UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	
Plaintiffs,	
v.	C.A. No. 01-30199-MAP
DEVAL L. PATRICK, et al.,	
Defendants	

Report on Implementation

The Defendants hereby submit this Report on Implementation ("Report") as requested by the Court at the October 14, 2014 status conference, in anticipation of the hearing scheduled for December 22, 2014.

As described in the Defendants' Interim Report submitted on September 26, 2014 and as discussed at the October 14, 2014 status conference, the parties remain focused on four areas of policy and practice. For each area the parties wrote a goal statement and agreed on specific actions for the Defendants to take to achieve the listed goals. This Report describes the status of the Defendants' work in each of these areas. It also reports on the status of data reports the Defendants agreed to provide to the Plaintiffs in the "Disengagement Criteria" document, and reports briefly on other notable developments and activities since the October 14, 2014 status conference.

I. Four Priority Policy Areas

A. Mobile Crisis Intervention (MCI)

GOAL: *Decrease the inappropriate and unnecessary use of Emergency Departments (EDs) as settings for Mobile Crisis Intervention, whether due to program factors internal to the MCI provider or due to the behavior of external referral sources.*

Status of the agreed-upon activities

The Defendants have:

- Hired Kappy Maddenwald, MSW, to review the current performance of MCI providers, with a particular focus on factors influencing the inappropriate use of EDs as settings for MCI encounters. Ms. Maddenwald will begin her work in Massachusetts on January 7, 2014, when she meets with the parties, and will complete her review and discussion of her findings with the parties on or about March 31, 2015.
- Changed the MCI encounter form to collect information about sources of referrals to emergency department (EDs). The new form has been in use since November 1, 2014 and the first data collected from the new form will be available to the parties in mid-January 2015.
- Revised the quarterly MCI Key Indicators Report to report the location of the encounter and the case disposition by age. The first new report, just issued, covers the period of July through September 2014, and reports the data in two age bands: 0-18 and 19-20. The next quarterly report, covering October through December 2014, due in March 2015, will report the data in three age bands: 0-14, 15-18 and 19-20.
- Worked closely with the Department of Mental Health (DMH) to improve the performance of their ESP/MCI programs. MassHealth's Office of Behavioral Health

(OBH) and the Children's Behavioral Health Initiative (CBHI) staff have been working closely with DMH to support and monitor the progress of their work with these programs. DMH hired Ms. Maddenwald to assess and coach the programs and DMH has dedicated significant managerial resources to this improvement effort. The work is ongoing, but the Defendants are seeing improvement in the percentage of MCI visits occurring in the community.[1]

B. Outpatient as a Hub

GOAL: *For children and youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider: 1) regularly assesses the child/youth's need for more intensive care coordination or other remedy services; 2) expeditiously discusses the need for other services with the caregiver; 3) offers to either make a referral to needed services or assist the caregiver to make the referral; and 4) with the caregiver's permission, participates in phone calls and/or meetings with the family and the new provider(s). In particular, if the outpatient provider becomes aware that the youth appears to meet medical necessity criteria for IHT and/or ICC, the outpatient provider must inform the youth's caregiver(s) about these services and offer to help the caregiver access one or both services for the youth.*[2]

[1] The percentage of visits occurring in the community for the Cape and Islands MCI program, which had been performing below other programs, was at 37.5% in July 2014, 29.27% in August and 66.67% in September. The proportion of visits in the community typically dips in the summer and recovers in the fall, but not to the extent reflected in these numbers. The September figure is higher than the goal set by MBPH for FY15 of 60%.

[2] The Plaintiffs' preferred language is: "For children or youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider regularly assesses the child/youth's need for more intensive care coordination or other remedy services. If the youth meets the medical necessity criteria for IHT or ICC, the outpatient provider must: 1) inform the youth's parent/guardian about these services; 2) *make the appropriate referral on their behalf,*

Status of the agreed-upon activities

- The Defendants are working intensively with the Massachusetts Behavioral Health Partnership (MBHP) to complete the report on the Outpatient Study. Data collection and analysis are complete and the written report is in its final stages of revision. It is a complex task meaningfully to weave together the four sources of data on the sample of 50 youth (interviews with caregivers; interviews with clinicians; reviews of the clinical record; analysis of claims data). In addition, it has taken longer than anticipated to analyze discrepancies between the four sources of data on specific youth. The Defendants hope to have the final report available by December 31, 2014, but it may not be available until early January 2015. The parties have agreed to meet shortly after the report is issued to discuss the findings and their implication for practice improvement activities.
- The Defendants are currently working on both the written guidance for outpatient providers and the plan for disseminating the guidance. The Defendants will use the Outpatient Study to inform the guidance and the dissemination plan and expect to complete both tasks by the end of January 2015.
- CBHI staff members Deborah McDonagh and Jack Simons and the CANS team at the Eunice Kennedy Shriver Center at the University of Massachusetts Medical School, (consisting of Philip N. Chase, Ph.D., Professor of Psychiatry, CANS Training Program Director and Nathan Gay, Psy.D., CANS Clinical Coordinator, and support staff), are hard at work on the revision of the CANS training and certification test, incorporating what the teams have learned over the past six years of CANS training

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unless the parent/guardian declines; and 3) with the parent/guardian's permission, participate in phone calls and/or meetings with the family and the new provider(s)."

and certification and best practices in adult learning. They have established an advisory committee of CANS users to inform the revision. The new training program will move beyond teaching clinicians to rate CANS items properly and will emphasize the use of the CANS in daily clinical practice, in the context of the CBHI system of care. This will include orienting clinicians to the various CBHI services, the role of the clinical hubs and the role of CANS in service planning and clinical collaboration. EOHHS projects that the launch of the new training and certification site will be in September 2015.

- The Defendants have agreed to add questions and prompts to the CANS to trigger reassessment of a youth's need for care coordination or other services and prompt the provider to help the family access any needed services. The Defendants have worked with the EOHHS IT team to develop a budget for this enhancement and have included a request for the new funds in its FY16 budget request.[3] If the funds are appropriated by the Legislature, the changes to the form could be implemented by December 2015. Pending completion of the changes to the CANS application, the Defendants will implement the prompts and guidance in a paper form to be included in the clinical chart. The Defendants expect to be able to implement the paper form by June 30, 2015.
- System developers are in the process of enhancing the CANS application to allow clinicians, with the parent/caregiver's permission, to share CANS with other providers and to access CANS prepared by other providers. This critical enhancement is currently scheduled to become operational on February 26, 2015;

[3] The Commonwealth's Executive Office of Administration and Finance must approve the budget prior to sending it to the Legislature for consideration.

however, as in any IT development project, problems can be identified in the testing phase that require additional programming to resolve, often adding two to four weeks to the process.

- The Defendants are currently working with the Departments of Mental Health, Children and Families and Public Health to revise their CBHI protocol documents. The Defendants anticipate completing the revisions of the protocol documents by June 30, 2015.

C. Intensive Care Coordination

GOAL: *Ensure access to ICC for children and youth who meet medical necessity criteria for the service and ensure that ICC providers deliver high-quality ICC services.*

Status of the agreed-upon activities

As described above, the Defendants are taking a number of steps to promote appropriate referrals to ICC from outpatient clinicians.

- The MCEs completed their review of CSAs that had an enrollment of fewer than 75 youth for a period of three months. Five CSAs met this criteria. All cited staffing problems as the root of their low enrollments. They report that when they are adequately staffed and do outreach to referral sources, they get referrals. All continue to have specific plans and strategies in place to increase staffing and enrollment.
- The MCEs also completed their review of CSAs that had one or more Care Coordinators with a caseload of more than sixteen youth for three consecutive months. Three Care Coordinators working for two CSAs met this criterion. In one of

these CSAs there was another Care Coordinator with a caseload of more than sixteen youth for one month. Both CSAs cited staff turnover as factors contributing to temporarily higher-than-usual caseloads. While staff might give two weeks or one month's notice before leaving, it typically took the agency one to two months to hire and train a new Care Coordinator. Both of the staff with higher caseloads in one of the agencies had been offered the option of increasing their caseload in order to increase their billable hours, a practice discouraged by the CBHI ICC Coaches as counter-productive. The parties briefly discussed these reports at a recent meeting and will discuss them in more depth at a future meeting.

- The Defendants are making final revisions to the final SOCPR Report for FY14. The Defendants expect to issue the report in mid-January 2015 and to meet with parties shortly thereafter to discuss the implications of the report for ICC policy and practice.
- There is a new development unrelated to this litigation that has great potential to reduce CSA staffing problems and, perhaps, support higher enrollments. The CSAs have proposed to pilot a day rate for ICC and Family Support and Training (FS&T) in FY16. The Office of Behavioral Health, the MCEs and CSA representatives have created an Alternative Payment Method working group to implement the day rate in CSAs serving approximately one-third of the enrolled population. Under a day rate, the CSAs will be paid a standard amount per child, per day, eliminating the need for staff to distinguish between billable and non-billable activities and to document their work in 15-minute units. Because day rates (as opposed to per-unit billing) can theoretically create a financial incentive to do less work with families, the Defendants will require providers who use the alternative rates to complete two-week time studies

two to four times a year. The CSAs strongly believe that eliminating 15-minute unit billing will significantly increase their ability to attract and retain staff. Having two groups of CSAs on two different payment methods will provide the Defendants an opportunity to learn about the impact of these two methods on ICC and FS&T practice. (The Defendants plan to assess the usefulness of the day rate during FY16, with possible expansion of the pilot to all CSAs.)

D. Clinical Outcomes

GOAL: *Implement a regular cycle of analysis of CANS data to monitor the demographic and clinical characteristics of children and youth using CBHI services and the clinical impact of those services.*

Status of the agreed-upon activities

- The work that the Defendants are doing to improve CANS training and make it more useful in daily clinical practice are strategies to improve the quality of the CANS clinical assessment process and the quality of the resulting data.
- The Defendants are working on the design of the semi-annual CANS reports. The Defendants expect to have a draft available for the Plaintiffs to review in late January.
- Once the new reports are in production, they will be shared with the parties, the providers and the public through the CBHI website.

E. Additional Items from the Disengagement Criteria

- Staff from DMH are working with the Court Monitor and CBHI staff to develop a chart review tool for the Court Monitor and DMH staff to use to review the records of

40 MassHealth-enrolled youth who were discharged from DMH inpatient, Intensive Residential Treatment Programs or Group Homes. The chart reviews are scheduled to be completed in the spring of 2015.

- The Defendants have given the Court Monitor and the Plaintiffs the most recent MCE network management reports for In Home Therapy (IHT), Therapeutic Mentoring (TM), and In-Home Behavioral Services (IHBS), and will distribute these reports to the parties on a quarterly basis. The reports include data on lengths of stay in these services as well as average units billed per month.
- The Defendants have completed the Practice Guidelines for MCI and expect to send them to MBHP to be distributed to the MCI programs next week.
- The Defendants have completed the Practice Guidelines for IHT, which are being formatted by the MassHealth publications unit, with an anticipated distribution to IHT providers in January. In addition, the Defendants have contracted with William Madsen, PhD. and Bonny Saulnier, MA, to conduct two half-day trainings on the IHT Practice Guidelines, delivered in each of five regions. The trainings are directed to the clinical leadership of IHT programs and have the capacity to accommodate two staff from each IHT program. The first set of trainings will be offered in January and February, 2015. The second set will be offered in April and May, 2015. Following the trainings, Dr. Madsen and Ms. Saulnier will provide coaching to IHT providers.
- The Practice Guidelines for TM have been revised and reviewed by the MassHealth Office of Behavioral Health (OBH) and the MCEs. The Defendants expect to send the revised TM Practice Guidelines to the Plaintiffs for review in January.

- The Practice Guidelines for IHBS have been extensively revised by Dr. Jack Simons. However, there is a difference of opinion between the parties about the proper focus for these Practice Guidelines. Generally, the Defendants have taken the position that IHBS providers, as behaviorists, are trained in a well-defined model of care. Consequently, the Practice Guidelines do not need to establish or refine a model of care, but should give the providers further guidance about delivering IHBS services in the context of the CBHI system of care, according to CBHI principles and values. The Plaintiffs have argued that the Practice Guidelines should give more direction to IHBS providers on how to deliver IHBS services. The parties are meeting on January 7, 2015 to attempt to resolve these differences. The outcome of that meeting will determine the timeframe for completing these Guidelines. The parties do not believe that Court intervention on this question is yet ripe, and may not be necessary at all.
- The finished report of the 2013 Clinical Topic Review conducted by Commonwealth Medicine on Behavioral Health Screening Among MassHealth Children and Adolescents will be available within a few weeks.
- FY2015 Massachusetts Practice Review (MPR): In October, the Defendants conducted ten case reviews as a pilot of the new case review tool, an adaptation of the SOCPR for the CBHI system of care. During the day-long debrief that followed the reviews, the reviewers (who included key OBH and CBHI staff and the Court Monitor) came to an unexpected consensus. The pattern of strengths and weaknesses seen in the most recent reviews was familiar: committed staff working in close, respectful partnership with families, working very hard, but too often seeming to miss

key clinical issues impacting the child and family. The Court Monitor has characterized this as "shallow assessment." As discussed during the debriefing, the reviewers came to four conclusions: 1) the reviewers are observing something more than the individual strengths and weaknesses of particular clinicians; 2) the reviewers suspect there are multiple factors producing the phenomenon of "shallow assessment" such as trends in clinical training, clinical record formats, or working in communities with overwhelming levels of trauma and loss; 3) it would be worthwhile to convene IHT clinical leaders to explore this problem, consider what factors are producing it and what might ameliorate it; and 4) the Defendants should take the considerable resources that would have supported the FY2015 MPR and use them to directly address this key quality issue that has been present, to some degree, in all rounds of care reviews. As a result, the Defendants have cancelled most case reviews for FY2015, with the exception of a review of ten children in June, to further refine the MPR tool. Instead of conducting the FY2015 MPR, the Defendants will use the financial and managerial resources for clinical quality improvement activities:

i. Convene IHT clinical leaders to discuss the issue of quality clinical assessments
ii. Conduct focus groups with in-state clinical training program faculty and students to explore how best to support field training for the clinical workforce
iii. Support the work of the Children's Behavioral Health Collaborative, a group of CSAs developing several promising staff training programs. (These programs are described in more detail below.) In particular,

fund additional capacity for trainings and a year-long certificate program for IHT supervisors in *Multicultural Family Therapy for Families with Intergenerational Trauma.*

iv. Engage Kappy Maddenwald to conduct intensive coaching and technical assistance activities with the MCI programs through June 2015.

v. Explore one or two other suggested quality improvement initiatives as well, and finalize the list of projects in January.

- The Children's Behavioral Health Workforce Collaborative (Collaborative) was formed by the Boston-area CSAs. Its mission is to strengthen the CBHI workforce in its capacity to deliver culturally responsive, patient-centered care for racially and ethnically diverse families and to reduce health disparities in Massachusetts. The Collaborative was supported with consulting resources paid for by DMH and CBHI. The Collaborative developed and implemented a community college course for "Community Behavioral Health Workers," targeted to people working as Family Partners, Therapeutic Mentors or Therapeutic Training and Support (TT&S) workers, or seeking these jobs. The first cohort of 19 students graduated in November. [4] The second project was to sponsor two days of training by Dr. Ken Hardy, a renowned trainer and clinician who specializes in training clinicians to work effectively in disadvantaged communities, particularly communities of color. Participants in the trainings asked for more sustained and in-depth training and Dr. Hardy and Collaborative members designed a yearlong training course for IHT supervisors. The Collaborative sought and was awarded two workforce

[4] In the week leading up to graduation, three students were able to leave public assistance because of jobs they got through their class internships.

development grants totaling $400,000 a year for two years. The funds will allow the Collaborative to expand to three other sites in the state: Springfield, New Bedford and Lowell. In each place both the paraprofessional training program and the IHT clinician training program will be delivered. (The funds CBHI will add to this initiative will allow Dr. Hardy to deliver his two-day training for IHT clinicians and TT&Ss as well as his year-long certificate program for IHT supervisors in two additional cities.)

Respectfully submitted,

MARTHA COAKLEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond BBO #559475
Assistant Attorney General
Government Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2078

Date: December 12, 2014

CERTIFICATE OF SERVICE

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General