr>
<td>DMAS.</td>
</tr>
<tr>
<td>4. The lack of evaluation research data by providers of TDT in Virginia may be the result</td>
</tr>
<tr>
<td>of DMAS not requiring such data be collected to receive funding.</td>
</tr>
<tr>
<td>5. Since 2004, regulatory changes have impacted who is able to provide TDT services.</td>
</tr>
<tr>
<td>6. Since 2004, regulatory changes have impacted how services are rendered.</td>
</tr>
<tr>
<td>7. Since 2004, regulatory changes have impacted the severity of clinical presenting</td>
</tr>
<tr>
<td>symptoms of children and adolescents admitted to the TDT program.</td>
</tr>
</tbody>
</table>

Data Collection: Units of Analysis

According to Yin (2009), case study research requires consideration and inclusion of multiple units of analysis, which can include both qualitative and quantitative data. Given that TDT is a relatively unexamined phenomenon, multiple units of data provided richer data to address the research question. For this case study the multiple units of analysis collected were DMAS regulations, DMAS budgetary data for TDT, and
structured interviews with key stake holding stakeholders. The following is a brief discussion of each unit of analysis that was collected in this study.

**DMAS Regulations:**

DMAS’s Community Mental Health and Rehabilitative Services manual, guiding the implementation of the TDT program, included the following chapters: (a) Chapter I (General Information), (b) Chapter II (Provider Participation Requirements), (c) Chapter III (Member Eligibility), (d) Chapter IV (Covered Services and Limitations), (e) Chapter V (Billing Instructions), (f) Chapter IV (Utilization Review and Control. Chapter II (Provider Participation Requirement), Chapter IV (Covered Services and Limitations, and Chapter VI (Utilization Review) were utilized for this study as their contents were able to directly address the primary research and propositional questions posed in this study. Chapter II outlines the provider requirements, such as licensing requirements and staff ratios that public and private agencies must follow in order to provide TDT services. Chapter IV details the criteria that participants must meet in order to receive TDT services, program components, requirements for program implementation, etc. Chapter VI discusses how DMAS engages in utilization review of providers of TDT to ensure that providers’ documentation related to service delivery is aligned with fee-for-service billing. Chapter I (General Information), Chapter III (Member Eligibility), and Chapter V (Billing Instructions) focus on technical and procedural areas for TDT and were not relevant to this study.

For fiscal year 2011, Chapter II, Chapter IV, and Chapter VI were accessed online through DMAS’ website at


under the
link “Community Mental Health Rehabilitation Services”. The electronic versions were printed off and placed in a binder in preparation for the analysis that was conducted.

For fiscal years 2004-2010, a Freedom of Information Act request was submitted to DMAS for Chapter II, Chapter IV, and Chapter VI as these versions were not available online. DMAS required a monetary fee to release the information to the researcher on a compact disc (CD). The researcher printed a hard copy of each chapter for fiscal years 2004-2010 and placed them in the binder containing the DMAS regulatory chapters for fiscal year 2011 noted above.

The researcher created a table in Microsoft Word to track the collection of the TDT regulations within Chapter II, Chapter IV, and Chapter VI per fiscal year. The intent of this table was to ensure that all chapters for fiscal years 2004-2011 were collected. Once collected, the chapters were placed in a binder and divided by fiscal year prior to the data analysis.

Each fiscal year, an updated iteration (or iterations) of the provider manuals was published by DMAS. Each chapter’s update was compared to the prior fiscal year. For example, all of the sections from the 2004 regulations of chapter II were compared to the 2005 updated regulations, 2005’s sections were compared to 2006. This analytic process continued for each fiscal year for chapter’s II, IV, and VI. This is discussed further in the data analysis section of this chapter.

**DMAS Budgetary Data: Fee-for-Service Expenses**

Feder and Katz-Gerro (2012) discuss how public policy pays specific attention to the analysis of the budgetary data allocated to social welfare programs, including those with an emphasis on mental health. Incorporating fee-for-service data was important as
this data reflected the total cost per fiscal year that DMAS paid providers to implement TDT services.

DMAS’s Division of Provider Reimbursement collected and maintained all fee-for-service data for the TDT program. The fee-for-service data is aggregated by month and totaled per fiscal year. This researcher obtained the TDT fee-for-service data for fiscal years 2007-2011 in a Microsoft Excel file. Fee-for-service data for 2004-2006 was not available. No explanation was provided to this researcher regarding the missing fee-for-service data that was requested.

**Structured Interviews:**

*Sample development.* The researcher conducted structured interviews with the following stakeholders via telephone: (a) a behavioral health representative from DMAS; (b) an administrator from a public agency, such as a Community Services Board, providing TDT services; (c) a TDT direct care staff in a public agency; (d) two administrators from private agencies (one for-profit and one not-for-profit agency) providing TDT services; (e) two direct care staff from private agencies (one for-profit and one not-for-profit agency) providing TDT services; and (f) a children’s mental health policy advocate. Purposive sampling was used to select the aforementioned stakeholders within TDT and children’s mental health services. While TDT is primarily a school-based mental health treatment program, school administrators, teachers, and other school staff were not included as a source of data as they do not directly interface with regulations guiding the implementation of TDT services. Given the emphasis placed on TDT regulations and the implementation of these regulations, school administrators, teachers, and staff would likely not have the contextual understanding of the TDT
program and how regulations have impacted the implementation of the program. Furthermore, their limited knowledge would reduce their capacity to respond to the structured interview questions outlined above in Table 3.2.

The researcher recruited all study stakeholders. The researcher utilized the licensed provider search embedded within the Department of Behavioral Health and Developmental Services website (lpss.dbhds.virginia.gov/LPSS/LPSS.aspx). The researcher utilized the search specifier of “children” in the search menu. A list of providers who offered mental health services was provided. The researcher went through the populated list of mental health providers (more than 1,000 providers who provide an array of community-based and residential-based mental health services). From this list, the researcher selected providers to contact. The researcher developed a randomized list of 20 providers based upon geographic regions of the Commonwealth. This list was in addition to a list of Community Services Boards (CSB’s), which acted as public non-profit agencies for the sample. Despite only having to contact four stakeholders, this researcher selected 20 providers since the populated list did not identify the type of mental health service provided. For example, some of the providers selected only provided intensive in-home counseling services and did not provide TDT. The researcher utilized the randomized list and found each agencies’ website to determine contact information for each stakeholder identified above. The researcher contacted potential study stakeholders by electronic mail and introduced the study using the script developed by this researcher (Appendix B). The consent form for the study was attached to the e-mail introducing the study. The researcher contacted a total of 10 individuals to participate in the study. Two potential stakeholders did not participate; one stakeholder
declined the invitation and the researcher did not receive a response from the other stakeholder. Both of these individuals were direct care stakeholders.

The strategy for collecting sources of data aimed for variation among stakeholders; this researcher based the online search and selection of stakeholders accordingly. Stakeholders were selected based on varied positions, regions, and degree of positional power (i.e. DMAS representative, agency administrator, direct care staff, etc.). Lincoln & Guba (1985) discuss the importance of variation within the sources of data when using a non-probability purposive sampling strategy, particularly with smaller numbers of data sources. Maximum variation, or heterogeneity, includes different perspectives or philosophies related to a specific phenomenon, different demographic characteristics, and various positions related to power (Cohen, 2006). While this study did not achieve true maximum variation based upon the number of data sources, variation within the data sources was achieved. The stakeholders selected for this study directly interface with TDT or had an extensive working knowledge of the TDT and regulations that guide the implementation of the TDT program. They were geographically diverse (i.e. southwest and central Virginia and Tidewater) and had positions with varying degrees of power within the TDT program. The inclusion of both public and private agencies within this study was important because of the varying perspectives that administrators and direct care staff could have related to the TDT program and regulatory changes. Approximately 76% of TDT services are provided by private agencies (Department of Behavioral Health and Developmental Services, 2012). The decision to include two administrators and direct care staff from private agencies was based upon the breakdown of private and public agencies in the Commonwealth of Virginia providing
TDT services. As a result, including additional private administrators and direct care staff was appropriate as private agencies were and continue to be highly represented in the population of TDT providers. Stakeholders were selected from different regions in the Commonwealth of Virginia. This helped to account for potential regional differences in how stakeholders responded. According to Karen Lawson, (personal communication, February 2, 2012) there are regional differences in the structure of agencies providing TDT services, how agencies approach implementing TDT services based upon their interpretation of the regulations, among other factors.

All study stakeholders had seven or more years of experience with TDT. This ensured that all stakeholders had thorough working knowledge of TDT programming and policies. This also ensured that stakeholders would have experienced at least some of the changes in policies guiding TDT programming.

**Interview questions.** Prior to the structured interviews being conducted for the research study, this researcher conducted a pilot interview with a TDT direct care clinician to determine the appropriateness and format of the questions for stakeholders. Based upon the pilot interview, slight changes were made to increase the clarity of the questions. See Table 3.2 for the finalized structured interview questions for this study.

The structured interview questions allowed the stakeholders to share their perspective and beliefs on how DMAS regulatory changes have impacted the implementation of TDT services. In addition, stakeholders were asked to explore what they believed the driving force of regulatory change to be as well as to explore the nature of the relationship between DMAS and providers of TDT. Lastly, stakeholders were able to discuss how TDT is evaluated to determine program efficacy (see Table 3.2). Two of
the four questions within the structured interview included prompts, which allowed the researcher to prompt stakeholders to address specific areas that are relevant to the research if the stakeholders do not address them after the question is asked.
Table 3.2 Structured Interview Questions and Prompts

Structured Interview Questions and Prompts

1. What is your current position and how do you interface with TDT programming or policy?

2. What is your understanding of the existing TDT regulations and how they guide the implementation of TDT programming?

3. What DMAS regulatory changes have impacted how TDT services are implemented in Virginia?
   - Program changes?
   - Clinical presentation of the population?
   - Staff changes?

4. Guided by DMAS policy, what role do you think the Administrative Services Only (ASO) Model provided by Magellan will have on how TDT is implemented?

5. What do you believe has been the driving force of the TDT regulatory changes since 2004?

6. What, if any, is your understanding of how TDT is evaluated to determine if the program is effective?
   - Type of evaluation conducted? Aspects of the program that are evaluated?
   - Who monitors this evaluation?

6. What is your understanding of the relationship between providers of TDT and DMAS? Impact of regulatory changes on this relationship?

7. What is your understanding of TDT (or similar programming with a potentially different name) policy development and implementation outside of the Commonwealth of Virginia?

8. Is there any additional information related to TDT policy implementation that you would like to offer
**Procedure.** Interviews were digitally recorded and later transcribed by this researcher. The researcher completed field notes during and after the interview to document key thoughts or ideas triggered by the interviews. The transcriptions were prepared and saved in Microsoft Word.

**Human Subjects Protection**

The Department of Health and Human Services (2012) human subject protection regulations were first issued in 1974. United States Code of Federal Regulations Title 45 ensures the protection of human subjects during the research process. This study was conducted as a requirement for the degree of Doctor of Philosophy in Social Work at Virginia Commonwealth University (VCU). As a result, the IRB (panel B) at VCU reviewed and approved this study to ensure compliance with all federal, state, and local guidelines related to human subjects protection. The IRB approval number is VCU IRB#: HM15474.

An expedited review was appropriate for this study as there was no more than minimal risk to the stakeholders of this study. The stakeholders who were selected to participate in this study did not represent vulnerable populations. Furthermore, a consent form was developed to ensure all study stakeholders were aware of the goals, risk and benefits of the study. All identifying information of each participant remained confidential and was only known to this researcher. Interviews were conducted after the consent received and reviewed. Informed consent included an explanation of the purpose of the research. The informed consent protocol included an electronic copy consent form explaining the research being conducted and the rights of research stakeholders. The researcher verbally reviewed the consent with the stakeholders again prior to the
interview. The stakeholders were given another opportunity to decide whether or not to agree to participate in the study. Stakeholders were verbally informed of the expected duration of the length of the interview, which is approximately 45-60 minutes. This process allowed stakeholders to determine if the time required placed undue strain or stress by engaging in the research process.

The researcher provided stakeholders with an electronic copy of the structured interview questions that were asked during the interview. Furthermore, risks and benefits of participation were verbally reviewed. Detailing the risk and benefits with the stakeholders allowed them an opportunity to self-assess their desire to continue to participate in the study. Lastly, stakeholders were verbally informed that their participation was completely voluntary; their ability to discontinue the interview at any time, and the confidential nature of all identifying information provided. Identifying information, such as name and position remained confidential. Identifiers were created for each participant and the participant’s positions remained generic when findings from the structured interviews were reported in chapter four. For example, “I1” reflects the first interview conducted with a TDT administrator. The study presented no more than minimal risk of harm to the stakeholders nor did it involve procedures for which consent is usually required outside research. Stakeholders were verbally told of the cost of participating in the research study, which was solely their time. A tangible incentive was not provided to study stakeholders. Stakeholders were verbally told of the potential benefits that may come from participating in this research study; this information was also included in the consent form. All stakeholders were provided an electronic copy of
the consent to keep along with contact information for the primary investigator, co-
primary investigator, and the Office of Research at VCU.

The DMAS regulations guiding the implementation of TDT and DMAS’s fee-for-
service data for TDT that were collected for the study did not include human subjects,
any private heath or identifying information, and had already been collected by DMAS;
therefore, the aforementioned human subject safeguards were not necessary.

**Data Analysis**

Qualitative and quantitative data obtained during the data collection phase of this
study were analyzed independently then collectively. The qualitative and quantitative
data complemented each other and provided a more thorough understanding of how
DMAS regulatory changes impacted the implementation of TDT services in Virginia.
Pioneered by Creswell & Plano-Clark (2011), the convergent parallel research design was
used in the data collection and data analysis phases of this study. The convergent parallel
research design called for the researcher to collect and analyze both qualitative and
quantitative data separately then compare the findings for the final interpretation (See
Figure 3.2). For this study, qualitative data included (a) structured interviews that were
conducted, transcribed, analyzed and (b) the TDT regulations that were analyzed. The
quantitative data included fee-for-service expenses that DMAS paid to providers of TDT
per fiscal year. Basic descriptive statistics were used to analyze the fee-for-service data.
These data were collected and analyzed separately; then they were compared and
interpreted together by comparing and contrasting findings from the analysis of the
regulations, interviews, and for-service data. The data analysis protocol is discussed in
the qualitative and quantitative analysis sections below.
Yin (2009) identified strategies, such as the use of theory and using both qualitative and quantitative data as part of the data collection and dissemination of case study research. According to Yin, explanation building explains “how” or “why” a phenomenon occurred. The explanation building process occurs during the case write up phase and is disseminated in the form of a narrative. The use of theory is important in explanation building because using theory increases the case study’s rigor. Furthermore, when the explanation of the case is grounded in theory and relevant literature the researcher has the capacity to link themes/patterns within the case study back to theory and relevant literature. This allowed the researcher to better explain the phenomenon under investigation. Yin (2009) emphasized the importance of examining how the data respond to the propositional questions and how each propositional question was or was not supported by the theories and literature included in the study. Analytic processes were developed for the specific units of analysis in this case study and are described below.
Qualitative Data: Analysis of TDT Regulations and Structured Interviews

The researcher utilized different qualitative analysis strategies to analyze the TDT regulatory data and the structured interview data: comparative textual analysis for the TDT regulatory data and thematic analysis for the structured interview data.

Comparative Textual Analysis of TDT Regulations. Comparative textual analysis was the analytic strategy utilized for the TDT regulations. Comparative textual analysis identifies the differences in specific content and formatting of two or more documents (Stahnke & Blitt, 2005) and compares and summarizes the differences as evidence of the changes from one document to the other (Stahnke & Blitt). While this analytic strategy is more common in the liberal arts such as linguistics and literature, it has been utilized within social work research. Scholars such as Ephross (1982) and Reisch (1983) utilized this analytic strategy when comparing content in social work texts. Additionally, comparative textual analysis has been used in mental health research to compare policy and programming content (McFadden, Seidman, & Rappaport, 1992 and Beattie, Daker-White, Gillard, & Means, 2004).

Similar to other qualitative analytic strategies, it is critical to read and reread the documents being analyzed when engaging in a comparative contextual analysis (Stahnke & Blitt, 2005); this researcher read each iteration of chapters’ II, IV, and VI three times to ensure a thorough understanding of the content within each update of the chapters. Beginning with 2004, the researcher compared sections in Chapter II of the DMAS’s Community Mental Health and Rehabilitative Services Manual with the comparable sections from 2005; then compared those same sections from 2005 to 2006. This process was replicated for each chapter, broken down by sections within the chapters, for fiscal
years 2004 through 2011. The researcher highlighted content and formatting changes between the regulatory documents. For example, when comparing the regulations located in chapter IV in 2009 to those from 2010 this researcher found that DMAS added an operational definition of what it meant to be at risk of an out of home placement in the 2010 iteration. This change was highlighted and documented in the margins of the regulations. It was important for this researcher to engage in this process several times to ensure that all of the changes between documents were documented in the margins of the chapter(s). The chapter-to-chapter changes in content and formatting from chapter to chapter constitute the findings of the TDT regulatory data analysis.

**Thematic Analysis of Structured Interviews.** Qualitative research scholars Stake (1995) and Creswell (2009 & 2013) have outlined thematic analysis as a conventional analytic strategy, which involves searching through data to identify any recurrent patterns (Creswell, 2009). A theme is a cluster of meaning (word, phrase, or sentence within raw data), which collectively defines and conveys the essence of selective lumps or units of data that emerged during the analysis (Stake, 1995).

Stake (1995) and Creswell (2009) emphasized the importance of the researcher becoming familiarized with the content of the transcriptions. As a result, this researcher read and reread the transcriptions multiple times, examining and re-examining the transcripts line by line, to facilitate a microanalysis of the data. After re-reading the transcripts, notes were made of major concepts, issues, etc. that were embedded in the clusters of meaning. Following Stake, this researcher read and re-read the transcripts to identify clusters of meaning in the data. After the clusters of meaning were organized, the researcher engaged in the coding process. Once the coding process was completed,
the researcher organized the codes and identified and labeled sub-themes. This was an iterative process whereby the researcher engaged in these analytic activities multiple times by reading and re-reading, coding and re-coding, and organizing and reorganizing the sub-themes.

The last step of the analytic phase was to operationalize the themes based upon the final sub-themes. McRoy (2009) distinguished between manifest and latent themes. Manifest themes are derived from content (i.e. concrete words and phrases) embedded in the raw data and latent themes are derived from the underlying meaning of the data. In this study, the final four themes were manifest themes. For example, the manifest theme of “suspected fraudulent practices and misuse of TDT services” was created from concrete words in the raw interview data including “fraudulent practices”. In addition to this theme, three other themes emerged from the data: regulatory oversight, cost containment, and evaluation of TDT. These manifest themes are fully explored in chapter four of this dissertation.

Quantitative Data: Analysis of Fee-for-Service Data

DMAS budgetary data was analyzed using Excel. The analysis examined the change in overall fee-for-service expenditures that occurred from fiscal year 2007 through 2011 and determined the percentage change between each fiscal year as well as the total percentage change. Specifically, the researcher presented the overall percentage change between select fiscal years. In addition, a table (see Table 4.2 in chapter four) was created to illustrate the cost increase over time.
Triangulation

Analyzing multiple forms of data allowed for themes/patterns and comparisons to be triangulated (Creswell, 2013). Denzin (1970) defined triangulation in research as a combination of a two or more data sources or methods in the study of a single phenomenon. Triangulating multiple units of analysis is a strength of the case study methodology (Yin, 2009). According to Creswell and Yin, triangulation is a technique to increase rigor and allows for more confidence in the findings. Triangulating the data provided a greater understanding of TDT and was used to support assertions presented by the data as well as to refute propositional questions discussed below (Yin).

Analysis of Propositional Questions

Table 3.1 presents the propositional questions of this study. The data that was gathered and analyzed for this study addressed and responded to each of these propositional questions. Each form of data addressed the propositional questions that were posed.

Propositional Question One. The first propositional question of this study stated that an increase in the fee-for-service expenditures for TDT services between fiscal years 2004 and 2009 led to DMAS contracting a third party authorizer. The fee-for-service data for TDT triangulated with the regulations to answer this propositional question. Furthermore, the structured interview question “What do you believe has been the driving force of the TDT regulatory changes since 2004?” contributed to the answer.

Propositional Question Two. The second propositional question of this study stated the top-down structure of TDT regulation development and implementation created tension between DMAS and providers of TDT. Structured interviews with key
stakeholders, particularly the question inquiring about the relationship between providers of TDT and DMAS, helped understand whether or not tension existed between TDT providers and DMAS.

**Propositional Question Three.** The third propositional question of this study stated that budgetary expenditures of TDT were a driving force in creating regulatory changes by DMAS. All units of analysis -- the structured interviews, TDT regulations, and fee-for-service data -- were able to address this propositional question. The fifth question within the structured interview protocol asked stakeholders what they believe the driving force of the TDT regulatory changes has been since 2004? Additionally, regulations and fee-for-service data had the capacity to respond to this propositional question.

**Propositional Question Four:** The forth propositional question of this study stated that the lack of evaluation research data by providers of TDT in Virginia may be the result of DMAS not requiring such data be collected to receive funding. A question within the structured interviews and the TDT regulations allowed this researcher to interrogate this propositional question. Specifically, question six (with sub questions) in the structured interview protocol asked stakeholders to discuss how TDT is evaluated to determine program efficacy? The prompts/sub-questions included: type of evaluation conducted, if any; aspects of the program that are evaluated, if any; and who monitors this evaluation, if anyone. Additionally, examining the TDT regulations, particularly Chapter IV (utilization review) allowed the researcher to understand if DMAS’s utilization review required providers to engage in evaluation research.
Propositional Questions Five, Six, and Seven. The fifth, sixth, and seventh propositional questions for this study focused on specific aspects of the TDT program: (a) who was able to provide TDT services; (b) how services were rendered; and (c) the severity of clinical presenting symptoms of children and adolescents admitted to the TDT program. The structured interviews and TDT regulations addressed these propositional questions. For example, the third question within the structured interview protocol asked key stakeholders “What DMAS regulatory changes have impacted how TDT services are implemented in Virginia?” Prompts for this question included queries about program changes, clinical presentation of the population, and staff changes. Furthermore, the comparative contextual analysis of the regulatory data allowed the researcher to determine changes in the regulations, how services were rendered, and the clinical presentation of children and youth admitted to the program.

Table 3.3 illustrates which unit of analysis within this research study addressed each of this study’s propositional questions.

Table 3.3

Units of Analysis Addressing Study’s Propositional Questions

<table>
<thead>
<tr>
<th>Units of Analysis</th>
<th>Propositional questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured interviews</td>
<td>1, 2, 3, 4, 5, 6, 7</td>
</tr>
<tr>
<td>TDT regulations</td>
<td>1, 3, 4, 5, 6, 7</td>
</tr>
<tr>
<td>DMAS’s fee-for-service data for TDT</td>
<td>1, 3</td>
</tr>
</tbody>
</table>

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Rigor

Rigor dimensions in social science research are essential to support the validity of the results and directly tied to the integrity of the research process from start to finish (Rubin & Babbie, 2011). The methodology of the research is of greater importance in determining appropriate rigor protocols than the type of methods (Miles & Huberman, 1994). This study was primarily qualitative in nature as a majority of the data that was collected and analyzed was qualitative. Secondary quantitative data was collected, analyzed, and triangulated with the qualitative data. Yin’s scholarly discussions on rigor use language that is more commonly seen in quantitative research. As a result, this researcher utilized the language of qualitative data analysis to discuss rigor of this study and followed the strategies outlined by Lincoln & Guba (1985) and Padgett (1998).

Lincoln, Guba, and Padgett discuss credibility, transferability, dependability, and confirmability as tests of rigor that establish trustworthiness in the research process (see Table 3.4). Lincoln, Guba, and Padgett’s rigor tests were selected because they are widely accepted in qualitative research and are well documented in the literature (Marshall & Rossman, 1999; Rubin, 2000; Shenton, 2004; and Stake, 1994). In addition to drawing primarily from the work of Lincoln, Guba, and Padgett, this researcher incorporated the technique of explanation building, as discussed in chapter five of this dissertation to achieve credibility (Yin).
### Table 3.4

**Case Study Techniques for Rigor**

<table>
<thead>
<tr>
<th>Test of Rigor</th>
<th>Case Study Research Technique</th>
<th>Phase of Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Interview technique</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Authority of the researcher</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Triangulation</td>
<td>Analysis; case write up</td>
</tr>
<tr>
<td></td>
<td>Explanation building</td>
<td>Case write up</td>
</tr>
<tr>
<td>Dependability</td>
<td>Dense description of research methods</td>
<td>Research planning</td>
</tr>
<tr>
<td></td>
<td>Develop case study database</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Establish chain of evidence</td>
<td>Analysis</td>
</tr>
<tr>
<td>Confirmability</td>
<td>Triangulation of data</td>
<td>Analysis; case write up</td>
</tr>
<tr>
<td></td>
<td>Reflexive journal</td>
<td>Analysis; case write up</td>
</tr>
</tbody>
</table>

**Credibility**

Similar to Yin’s (2009) use of internal validity, credibility is one of the most important tests of rigor and helps to establish trustworthiness in a qualitative study (Lincoln & Guba, 1985). Credibility is an evaluation of whether or not the research findings represent a “credible” conceptual interpretation of the data drawn from the stakeholders’ original data (Lincoln & Guba, p. 296; Padgett, 1998; Rubin, 2000). Similarly, Yin’s discussion focused on the case study’s ability to make inferences after the units of analysis have been analyzed. There are several techniques used to establish
credibility within the research process, including explanation building, triangulation, interviewer technique, and established authority of the researcher.

**Explanation Building.** Explanation building analyzes units of analysis to build an explanation about the case; it typically occurs in narrative form. Using theory, such as implementation theory, to help understand and/or explain inferences within the data analysis is critical in order to answer “how” and “why” research questions (Yin). Implementation theory (Elmore, 1984; Paudel, 2009; and Pressman and Wildavsky, 1984) and relevant literature was used to ground the findings and discussion, which is presented in chapter five of this dissertation. The main research question of “How have DMAS regulator changes impacted the implementation of TDT services?” was aligned with “how”/”why” language that Yin discussed.

**Triangulation.** Triangulation involves analyzing, and collectively interpreting multiple forms of data. According to Lincoln & Guba (1985) and Padgett (1998) using multiple forms of data collectively within a research study compensates for possible limitations and exploits benefits of each data source. Within this study, the three forms of data that were collected and triangulated are discussed in detail above.

**Interview technique to promote honesty from key stakeholders.** Lincoln and Guba (1985) discussed the importance of developing rapport with stakeholders who participate in the research process. Aligned with basic IRB guidelines that this study followed, each stakeholder who was approached to participate in this study was given opportunities to refuse to participate in the study. This not only ensured human subject protection but also ensured that the interviews involved only those who were genuinely willing to participate and offer their insight freely. The researcher, who is also an
experienced clinician, used clinical interviewing skills to encourage stakeholders to be open and speak freely when responding to the structured interview questions.

**Established authority of the researcher.** According to Patton (1990), the credibility of the researcher is especially important, as the researcher is the major instrument of data collection and analysis. The nature of the biographical information that should be supplied in the research report is a matter of debate. Maykut & Morehouse (1994) recommended including professional information relevant to the phenomenon under study when engaging with stakeholders. After this researcher reviewed the consent form with the participants, the researcher provided a brief overview of her professional and research related experience related to TDT programming and policy in order to affirm the researcher’s expertise and ability to engage in the research being conducted.

**Dependability**

Guba (1981) proposed that the dependability criterion relates to the consistency of findings. Because many qualitative methods are tailored to the research situation, there are no methodological shorthand descriptions, such as inter rater reliability, commonly used in quantitative studies (Krefting, 1991). The exact methods of data gathering, analysis, and interpretation in qualitative research must be described in detail. Such dense description of methods provides information as to how repeatable the study might be or how unique the situation (Kielhofner, 1982). In addition to a dense description of the methods outlined in this chapter, a case study database and an established chain of evidence were techniques employed by this researcher to achieve dependability.

**Dense Description of the Methods.** In order to address the dependability issue more directly, the processes within a research study should be detailed, thereby enabling
a future researcher to understand the basic methods of the study. Such in-depth coverage also allows others to assess the extent to which proper research practices were followed (Krefting, 1991). This chapter outlined the methods that were followed in the areas of sampling, data collection, and analysis. Such description was provided as a means to achieve dependability.

**Develop case study database.** Yin (2009) suggested creating a case study database during the data analysis process to increase the reliability by organizing the information and documenting what data have been collected. According to Bernard and Ryan (2010), database management consists of records, which are the analyzed unit of analysis (structured interviews, regulations, and fee-for-service data). The fee-for-service data was stored and analyzed in Excel; whereas, the transcribed interviews were maintained in Microsoft Word and the TDT regulations were maintained in hard copy files. A Microsoft Word table was used to ensure all chapters were collected for each fiscal year between 2004-2011.

**Establish chain of evidence.** Lee, Mishna, and Brennenstuhl (2010) discussed the need to be transparent and explicit in how the chain of evidence links interpretations of the data back to the raw data. Similarly, Yin (2009) highlighted that maintaining a chain of evidence allows the researcher to increase the reliability of the case study by linking the case study questions with the findings through several steps. To establish the chain of evidence, the researcher created line numbers within each transcribed interview and regulation. Each of these documents was also numbered. This allowed the researcher to link themes/patterns back to the raw data. Specifically, subscripts were used for each theme/pattern indicating the interview or regulation and the specific line
within the document. Identifiers were created for each study participant and regulation. “I” was used as the identifier for interviews and “R” was used for regulations. A table in chapter four presents these identifiers. The first number within the subscript represents the interview (I) and regulation (R) number and the second number represents the line within the document where the raw data originated. For example, “I1L25”, illustrates that the raw data is can be traced back to the first interview on line 25. The transcribed interviews were maintained in Microsoft Word, a hard copy of the regulations were maintained in file folders, separated by fiscal year, and the fee-for-service data was maintained in Microsoft Excel.

Confirmability

Researchers need to demonstrate that their data and the interpretations drawn from it are rooted in circumstances and conditions outside the researchers’ own imagination and are coherent and logically assembled (Ghauri 2004). By demonstrating this, the researcher is able to conclude the findings are a result of the focused inquiry and not researcher bias. Reference to literature and other scholarly findings has the capacity to confirm the researchers interpretation of the data. There are various techniques that are used to establish confirmability in qualitative research, such as triangulation.

Triangulation. Triangulation of multiple sources of data strengthened the researchers assertions and conclusions. Guba (1985) noted that an investigator should provide documentation for every claim or interpretation from at least two sources to ensure that the data support the researcher's analysis and interpretation of the findings. Chapter three of this dissertation illustrated how the data units were collectively presented when explaining the phenomena of TDT programming and policy (see Table
3.); triangulation specifically occurs when the researcher utilized findings from all three units of analysis to address the study’s propositional questions.

**Objectivity in reflexivity.** Rodwell (1998) discussed the reflexive journal as “the diary of the inquirer’s journey through the project” (p.105), the ideas and connections regarding the data provided by stakeholders and the author’s interpretation of what is uncovered in this case study will be recorded. Along with noting themes and patterns that emerge from the research, journaling was completed to ensure that the researcher remained as objective as possible in the research process. The researcher reviewed and examined the journal after each interview and during each phase of the qualitative and quantitative analysis and when writing chapter five of this dissertation.

**Chapter Three Summary**

Chapter three presented an overview of case study research methodology, which was used to understand how DMAS regulatory changes impacted the implementation of TDT services in the Commonwealth of Virginia. Implementation theory (Elmore, 1984; Paudel, 2009; and Pressman & Wildavsky, 1984) as well as other elements from the literature review informed the development of the propositional questions discussed within this chapter. To ensure adequate depth within this case study, both qualitative and quantitative data were included. A data analysis plan was established. This plan outlined an analytical strategy for each piece of data (unit of analysis) being collected for this study. Techniques for ensuring rigor within this case study were outlined and discussed. Chapter four will discuss the results of the data analysis. Chapter five will include a discussion and interpretation and the results presented in Chapter four.
CHAPTER FOUR

Results

The purpose of this research study was to understand how DMAS regulatory changes impacted the implementation of TDT services in the Commonwealth of Virginia. Multiple units of analysis were collected and analyzed for this study and are presented in this chapter: (a) TDT fee-for-service data, (b) TDT regulatory data captured in Chapters II, IV, and VI from the Community Mental Health Rehabilitative manual guiding the implementation and utilization review of TDT services, and (c) structured interviews with eight key TDT stakeholders. This chapter is divided into six sections, including (a) data identifiers (b) TDT fee-for-service; (c) Department of Medical Assistance Services regulations; (d) structured interviews, (e) propositional questions, and (f) the summary Analysis

Data Identifiers

To ensure greater clarity while presenting the findings, specific identifiers were created for each participant who responded to the structured interviews and for the regulations. Table 4.1 presents the identifiers (reading across the rows) referenced throughout this chapter.
Table 4.1

Data Identifiers

<table>
<thead>
<tr>
<th>Regulation Identifiers</th>
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</thead>
<tbody>
<tr>
<td><strong>Identifier</strong></td>
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<td>R15</td>
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<td>R17</td>
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<tr>
<td>R19</td>
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<tr>
<td>R21</td>
</tr>
<tr>
<td>R23</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Structured Interview Identifiers</th>
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<tbody>
<tr>
<td><strong>Identifier</strong></td>
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<td>I1</td>
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<td>I3</td>
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<tr>
<td>I5</td>
</tr>
<tr>
<td>I7</td>
</tr>
</tbody>
</table>

**TDT Fee-for-Service**

CMS (2012) defines fee-for-service as a system where Medicaid funded providers were paid for each service delivered. DMAS’s Division of Provider Reimbursement collected and maintained all fee-for-service data for the TDT program.

The fee-for-service data was aggregated by month and totaled per fiscal year. This researcher obtained the TDT fee-for-service data for fiscal years 2007-2011 in a
Microsoft Excel file. The sum that DMAS calculated on a monthly basis reflects the total fee-for-services monthly expenditures paid to TDT providers. The researcher requested this fee-for-service data from the Deputy Director of Complex Care at DMAS.

Fee-for-service data for fiscal years 2004, 2005, and 2006 were not available when this researcher made a request and no rationale for the missing data was provided to this researcher. Given this, the TDT fee-for-service data were analyzed for 2007 – 2011, the years that data was available. The researcher analyzed data in Excel, calculating the percentage change in fee-for-service by fiscal year. Findings from the analysis illustrated the following fee for-service fiscal increases and percentage change: 2007-2008 increased by $21,850,967, which was a 49% increase; 2008-2009 increased by $105,858,162, which was a 69% increase; 2009-2010 increased by $32,243,857, which was a 29% increase; and 2010-2011 by $21,155,253, which was a 15% increase. The analysis revealed that the overall increase, between 2007 and 2011 fiscal year grew by $121,108,233.00, which was a 269% increase. Table 4.2 illustrates the fiscal year fee-for-service data for 2007 through 2011.
### Table 4.2

*Annual Day Treatment Expenditures*

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>TDT Fee-for-Service Expenditures</th>
<th>Fee-for-Service Difference by Fiscal Year</th>
<th>Percentage Change between Fiscal Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$44,971,094</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2008</td>
<td>$66,822,061</td>
<td>⬆ $21,850,967</td>
<td>⬆ 49%</td>
</tr>
<tr>
<td>2009</td>
<td>$112,680,222</td>
<td>⬆ $105,858,162</td>
<td>⬆ 69%</td>
</tr>
<tr>
<td>2010</td>
<td>$144,924,073</td>
<td>⬆ $32,243,857</td>
<td>⬆ 29%</td>
</tr>
<tr>
<td>2011</td>
<td>$166,079,327</td>
<td>⬆ $21,155,253</td>
<td>⬆ 15%</td>
</tr>
</tbody>
</table>

**DMAS Regulations**

A comparative textual analysis, as outlined in chapter three of this dissertation, was conducted for the DMAS regulations found in Chapter II (Provider Participation Requirement), Chapter IV (Covered Services and Limitations), and Chapter VI (Utilization Review), of the Community Mental Health Rehabilitative Service Manual. The comparative textual analysis identified differences in content and formatting of the regulations as specified in each of the chapters for each yearly iteration (i.e. 2004 regulations compared to 2005, 2005 regulations compared to 2006, etc.)

The focus of the regulatory analysis was the sections within Chapters II, IV, and VI for fiscal years 2004-2011. Table 4.3 identifies the sections within each chapter of the Community Mental Health Rehabilitative Services regulation manual guiding the implementation of TDT services. The comparative textual analysis for the regulatory data below is presented chapter by chapter.
Table 4.3

Sections within Chapters of the Community Mental Health Rehabilitative Services Regulations Guiding Therapeutic Day Treatment

<table>
<thead>
<tr>
<th>Chapter II: Provider Participation Requirements</th>
<th>Chapter IV: Covered Services and Limitations</th>
<th>Chapter VI: Utilization Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participating Provider</td>
<td>• Service Definition</td>
<td>• Introduction</td>
</tr>
<tr>
<td>• Medicaid Program Information</td>
<td>• Eligibility Criteria</td>
<td>• Compliance Reviews</td>
</tr>
<tr>
<td>• Provider Enrollment</td>
<td>• Required Activities</td>
<td>• Fraudulent Claims (Provider Fraud; Recipient Fraud)</td>
</tr>
<tr>
<td>• Participation Requirements</td>
<td>• Service Unit and Maximum Service Limitations</td>
<td>• Referrals to Client Medical Management (CMM) Program</td>
</tr>
<tr>
<td>• Provider Qualifications</td>
<td></td>
<td>• Utilization Review (UR)-General Requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documentation Required for Community Mental Health Rehabilitative Services and Case Management Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Therapeutic Day Treatment Services for Children Under Age 21</td>
</tr>
</tbody>
</table>
Chapter II: Provider Participation Requirements

Participating Provider. The Participating Provider section in Chapter II defines the requirements to be considered a participating provider in the network that DMAS oversees. Findings from the analysis indicated that there were no changes in this section of Chapter II between fiscal years 2004 and 2011.

Medicaid Program Information. The Medicaid Program Information section outlines DMAS’s responsibility, under Federal regulations, to inform providers of regulatory changes related to the programming the provider offers. Findings from the analysis indicated that there were no changes in this section of Chapter II between fiscal years 2004 and 2011.
**Participation Requirements.** The Participation Requirements section outlines that all providers must adhere to the conditions of participation outlined in their provider agreements. DMAS outlines activities that all providers must engage in. For example, notifying DMAS of any changes in the programming offered (R22,L21-23), ensuring freedom of choice of Medicaid recipients (R22,L23), complying with Title VI of the Civil Rights Act of 1964 (R22,L28), etc. Findings from the analysis indicated that the content within this section remained unchanged between fiscal years 2004 and 2011.

**Provider Qualifications.** DMAS outlines what the providers of Medicaid funded programming must do in order to provide services and receive funding. Such basic qualifications include, the ability to document and maintain individual case records (R22,L76-77), hold an active license with the Department of Behavioral Health and Developmental Services (R22,L85), maintain appropriate staffing ratios to meet the needs of children and adolescents in the program (R22,L87-89), and maintain staffing according to DMAS’s credentialing standards, etc. DMAS’s definition of “licensed mental health professional” (LMHP) refers to a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, a registered psychiatric clinical nurse specialist or a licensed psychiatric nurse practitioner. This definition remained consistent in the regulations from 2004-2011. (R1; R4; R7; R10; R13; R16; R19; and R22)

According to DMAS, a qualified mental health professional (QMHP) refers to a person in the human services who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP, the
person must have the designated clinical experience and must either: (1) be a physician licensed in Virginia; (2) have a master’s degree in psychology from an accredited college or university with at least one year of clinical experience with children or adolescents; (3) have a social work bachelor’s or master’s degree from an accredited college or university with at least one year of documented clinical experience with children and adolescents; (4) be a registered nurse with at least one year of clinical experience with children and adolescents; or (5) have at least a bachelor’s degree in a human services field or in special education. Clinical Experience means providing direct behavioral health services to children and adolescents with mental illness. It includes supervised internships, supervised practicum’s, and supervised field experience. A human services field is defined as social work, psychology, sociology, or counseling. (R19,L.210-223) Prior to 2010, DMAS included criminal justice as a human service field. (R1; R4; R7; R10; R13; & R16). In the definition of human services field, outlined above, criminal justice was not included as a human services field for fiscal years 2010 and 2011. (R19 & R 22) Table 4.4 illustrates this change in chapter II for fiscal year 2010.
Table 4.4

Changes within Chapter II: Provider Participation Requirements

<table>
<thead>
<tr>
<th>Participating Provider</th>
<th>Medicaid Program Information</th>
<th>Participation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Provider Qualifications</td>
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Chapter IV: Covered Services and Limitations.

Service Definition. In 2004, the section “Service Definition” offered a one-sentence summary of TDT services as “psychotherapeutic interventions combined with education and mental health treatment offered in programs of two or more hours per day…” (R1,L1-2). Prior to 2009, iterations of this section only stated “children and adolescents” (R1,L3; R4,L3; R7,L3; R10,L3; & R13,L3); no specific age limit was identified in any iteration of chapter IV for fiscal years 2004 through 2008 (R1, R4, R7, R10, & R13). In 2009, DMAS added that individuals “up to the age of 21” (R17,L5) were eligible “as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service” (R17,L5).

Eligibility Criteria. In the section “Eligibility Criteria”, DMAS outlined criteria that children and adolescents were required to meet in order to be eligible for TDT services. The TDT eligibility criteria outlined by DMAS required that participants must meet two of the three following criteria: (1) have difficulty establishing or maintaining
normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community; (2) exhibit inappropriate behavior that requires repeated interventions by the mental health, social services, educational system, or judicial systems; and (3) exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior (R1, R4, R7, R10, & R13).

In 2005, a portion of the eligibility statement was underlined and bolded “Children and adolescents must demonstrate a clinical necessity for the services arising from a condition due to a mental, behavioral, or emotional illness that results in a significant functional impairment in major life activities are eligible.” (R6,L142-144). The underlining of this content carried through the 2008 regulations; it was not used in 2009 or subsequent iterations of the regulations. The bolding of “mental, behavioral, or emotional illness” continued to be present in all subsequent iterations.

In 2006, an additional statement further clarifying who was eligible for TDT services was added under the Eligibility Criteria Section, requiring individuals who receive TDT services to have the functional capacity to understand and benefit from interventions within the TDT program. DMAS asserted that it was unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria (R8,L137-141). In addition, a statement was added requiring providers to integrate treatment for mental health and substance abuse disorders, specifically when treating a substance abuse treatment would be expected to positively impact the mental health condition (R8,L90-93).
The first eligibility criteria for TDT services states a child or adolescent must “Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.” (R20,L.50-53) Prior to 2010, DMAS did not operationally define “out of home placement”. The 2010 iteration of the regulations operationally defined out of home placement as a group home, regular or treatment foster care, emergency shelter (for child only, due to MH/behavioral problems), psychiatric hospitalization or juvenile justice/incarceration placement. (R20,L.59-70)

In 2010, DMAS added a clarifying description to the eligibility criteria listed above. For example, the second criterion: “Exhibit such inappropriate behavioral that repeated interventions by the mental health, social services, or judicial system are necessary” included the following clarifying statement: “For example, crisis intervention services have been provided, or outside intervention for truancy has been made”. (R20,L.54-56) Additionally, the 2010 iteration further clarified the meaning of “year-round treatment” (R20,L.74), by stating, “Require year-around (9-12 months) treatment…” (R20,L.74).

In addition to meeting two of the three TDT criteria outlined by DMAS since 2004, children and adolescents must meet one of the five additional criteria and child-specific documentation related to the criteria/criterion must be in the medical record. (R20,L.71-73). The following are the additional five criteria: (1) requires year-around (9-12 months) treatment in order to sustain behavioral or emotional gains, (2) behavioral and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without this programming during the school day
or a supplement to the school day or school year, (3) would otherwise be placed on homebound instruction because of severe emotional or behavioral problems, or both, that interfere with learning, (4) have deficits in social skills, peer relations, or dealing with authority; are hyperactive; have poor impulse control; or are extremely depressed or marginally connected to reality, and (5) children in preschool enrichment and early interventions programs when the child’s emotional and behavioral problems, or both, are so severe that he/she cannot function in these programs without therapeutic day treatment services. (R20, L74-93) In 2010, DMAS included italicized language that required providers to document each of these criteria in the medical record for TDT participants (R20).

In 2011, DMAS added the Virginia Independent Clinical Assessment Program (VICAP) to the Eligibility Criteria section. The regulations reference VICAP as both the actual program and the assessment product produced by the program. DMAS required a completed VICAP, conducted by the CSB, prior to the authorization of new service requests for TDT services. (R22, L7-14) An aim of the VICAP was to determine the most appropriate and least restrictive mental health service appropriate for children and adolescents seeking mental health support through Medicaid funded programs. Figure 4.1 illustrates the VICAP process (per R22).
**Figure 4.1**

*TDT Authorization Process - Virginia Independent Clinical Assessment Program (VICAP)*

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Parent/guardian referred to CSB; parent/guardians requests an independent assessment appointment.</td>
</tr>
<tr>
<td>2.</td>
<td>Once the parent/guardian contacts the CSB, the independent clinical assessment appointment is offered within 10 business days of a request for TDT services. Medical transportation may be used to transport the child and parent/guardian to the assessment.</td>
</tr>
<tr>
<td>3.</td>
<td>Independent clinical assessment with the child and parent/guardian is conducted using a standardized format. Recommendations for the most appropriate, medically necessary services, are made if indicated.</td>
</tr>
<tr>
<td>4.</td>
<td>Parent/guardian is informed about the recommended service options and their freedom of choice of providers. If the parent selects a provider, a release will be signed and the independent assessment will be sent to the provider.</td>
</tr>
<tr>
<td>5.</td>
<td>Electronic submission of the independent clinical assessment summary occurs within one business day of completing the assessment KePRO’s (Keystone Peer Review Organization) iEXCHANGE™ system; the assessment document is completed within three business days. The assessment is active for 30 days.</td>
</tr>
<tr>
<td>6.</td>
<td>If community mental health services were recommended, the parent/guardian chooses and contacts a provider. The provider requests a copy of the independent assessment (if provider did not receive a copy from the CSB); the copy is sent to the provider within five business days. Supported by the independent assessment, the service provider conducts an assessment and initial ISP.</td>
</tr>
<tr>
<td>7.</td>
<td>If the provider concurs that the child meets criteria for services, the provider submits a service authorization request to KePRO, a third party authorizer. A copy of the independent assessment must remain in the child’s file.</td>
</tr>
<tr>
<td>8.</td>
<td>If the service provider identifies additional services that may be needed, the provider must contact the independent assessor and request a change within 30 days.</td>
</tr>
</tbody>
</table>
**Required Activities.** The “Required Activities” section bounds and is the essence of the TDT program by outlining activities that providers must engage in to be reimbursed for administering the program. These activities demonstrate the programs alignment with best practice standards in children’s mental health, such as Systems of Care. Findings from the analysis indicated there were numerous changes in this section between 2004 and 2011.

In 2005, DMAS regulations stated that “Services must not duplicate those services provided by the school” (R5,L195). In 2006, the following were additions to the Required Activities section and remained in all iterations of the Chapter IV from 2006-2011 (R8; R11; R14; R17; R20; & R23). As part of mental health case management in the TDT program, providers were required to: (1) refer children to their primary care physicians as needed and engage in coordination of care (R8,L97-100); (2) engage in ongoing medication education as appropriate (R8,L108); (3) collaborate and engage in care coordination with outside service providers (i.e. Department of Juvenile Justice, Department of Social Services, teachers and other school personnel, mental and physical health professionals, etc.) (R8,L108-109); (4) provide weekly family counseling (either in person or by telephone) and facilitate family support in the treatment process (R8,L110-111); (5) create a daily log of services provided including a description of the child or adolescent’s behavior, the staff’s individualized intervention, and the response to the interventions (R8,L113-116); (6) ensure services are provided, at minimum, by a qualified paraprofessional under the supervision of a QMHP (R8,L117-119) and be documented in the clinical record monthly (R8,L120-123); and (7) ensure all treatment planning,
interventions, and treatment documentation is individualized to meet the mental health, social, and emotional needs of the child or adolescent (R8,L124-126)

The 2006 iteration of Chapter IV stated, “If services are billed for time that the staff member is not in the classroom, specific objectives regarding classroom behavior must be identified. These objectives must be included in the Individualized Service Plan.” (R9,L19-21) A case manager who carried a TDT caseload of 6 children was able to bill Medicaid for three units of service (for services provided for an entire academic day) by having the children on his or her caseload implement behavioral based strategies, which addressed specific goals and objectives outlined in the ISP. For example, Johnny and Sue were children on the Mr. Smith’s caseload. Johnny struggled with being able to manage his anger while Sue’s symptoms of depression caused her to be withdrawn in the classroom. A strategy on Johnny’s ISP stated that he would implement a portion of his behavior modification plan by placing a sticker on his behavior chart every time he was able to manage his anger within the school setting. A strategy on Sue’s ISP stated that she would write entries in her journal and share them with her case manager when she experienced feelings of loneliness, helplessness, and/or sadness. Mr. Smith was able to bill for the indirect time that Johnny was using his behavior chart, while he provided direct services to Sue by processing her journal.

In 2010, DMAS removed “indirect time” from this section noting they would only reimburse for direct service activities; time not actively involved in providing services directed by the Individualized Service Plan (ISP) was no longer permitted. (R17,L63-65). DMAS outlined activities that were deemed direct service activities such as: (1) completing diagnostic evaluations, identifying treatment needs; (2) consultation with
teachers and others involved in the individual’s treatment and observation in the classroom; (3) planning and implementing individualized pro-social skills curriculums and interventions; (4) monitoring progress in demonstrating the acquisition of pro-social skills; (5) planning and implementing individualized behavior modification programs, (6) collaboration with school personnel, family, and others involved in the individual’s treatment; (6) responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day, (7) individual, group, and family counseling based on specific TDT objectives identified in the ISP; (8) collaborating with all other community practitioners providing services to the individual, including scheduling appointments and meetings; and (9) medication education. (R17, L67-79)

In addition to indirect time no longer being billable in 2010, paraprofessionals were no longer allowed to provided TDT services, (R20,L71). Only individuals who were qualified mental health professionals (bachelor’s degree with one year of clinical experience with children) or licensed mental health professionals (licensed clinical social workers or licensed professional counselors) were authorized to provide TDT services. (R20, L72-73)

Service Units and Maximum Service Limitations. The Service Units and Maximum Service Limitations section bounds what services can be billed to DMAS for TDT programming, what the services units are, and what the maximum service limits are. In 2005, DMAS added, “Services must not duplicate those services provided by the school” (R5,L195). This statement by DMAS was also included in the Required Activities section of the regulations. There were several changes made within this section in 2006.
In previous iterations, service units were defined as “One unit of service is defined as a minimum of two but less than three hours on a given day” (R2,L186-187;R5L197-198). In 2006, DMAS defined service units as “One unit of service is defined as a minimum of two but less than three hours on a given day. Two units = three hours but less than five hours per day. Three units = five or more hours per day. (R8,L210-212).

In 2008, there was another change in how DMAS outlined the service units. In 2008, under the Service Units and Maximum Service Limitations section, DMAS defined services units as “One unit = 2 to 2.99 hours; two units = 3-4.99 hours; three units = 5 plus hours” (R14,L220-222). This change marks the third change in how DMAS defined service limits since 2004.

Furthermore, in 2009, DMAS restricted the amount of service units providers could bill for by stating, “No more than three units can be billed per day.” (R17,L110) In addition, they noted that a maximum of 780 units per fiscal year could be billed for a child or adolescent in the program. (R17,L111-116)

In addition to the aforementioned changes, DMAS required that TDT participants must receive at least one hour of direct (face-to-face) service per day. The hours of service provision may occur before, during, or after school”. (R8,L213-216). Also, DMAS required that for services billed for time that the staff member is not in the classroom, specific objectives regarding classroom behavior must be identified. These objectives must be included on the Individualized Service Plan (ISP) (R8, L219-221) (Note: This was prior to the 2010 change in the Required Activities section restricting providers ability to bill for indirect services.)
Table 4.5

Changes within Chapter Four: Covered Services and Limitations

<table>
<thead>
<tr>
<th>Service Definition</th>
<th>2004</th>
<th>2005</th>
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<th>2007</th>
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<th>2009</th>
<th>2010</th>
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<td>Service Units and Maximum Service Limitations</td>
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*“X” denotes change in regulations

Chapter VI: Utilization Review.

Introduction. The Introduction section of Chapter VI addresses DMAS’s responsibility, under federal regulations, to review and evaluate the care and services through utilization review of providers. Findings from the analysis indicated that there were no changes in the Introduction section between fiscal years 2004 and 2011.

Compliance Review. Compliance review section addresses how DMAS approaches compliance and utilization review of the TDT program. In 2009, DMAS updated the Compliance Review section to reflect Health Management Strategies (HMS) role in utilization review of TDT services. Prior to 2009, DMAS did not specify what agency would conduct compliance and utilization reviews (R3, R6, R9, R12, & R15). Despite this requirement, DMAS did not fully explicate how HMS would engage in utilization review; it was simply stated that HMS would be the third party reviewer for
Fraudulent Claims. The Fraudulent Claims section of Chapter VI outlines the meaning of the concept fraud (R3,L40). This section further describes the implications of committing Medicaid fraud for providers receiving reimbursement for fraudulent services or fee-for-service billing. (R3,L43-44) There were no changes in this section for fiscal years 2004-2011 (R3, R6, R9, R12, R15, R 18, R21, and R24).

Utilization Review – General Requirements. Within this section, utilization review was defined as “desk audits, on-site record review, and potential observation of service delivery” (R3,L51-52) This section outlined what typically occurred during a utilization review, such as reviewing the appropriateness for admission into TDT, medical necessity of TDT services, provider qualifications, etc. (R3,L56-59) Findings from the analysis indicated that DMAS did not modify this section between fiscal years 2004-2011.

Admission to Services. The Admission to Services section outlined DMAS’s requirement as to whether or not the child or adolescent met criteria for TDT services. (R3,L190) During utilization review, the reviewer from DMAS needed to ensure that the services were authorized by a LMHP. It further specified that the signature and credentials of the LMHP must be clearly documented. There were no changes in this section between 2004 and 2011 (R3, R6, R9, R12, R15, R 18, R21, and R24).

Medical/Clinical Necessity. The Medical/Clinical Necessity section outlined how clinical necessity was established for TDT services. In 2004, the Medical/Clinical Necessity section required that an LMHP sign off on the diagnostic assessment.
However, in 2006 this requirement was rolled into the first bullet point, which outlined that a QMHP or LMHP was able to conduct the initial assessment and subsequently a LMHP would sign off on the assessment to authorize services. (R9,L218-219) In 2010, DMAS required at least a QMHP to complete the assessment and an LMHP to sign off on the assessment. In parentheses, DMAS added, “Note service admission criteria outlined in Chapter IV of this manual.” (R21,L301-303).

**Services Provided by Qualified Providers.** DMAS outlined the steps that providers must take to ensure services are delivered by qualified TDT providers. DMAS noted the provider’s ability to deliver services consistent with the service plan and with fee-for-service expenditures. Findings from the analysis demonstrated no change in this section of Chapter VI.

**Delivered Services Consistent with Reimbursement Received.** This section outlined how DMAS, during a utilization review, determined if the fee-for-service billing coincides with the documentation of services delivered. In 2010, Under the Delivered Services Consistent with Reimbursement Received section, DMAS added, “The reviewer determines that the caseload cannot exceed 6 day treatment clients for the QMHP providing services to the child.” (R21,L355-356) Table 4.6 illustrates the sections that DMAS modified between fiscal years 2004 and 2011.
Table 4.6

Changes within Chapter Six: Utilization Review

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**“X” denotes change in regulations**
Structured Interviews

**Characteristics of Interview Sample.** Structured interviews were used to collect data from two stakeholder groups: provider stakeholders, which consisted of administrators and direct care staff; and, policy level stakeholders which included a DMAS representative and a mental health policy advocate. Provider stakeholders oversee or implement services in various regions of the state, including Central Virginia, Tidewater, and parts of Southwest Virginia, which represent rural, urban, and suburban areas. The DMAS representative and policy advocate oversee Medicaid and policy efforts across the entire Commonwealth. The following individuals participated in the structured interviews: a private for-profit administrator, a private for-profit direct care staff, a private not-for-profit administrator, a private non-for-profit direct care staff, a non-for-profit administrator, a non-for-profit direct care staff, a DMAS representative, and a mental health policy advocate. Stakeholder experience with TDT services ranged from 7-15 years. Collectively, the stakeholders who participated provided a cumulative total of 79 years of service in TDT.

**Thematic Analysis.** As discussed in chapter three, thematic analysis is a conventional practice in qualitative research, whereby this researcher searched through data to identify any recurrent patterns (Creswell, 2009). Manifest themes emerged from the iterative analytic process of identifying clusters of meaning, coding, identifying sub-themes and finalizing the four major themes.

Prior to the data analysis, responses to the structured interviews were digitally recorded and transcribed into a Microsoft Word document. Clusters of meaning were identified within the transcriptions and placed on note cards. The note cards were
organized based upon patterns within the units. The note cards were organized into 17 sub-themes; this was an iterative process where the units were organized and re-organized several times. These sub-themes included: 1) cost, 2) TDT reimbursement rate, 3) unethical practices in direct care, 4) misuse of client information, 5) unethical marketing of the TDT program, 6) greed and fraud, 7) regulatory changes, 8) VICAP, (9) KePRO, 10) TDT regulations, 11) staff qualifications/credentialed, 12) audits/HMS, 13) evaluation, 14) TDT criteria, 15) program efficacy, 16) regulatory oversight, 17) CSB’s and private agencies. Based upon this organizing process, the final four themes emerged: 1) fraudulent practices and misuse of TDT services, 2) regulatory oversight, 3) cost containment, and 4) evaluation. Based upon the manifest content, which implies the use of concrete words and phrases embedded in the raw data, the researcher developed an operationalized definition of each theme.

**Suspected Fraudulent Practices and Misuse of TDT Services.** The theme “suspected fraudulent practices and misuse of TDT services” was defined as activities that providers engaged in that were suspected of defrauding DMAS and/or Medicaid recipients. Almost all TDT stakeholders mentioned or discussed at length suspected fraud and misuse of TDT, particularly between fiscal years 2006 and 2009 (I1; I2; I3; I4; I5; I6; I7; and I8). A stakeholder shared a story regarding inappropriate practices occurring within TDT services:

“There was a lady who called me who was a hairdresser. She called me within months of me stepping into my new position. She was very angry and said that there was a day treatment provider who had not paid her for the services she provided and she wanted to be paid. I asked her what she wanted to be paid
for…this was before our marketing guidelines were implemented. The agency was paying $150 per child to her to enroll kids in the program. She was a hairdresser and owned her own salon. She was furious. She was mad that the agency had not paid her. She had found all of these kids and enrolled them in the program. She was getting truancy reports, which is protected information and illegal. She had a buddy who was a truancy officer in a school system and she went over and paid him for the list. She went and knocked on doors and enrolled these kids in day treatment and then said I enrolled 200 and some children in the program and I want my money and they didn’t pay her. She told me that she wanted her money now and she wanted me to do something about it. I asked her what her qualifications were. She said, well, I have a Bachelors degree in sociology but worked in a hair salon. She was literally going out and diagnosing children with serious behavioral health disorders. I couldn’t even sleep that night after I found out. I’m not saying that many of them were doing it. But there were so many agencies that were engaging in similar practices that had us very concerned. People were horrified…providers were horrified. There are legitimate providers with licensed clinicians who do the right thing. The providers who were engaging in unethical and fraudulent practices were making the good providers look very bad.”(I5,L84–104)

There was significant concern regarding how some TDT providers were marketing their programs. The stakeholder stated,

“Instead of [TDT] providers saying this is a program that helps individuals with serious emotional issues or behavioral issues the program was being painted as
summer camp or an after school program for kids so their parents would not have to worry about them after they got out of school. They were opening going out into communities and cold calling people. They were going into day care centers and homeless shelters. They were obtaining truancy reports from schools systems and enrolling children in mass groups. Children were being signed up for TDT without parents realizing they were enrolled in a mental health program. In the beginning some children weren’t even being given a diagnosis, they were just being enrolled.” (I5,L50-58) “Families were being given iPads, PCs, cash incentives, and food to enroll children in the program. Providers were going in and saying, trust us and yet they were taking advantage of families. It wasn’t all day treatment provider but it was enough that we had to do something.” (I5,L124-126)

The stakeholder went on to say that there were questions being raised by the General Assembly about the need for day treatment services. “The General Assembly was saying, shouldn’t we just shut this down, it seems extremely fraudulent.” (I5,L111) “So [DMAS] found children being misdiagnosed for the sole purpose of providers benefiting financially. Providers were starting and within a year or two were making millions of dollars. [DMAS] actually had to defend the integrity of the service, saying yes it was appropriate and needed.” (I5,L113-116) Additionally, other stakeholders mentioned, “pop up agencies” (11,L198; I5,L214; and I7,L173), which were mom and pop like agencies who quickly began providing services with high profit margins. Several years ago “you could literally go on Craigslist and purchase day treatment in a box. This meant that someone else had written the program description, policies, paperwork, etc and they were
selling it to anyone who would pay…and they were guaranteeing people they could earn one million dollars in a year.” (I3, L139-143) Another stakeholder shared the same story and concern and noted “some start up agencies were making millions of dollars on TDT services within a year or two.” (I5,L115) The consensus among stakeholders was that the agencies engaging in fraudulent practices were making credible and legitimate agencies look poorly (I1,L216;I2,L110-111; I4,L222; and I7,L151). Stakeholders indicated many of these practices, along with rising costs in fee-for-service expenditures, led DMAS to tighten and clarify the regulations guiding the implementation of TDT services as well as develop marketing guidelines. (I5,L48-50;I6,L80-83;I7,L61-64)

**Regulatory Oversight.** Regulatory oversight emerged as a prominent theme within the interview data (I1; I2; I3; I5; I6; I7; and I8). This theme was defined as DMAS’s practice of overseeing providers of TDT using written regulations. The TDT administrator stated that DMAS regulations guiding the implementation of TDT services were “…in essence contract law and an agreement with our providers that stipulate our expectations, when we pay for services, and if the expectations of providers to conduct the services in a clinical manner is met” (I1,L20-22). “To be honest with you our regulations are not that detailed in terms of who can be eligible, what the criteria are, what the documentation expectations are, and also staff qualifications.” (I1,L23-25) The lack of detail was attributed to CSB’s originally being the sole providers of TDT services in Virginia (I3,L29-30). “CSB’s had boards with strict oversight and they [TDT regulations] were written in a fairlygrey manner and were vague to allow for maximum flexibility in service delivery and provision by the CSB’s (I5,L31-34).
“In 2000 when the federal government required DMAS to open services to private providers (SIC). DMAS never really made any changes to the regulations and the vagueness of the regulations led to significant growth in the program with provider being able to interpret the regulations different than our intentions. As a result DMAS had quite a few problems with the program.” (I5,L34-39) DMAS had to do a lot of changes [to the regulations] to ensure that people clearly understood the regulations guiding services (I5,L60-63)

A TDT administrator echoed the prior sentiments and stated, “My opinion…the state did not have the amount of oversight on the services when they exploded and they [DMAS] weren’t able to effectively or efficiently monitor the services.” (I3,L75-77) Similarly, “how the regulations are written and how they are interpreted. When you read the regulations there are not many guidelines or parameters to what the services need to entail. It’s really left up to the agency to determine.”(I3,L41-44)

The DMAS representative addressed the role of the regulations concerning who was able to provide TDT services.

“Part of the problem we had with the services is that they were being provided mainly by individuals without the educational background to provide such an intensive service. I cannot blame the providers. They found a loophole in the regulations and hired staff accordingly. There were some people who had no experience with children what so ever and were going in and working with significantly needy children and that’s the problem we had. You had a whole group of kids who did not necessarily need the services and providers were making a mint by doing that and the services were not really clinical in nature…it
was more like babysitting. Then you had a whole group of kids who did need that level of care and providers were giving babysitting services rather than intensive mental health services because the staff providing the services were not really qualified.” (I5,L134-144) Providers were using paraprofessionals, who are individuals with little to no clinical experience, to work with children with significant behavioral and emotional disorders and had no idea what they were doing. We have clinical examples of children who really did have significant needs and fell through the cracks because the providers who were working with them didn’t know how to do that well. (I5,L149-152)

Many stakeholders welcomed having tighter regulations around provider qualifications (I1; I2; I3; I5; I6; and I7). One TDT administrator stated,

“When we hire staff, making sure they have the qualifications that have been newly defined is really important and has affected who we have been able to hire. Which I would say is a positive change and has brought TDT services to have more qualified staff providing services. Before the regulations were updated, you only had to have a high school diploma and 4 years of experience. (I1,L61-64)

The policy advocate applauded regulatory change focused on staff qualifications and noted, “it required agencies to have staff who had the educational background and experience to provide services to children with intense mental health needs. (I6,L80-82)

Furthermore, the TDT administrator expressed that prior regulations “…made a windfall for less-educated providers to be hired and provide services to children with significant mental health issues.” (I5,L95-96) For example, prior to the 2010 iteration of the regulations, a paraprofessional case manager was being reimbursed approximately $115
for three units of service whereas a physician was being reimbursed $48 for an outpatient office visit. Some stakeholders discussed “benefits to the clinical nature of the program that came along with the increasing provider qualifications.” (I1, L65-66; I3, L70-71; I7, L55-58) Along with the elimination of paraprofessionals in TDT programming, a TDT administrator discussed the impact of having to hire and maintain a staff of QMHP’s, which was required by DMAS in 2010, and stated

“…a catch 22. Having a year of clinical experience with children and adolescents is tough. Some folks graduate with a MSW, have had 2 internships, but might not necessarily have a year of clinical experience working with children. It really limits our pool of qualified applicants because we can’t afford to hire someone who does not have the QMHP credential because no revenue can be collected without devoting significant resources to supervise a QMHP-e. Case managers that are not QMHP’s have to be supervised by a LMHP. These folks are being supervised at the same level as someone working towards licensure. I do not think it’s a bad thing; there just is not enough flexibility. I do not know how agencies are going to keep going; they are eventually going to cave in. If you can only provide training to five percent of graduates at a time, who do not have the clinical experience they need to be a QMHP…well, do the numbers. There eventually won’t be enough workers to provide day treatment. LMHP’s are incredibly difficult to find because of the tightening licensure requirements from the Board of Health Professionals.” (I1, L75-87)
The aim of the regulatory changes has always been to positively impact TDT service implementation (I5,L175-176). The DMAS representative reflected upon the changes that were implemented, saying

“Unfortunately, some of the change we had to make negatively impacted some providers, many of them were really good providers. When the General Assembly sees such tremendous growth in services one thing they assume is that we are paying too much. So, for example, they cut the reimbursement rate for services and it didn’t matter that some providers were heavily using licensed clinicians. They needed that money to pay qualified staff.” (I5,L179-185)

In addition to stakeholders addressing staffing qualification changes that emerged through greater regulatory oversight, stakeholders discussed HMS. Many identified HMS as an agency brought in to assist DMAS with oversight of the TDT program. (I1,L55;I5,L90;I7,L71;I8, & L43-44) According to the DMAS representative, “A great deal of time was spent here making sure the auditing folks [HMS] understood our policy interpretation.” (I5,L15-16) Despite this, TDT administrators (I1 and I3) expressed concern regarding the auditing process conducted by HMS whereby one expressed,

“We have been concerned about the interpretations of the regulations between Medicaid and the auditing body HMS. We do our due diligence; attending Medicaid meetings, stay up to date on new regulations that have been implemented. Then it’s different when they [HMS] come in and audit. Great resources are spent and lost during the process of trying to understand what is required. We have to save everything from DMAS…like Memos, e-mails, and
regulations so you can go back and provide the decisions you made were appropriate to HMS.” (I1,L152-164)

A TDT administrator expressed concerns related to the implementation of the HMS audit within the TDT regulations (I3). This administrator’s concern was focused on the lack of process as well as the outcome of the HMS audit. The administrator stated,

“When I first started to provide day treatment, Medicaid audited our charts. The individuals who came out to audit were there to find deficits but they came from a standpoint of identifying the deficient but also identified specifically how to correct it (SIC). It seemed like they [DMAS] wanted you to get it right. Now, the audits are more or less them [HMS] coming in, requesting charts and then giving you a meeting time to discuss what you owe and how to arrange payment. They don’t even take the time to say how you can correct certain things. They only come in and find what’s wrong and issue penalties for that.” (I3,L140-147)

Findings from the structured interview analysis indicated that there was a mutual understanding between TDT providers and DMAS regarding the TDT audits.

“It’s possible that providers have told you their dissatisfaction with audits. For many years the reviews that were done here were more on quality assurance and was not financially based unless there were significant problems then money was taken back.” (I5,L4-7)

“For many of these providers it was the first time they had been audited, which for many was a very harsh, eye opening experience. It came with its share of bumps on the way with folks getting used to that…” (I5,L13-15) The DMAS representative stated, “The
Division of Program Integrity oversees the HMS contract.” (I5,L2-4) “A conscious effort was made in 2010 when growth of Medicaid programs was growing rapidly to separate policy and programming and auditing to prevent a conflict of interest within the agency.” (I5,L16-18).

While analyzing the structured interview data, this researcher noted in the reflexive journal the frequency that participating stakeholders mentioned or discussed VICAP. Specifically, in 42 pages of transcriptions VICAP emerged approximately 50 times, with every stakeholder discussing the VICAP at length. Many stakeholders expressed collective concerns about how the VICAP process negatively impacted children and adolescents with presenting mental health needs as well as negatively impacted how TDT was implemented. A TDT direct care staff expressed,

“Without thorough auditing by DMAS, agencies were able to engage in highly unethical practices that were likely fraudulent in nature. So, I understand the need for an independent assessment process to increase clinical oversight. However, VICAP really hurt children’s ability to access mental health. I understand that they really needed to make planned changes to TDT, the implementation of this regulatory process really negatively impacted individuals. There weren’t many checks and balances at the time so VICAP served as that oversight process in a way but again accessing services became a huge issue. I really understand the reasoning for it; I was really hoping DMAS would be able to address this issue without limiting access to services. (I2,L100-107)
Two administrators expressed concern regarding CSB’s overseeing the assessment process and how the process was truly not independent and non-biased (I1 and I7). One stakeholder stated,

“CSB’s were directed to oversee the VICAP process. The intent was to ensure the assessments were conducted in a non-biased manner. Well, CSB’s were contracting out some of the VICAP work because the demand was so high. So, qualified individuals in the community were conducting the VICAP assessment. Many of these individuals also worked for day treatment agencies outside of the CSB. It really introduced the issue of boundaries and dual relationships. There was no way it was independent. CSB’s were doing the VICAP’s and also providing TDT. For example, one school that we provide services for really recognized the improvement in the clients we were working with. The school became concerned when the CSB, [who also provided services within the school], had 10 times the amount of clients we had after the VICAP process was introduced. The school provided the families with bright neon colored cards telling the families they had a choice of who would provide TDT services and laid out the assessment process (I1,L97-109)

An administrator expressed some of the struggles they experienced while implementing the VICAP, while also echoing the need for regulatory tightening.

“We saw, like many other agencies, the need for DMAS to step in and address what was happening in TDT. We welcomed the opportunity to support this regulatory process. It was hard though. We are a high volume CSB. We didn’t have the staff to fully implement the VICAP in house. We had to find and pay
community clinician’s to do them for us, in addition to what our staff was doing here. It created a barrier between private agencies and us. So, we get the need, we supported it…it was just hard.” (I7,L99-105)

The DMAS representative captured the essence of the regulatory changes and increased oversight by saying, “Our [DMAS] mantra has been the right care at the right time by qualified providers with positive health outcomes. (I5,L178-179)

The general consensus among some stakeholders was that regulatory changes needed to be made. (I1,L55-58;I3,L90-21, & I6,L101-104) Despite this, some administrators shared some of their struggles with the revised regulatory changes that were implemented over time. One administrator stated, “There have been so many regulatory changes that’s it been hard to keep up. Agencies run the risk of believing they are following the Medicaid regulations, only to find out during an audit that they are not given the different interpretations of rapidly changing regulations.” (I1,L45-51) Another stakeholder focused concern around children and adolescents with presenting mental health issues and expressed,

“In the process of getting the regulations to where they need to be, I think we are going to do a great disservice to many children who are benefiting from the service and may no longer be able to receive it. I feel like children who would have benefited from the services are actually paying the price of agencies that came in and took advantage of the system. Ultimately, we have to get the services and the regulations to a point where agencies can’t take advantage of the most disenfranchised populations out there…children who are poor with mental health needs. So, we need to control agencies that have exploited these
children…I’m just afraid that these children may suffer while these things are worked out. (I3,L150-159)

The DMAS representative acknowledged concerns, as illustrated above, that some providers have by stating,

“Some of the regulatory changes we made over the past 4 years, did it negatively impact day treatment? Our data says no. There was a dip in the growth but day treatment continues to grow, so if providers are saying that the changes and requirements are negatively impacting us, well, the expenditures on the day treatment side do not indicate that. What we have done is strengthen the services in order to justify offering the services. We’ve put things in place that will allow us to say that children who receive the service actually need it. So, if we have auditors go out and are able to say yes, the services being provided are clinically appropriate then that’s great. (I5,L6-15)

Cost Containment. Cost containment emerged as a prominent theme within the interview data (I1; I2; I4; I5; and I6). Based upon the analysis, this theme was defined as strategies employed to contain cost within community-based mental health programming, particularly TDT. While steps were taken prior to 2008 to reign in TDT spending, the election of President Obama pushed DMAS to place an emphasis on cost containment. The DMAS administrator noted, “When the Obama administration first came in there was a huge, heavy focus on Medicaid agencies doing financial reviews, federal oversight became more stringent. (I5,L6-9) With the emphasis placed on reducing spending

“CMS [Centers for Medicaid and Medicare Services], who pays 50% of Medicaid’s fee-for-service expenditures, came in and did an audit because of the
issues that were arising. I would say they were horrified by what they saw. They [CMS] were going to issue an overpayment to us saying you owe us millions of dollars because they found providers littering around in the hallways, waiting for kids to have issues yet they were billing for an entire days worth of services. The regulations once allowed for indirect billing, we have since changed that. We can no longer do that. We can’t pay for someone to wait in the hallway waiting for something to happen, which is what was happening. (I5,L69-77)

In addition to changes within the regulations, a TDT administrator expressed

“DMAS also decreased the reimbursement rate to rein in costs. So, agencies had to have more qualified staff for children with more severe mental health disorders, while accepting a lower reimbursement rate. The impact of these changes was monumental for agencies providing services. The changes create utter chaos. It became more difficult to retain quality staff and increased staff turnover. Agencies were forced to use clinical staff in a different role. Agencies had to manage a staffing curve if you will. We weren’t able to find people who met the requirement. Many of these providers were given 4-5 months, at most, to implement these changes. Agencies were no longer able to focus on providing clinical services because they were trying to keep the lights.” (I1,L75-85)

A TDT direct care staff discussed HMS, KePRO and VICAP as programming efforts to reduce TDT costs. The stakeholder stated,

“Community-based services grew unchecked because DMAS was unable to audit and control the amount of individuals and services, specifically efficacious services, and how many individuals should be providing services. It became
lucrative for individuals to try to get into the business to profit from it. DMAS brought in HMS to try and put a check on agencies to rein in costs and ensure the services they were paying for were legitimately happening and were needed. Then they moved to KePRO, a third party authorizer for TDT, along with other regulatory changes. Then there was VICAP, another checks and balance program further aimed and driving down costs. I think VICAP really hurt Virginia’s ability to access mental health. I understand that they really needed to make planned changes to TDT to reduce costs but the implementation negatively impacted children. VICAP was an attempt to reduce the amount of spending on Medicaid for service delivery. They were able to accomplish this and exceeded their goal to reduce spending. So, wherever they were spending money is where they went back to try and put checks and balances in place.” (I2,L100-115)

Despite some of the concerns expressed by some stakeholders regarding cost containment strategies, the policy advocate participating in this study stated,

“We really supported Medicaid’s efforts to reduce costs associated with waste in community mental health. Hundreds of millions of dollars are being spent on day treatment alone in Virginia. It was important to take a step back and make sure we were spending this valuable money wisely by making sure the money being spent is for children and adolescents who truly need the service.” (I6,L112-116)

**Evaluation of TDT.** The theme “evaluation of TDT” was defined as a process in which TDT providers determine program efficacy (I1; I2; I3; and I5). Between fiscal years 2007 and 2011, $535,476,777.30 fee-for-service dollars have been paid to providers for TDT services as a whole across the Commonwealth. The TDT administrator stated,
“As I have mentioned, we can tell you how much money we have spent, how many people we served. But it would be very difficult for us to tell how individuals are doing after they receive the service. That’s an area we are looking at because we have to go beyond the regulations and evaluate the services being provided.” (I5,L22-26) I hope that you can make recommendations in your study [dissertation] to move the evaluation of TDT services forward (I5,L283-285) The DMAS representative also noted that a formal evaluation [including all providers across the Commonwealth] has not taken place yet “because it’s been such a struggle to get the fraud, misuse, and expenditures under control.” (I5,L300-301) Furthermore, “part of the problem is that we [DMAS] do not require providers to evaluate their services…” (I5,L314-315)” Beyond the fact that evaluations are not required to receive reimbursement, nor is it outlined in the Required Activities section in chapter, “many agencies don’t have the capacity [to evaluate their program] and don’t know where to start with evaluating their programs.” (I5,L328-329) A TDT administrator who engaged in this study noted there was no consensus on how TDT was evaluated because the collective notion was that there was any standard or regulatory expectation. An administrator expressed, “I feel like that [not requiring providers to engage in evaluation work for their program] is a major downfall of the program itself. (I3,L100-101)

Despite DMAS not requiring providers to evaluate their program(s), some stakeholders engage in evaluation research. For example, an administrator laid out a rigorous design for evaluating the program that this stakeholder oversees (I1). The administrator mentioned selecting instruments based upon a literature review that had strong inter-rater reliability and focused on mental health symptoms and improvement over time (I1,L122-123). In addition, the agency’s computer-based records management
system allows them to track children’s progress towards achieving goals on their ISP’s.

(I1,L145-147)

A TDT direct care staff said,

“Funny enough in some areas, schools are driving the quality assurance to understand the effectiveness of the services students are receiving. I say funny enough because the schools do not have any regulatory oversight of TDT, nor do they fund the program. It gets tricky when it comes to collecting data because schools want to focus on SOL scores, attendance, and grades yet therapeutic day is a mental health program, which typically functions in schools. So, are grades and attendance the types of outcomes we should be collecting? Do they have the capacity to illustrate improvement in a child’s mental health? (I2,L160-167)

The consensus among stakeholders, despite limited capacity to do so, was to require all providers to evaluate their program, noting this was a deficit that needed to be addressed (I1; I2; I3; and I5). The TDT administrator noted that Magellan would be taking steps to build a more standardized evaluation model with the input of stakeholders. (I5,L216-218)

**Case Study Propositional Questions**

Seven propositional questions where developed and outlined in chapter two and discussed in chapter three of this dissertation. After the analysis was conducted for each of the units of analysis, the findings were triangulated to answer each propositional question posed for this study.

**Propositional Question One: An increase in the fee-for-service expenditures for TDT services led to DMAS contracting with a third party authorizer.** While no causation can be established between the increase in fee-for-service expenditures and
DMAS’s contracting with a third party authorizer, triangulation of the findings from the structured interview, regulatory, and fee-for-service analyses generally supported this propositional question. The percentage increase in fee-for-service between fiscal year 2007 and 2008 was 49% and 2008 and 2009 was 69%. The PA process was implemented in 2009. Subsequently, the rate of increase slowed to 29% in 2010 and down to 15 % in 2011 (see Table 4.2). Triangulating these fee-for-service findings with the findings from stakeholder interviews further supported this propositional question. Embedded in the theme of Cost Containment, some of the stakeholders believed KePRO’s role was to reduce TDT fee-for-service expenditures and increase oversight of children and adolescents admitted to the program (I2,L77-78; I3,L65-68; I5,L100-102).

Propositional Question Two: The top-down structure of TDT regulation development and implementation has created tension between DMAS and providers of TDT. Findings from the analysis of the structured interviews were mixed in support of this propositional question. On the one hand, the General Assembly dictated many of the regulatory changes, placing them at the forefront as TDT policy makers. This left DMAS to respond to policy mandates by the General Assembly. Findings from the analysis of the regulations illustrated that DMAS’s response was in the form of regulatory changes, such as KePRO, VICAP, caseload limits, rate reductions, etc. Providers of TDT were responsible for implementing the program in accordance with the updated regulations. Despite some degree of frustration, provider stakeholders appeared to empathize with DMAS in terms of how the agency had to balance appropriate oversight of the program in the midst of the tremendous growth with their attempts to justify the integrity of the program to the General Assembly.
A stakeholder stated the House appropriations committee and the Senate finance committee wanted to cut TDT completely and had discussed taking such action when expenditures started rapidly increasing. DMAS had to advocate for TDT at the General Assembly to allow time for DMAS to address the issues within the program. The General Assembly advised DMAS that if the issues were not corrected to their satisfaction the program would be eliminated. DMAS believed it would have been detrimental for children and adolescents who truly needed the service; more children would have been hospitalized. The DMAS representative noted how hard they tried to get things under control while responding to the concerns and worries about regulatory and programmatic changes from the providers. These concerns drove DMAS to work closely with providers. Embedded in the theme of *Regulatory Oversight*, a TDT administrator recognized the struggles that DMAS experienced and said,

“We can’t blame Medicaid because it’s been a juggling act for them as they have responded to the regulatory changes that had to be made in response to the General Assembly. DMAS is usually fairly helpful and tries to support ideas related to optional changes. There are lots of discussion groups with many stakeholders involved. There is not necessarily animosity towards DMAS related to the regulation changes but more frustration and not knowing what’s next.” (I1,L62-71)

Also embedded in the theme of *Regulatory Oversight*, another stakeholder noted DMAS’s willingness to communicate and clarify the updates for TDT providers. They have even sent representatives to meetings and held meetings for agencies to help foster a working relationship. (I7,L82-84) Lastly, another stakeholder shared that a solid
relationship exists because feedback is being heard and the dialogue continues between providers and DMAS. (I2,L_{108-109})

**Propositional Question Three: Budgetary expenditures of TDT were a driving force in creating regulatory changes by DMAS.** In isolation, the analysis of the TDT regulations did not indicate DMAS’s rationale for the regulatory changes that took place between fiscal years 2004-2011. However, triangulating the fee-for-service findings, findings from the regulatory analysis, and the structured interview themes of *Suspected Fraudulent Practices and Misuse of TDT Services, Cost Containment, and Regulatory Oversight* provided support to confirm this propositional question. The fee-for-service analysis indicated a 49% increase in expenditures between fiscal years 2007 and 2008 and a 69% increase between fiscal years 2008 and 2009. Embedded in the theme of regulatory oversight, stakeholders noted all of the regulatory changes that took place between fiscal years 2004 and 2011. Such changes included changes in staffing qualifications (R20 & I1,L_{76-82}), HMS as an auditing body (R20; I1,L_{55}; I2,L_{105}; I5, L_{90}; I7,L_{71}; &I8,L_{43}) KePRO as a third party authorizer (R20 & I2,L_{107}) and VICAP as an independent clinical assessment program (R23; I1,L_{97-109};I2,L_{108-112}, & I7,L_{99-105}). These regulatory changes began in 2009 on the heels of a 69% increase in fee-for-service expenditures. Embedded within the theme of suspected fraudulent practices and misuse of TDT services, several stakeholders indicated that DMAS’s tightening and clarification the regulations was, in part, due to aforementioned rising fee-for-service expenditures. (I5,L_{48-50};I6,L_{80-83};I7,L_{61-64})

**Propositional Question Four: The lack of evaluation research data by providers of TDT in Virginia may be the result of DMAS not requiring such data be**
collected to receive funding. Findings from the interview and regulatory analyses did not fully support this propositional question. While findings from the regulatory analysis indicated there were no requirements within the regulations that DMAS put in place for providers of TDT to evaluate their program, stakeholders who participated in this study discussed engaging in some form of program evaluation. Clusters of meaning embedded in the theme Evaluation Research illustrated much variation in providers’ attempts to evaluate their programs. For example, one provider built an evaluation model that was informed by the literature and selected instruments with well-documented inter-rater reliability used only by master’s level clinicians (I1,L201-203). Data was collected around key areas related to emotional, mental, and behavioral functioning within multiple domains I1,L205-206). Additionally, our evaluation work centers on a behavioral level system, which was specifically developed for our day treatment program. (I1,L201-203). The administrator noted that it was important to understand if the program was effective because “if we recognize something is working, we are able to see that through the data and keep doing it.” (I1,L205-206) Another TDT stakeholder simply stated, “we do collect outcome measures, which focus on three main areas - attendance, grades, and disciplinary actions by the school.” (I4,L50-51). While some stakeholders who participated in this study expressed how they evaluated their programs, the DMAS administrator noted that “part of the problem is that we [DMAS] do not require providers to evaluate their services…(I5,L314-315)” and “many agencies don’t have the capacity [to evaluate their program] and don’t know where to start with evaluating their programs.” (I5,L328-329)

Propositional Question Five: Since 2004, regulatory changes have impacted who is able to provide TDT services. Findings from the structured interview and
regulatory analyses supported this propositional question. Prior to 2010, paraprofessionals were able to provide TDT services to children and adolescents; however, the 2010 iteration of Chapter IV: Covered Services and Limitations authorized only QMHP’s and LMHP’s to provide TDT services. (R20,L102-105) Embedded in the theme of *Regulatory Oversight*, the TDT administrator noted that providers were using paraprofessionals, who were individuals with little to no clinical experience, to work with children with significant behavioral and emotional disorders. There were clinical examples of children who really did have significant needs and fell through the cracks because the providers who were working with them did not have the clinical knowledge to appropriately meet their needs (I5,L149-152). These examples, embedded within the theme of regulatory oversight, demonstrate some of the practices that lead DMAS to revise the TDT regulations that addressed staffing requirements.

**Propositional Question Six: Since 2004, regulatory changes have impacted how services are rendered.** Findings from the structured interview and regulatory analyses support this propositional question. Effective July 2011 DMAS required an independent clinical assessment as part of the service authorization process. (R23,L78-80) The VICAP process fundamentally changed how services were rendered. A TDT administrator noted,

“There was a long waiting period for individuals to schedule VICAP assessments. Many providers were providing services for free, while waiting for approval through VICAP. Agencies were committed to providing services to children who were very ill due to clinical necessity, despite the fact they weren’t getting paid. It would have been unethical to stop treatment. Nevertheless,
providers do not have the resources to continue to do that for long.” (11,L109-114)

Embedded in the themes of Cost Containment and Regulatory Oversight, stakeholders echoed the aforementioned sentiments of the TDT administrator by noting how the VICAP slowed down the enrollment process for the children (14,L103) along with other regulatory changes that impacted how the services were implemented. VICAP in isolation may not have been felt so severely but just prior to VICAP being rolled out; staffing requirements became much stricter. The impact of these changes was monumental for agencies providing services and created utter chaos. (13,L204-209)

Propositional Question Seven: Since 2004, regulatory changes have impacted the severity of clinical presenting symptoms of children and adolescents admitted to the TDT program. Findings from the structured interview and regulatory analyses could not fully support this propositional question. The specific wording of the eligibility criteria for the TDT program, as outlined in the “Eligibility Criteria” section in Chapter IV of the Community Mental Health Rehabilitation Services manual, did not change. As outlined in the regulatory analysis, DMAS further operationalized (i.e. providing examples and making clarifying statements related to each criterion) each criterion for providers in the 2010 iteration of Chapter IV: Covered Services and Limitations (R20), which is a change within the regulations but not to each criterion. Despite each criterion remaining the same, many providers believed that the interpretation of the eligibility criteria changed over time. One stakeholder said, “Since the interpretation of the criteria has gotten stricter by DMAS [and HMS], some children who could definitely benefit from the service are not able to receive the service. We are seeing more difficult cases now.” (17,L44-46) Again, findings from the regulatory analysis indicated that the specific
language and content of each criterion did not change but stakeholders noted that DMAS and HMS interpreted the criteria differently. (I2; I3; and I6). Stakeholders expressed that the severity of the individuals served has increased dramatically since 2008 noting the following differences they have seen in practice (1) The amount of children with hospitalizations and other intense community treatment is extremely high now; (2) A lot of children who would have been in residential placements are now in the community and are being maintained in the local school environments; (3) The severity of the diagnoses has increased and includes Major Depression, Conduct Disorder, and Psychosis; (4) There are many more children with suicidal and homicidal ideations, and severely aggressive, truancy issues; and (5) Before the regulation changes there was some who received the services earlier and needed them for a shorter amount of now. Now, by the time children qualify for the TDT program the situation is very severe. (I2,L193-202; I3,L207-201; and I6,L177-179) Again however, these assertions could not be supported with findings from the regulatory analysis.

Chapter Four Summary

The focus of this research study was to understand how DMAS’s regulatory changes impacted the implementation of TDT services in Virginia. The fee-for-services analysis found that there was a 269% increase in fee-for-service expenditures between fiscal years 2007 and 2011; with the rate of increasing slowing down after 2009 when a majority of the regulatory changes occurred. The analysis of the regulations found DMAS added language to provide greater clarity to the existing regulators. Some of these changes included the implementation of the PA process with KePRO as well as the VICAP. Additionally, staff requirements changed and paraprofessionals were no longer
able to provide TDT programming. Caseload limits were also set for TDT programming.

Four themes emerged through the analysis of the structured interviews. These themes include: 1) Fraudulent Practices and Misuse Of TDT Services, 2) Regulatory Oversight, 3) Cost Containment, and 4) Evaluation. The findings from the analyzing each unit of analysis were triangulated, in an effort to understand the complexity of the case as well as to be able to respond to the propositional study questions posed in this study. Based upon the analysis, four of the seven propositional questions posed by this researcher were supported. Utilizing explanation building, chapter five focuses on the implications of this study.
CHAPTER FIVE

Discussion

This dissertation was intended to understand how DMAS regulatory changes impacted the implementation of the TDT program in the Commonwealth of Virginia. The following seven propositional questions were posed in this study: (1) An increase in the fee-for-service expenditures for TDT services between fiscal years 2004 and 2009 led to DMAS contracting with a third party authorizer; (2) The top-down structure of TDT regulation development and implementation has created tension between DMAS and providers of TDT; (3) Budgetary expenditures of TDT were a driving force in creating regulatory changes by DMAS; (4) The lack of evaluation research data by providers of TDT in Virginia may be the result of DMAS not requiring such data be collected to receive funding; (5) Since 2004, regulatory changes have impacted who is able to provide TDT services; (6) Since 2004, regulatory changes have impacted how services are rendered; and (7) Since 2004, regulatory changes have impacted the severity of clinical presenting symptoms of children and adolescents admitted to the TDT program. This chapter will discuss the findings from chapter four in the context of theory and relevant literature from chapters one and two of this dissertation. Next, the limitations and strengths of this case study are discussed. Lastly, this chapter ends with a discussion of future scholarship in the areas of policy, practice, and research.

Propositional Questions

Implementation theory (Anderson & Sotire-Hussey, 2006; Elmore, 1978; Paudel, 2009; Pressman & Wildavsky, 1984) and relevant literature focusing on policy implementation (Easton, 1968; Fixen, et al., 2005; Friedman, 2003; May, 2003; Palumbo
and evaluation research and program efficacy (Green, Sommers, & Cohen, 2005 and Jackson, Frederico, Tanti, & Black, 2009; and Vernberg et al., 2008) guided the development of the propositional questions. Consistent with Yin’s case study methodology, each propositional question needs to be contextualized within this theoretical literature to complete the analysis and bring a full understanding to the case under study. Below is a discussion of how implementation theory and/or relevant literature address each question.

**Propositional Question One: An increase in the fee-for-service expenditures for TDT services between fiscal years 2004 and 2009 led to DMAS contracting with a third party authorizer.** As reflected in table 3.3 (Units of Analysis Addressing Study’s Propositional Questions), findings from the analysis of the fee for service, regulatory, and interview data generally supported this propositional question. In 2009, DMAS contracted with KePRO, a third party authorizer, to oversee the implementation of the Eligibility Criteria section of Chapter IV: Covered Services and Limitations of the TDT regulations. Stakeholders suggested that the introduction of KePRO was connected to the rise in fee-for-service expenditures, which increased by 49% between fiscal years 2007 and 2008 and 69% between fiscal years 2008 and 2009. After the implementation of KePRO in 2009 the rate of increase of fee-for-service expenditure slowed to 29% in 2009-2010 to 15% in 2010-2011.

Findings from this study supported select research points published by Voices for Virginia’s Children. As documented in the aforementioned paragraph, expenditures for community-based mental health services, including TDT, increased significantly in
recent years, partly due to the decreased used of residential care. For example, in fiscal year 2010 these services for adults and children cost $466.4 million, with services to children comprising 60% of the total (Voices for Virginia’s Children, 2012). The two services with the most explosive growth were intensive in-home and therapeutic day treatment, which accounted for almost 70% of the total spending for community-based mental health services in Virginia. Increased enrollment in the TDT program lead to exponential growth in the number of private providers and provision of services to children who did not need them (Voices for Virginia’s Children); these assertions were supported by the aforementioned triangulated findings. Despite searching in the public domain and contacting a stakeholder at DMAS, the researcher was unable to determine the number of children receiving TDT services before and after the implementation of KePRO.

The introduction of KePRO, a third party authorizer, can be interpreted as a policy strategy implemented by DMAS to ensure greater oversight over the services provided to the children and adolescents admitted to the TDT program. These findings support Easton (1968) and Fixen et al.’s (2005) assertions that strategies to increase policy oversight are employed by policy makers to hold those who are enacting the policy accountable to the policy intent as well as Elmore (1978) and Anderson & Sotir’s (2006) discussion related to effective policy implementation, whereby policy makers allocate tasks and standards that are aligned with and reflect the intent of the policy.

**Propositional Question Two: The top-down structure of TDT regulation development and implementation has created tension between DMAS and providers of TDT.** This question was answered by the structured interview data analysis that
suggested findings were mixed. Top-down theorists identified policy developers as central actors who drive the development and implementation of policy (Paudel, 2009). As a part of implementation theory, the top-down/bottom-up perspective was selected because it is widely accepted within the literature as the primary means to understand the policy development and implementation process (Paudel, 2009). When this study was initially conceptualized, DMAS was identified as the primary policy maker for TDT during the study period from 2004 through 2010 and was considered the main driver of the regulatory changes according to the top-down theorists. Despite being widely accepted in the literature, the perspective does not account for the complex, multilayered bureaucratic process of policy development and implementation that happened in relation to TDT. The study revealed that once expenditures began their rapid ascent, the General Assembly stepped in and mandated changes to bring the spending under control. DMAS incorporated these mandates into the regulatory changes, carried the changes to the providers who in turn were responsible for the implementation. Rather than tension existing between providers and DMAS, originally conceived as the primary policy-maker in this study, this process lead stakeholders to empathize with DMAS because they, the providers, recognized DMAS’s attempts to justify the integrity of the program to the General Assembly while balancing oversight of the program during a time of tremendous growth. Additionally, the General Assembly’s mandates necessitated that DMAS work closely with providers and, in a sense, created an alliance to maintain the program. Stakeholders noted DMAS’ willingness to clarify policy changes and respond to questions related these changes. This is particularly important as it supports Freidman’s (2003) scholarship that emphasizes the importance of relationships between policy
stakeholders. Additionally, Friedman’s work accounts for different levels of policy makers in the policy implementation process, which is a critical tenet that is absent in the top-down/bottom-up perspective.

Collectively, the gaps in the top-down/bottom-up perspective illustrate a potential need for a more comprehensive perspective on policy development and implementation. Such a theory may include basic tenets that suggest: (a) top-down policy implementation is a layered process that may include more than one policy stakeholder at the top and others within the middle of a large system; (b) a formal structure of policy implementation exists with potential open lines of communication between policy stakeholders; (c) there may be an uneven distribution of power and authority between policy decision-makers whereby the chief policy maker maintains central power over any other policy maker within the larger system.

Propositional Question Three: Budgetary expenditures of TDT were a driving force in creating regulatory changes by DMAS. As outlined in chapter four, triangulated findings from the structured interview, regulatory, and fee-for-service analysis supported this propositional question. DMAS functions as a funding source for children’s mental health services, including TDT, in the Commonwealth. TDT is one of the programs through which DMAS implements its mandate to provide high quality and cost effective mental health care, within the least restrictive setting to qualifying Virginia children. After rising costs in fiscal years 2007 and 2008, the number of regulatory changes began to increase to better ensure DMAS could meet its mandate to provide cost effective mental health programs. Several TDT stakeholders interpreted the changes
made to the regulations guiding the implementation of the TDT program as attempts to rein in spending and maintain the clinical integrity of the program.

This finding brings to light Elmore (1978) and Anderson & Sotir & Hussey’s (2006) discussion of effective policy implementation whereby a system of quality oversight control is developed as a means to hold those who are following the policy accountable for the enactment of the policy in practice. Prior to HMS being selected as an auditing body, there was no systematic way to manage oversight of TDT expenditures as a reflection of the actual services being delivered and alignment of the implementation of services with the regulations. In 2010, the introduction of HMS was a regulatory change within Chapter VI of the Community Mental Health and Rehabilitative manual. HMS’s sole responsibility was to 1) ensure providers were enacting the program as DMAS’s regulations intended and 2) issue fee-for-service retracts when providers did not enact the policies as intended.

The VICAP, a component of the TDT regulations, was a policy response (directed by the 2011 Acts of the Assembly) to the “unprecedented growth” in fee-for services expenditures for the TDT program. In addition to addressing growth in fee-for-service expenditures, the VICAP was intended to ensure children and families received the most clinically appropriate services based upon level of need (DMAS, 2011). The intent of VICAP was to better ensure that children and adolescents were thoroughly screened to determine the clinical appropriateness of the TDT program. Additionally, the VICAP was intended to determine if children and adolescents referred for the TDT program met the admission criteria outlined in Chapter IV: Covered Services and Limitations of the Community Mental Health Rehabilitative manual. Similar to KePRO, VICAP was
another policy effort to ensure the TDT program and regulations were being implemented according to DMAS’s intent.

**Propositional Question Four: The lack of evaluation research data by providers of TDT in Virginia may be the result of DMAS not requiring such data be collected to receive funding.** Findings from the structured interview and regulatory and analysis could not fully support this propositional question. Both the TDT regulations and the stakeholder interviews indicate that DMAS does not require providers to evaluate their programs to determine program efficacy. However, TDT stakeholder providers who participated in this study outlined various ways they engage in program evaluation for their specific programs; with findings in chapter four demonstrating the ad hoc nature in which providers are engaging in evaluation research of the TDT program. However, the DMAS representative noted that, while some programs may engage in some level of program evaluation, many TDT providers do not have the capacity to evaluate their programs.

The literature indicates that policy level decisions by political officials and policy makers typically dictate how funds are allocated to community-based mental health programming for children and adolescents and how the allocation of these funds should be linked to evaluation research to support programmatic efficacy (Green, Sommers, & Cohen, 2005). Given that there is no required evaluation mandate and no system wide evaluation approach, the TDT in this case study is not aligned with the literature and national practices (Jackson, Frederico, Tanti, & Black, 2009; Vernberg et al., 2008).

While DMAS documents how much money has been spent on the TDT program and how many children were provided serves they do not have a systematic way of
collecting data that provides information about the actual impact of the program, (i.e. how individuals are doing after they are discharged from the TDT program). The DMAS administrator noted that evaluation is a critical need facing the TDT program as a whole across the Commonwealth (I5,L.22-26) Beginning to develop an evaluation model and bringing the model into the TDT regulations in the form of a regulatory mandate would begin to align the TDT program and regulations guiding the program with national policy and practice standards. In addition to ensuring that the policy (and evaluation mandate) is aligned with national practices, engaging in systematic evaluation research would respond to DMAS’s mandate to provide quality and cost effective mental health services.

**Propositional Question Five: Since 2004, regulatory changes have impacted who is able to provide TDT services.** Findings from the structured interview and regulatory analysis supported this propositional question. In 2010, DMAS regulatory changes required all direct care staff to be a qualified mental health professional (QMHP). Prior to this change, paraprofessionals were able to be direct care staff within TDT programs. There is a notable difference between the educational and experience attributes of a QMHP and a paraprofessional. Specifically, a QMHP is required to have a bachelor’s degree in a human services related field (i.e. psychology, sociology, social work, special education, etc.) and one year of clinical experience working with children and adolescents while paraprofessionals were required to have a high school diploma and four years of clinical experience working with children. Findings from the structured interview analysis indicated that this change was driven in part by DMAS’s concern that paraprofessionals did not have the required knowledge and clinical experience to meet the presenting mental health needs of children and adolescents in the program.
According to the top-down perspective, policy developers specify policy goals and then the implementation of the policy is carried out successfully by strict oversight mechanisms outlined within the policy (Palumbo & Calista, 1990; Younis & Davidson, 1990). Aligned with the top-down perspective, DMAS’s policy decision to restrict who is able to provide TDT services was a strict oversight measure to better ensure that direct care staff have the knowledge and skills to address the mental health needs to children and adolescents enrolled in the program. To ensure oversight of this policy component, HMS (as outlined in Chapter VI of the Community Mental Health and Rehabilitative manual) is responsible for ensuring that providers employ direct care staff with the required educational history and clinical experience outlined within DMAS’s regulations guiding the implementation of the TDT program.

Propositional Question Six: Since 2004, regulatory changes have impacted how services are rendered. Findings from the structured interview and regulatory analyses supported this propositional question. TDT stakeholders placed significant emphasis on the implementation of VICAP as a regulatory change that impacted how TDT services were rendered. As outlined in the discussion of propositional question three, the intent of VICAP was to assess whether or not the children or adolescents met the eligibility criteria outlined by DMAS and, if they met the criteria, to ensure children and families received the most clinically appropriate services based upon presenting clinical symptoms. Several stakeholders noted challenges in navigating the VICAP as well as the complexity associated with enrolling children and adolescents in the program. May (2003) warns about developing complex policy implementation activities because such activities can negatively impact the implementation of the policy. When DMAS
implemented VICAP, KePRO and the initial assessment conducted by providers remained in place. Collectively, these policy components required the following activities before a child and adolescent could potentially be enrolled in the TDT program: (1) seek an independent assessment (VICAP) to determine if TDT was an appropriate service and assess eligibility; (2) if the independent assessment indicates that TDT is an appropriate program, a clinical assessment is conducted by a TDT provider; (3) TDT provider must submit clinical information to KePRO for final authorization to participate in TDT services. Aligned with May’s warning, TDT stakeholders expressed concern regarding the multi-layered admission processing, describing a much slower admission process that was unnecessarily complex for families and providers to navigate.

In addition to VICAP, DMAS made additional changes to the regulations requiring TDT providers to: collaborate with care providers outside of the TDT program; collaborate with the parent/guardian of program participants on a weekly basis; and ensure the individualized service plan and subsequent service provision are delivered in an individualized manner to meet the unique needs of each child and adolescent enrolled in the TDT program. These changes are particularly important given their alignment with the principles of the Systems of Care framework, which is a best practice framework in children’s mental health. The Systems of Care framework requires programs to include the following components: (a) inclusion of families in planning services for their children; (b) integration of cultural competence into children’s services; (c) encouragement of cross-system efforts to meet the range of needs experienced in children (Stroul & Friedman, 1986). Additionally, the Systems of Care framework identifies the importance of mental health programming being flexible and individualized. While some
of the regulatory changes impacting the implementation of the TDT program were seen by some stakeholders as being overly complex, other changes propelled the program forward by following best practice standards embedded within Systems of Care.

**Propositional Question Seven: Since 2004, regulatory changes have impacted the severity of clinical presenting symptoms of children and adolescents admitted to the TDT program.** Findings from the structured interview and regulatory analyses could not fully support this propositional question. The eligibility criteria for the TDT program did not change, however; several TDT stakeholders detailed how they have seen the severity of clinical symptoms (i.e. hospitalizations, acuity of diagnoses and presenting symptoms, etc.) increase since 2004.

While the propositional question was not supported, it is important to note that DMAS operationalized and clarified each criterion regarding admissions in 2010, which was during the timeframe for this study. May (2003) noted the difficulty in following policy when the language embedded in the policy is vague, an issue present with the TDT eligibility criteria prior to 2010. By operationalizing each criterion, DMAS addressed the issue of potentially vague eligibility criteria embedded within the TDT regulations. The apparent need to further operationalize the criteria occurred in a national policy and practice context, which was directing services for children with intense mental health needs to the community rather than residential and in-patient settings.

**Study Limitations**

As with any research study, there are limitations within this study that should be noted. The limitations for this case study are divided into three sections: (a) case study research, (b) structured interviews, (c) fee-for-service data, and (d) retrospective data.
**Case Study Research.** There are four limitations of case study research that pertain to this particular study. One limitation is the limited number of units of analysis included as sources of data, which is described within the subheading of “structured interviews” (Creswell, 2013; Lincoln & Guba, 1985; Yin, 2009). While not the intent of case study research, it is important to understand that due to the nature of case study research, in light of the limited number of units of analysis, findings from case study research are not generalizable. Additionally, scholars acknowledge that case study research represents depth of a phenomenon rather than breadth (Finn & Jacobson, 2008; Jacobson, Pruitt-Chapin & Rugeley, 2009). Lastly, researcher bias is another known limitation of case study research (Yin, 2009). This researcher identified three tests of rigor (credibility, confirmability, and dependability) and followed a protocol with research techniques to ensure these test of rigor were established. Despite this, the potential for researcher bias may persist throughout the research process.

**Structured Interviews.** One of the challenges of the case study methodology is the inclusion of a limited number of participants, which, as previously discussed limits the generalizability of findings from the study. Another well-documented limitation of engaging in structured interviews is the potential interview bias during the data collection phase (Finn & Jacobson, 2008; Jacobson, Pruitt-Chapin & Rugeley, 2009; Russ-Eft & Preskill, 2001). While this researcher selected participants based upon their knowledge of the TDT program and set parameters around who was able to participate, engaging in structured interviews relies on the stakeholders giving accurate and complete answers and the ability to recall critical information, another known limitation of interview data (Breakwell, Hammond, & Fife-Schaw, 1995). Despite this researcher’s purposeful
selection of stakeholders, this limitation is relevant given that data collection occurred in 2013 and stakeholders were asked to recall information between 2004 and 2011.

The researcher purposefully selected stakeholders to participate in the structured interview process; this researcher did not select a Delegate or Senator from the General Assembly to participate in this study. Despite the clearly defined role of the General Assembly in generating policy around children’s mental health presented in chapter two of this dissertation, this researcher did not fully account for the role that the General Assembly had in the directing regulatory changes guiding the implementation of the TDT program. Findings from the analysis indicated that the General Assembly’s role in regulatory change was significant. As a result, not including a member from the General Assembly in the structured interviews is a limitation as this legislative perspective could have re-shaped how some of the findings in this study are presented.

**Fee-for-Service data.** As outlined in chapter three of this dissertation, this researcher requested fee-for-service data for fiscal years 2004-2011. The researcher received fee-for-service data for fiscal years 2007-2011 and was advised that the fee-for-service data for fiscal years 2004-2011 was unavailable at the time of the request. Not including the fiscal data for 2004-2006 did not allow the researcher to capture the full scope of fee-for-service expenditure changes for the time period selected for this study. An additional limitation of secondary data is the inability to determine the data’s accuracy Trzesniewski, Donnellan, & Lucas, (2011). This was applicable to this study in that this researcher was unable to compare billing sheets or electronic billing records with the fee-for-service data received from DMAS.
Retrospective data. The scope of this study covered a seven-year period between fiscal years 2007-2011. With this, participants in this research study were asked to recall and reflect upon policy changes during this entire span of time. While the primary focus of the structured interview questions was on written regulations, stakeholders had to recall regulatory changes that occurred between 2004 and 2011. Furthermore, data was collected in January 2013; a year and a half from the end of the timeframe outlined in the methods, illustrating the limitation of retrospective data since recalling memories from the past may not be accurate (Drake & Jonson-Reid, 2008).

Strengths

While there are limitations of this case study, there are also strengths that should be noted. The following sections highlight the strengths of this case study and are divided into the following three sections: (a) multiple forms of data, (b) rigor, and (c) stakeholder perspectives.

Multiple forms of data collection. One of the advantages of engaging in case study research is the multiple forms of data collected in the research process (Yin, 2009). Both quantitative and qualitative data helped to provide a better understanding of how regulatory changes impacted the implementation of the TDT program. Quantitative and qualitative data were triangulated to provide layers of evidence to support the results of the data.

Rigor. Another strength of this case study was the use of case study research rigor techniques associated with tests of rigor in qualitative research (i.e. credibility, dependability, and confirmability). Given the scant literature base that exists for TDT, it was important to ensure that the methods were dense and a thorough chain of evidence
was established. This allows researchers, policy makers, and practitioners to use the methods outlined in this case study to engage in similar research in the future. Additionally, the chain of evidence allows all findings from the regulatory analysis to be traced back to the original source, which can be helpful in informing future research and policy.

Stakeholder Perspectives. While a member of the General Assembly was not included in this study, the researcher was attentive to ensure that stakeholders selected reflected stakeholding groups that interface with the TDT program. Stakeholding groups represented varying degrees of power from a DMAS administrator to a direct care staff providing TDT services. Additionally, stakeholders covered the three primary regions where TDT services are implemented: central and southwest Virginia and Tidewater.

Implications

Policy. As outlined in the discussion for propositional question two, there is a need for a more comprehensive theory to account for the complexities that currently exist in policy implementation, as the top-down/bottom up perspective does not account for the nested layers of policy stakeholders. This chapter presented tenets that could be utilized by policy implementation scholars to develop a more comprehensive theory to understand policy implementation.

This study illustrated some of the lessons learned based upon findings presented in chapter four. For example, 1) the fiscal and programmatic impact of vague regulations and limited oversight on service provision of the TDT program; 2) the arduous nature of reactionary policy change in an effort to ensure the policy intent to be achieved; 3) the potential negative impact on service provision with the implementation of rapid policy
change directly impacting admission and program delivery; and 4) the fiscal and programmatic impact of allowing both public and private agencies to provide a Medicaid funding program with limited oversight. These lessons learned have the capacity to inform how policy makers develop and implement policy by critically reflecting on DMAS’s experience and how they responded to what emerged related to the regulations and service provision of TDT between fiscal years 2004 and 2011.

Outlined in the discussion related to the fourth propositional question, it is important to consider the role of policy dictating the implementation of evaluation research is critical in future policy development around children’s mental health programming. Due to the fiscal constrains in many local, state, and national budgets ensuring efficacy of mental health programming that is linked to these budgets is critical.

Furthermore, connecting policy and research, it will be important to understand the impact of VICAP as a part of the TDT regulations. VICAP was implemented at the end of the time span covered in this case study. As a result, the full impact of VICAP could not be sufficiently explored. Such impact research could be beneficial in shaping future policy guiding the implementation of TDT program along with other community-based mental health programs in the Commonwealth and in other states that choose to follow the Commonwealth’s model.

**Practice.** This study elaborated on the role that Systems of Care, as a best practice framework, has in community-based mental health. From a direct practice perspective it is important that clinicians and administrators understand the three core values of Systems of Care outlined by Stroul & Friedman (1986). By understanding these core values clinicians and administrators could be more attentive to various aspects of
mental health service provision, including program development and implementation to ensure best practice stands are met.

**Research.** As noted in the policy section, impact research focusing on VICAP is critical moving forward given the impact that VICAP has had on the implementation of the TDT program and the impact on service delivery. Furthermore, as indicated in chapter four, it was the most frequent concept that emerged in the analysis and was one of the most significant policy changes implemented by DMAS. To date, there is no policy research that has been conducted to determine the impact of VICAP on the provision of the TDT program. One of the most significant gaps indicated by this case study is the need for an evaluation model to be developed for all TDT providers to implement to determine the efficacy of the TDT program. The current evaluation research for TDT has been conducted in an ad hoc manner and no large-scale evaluation has been conducted by DMAS. In an effort to propel TDT evaluation research forward, this researcher developed a logic model for the TDT program (see Appendix A). Logic models are frequently utilized in evaluation research (Dykeman, MacIntosh, Seaman, & Davidson, 2003; Fielden, Rusch, Masinda, Sands, Frankish, & Evoy, 2006; Helitzer, Hollis, Hernandez, Sanders, Roybal, & Van Deusen, 2009; Hill & Theis, 2010; Savaya & Waysman, 2008) as they link program components with the evaluation. While there are many ways a logic model can be visually depicted, they are usually presented in the form of a diagram that includes a series of boxes linked by arrows (Savaya & Waysman, 2009). Typically, logic models include the following components: inputs, activities, outputs, and outcomes. Inputs are the human, financial, and organizational resources needed that need to be invested in a program so that it will be able to perform its planned
activities (Savaya & Waysman). Activities are components of the program that are implemented by individuals who work within the program. Outputs are directly linked to specific program activities (Fielden et al., 2007; Savaya & Waysman). Outputs convey what processes should occur when program components are enacted. Outcomes represent the goals that the program aims to achieve. This researcher utilized the TDT regulations, a data source in this study to develop the logic model. Again, the intent of this logic model is to offer a tangible document that can be utilized by DMAS and TDT providers as foundation to develop a comprehensive evaluation model.

**Social Work Education.** The intersection and integration of research, policy, and practice in social work curricula and practice has been widely discussed within the social work literature (Dalton & Wright, 2003; Huphreys et al, 1993; Miller, 1987). Furthermore, Educational Policy and Accreditation Standards (EPAS) published by the Council on Social Work Education in 2008 demonstrated the need to integrate these core areas within all social work courses. Within this study, the General Assembly as a policy making body was a focal point in discussing regulatory change by the DMAS administrator, the policy advocate, as well as TDT administrators. The TDT direct care staff did not discuss the role of the General Assembly, as a policy making body, in the regulatory changes impacting the implementation of TDT. The lack of discussion highlights the potential oversight of direct care staff in terms of linking regulatory changes, some of which significantly impact the service provision of TDT, who the General Assembly as a policy making entity. This is reflective of what has been documented in the literature regarding the limited capacity of select social workers, which engage in clinical practice, to understand how policy impacts their practice. In an
era of increased use of technology and curricula innovation, social work education should continue to identify strategies to allow social work students to fully integrate these areas not only within the classroom but in professional social work practice.

Conclusion

Established in chapter one of this dissertation, research focusing on TDT, as a community-mental health treatment program, is extremely limited. An aim of this case study was to begin to establish a literature base for the TDT program by responding to the primary research question of how DMAS regulations impacted the implementation of TDT in the Commonwealth of Virginia. In an effort to contain rising fee-for-service expenditures DMAS revised and further operationalized the regulations guiding the implementation of TDT. These revisions impacted how TDT providers implemented the program, in areas such as staffing and service delivery. Continued meaningful policy and evaluation research is needed to better understand and establish TDT as a community-mental health treatment program outside of the Commonwealth of Virginia.
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doi:10.1037/0735-7028.23.6.515


DOI: 10.1177/1525822X0101300412


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Appendix A

Logic Model
## Therapeutic Day Treatment Logic Model

<table>
<thead>
<tr>
<th>Resources</th>
<th>Program Components – Interventions Delivered by Day Treatment Staff</th>
<th>Psychological and Social Processes experienced by the Participant in the Program</th>
<th>Interim Outcomes: Program Goals</th>
<th>Long-Term Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct service time</td>
<td>Biopsychosocial assessment/Initial Service Plan completed at intake (thorough assessment of presenting symptoms, support systems, etc.; assess eligibility for the day treatment program; identify an appropriate Axis I DSM diagnosis).</td>
<td>Understanding of presenting behavior and targeted goals, objectives and strategies. This process sets an individual baseline for the participants as they begin working towards targeted behavioral goals.</td>
<td>1. Participants will increase pro-social behavior within their community environments</td>
<td></td>
</tr>
<tr>
<td>Management and Support staff time</td>
<td>Case management focuses on face-to-face behaviorally based interventions (behavior modification) within the classroom and general school environment, crisis intervention (as needed), and coordination with teachers and other school personnel related to progress towards service plan goals.</td>
<td>Provides participants an understanding of pro-social behavior through targeted positive reinforcement and modeling. Increases participants awareness of maladaptive behaviors which can be modified through reinforcement and modeling by the case manager. Participants become aware of the consequences of their behavior. All in an effort to increase overall functioning.</td>
<td>2. Participants will increase pro-social behavior within their school environments (no longer placing them at risk of an out of school placement)</td>
<td></td>
</tr>
<tr>
<td>Equipment (cell phones, computers, printers, paper, ink cartridge, vans, gas)</td>
<td>Psychoeducational (social skill) groups are facilitated daily by case managers and focus on social skill development. Topics include: anger management, problem solving, positive peer relationships, etc. Goal trips are utilized within the level system as a tool to allow participants to implement skills they learn in social skill groups and as a reward for displaying pro-social behavior</td>
<td>Participants have an opportunity to engage collectively with their peers in a group setting; promotes the development and utilization of prosocial behavior while developing skills that are discussed within the group.</td>
<td>3. Participants will increase pro-social behavior within their home environments (no longer placing them at possible risk of an out of home placement)</td>
<td></td>
</tr>
<tr>
<td>Supplies (supplies for social skill groups (i.e. play dough, construction paper, colored pencils, markers, etc.), weekly behavioral incentives purchased by each site, social skill group curricula (elementary, middle, and high school curricula), DSM-Vs, treatment planning books</td>
<td>Medication education is facilitated monthly by day treatment staff to discuss compliance with medicine and side effects.</td>
<td>Participants develop an understanding of medication side effects; relationship between their medication and diagnosis. Participants can explore feelings associated with school, family, and community systems as well as any presenting stressors. Participants can also develop pro-social behavior through the clinician’s use of psychoeducational programming during individual counseling sessions.</td>
<td>4. Participants will increase their ability to establish and maintain normal interpersonal relationships</td>
<td>Participants will no longer require intensive mental health services due to their ability to display pro-social behavior and maintain interpersonal relationships.</td>
</tr>
<tr>
<td>Food (family nights, trainings for employees)</td>
<td>Individual counseling (if deemed eligible based upon need) is held on a bi-weekly basis for a minimum of 30 minutes.</td>
<td>Participants will have an increase in overall academic performance.</td>
<td>5. Participants will no longer require year around treatment to sustain behavior or emotional gains</td>
<td></td>
</tr>
<tr>
<td>Rent for off site location</td>
<td>These components of the program determine how the participant progresses through the program and moves through the level system (4 level behaviorally based system)</td>
<td>Promotes parental involvement and collaboration in treatment planning and implementation. Provides parents with insight into effective strategies to increase pro-social behavior.</td>
<td>6. Participants will have a reduction in overall suspension rates.</td>
<td></td>
</tr>
</tbody>
</table>

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**Therapeutic Day Treatment Logic Model**

**Program Components – Interventions Delivered by Day Treatment Staff**

- Biopsychosocial assessment/Initial Service Plan completed at intake (thorough assessment of presenting symptoms, support systems, etc.; assess eligibility for the day treatment program; identify an appropriate Axis I DSM diagnosis).
- Case management focuses on face-to-face behaviorally based interventions (behavior modification) within the classroom and general school environment, crisis intervention (as needed), and coordination with teachers and other school personnel related to progress towards service plan goals.
- Psychoeducational (social skill) groups are facilitated daily by case managers and focus on social skill development. Topics include: anger management, problem solving, positive peer relationships, etc. Goal trips are utilized within the level system as a tool to allow participants to implement skills they learn in social skill groups and as a reward for displaying pro-social behavior.
- Medication education is facilitated monthly by day treatment staff to discuss compliance with medicine and side effects.
- Individual counseling (if deemed eligible based upon need) is held on a bi-weekly basis for a minimum of 30 minutes.

**Psychological and Social Processes experienced by the Participant in the Program**

- Understanding of presenting behavior and targeted goals, objectives and strategies. This process sets an individual baseline for the participants as they begin working towards targeted behavioral goals.
- Provides participants an understanding of pro-social behavior through targeted positive reinforcement and modeling. Increases participants awareness of maladaptive behaviors which can be modified through reinforcement and modeling by the case manager. Participants become aware of the consequences of their behavior. All in an effort to increase overall functioning.
- Participants have an opportunity to engage collectively with their peers in a group setting; promotes the development and utilization of prosocial behavior while developing skills that are discussed within the group.
- Participants develop an understanding of medication side effects; relationship between their medication and diagnosis. Participants can explore feelings associated with school, family, and community systems as well as any presenting stressors. Participants can also develop pro-social behavior through the clinician’s use of psychoeducational programming during individual counseling sessions.

**Interim Outcomes: Program Goals**

1. Participants will increase pro-social behavior within their community environments
2. Participants will increase pro-social behavior within their school environments (no longer placing them at risk of an out of school placement)
3. Participants will increase pro-social behavior within their home environments (no longer placing them at possible risk of an out of home placement)
4. Participants will increase their ability to establish and maintain normal interpersonal relationships
5. Participants will no longer require year around treatment to sustain behavior or emotional gains
6. Participants will have a reduction in overall suspension rates.
7. Participants will have an increase in overall academic performance.

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**Long-Term Outcome**

Participants will no longer require intensive mental health services due to their ability to display pro-social behavior and maintain interpersonal relationships.
Appendix B

Informed Consent
RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: Understanding the Impact of Regulatory Changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach

VCU IRB: #HM15474

<table>
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<th>ORAL CONSENT FORM: Statement of Research Purposes (Waiver of Signed Consent)</th>
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<tr>
<td><strong>Title of Research Project:</strong> Understanding the Impact of Regulatory Changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach</td>
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| **Investigators:** Mary Secret, Ph.D. (P.I.); Virginia Commonwealth University School of Social Work
Academic Learning Commons
1000 Floyd Avenue, Third Floor
Richmond, Virginia 23284
mcsecret@vcu.edu
(804) 828-2379 |
| Angie Mann-Williams, LCSW (Co-P.I.)
Virginia Commonwealth University
School of Social Work
Academic Learning Commons
1000 Floyd Avenue, Third Floor
Richmond, Virginia 23284
amann@vcu.edu
(804) 283-3273 |

The researcher/study staff named above is the best person(s) to call for questions about your participation in this study.

**VCU Office of Research:** If you have any general questions about your rights as a participant in this or any other research, you may contact:

Office of Research
Virginia Commonwealth University
800 East Leigh Street, Suite 3000
P.O. Box 980568
Richmond, VA 23298
Telephone: (804) 827-2157

Contact this number for general questions, concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk with someone else. General information about participation in research studies can also be found at http://www.research.vcu.edu/irb/volunteers.htm.
If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

**Explanation of Research Project:**

I am conducting a research study as a Ph.D. candidate in the School of Social Work at Virginia Commonwealth University in Richmond, Virginia. The name of the research study is “Understanding the Impact of Regulatory changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach”.

The purpose of this research study is to understand how The Department of Medical Assistance regulatory changes have impacted the implementation of therapeutic day treatment. You have been selected based upon your knowledge of therapeutic day treatment and the regulations that guide the implementation of the program.

After you have had all your questions answered and understand what will happen to you, you can decide to be in this research study. If you elect to participate in the study, you will be asked to verbally consent to participate in this research study. In this study you will be asked to participate in one interview. There will be a total of 8 individuals who will be interviewed for this study. These interviews will not be the sole source of data for the study as regulatory and fee-for-service data are also being analyzed. The interview will last approximately 60-90 minutes and includes 7 questions with prompts. You will be provided a copy of these questions prior to the interview. The interview will be digitally recorded with an audio recorder. Any information you provide will be confidential. This means that while we may publish and share the information about study findings, the data will be aggregated and neither your name nor any identifying information identity will be provided. You can stop answering questions at any point in the interview. Your participation in this study is voluntary. There is no compensation made for your participation in the study. If you wish not to be a part of this study, please inform us so.

Every precaution will be made to maintain confidentiality including the use of different names and generic title (i.e. “A day treatment administrator”) for you constructed by the researcher when discussing the results of the data analysis. The tape recorder will be placed in a secure box that the researchers have access to. Additionally, the transcripts will be saved on a computer that is password protected in a Microsoft Word file. The audio recordings will be erased 3 months after the conclusion of the study. The transcripts of the audio recordings, which include no identifying data, will be maintained in a file on the Co-P.I.’s computer that is password protected.

The subject matter of this research study is unlikely to create any risks or discomfort to human subjects. You are not required to discuss or respond to any question(s) that you are not comfortable responding to.

You may not get any direct benefit from this study, but the information learned from people in this study may help build a deeper knowledge base about therapeutic day treatment in the
Commonwealth of Virginia, which could impact therapeutic day treatment policies and practice. Furthermore, the findings from this study will contribute to the scholarly literature in the area of community and school-based mental health treatment and policy.

There are no costs for participating in this study other than the time you will spend participating in the interview. There is no compensation for participation in the study.

Your participation in this study is completely voluntary and you can choose not to participate in the study. Furthermore, you can also choose to withdraw from the study at any point during the interview.

Do you have any questions about the project?

If you want to talk to anyone about this research project, the contact information of the principal investigator for this study is listed above.

Do you agree to participate in this study?

______________________________________Pseudonym and Title of Study Participant
___________________________________________________ Signature of Investigator
________________________________________Date/Time of Consent Form Agreement

*A copy of this script will be provided to all study stakeholders via electronic mail.
Appendix C

Electronic Mail Script
Date: _____/____/____

Dear ______________,

I am writing to invite you to participate in a research study titled “Understanding the Impact of Regulatory Changes on the Implementation of Therapeutic Day Treatment: A Case Study Approach. You have been selected based upon your professional position and how your position interfaces with day treatment services. The focus of this study is TDT policy spanning seven years, 2004-2011. Participants who engage in this study should have a thorough understanding of day treatment regulations during this time period. I have attached a consent form that briefly explains the study as well as your rights if you chose to participate in the study. Participation in this study is completely voluntary. You can choose not to participate in this study. If you are interested in participating in the study please contact me via e-mail or telephone so a meeting can be set up where I personally review the consent with you. Thank you for your consideration!

Sincerely,

Angie Mann-Williams, LCSW (Co-P.I.)
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Telephone: (804) 827-2157
Appendix D

Structured Interview Questions
Structured Interview Questions and Prompts

1. What is your current position and how do you interface with TDT programming or policy?

2. What is your understanding of the existing TDT regulations and how they guide the implementation of TDT programming?

3. What DMAS regulatory changes have impacted how TDT services are implemented in Virginia?
   - Program changes?
   - Clinical presentation of the population?
   - Staff changes?

4. Guided by DMAS policy, what role do you think the Administrative Services Only (ASO) Model provided by Magellan will have on how TDT is implemented?

5. What do you believe has been the driving force of the TDT regulatory changes since 2004?

6. What, if any, is your understanding of how TDT is evaluated to determine if the program is effective?
   - Type of evaluation conducted? Aspects of the program that are evaluated?
   - Who monitors this evaluation?

6. What is your understanding of the relationship between providers of TDT and DMAS?
   - Impact of regulatory changes on this relationship?

7. What is your understanding of TDT (or similar programming with a potentially different name) policy development and implementation outside of the Commonwealth of Virginia?

8. Is there any additional information related to TDT policy implementation that you would like to offer?
Appendix E

Therapeutic Day Treatment Regulations and Appendix D Tracking Spreadsheet
### Department of Medical Assistance Services Therapeutic Day Treatment Regulations

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</tr>
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</table>
Vita

Angie Marie Mann-Williams was born on February 27, 1981 in Richmond, Virginia, and is a citizen of the United States. She graduated from Salem High School, Salem, Virginia in 1999. She received a Bachelor of Social Work from Virginia Commonwealth University in 2003 and a Master of Social Work from Virginia Commonwealth University in 2004. After receiving her Master of Social Work, she held multiple positions in the area of children’s mental health in Richmond, Virginia. She also spent began teaching as an adjunct faculty in the School of Social Work in 2007.