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**Rosie D. Feature Article June 2012**

***Rosie D.* Turns Five: The Status of Compliance  
Defendants' Semi-Annual Report on Implementation**

The [**Defendants’ Report on Implementation**](http://rosied.org/Resources/Documents/Doc.%20575..pdf) describes in detail all of the Commonwealth's efforts since 2007 to develop and implement a children’s mental health service system built on the *Rosie D.* remedial services. The 112-page report claims that the defendants have “fully complied” with each requirement under the *Rosie D.* Judgment. The defendants also manually filed a CD with 72 documents, such as member brochures, provider educational materials, evaluation reports, and service utilization data to support their claim of compliance.

The Defendants’ Report cites the Commonwealth’s commitment to transform the children’s mental health system, and describes the work of the Children’s Behavioral Health Initiative (CBHI) to implement the key components of that system, including outreach, screening, assessments, service coordination, in-home supports, service utilization, and quality improvement measures. The report highlights quantitative data through the end of 2011 to illustrate the defendants’ progress.

For example, clinicians screened between 81,000 and 92,000 children and youth during each quarter of the 2011 federal fiscal year (October 2010-September 2011). Over 14,000 youth have received Intensive Care Coordination (ICC) since June 30, 2009. Since In-Home Support services were first offered in the fall of 2009, 19,766 youth have had In-Home Therapy, more than 11,500 have had Therapeutic Mentoring, and more than 1,850 have received In-Home Behavioral Services. Inpatient psychiatric hospitalization of youth also has decreased significantly since the implementation of the *Rosie D.* services.

More Mobile Crisis Interventions are occurring in the community, although still far less than envisioned under the Judgment: in November 2011, 57% of MCI encounters occurred in the community, up from 37% in June of 2009. But this still means that nearly half of all youth who need MCI services are being seen in emergency departments.

The defendants also cite ongoing and comprehensive activities to inform providers, families, community groups, advocates, school personnel, and state agency staff about the remedial services and how to access them. Training has been extensive across provider agencies, and thousands of clinicians throughout the Commonwealth have been certified and re-certified to administer the CANS clinical assessment tool. The defendants acknowledge that more training is required to better integrate information from multiple sources into the CANS, as well as using it in treatment planning and for tracking treatment progress.

The defendants concede they cannot yet use the CANS to extrapolate child outcomes, as required under the Judgment. Calling it an “ongoing effort,” they allow that they do “not anticipate simple answers about service impact from the CANS.”

The defendants also acknowledge their data systems cannot track the intensity, frequency and duration of the remedial home-based services as set forth in a youth’s Individual Care Plan, but rather, can only indicate that the youth has utilized the service.

They acknowledge the Community Service Reviews administered by the Court Monitor are helpful tools to learn how care planning teams are developing goals and strategies to implement remedial services. However, the defendants’ report does not discuss the CSR findings, which, at best, indicate that the system is still struggling to fulfill the mandate of the Judgment and to meet children’s needs.

The defendants instead point to proposed and upcoming quality improvement activities to assess progress. For example, they are preparing to use the System of Care Process review to conduct a case review of a sample of children receiving behavioral health services. They also are planning a clinical review to determine if behavioral screens were performed, whether a standardized tool was used, whether follow-up care was recommended, and whether treatment was sought based on the filing of a subsequent treatment claim. In addition, they are planning to conduct a small study of families whose children had positive behavioral screens, but who did not seek or receive a follow-up service, in order to determine what barriers may have restricted their access to treatment. Most of these initiatives are slated for the 2012-13 fiscal year.

**Plaintiffs Challenge Defendants’ Compliance Claims**

In response to the Defendants’ Report on Implementation, the plaintiffs filed their [**18th Status Report**](http://rosied.org/Resources/Documents/Doc.%20578.pdf), which challenges the Commonwealth’s assertions of compliance with the *Rosie D.* Judgment and the Medicaid Act. In their report, filed June 13, 2012, the plaintiffs identify thirteen areas where compliance has not been achieved. They request that the Court instruct the parties to work with the Court Monitor to develop disengagement criteria for each outstanding requirement of the Judgment and federal law.

At the outset, the plaintiffs acknowledge the defendants’ considerable progress over the past five years transforming the children’s mental health system. The plaintiffs cite the defendants’ impressive array of outreach materials, the high numbers of youth who have had behavioral health screens and mental health assessments, and the increasing number of children who have had and are receiving remedial services. They also acknowledge the defendants’ commitment to implementing the Judgment through the CBHI, and single out Emily Sherwood, the compliance coordinator, for her work.

But, as the plaintiffs emphasize in their report, progress is not the same as compliance. In order to relinquish its jurisdiction over the *Rosie D.* case, the Court must first find that the defendants have fulfilled all their obligations set forth in the Judgment, and are complying with EPSDT and other relevant portions of the federal Medicaid Act. In addition, the Court must determine that the defendants have put in place a durable remedy so that the violations which led to the lawsuit – notably, failure to promptly provide home-based services to children with serious emotional disturbance (SED) – are not revisited.

The Judgment, which incorporated a Remedial Plan, sought to ensure that Medicaid-eligible children with SED receive home-based services with the requisite frequency, intensity and duration, as set forth in each child’s Individual Care Plan. It also required that the defendants collect data which demonstrates their compliance with this mandate. But as the defendants concede in their Report on Implementation, their data collection system does not track frequency, intensity and duration of services. Moreover, the defendants acknowledge they do not have outcome data required to demonstrate they are meeting the core purpose of the EPSDT mandate: providing services that correct or ameliorate disabling conditions. As the plaintiffs underscore in their Report, without such critical data and outcomes, it is impossible for the Court to determine compliance with EPSDT requirements.

In addition, the plaintiffs contend it also is premature for the Court to disengage from this case because the defendants thus far have failed to demonstrate compliance with 10 provisions of the *Rosie D.* Judgment. The plaintiffs maintain there is “compelling evidence” the system is not yet in compliance regarding follow-up screenings, assessments, and the delivery and coordination of certain services, including Intensive Care Coordination and Mobile Crisis Intervention. Also, they maintain there is insufficient evidence – and in some cases, no evidence – that substantial compliance has been realized in areas such as crisis stabilization, performance standards, data collection and youth outcomes.

For example, on average, only about 25% of youth with positive behavioral health screens receive follow-up services – undermining the EPSDT mandate for prompt treatment to correct or ameliorate disabling conditions. Only half of all youth receiving CBHI services, especially those treated by outpatient providers, have a CANS assessment – a mental health evaluation to inform and guide treatment services. Moreover, the defendants had intended to use the CANS to evaluate the impact and effectiveness of home-based services, but they now contend they will need several years of data to conduct such an analysis. In addition, they have absolutely no data on crisis stabilization services, which were just initiated on May 31, 2012.

Indeed, contrary to the Judgment, the defendants have not established a “defined scheme for monitoring success,” including child-specific outcomes, provider-specific outcomes and system-wise practice outcome measures. The only child-specific measures come from the Court Monitor’s Community Service Reviews (CSRs). As the Plaintiffs’ 18th Status Report points out, the CSR findings from 2010 to 2012 indicate significant problems in the delivery of remedial services. The CSR findings, based on hundreds – if not thousands – of interviews with families, providers, community service agencies and other collaterals throughout the state, suggest that many youth are not benefiting from remedial services and are not projected to improve over time. The Report also concludes that the children's mental health system itself is not functioning at an adequate, never mind optimal, level.