UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,

Plaintiffs,

v.

DEVAL L. Patrick, et al.,

Defendants

C.A. No.
01-30199-MAP

Defendant's 16th Report on Implementation

The Defendants hereby submit this Report on Implementation ("Report") pursuant to paragraphs 37(c)(i), 38(d)(i), 39(c)(i), and 47(b) of the Judgment dated July 16, 2007 in the above-captioned case ("Judgment"). This Report covers the period since March 21, 2014 and focuses on (1) discussions with Plaintiffs on key concerns, (2) progress on various activities including Practice Guidelines, System of Care Practice Review (SOCPR), CANS implementation, and the study of Outpatient as a "hub", and (3) status of other deliverables.

1. **Discussion with plaintiffs regarding key concerns**

During this reporting period the parties have engaged in productive discussion on four key areas Plaintiffs identified as needing improvement. These areas include: (1) Mobile Crisis Intervention, with a particular focus on the percentage of visits occurring in community based settings and the reasons therefor; (2) "hub" functions for youth with SED in Outpatient treatment; (3) ICC capacity and the need to ensure that youth who need ICC receive it; and (4) measurement of

clinical and functional outcomes to be used for quality improvement going forward. Plaintiffs produced memoranda on the first three topics identified, above, reflecting their concerns and recommendations; these were discussed in what Defendants would characterize as robust and productive meetings of the parties and the Court Monitor on May 16 and May 19, 2014. Defendants believe that the parties' interests are significantly aligned, and that the Defendants' proposed plan, submitted to the Plaintiffs on June 10, 2014, is responsive to the Plaintiffs stated concerns. In that proposal, the Defendants identified certain concrete steps they are willing to undertake in response to concerns raised by the Plaintiffs, as part of a potential global agreement among the parties to terminate the monitoring phase of this litigation. (Many, but not all, of the steps proposed by the Defendants mirror proposals made by the Plaintiffs in their memoranda.) Monitoring and reporting are currently scheduled to end on December 31, 2014, and, provided that Plaintiffs and Defendants ultimately reach consensus as to the further steps that need to be taken, the Defendants believe that no further modification of that date should be necessary. This link (i.e., tying the proposed activities to a consensual termination of monitoring) was part of the Defendants' June 10 proposal, but has not yet been discussed by the parties.

To follow is a synopsis of the plan that the Defendants proposed:

A. Plaintiffs requested activity designed to decrease the use of MCI occurring in the ED and increase community-based interventions to fixed percentages.

In response, Defendants propose to:

1. arrange a meeting of the parties, the Court Monitor and Kappy Madenwald to, among other things, identify and discuss potential barriers to achieving higher rates for community-based service delivery and, if appropriate, to explore whether there are reasonable additional

quality improvement steps that might be employed to decrease the number of visits occurring in EDs -- especially in regions where ED rates trend higher than average; and

2. direct MBHP to revise the electronic encounter form providers complete and submit to MBHP following each MCI encounter. The new form will capture information on how the family was directed to the ED, if the encounter occurred in an ED. This information will help The Defendants better understand the paths that lead to ED encounters, to help devise interventions that will alter those paths in cases where ED encounters are inappropriate. This change will require changes to provider IT systems.

In addition:

3. The Defendants are already revising the reporting tool used to collect provider-specific data on the location of MCI visits (ESP community-based location vs. ED vs other mobile location), and the disposition (hospital vs CBAT vs remaining in community), so the results will be broken out by age of youth. Because incidents of medical need due to injury or overdose tend to increase with the youth's age, and the age composition of populations served may vary by geography, this adapted tool will enable Defendants to isolate providers who conduct a disproportionate percentage of MCI encounters (given the average age of the population they serve) in an ED setting; and

4. DMH is working to increase the use of community-based services for DMH-operated teams, with a focus on the ESP that covers the Cape and Islands. The Cape and Islands ESP is currently located in Pocasset, which is not geographically central to the demand in the region it is serving. DMH has been working to secure a new location in Hyannis and

estimates that a move will occur in 2015. DMH has engaged Kappy Madenwald as a consultant, and has been working with her for several months, to ensure that the DMH-operated teams maximize community-based encounters. The contract with Ms. Madenwald runs through FY15.

B. Plaintiffs want the Defendants to ensure that Outpatient providers treating members, who are not also receiving IHT or ICC, provide adequate assistance to obtain other appropriate remedy services, and also provide coordination of the member's supports and services.

In response, Defendants propose to:

1. require an OP provider to describe IHT and ICC to families when the youth is eligible to receive them, and offer to assist the family to get the services;

2. add questions to the CANS to prompt providers to assess whether the child and family need a higher level of care coordination, and whether they need other BH services;

3. remind providers that they are required to provide the CBHI brochure on at least an annual basis, since educating members and families about the available services can facilitate conversations between the members and their providers;

4. conduct a second iteration of the "OP as hub" study that was conducted last autumn, to clarify the current level of performance of OP as a hub;

5. redesign the CANS training and certification process to include material on the array of remedy services, on the role of referral and care coordination in all hub levels, and on the

use of the CANS for informing service need and for clinical collaboration. The Commonwealth has discussed this expanded training approach with John Lyons (the designer of the CANS tool) who strongly supports it. In response to provider requests, the Defendants are revising the consent process to facilitate the sharing of CANS data among clinicians working with a member, including OP clinicians (whether or not they are the hub); and

6. revise the CBHI Interagency Protocols, to include a focus on the obligations of service coordination, social work, and case management staff where youth have only out-patient therapy as their clinical hub. Defendants anticipate these revisions will occur in 2015.
    a. In addition:
7. In May, MassHealth managed care reminded OP providers how to bill for collateral contacts and case/family/bridge consultations (bridge consultations are for discharge planning meetings held in inpatient or CBAT). In addition, MCEs are engaged in QI activities with OP providers around hub functions; and
8. As of May 2014 the Defendants will not pay an OP provider for an assessment if the CANS is not completed.

C. Plaintiffs expressed a number of concerns about ICC staffing, volume, utilization and caseloads and requested the Defendants to engage in certain quality improvement activities.

In response, Defendants propose to:

1. determine the number of unduplicated members who have received ICC, to clarify how many children have received the ICC service;

2. add questions to the initial section of the CANS assessment tool to prompt providers to assess whether the child and family need a higher level of care coordination, and whether the child and family have a need for other BH services;

3. identify CSAs with enrollment of fewer than 75 members and direct MCEs to investigate whether enrollment under 75 is associated with, or due to, practices that need to be improved through increased program visibility with schools, state agencies, day care providers, after school programs and other agencies in the communities they serve, or through other means;

4. examine whether enrollment in some CSAs is unusually low when adjusted by DCF case numbers for the same geographic areas;

5. include in revisions to CBHI Interagency Protocols, a focus on the obligations of service coordination, social work, and case management staff where youth have only out-patient therapy as their clinical hub; and

6. direct MCEs to provide CSA-level caseload data and to review practice in CSAs with higher caseloads.

D. Plaintiffs want Defendants to collect outcomes data and use it for ongoing quality improvement.

In response, Defendants propose to:

1. use CANS to track clinical and functional outcomes; and

2. monitor changes in the first three CANS domains (functioning, symptoms, and risk factors), tracking change at the item level and at the domain level, and using the Reliable Change Index methodology for change at the domain level.

In addition:

The Defendants have quality improvement plans for the CANS tool including a new consent procedure, new training and certification, and clinical reports, and improving CANS practice at the individual and program level continue to be top priorities.

2. Progress on other activities

(a) Practice Guidelines (Part IV of Disengagement Criteria):

Plaintiffs requested changes to the guidelines for Mobile Crisis Intervention (MCI); the author, Kappy Maddenwald, has responded and the version with her changes has been sent to Plaintiffs for final review. Guidelines for In-home Therapy (IHT) have been sent to Plaintiffs for review. Guidelines for Therapeutic Mentoring and In-home Behavioral Services will be completed over the summer.

(b) System of Care Practice Review (SOCPR – Section I #5, Section II #1, and Section V #4 of Disengagement Criteria):

The Commonwealth has now completed the planned cycle of five waves of case reviews using the SOCPR, and has issued reports for these regions: Boston / Metro, Northeast, and Central. Reports for the two remaining regions are in process and will be followed by a year-end summary. The logistics of the SOCPR training and review process have been continually refined over the

year; the Commonwealth will make content revisions to the protocol over the summer. The process will continue to evolve with an emphasis on efficiently gathering data that support an active quality improvement process, and on long-term sustainability of the SOCPR process in an environment of limited resources. The tool will be renamed Massachusetts Practice Review, to reflect the many ways in which the tool has been tailored to Massachusetts' unique system of care. The plan for next year samples IHT only (not ICC), since past reviews indicate a greater opportunity for improvement in IHT; this also permits the Defendants to reduce the total number of cases from 120 to 72, freeing up time and resources required for protocol revisions. During FY15 Defendants also plan to develop an improved method for assessing interrater reliability, and new approaches to using SOCPR findings in quality improvement activities with providers.

(c) CANS (Section V #2, Section III of Disengagement Criteria)

As of May 1, MassHealth MCEs deny payment to outpatient providers who bill for a diagnostic assessment without completing a CANS evaluation. This is expected to have a significant impact on CANS compliance in the outpatient level of care. The monthly rate of enrollment of new organizations in the Virtual Gateway for the CBHI application has approximately doubled since this policy was announced to providers.

Work continues with the UMass Medical School CANS training team on revising the CANS training and certification process, emphasizing the use of the CANS in the context of remedy services including "hub" services. This revision offers an excellent opportunity to ensure that clinicians, including outpatient clinicians, fully understand the "hub" function and responsibilities.

Defendants met with John Lyons, developer of the CANS, on June 6, 2014, to discuss various aspects of CANS implementation including approaches to system-level outcome monitoring which will be implemented on an ongoing basis.

Work progresses on IT modifications which will allow providers, with caregiver consent, to view and copy CANS produced by other providers; this modification should go into production around the end of calendar 2014 and will increase the capacity of CANS to be a tool for clinical collaboration among providers working with a particular youth.

(d) **Study of Outpatient as a hub** (Comprehensive Outpatient Study – Section I #6 in Disengagement Criteria):

Work has continued on the new study of Outpatient as a hub, involving MBHP and Consumer Quality Initiatives (CQI, the consumer-run organization that will interview caregivers), with great attention having been given to the design of the interview protocols and chart review tool. Caregiver and clinician protocols have been piloted and a number of caregiver interviews have been conducted. The Defendants have shared the protocols with Plaintiffs. Defendants have been told that the study will be complete by no later than December 5, 2014, but are pressing CQI for an earlier end-date.

3. Other Data Requests in Part V of the Disengagement Criteria

Status of other data requests from the Disengagement Criteria document dated June 14, 2013 is detailed in the table below.

No.	Criterion	Description	Status	When expected
Section 5, #1	% of youth with a + screen who receive follow up BH services within 90 days of the screening	MassHealth's Primary Care Clinician (PCC) Plan collects this data point and shares it with large primary care providers.	For the period of April 1, 2013-Sept 30, 2013 the rate of follow up BH services was 49.74 %	The next cycle will be available after October 2014.
Section 5, #2	CANS compliance data	MassHealth receives reports from each of the MCEs on CANS compliance by service.	See Attachment A for FY 2014, Q2 (Sept-Dec 2013) data. The CANS Billing in Outpatient summary was shared with Plaintiffs and Monitor June 6, 2014	FY 2014, Q3 data anticipated in September 2014.
Section	WFI/TOM	Measure of ICC teams	FY 2013 report provided to	FY 2014 report

5, #3		adherence to principles of quality Wraparound and facilitation of Wraparound process.	Plaintiffs and Monitors in Dec 2013.	anticipated September 2014.
Section 5, #4	SOCPR Reports on ICC/IHT	Commonwealth case review process of IHT from June 2013-May 2014.	Plaintiffs and Monitors received Boston Metro report in November 2013, the Northeast report in February 2014, and the Central Report in June 2014.	The Southeastern report will be available July 2014 and the Western Report will be available in September 2014.
Section 5, #5	MCI Pre/Post Report	BH service utilization prior to and following an MCI encounter,	Last report covering FY 2014, Q1 (July-Sept 2013) provided April 25, 2014	FY 2014, Q2 data anticipated in July 2014.
Section 5, #6	CBAT Length of Stay (LOS)	MassHealth receives reports from each MCEs on average LOS in CBAT.	Delays from the MCE prevented the reporting of this data in the March 2014 Court report. For FY 14, Q1 (July-Sept) –see table below	FY 14, Q2 data available September 2014.
Section 5, #7	MCI Length of Encounter (LOE)	MassHealth receives reports from each MCE setting out the average length of encounter (LOE) in MCI	FY 2014, Q2 (Oct-Dec 2013): Average LOE in MCI was 2.29, 1.9, and1.91 days in the three larger health plans and 2.1, 1.6, and 2.27 days in the three smaller health plans.	FY 2014, Q3 data anticipated in Sept 2014.
Section 2, #2	Length of stay in IHT, TM and IHBS	Youth receive other remedial services with the intensity and duration their conditions require	The IHT Key Indicator that report covered FY 2014 Q1 (Jul-Sept 2013) and was provided in Feb 24, 2014. MBHP is in the process of revising the format of the IHT Key Indicator report IHT report which is delaying the delivery of this data.	MBHP does not currently produce reports showing length of enrollment in IHBS and TM.

The average length of stay (LOS) in days in CBAT, broken out by age, is presented in order of largest to smallest MCE:

	A	B	C	D	E	F
0-12 yrs	19.1	7.5	10.8	14.3	10.6	0
13-18 yrs	17	6.3	8	5	5.1	7 (1 user)
19-20 yrs	0	1	10 (1 user)	0	1	0

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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