UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Western Division

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

DEFENDANTS' INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the December 10, 2015 status conference, in preparation for the hearing scheduled for March 4, 2016. The Defendants hereby report as follows:

Since the last status conference, the Defendants, the Plaintiffs and the Court Monitor met twice, on December 17, 2015, and on January 5, 2016, and had one conference call on January 28, 2016. The parties discussed issues related to CSA access and enrollment, Outpatient as a hub, and the progress of various projects.

In this report the Defendants follow the convention of their prior reports, in which disengagement activities are organized under main headings with associated goals.

I. Mobile Crisis Intervention ("MCI")

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

As stated in the Commonwealth's last status report, on November 13, 2015, staff from MassHealth attended a statewide meeting of Mobile Crisis Intervention providers, convened by the Massachusetts Behavioral Health Partnership (which oversees the statewide network of Emergency Service Programs[1]). At that meeting, providers said that materials produced and disseminated by MassHealth would be more influential than currently existing provider-produced materials; subsequently, MassHealth has begun planning with a marketing consultant and budgeting for a public information campaign to inform families and referrers of the benefits of using MCI. This plan is expected to go forward in FY 2017 contingent upon the availability of funds.

It may be helpful for the Court to understand the frequency and intensity of oversight of MCI by MBHP. MBHP convenes meetings with ESP/MCI program directors on a statewide basis monthly, for 2 hours, with representatives from other MCEs joining during the second hour. A representative of the Office of Behavioral Health also attends these meetings. Regional ESP/MCI meetings with MBHP occur on a monthly or bi-monthly basis. Individual Network Management meetings occur monthly or bi-monthly. The rate of recurrence of these meetings is

[1] MBHP's process to procure ESPs in the Southeast region is still in process. Whether the current state-run programs will be privatized and the timetable on which this occurs depends on the State Auditor's privatization review currently in process. *See* M.G.L. c. 7, §§ 52-55.

based on volume of ESP or performance/quality concerns. Regardless of frequency of meetings, every ESP receives a detailed data packet containing quality indicator data and other monthly data pertinent to its ESP. These data include MCI response time indicators and percentage of MCI visits occurring in the community. ESP/MCI also receive quarterly data reports including Length of MCI Intervention Episodes and Key Indicator data for all ESPs.

Regarding improved use of data, MBHP will also begin to share with providers a report designed by Kappy Madenwald, a national expert on Mobile Crisis Intervention, who worked extensively with the parties to evaluate and address concerns about, among other things, the location and duration of MCI encounters. The Maddenwald report indicates the distribution of MCI Length of Encounter, rather than just the mean length of encounter (which providers already receive on a quarterly basis). Ms. Madenwald developed the report because it helps to show whether the MCI team is individualizing the use of the 7-day follow-up option (good practice), versus giving each family a standard follow-up (poor practice). This will be an annual (fiscal year) report. In addition, MBHP will discuss the pre/post MCI report (designed by the Court Monitor and produced by MassHealth) at an ESP statewide meeting in the spring of 2016.

Regarding outreach to referrers, in 2015, the Office of Behavioral Health began meeting with the statewide Director of the School-Based Health Center Program at the Department of Public Health (DPH), with a focus on improving Health Center staff knowledge of CBHI and staff's ability to collaborate with CBHI services, including Mobile Crisis Intervention. DPH supports 33 such centers across the state, mostly in communities where youth are at greatest psychosocial risk. It was the impression of the Director, based on anecdotal information, that many centers were calling ambulances for students with Behavioral Health crises, rather than

calling MCI (School-based health centers do not systematically gather data on this, however). In October, CBHI facilitated a presentation by the Director of the Worcester-area MCI program to a statewide meeting of School-Based Health Center Staff (approximately 100 attendees). Health center personnel were eager for this information. At a subsequent meeting, the Lawrence-area MCI director presented to behavioral health clinicians from the School Based Health Centers. DPH is following up with a pilot training of school personnel from multiple buildings in one district (Lynn) by Kappy Madenwald, which is intended to improve school-based crisis planning and will likely further enhance collaboration with MCI. This training in the spring of 2016 will be jointly sponsored by MassHealth and the Children's Behavioral Health Knowledge Center (CBHKC) at the Department of Mental Health (DMH).

One example of positive outcomes from CBHI outreach to school districts in the past year has been that one large urban school district, which historically prohibited MCI from intervening on school property, has reversed its stance and now invites MCI into its school buildings for delivery of crisis services.

At the last court hearing, the Court suggested that the parties evaluate whether any of the disengagement activities had reached a point that they no longer required ongoing attention by the Court. Defendants respectfully suggest that MCI has reached this point. In light of the Defendants' active and systematic engagement with MCI providers and ongoing quality improvement efforts in MCI, Defendants believe that MCI has matured into a strong and viable program that can reliably identify and address future and ongoing issues. For example, reduction of the percent of visits occurring in emergency departments will be an ongoing focus of the Office of Behavioral Health. Defendants believe, however, that continued Court reporting and

ongoing litigation over MCI will divert Defendants' efforts from direct quality improvement activities, where the shared goal is clear and the mechanisms to reach that goal are already in place. Therefore, Defendants respectfully request that the Court consider removing MCI from the list of required topics for further status reports.

II. Outpatient (OP) as a Hub

GOAL: For children or youth receiving outpatient therapy but not receiving In-Home Therapy (IHT) or Intensive Care Coordination (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 parent or 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]

[2] As noted in previous reports to the Court, this is the Defendant's formulation of the appropriate goal for outpatient-as-a-hub. 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, 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)." (Emphasis supplied.) As the underscored language makes clear, the parties' lingering dispute turns on whether an outpatient clinician should (a) refer a child/youth to an ICC

This subject is addressed in detail in Defendants' memorandum to the Court on Outpatient as a Hub, filed contemporaneously herewith. Briefly, MassHealth continues to work to strengthen Outpatient as a hub, in the belief that Outpatient can serve this purpose very well for a substantial subgroup of class members, and that the system depends on the capacity of the OP system to service the large numbers of youth (Class members) in need of care coordination.

Many of the ongoing quality improvement activities for OP have been previously described by Defendants, including:

- Development of an entirely new CANS training and certification program, which should help outpatient providers understand more fully their functions as hub providers. Defendants now expect this new program will launch in March, 2016.[3]
- Requiring OP providers to discuss ICC as an option for families with a child who meets Medical Necessity criteria for ICC, a requirement that was instituted in December 2015. The assessment of need for ICC must be documented within 30 days of the initial visit, and at six-month intervals thereafter.
- Development of a brief educational video about ICC for parents and providers. The raw video footage has been shot for this project and is currently being edited. The video should be available in spring 2016.

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or IHT provider at the direction of a parent or caregiver who has been briefed on the benefits of those services and whom the outpatient clinician has offered to help in making such arrangements ; or (b) make that referral as a matter of course upon finding that the child/youth meets the medical necessity criteria for the service, unless specifically directed not to do so by the parent or caregiver.

[3] This is a change in schedule from February of 2016, the date that was previously reported.

- Finalization of *Guidelines for Outpatient Therapy as a CBHI Clinical Hub*. Defendants expect to finalize this document by the March 4, 2016 status hearing and are developing a plan for dissemination and implementation, including assessing results through review of OP records by MCEs in FY2017.
- Revising state agency protocols. As previously reported, this has proven to be challenging, due to loss of staff in sister agencies. MassHealth is examining alternative plans for communicating the needed information to state agency staff regarding referral of youth to CBHI services.

III. 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.

This item relates to a long-standing concern of Plaintiffs regarding what they believe to be underutilization of ICC. Defendants are not convinced that ICC is severely underutilized, but agree that it is important to ensure that families of children who meet medical necessity criteria for CSA services are well informed about those services, and that they have easy access to them. Defendants are concerned that workforce shortages described in previous status reports continue to affect MassHealth providers; the difficulty has been apparent longest and most acutely in ICC. In order to better understand the factors affecting CSA access, Plaintiffs suggested at the meeting of the parties on November 16, 2015, that the parties should jointly examine data on CSA quality, caseloads and enrollment level to see if any patterns emerge that may influence access. The parties met with the Court Monitor on January 5, 2016, to review available data on CSAs. Unfortunately, the parties could not agree on seeing meaningful patterns in the data. Plaintiffs

expressed concern that some CSAs have wait lists due to poor management. Of course it probably is true that CSAs vary in the effectiveness of their management practices; the question is whether that variation, or other factors, is the root cause of access problems.

Defendants stated that Technical Assistance Teams from the Managed Care Entities (MCEs) meet regularly with CSA managers to review key indicators (such as wait times and number of children waiting) and to develop strategies to address access issues. Plaintiffs noted that they have no direct knowledge of what happens in TA meetings. Defendants understand that this is true, and in response have undertaken two steps to better illuminate the TA process.

First, MassHealth requested copies of development plans from 13 CSAs that Plaintiffs have noted had a 13-month average above the 14 day standard for average wait times (all CSAs have Quality Improvement Development Plans that are discussed with their TA teams). All but one of the CSAs had goals relating to increasing staffing and decreasing wait times. (The one CSA that did not address access in its goals had at the time the plan was written no youths waiting except by choice.) All plans listed multiple strategies for dealing with understaffing and for reducing wait times and supporting children and families while waiting. Most also addressed other issues related to staff turnover such as methods of training new staff and bringing them quickly to a level of competent practice.

Second, because Defendants recognize that written plans do not always signify real concern or action, staff from Office of Behavioral Health (Jennifer Hallisey, Laura Conrad, and Jack Simons) are scheduled to attend upcoming TA meetings for all 13 of the CSAs identified by the Plaintiffs. Defendants are undertaking this effort to observe more directly how access issues

are being addressed by TA teams. Defendants believe this will permit them to address Plaintiffs' concerns more fully.

Currently, aggressive hiring by the Department of Children and Families (DCF) is creating intense competition for MassHealth providers, with DCF offering salaries around $10,000 higher than MassHealth providers offer. Defendants are hopeful that the DCF hiring pressure will ease in calendar 2016. Defendants are also optimistic that the Alternative Payment Methodology (APM) pilot currently underway at 10 CSAs will reduce stress for CSA staff Care Coordinators by removing the need to track productivity in 15-minute units, aiding in CSA hiring and retention. Finally, a rate increase for CSAs went into effect on January 1, 2016, which may allow CSAs to offer more attractive salaries.

IV. 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.

Defendants are still at work on Chapter 2 of the CANS outcomes data analysis. A brief preview of the results of the analysis using the Reliable Change (RC) methodology was offered to the Plaintiffs at a meeting of the parties on December 17, demonstrating that very little change appears in the outcome data when the RC methodology is applied. Staff shortages at the Office of Behavioral Health have required Defendants to prioritize other activities, as described in this report. Defendants will produce the report from which these data were extracted by the end of March 2016.

V. Additional Items from the Disengagement Criteria

MPR case reviews and reports

The Defendants completed the first full wave of 40 case reviews using the new Massachusetts Practice Review (MPR) protocol in October, 2015. (Pilot reviews with the MPR occurred in October 2014 and June 2015). Defendants will conduct 120 case reviews in state fiscal year 2016, with additional waves in March /April and May /June, 2016. Brief reports on each wave of reviews will be produced three months after the reviews are completed, with a final, comprehensive report produced in the fall of 2016. To maximize reliability and efficiency, the Commonwealth has selected a smaller pool of reviewers than in the past, each of whom has committed to performing a relatively large number of reviews over the course of the year.

The report on the October 2015 review is nearly final and may be available by the hearing date of March 4, 2016. This wave consisted of IHT cases only. Although scores from the MPR are not comparable to scores from prior case review protocols, there was consensus among experienced reviewers that much of the progress they expected to see by IHT providers has not materialized. Areas of concern include assessment, service planning, care coordination, family therapy interventions, and managing transitions. Exemplary and good practices occur often, but fair, poor, and adverse practices all occur more often than Defendants consider acceptable. Staff turnover and hiring of relatively inexperienced clinicians appear to be factors compromising quality. This has led MassHealth to prioritize interventions that can help improve IHT practice, especially for early-career clinicians. The Commonwealth's activities to this end are described below under Strengthening IHT.

DMH Chart Reviews

The Department of Mental Health (DMH) continues to work with the Court Monitor, with MassHealth's expert consultant Carol Gyurina, and with the Office of Behavioral Health on characterizing and selecting cases for review by the Court Monitor.

IHBS Guidelines

IHBS Guidelines have been issued by MassHealth and will be presented by staff from the Office of Behavioral Health at the IHBS Statewide meeting convened by the MCEs on February 26, 2016. MassHealth will discuss with IHBS providers how the Guidelines should be disseminated and implemented.

Guidelines for Outpatient Therapy as a CBHI Clinical Hub

As mentioned previously, Defendants expect to finalize this document by March 4, 2016, and are developing plans for dissemination, implementation, and assessment of how the guidelines are used. This will likely include reviews of OP charts by the MCEs.

Strengthening IHT

While strengthening IHT (with the exception of developing and disseminating IHT Practice Guidelines) is beyond the scope of disengagement activities, the Defendants in their status reports have repeatedly mentioned this as an important quality improvement goal. Defendants have previously reported on training and coaching activities already undertaken to strengthen IHT, and described in the last status report a plan to develop a Practice Profile for IHT, along with appropriate implementation supports. In consultation with the National Implementation Research Network (NIRN), MassHealth and the Children's Behavioral Health

Knowledge Center held a full-day kickoff meeting on November 16 with a representative group of IHT providers and other stakeholders, including the Court Monitor. This meeting has been followed by a series of half-day working sessions, typically with 25 to 30 IHT supervisors and other stakeholders, including the Court Monitor, to discuss and arrive at consensus on best practice, developmentally acceptable practice for numerous facets under each of nine core elements. The list of core elements and schedule for working on them is as follows (future dates subject to change):

Core element	**Date (2016)**
Engagement	January 13th
Cultural relevance	January 13th
Assessment & clinical understanding	January 27th
Safety planning	January 27th
Collaborative treatment planning	February 3rd
Care coordination	February 3rd
Practicing Cultural Relevance, 2nd work session	February 10th
Engaging natural supports	March 2nd
Preparation to end treatment	March 2nd
Intensive family therapy	March 23rd

IHT providers have given their time to this project in abundance. All sessions have been productive, and the level of consensus about fundamentals is, to date, remarkable. Although some stakeholders have expressed concerns that the practice profile will turn into additional administrative demands on providers, most feedback is strongly positive. Providers welcome the chance to clarify IHT and to develop implementation supports for practitioners and supervisors. Providers generally acknowledge that the IHT workforce is relatively green and in need of much support. Defendants believe that the success of CSAs provides evidence that implementation supports such as training, coaching and fidelity assessment can help IHT programs to achieve a consistent level of quality in both treatment and care coordination. The work of developing the practice profile will go into the spring, with an initial profile available around June. The profile will then undergo testing at numerous IHT sites; lessons learned from those test cycles will be incorporated into the profile in the fall of 2016. In the meantime, MassHealth will be developing a plan for implementation supports during the spring of 2016, to be launched in FY17. Defendants are currently budgeting for IHT implementation supports (such as training and coaching) in FY17 and will pilot some additional training in FY16.

VI. Emerging Workforce Issues Affecting Access and Quality

Defendants have alerted the Court in previous reports to concerns about workforce trends that affect both access and quality of services. Some of the evidence giving rise to these concerns is quantitative, such as waitlists for services. Some of the evidence is qualitative, consisting of provider descriptions of increasing difficulty in hiring (first ICC staff, and then IHT clinicians, and more recently Bachelor's Degree-level staff). Newspapers now report shortages of skilled workers in many industries. Although lacking definitive data, Defendants suspect that

a large-scale change is underway in the workforce. While Defendants will not be able to fix these issues alone, Defendants believe this issue deserves attention, data collection, analysis, and thoughtful intervention in areas that are susceptible to intervention.

The Office of Behavioral Health, in collaboration with the Children's Behavioral Health Knowledge Center at DMH, has begun to plan to engage stakeholders around children's behavioral health workforce issues. On March 3, MassHealth and CBHKC will meet with national expert Michael Hoge PhD, to learn about his work with the Annapolis Coalition on Behavioral Health Workforce Education and in behavioral health workforce development in Connecticut.

MassHealth and CBHKC have also begun meeting with stakeholders regarding understanding and acting on workforce issues. The pipeline that produces skilled and resilient clinicians is a long one, and intervention might be designed at various points along that path. Straight pipeline models may, furthermore, be inadequate for understanding workforce solutions in an era of team-based care. Plaintiffs have described a positive experience using paraprofessionals to extend the reach of attorneys in performing legal advocacy. Defendants agree with this creative approach. Defendants believe that the most effective responses to workforce challenges will involve many stakeholders – including providers and their trade and professional associations, graduate training programs and their national accrediting bodies, state licensing boards, insurers (including MassHealth and its MCEs) and consumer organizations. While the workforce pipeline is a broad and complex system, MassHealth intends to continue its efforts to intervene, where it can, to expand the universe of clinicians available and willing to deliver remedy services.

Respectfully Submitted,

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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.

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