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

Affidavit of Emily Sherwood

I, Emily Sherwood, hereby depose and state as follows:

1. I am the Director of Children's Behavioral Health Interagency Initiatives for the Massachusetts Executive Office of Health and Human Services (EOHHS), and as such, I serve as EOHHS' Compliance Coordinator for implementation of the judgment in the above-captioned matter.

CHRONOLOGY OF THE DEFENDANTS' DISCUSSIONS WITH THE COURT MONITOR ABOUT THE COMMUNITY SERVICE REVIEW

2. During the spring of 2009, the parties and Ms. Karen Snyder discussed "processes for monitoring the progress of implementation as well as tracking key outcome indicators as the system matures." [1]

[1] Memorandum from Karen Snyder to Steven Schwartz and Emily Sherwood, June 28, 2009, "Development of Quality Management Process," page 1.

3. By the fall of 2009, the Monitor had spoken with various experts in system performance measurement and settled on using the Community Service Review (CSR) as a primary method "to gain knowledge about how well the system is performing for class members, and whether or not they are benefiting from the actions of the State."[2] The CSR is a proprietary survey tool, developed by Human Systems and Outcomes, Inc. for "(1) appraising the current status of a youth identified with special needs (e.g., a youth with a serious emotional disorder) in key life areas, (2) status of the parent/caregiver, (3) recent progress made by the youth, and (4) performance of key system of care practices for the same youth and family."[3][4] I did not review versions of the CSR that had been used in other states, since the Monitor informed us that she would be convening a multi-stakeholder group to develop a version of the tool specifically to review Intensive Care Coordination and In-Home Therapy. This group, referred to as "the CSR design team" by the Monitor, was to include state agency clinicians and managers, provider clinical managers, family advocates and expert consultants.

4. During the last quarter of 2009 and the first quarter of 2010, our work related to the CSR focused on supporting CSR implementation by: 1) working with the Monitor on overall logistics planning; 2) informing internal stakeholders about the CSR process; 3) recruiting

[2] "Measuring Practice Requirements Specified in Rosie D. et. al Judgment," Design Team Working Paper, prepared by the Court Monitor in January 2010, page 1.

[3] Community Service Review, Human Systems and Outcomes, Inc., 2010.

[4] Upon information and belief, at least in one state, a substantially similar version of the CSR has been referred to as QSR (Quality Service Review).

and freeing up state staff to participate in the two and a half day CSR Design Team session; and 4) developing and testing methods for selecting samples of children and youth whose cases would be reviewed.

5. The CSR Design Team met during the first week of February. Following those meetings Kelly English, Ph.D., LICSW, MassHealth's Office of Behavioral Health's participant on the Design Team, reported to me her concerns with the draft CSR. She stated that it had not been sufficiently tailored to the remedy services in this case, and would hold the state responsible for the activities of individuals and entities who are not CBHI service providers or MassHealth staff.

6. At our regular weekly meeting on March 9, 2009, Ms. Snyder gave me a copy of the draft CSR "Practice Performance Indicators," reflecting the work of the Massachusetts Design Team. Shortly after that, I received a copy of the written feedback Kelly English had sent to Ms. Snyder and her CSR consultants. Ms. English's comments ranged from simple corrections to CSR language to align it with terms used in the remedy services, to more substantive comments about the need to conceptually align the CSR with Wraparound, to comments about the CSR's overbroad scope in such areas as the Youth Status Indicators and Caregiver/Family Satisfaction.

7. On March 16, 2010, I expressed these concerns to the Monitor. Some time during the latter half of March, I asked Ms. Snyder to schedule a conference call with her consultants, including Ivor Groves, co-developer of the CSR. During the call, I asked Dr. Groves

whether he considered it essential to the CSR process that information about the child's status be *scored* in addition to being collected. He agreed that scoring these indicators was not essential to the CSR process.

8. As Ms. Snyder and I continued to discuss the Defendants' concerns about the scope and appropriateness of the CSR, it became clear that she would not be able to substantially edit the draft CSR before the pilot case reviews were conducted the week of April 12-16, 2010. Because of my growing concern with the scope and the appropriateness of the CSR for reviewing ICC and IHT, on March 30, 2010, I asked Ms. Snyder to confirm that the CSR implementation schedule would include time for the Defendants to review and comment in writing on the next draft of the CSR, before it was finalized. She indicated that it would.

9. On May 19, 2010, at our first meeting after Ms. Snyder returned from vacation, I provided her with a written overview of our concerns and reviewed them with her verbally.

10. On June 4, 2010, I sent Ms. Snyder a more detailed version of my written overview in the form of a memorandum in preparation for a meeting scheduled for June 8, 2010. During the meeting, Ms. Snyder told us she was in the process of revising the CSR to more closely align the language and concepts with the remedy services in Massachusetts. We had a rich and lengthy discussion of our views of compliance as they related to the CSR. I understood Ms. Snyder to say that while measures of a child's functional or clinical status and progress were important information to have, she didn't see them as measures of compliance with the Judgment.

11. On June 30, 2010, Ms. Snyder sent the parties her revisions to the Youth and Caregiver Status Indictors and Youth Progress Indicators, indicating that a second set of revisions, to the Practice Indicators, would follow. We received the additional revisions during the week of July 5-11, 2010. From June 30, 2010, through July 13, 2010, we met three times to discuss the CSR, but ultimately, although Ms. Snyder changed the terminology used in the CSR to more closely align with the terminology used in the remedy services, the scope continues to exceed the scope of the Remedy and the Rosie D. litigation itself. We sent our written comments on the redraft to Ms. Snyder on Aug. 3, 2010. This document is attached hereto as Exhibit 1.

DEFENDANTS' OBJECTIONS TO THE REVISED VERSION OF THE COMMUNITY SERVICE REVIEW

12. The version of the CSR as edited by Ms. Snyder is attached hereto and incorporated by reference as Exhibit 2. We continue to have the following concerns about the use of the CSR in this context:

13. The CSR proposes to evaluate the remedy plan based on, among other things, the performance of system actors other than MassHealth, and its contracted providers.

- It contains questions and measures that explicitly evaluate the work of local school districts, the Department of Children and Families, Probation and Residential providers. (For examples, see Youth Status Review 1 (Stability), 4 (Permanency) and 6 (Education Status) and Practice Review 7 (Matching Interventions to Needs)).
- The Practice Review section evaluates the performance of entire Care Planning Teams as well as the implementation of Care Plan elements by service delivery

systems outside of MassHealth. As a result, depending on the membership of the reviewed cases, it has the potential of evaluating the work of a wide range of state agencies and local school districts. (For examples, see Practice Review 1, 3, 4, 6, 7, 9, 10, 11, 12).

- By scoring Youth and Caregiver Status and Youth Progress the CSR appears to hold the Defendants accountable for the youth's clinical, functional and legal status, as if the sole determinant of the youth's status is the quality of the ICC or IHT service. In fact, the youth's status is impacted by a variety of factors beyond the control of the service provider, MassHealth, or its health plans, such as: the severity of the youth's mental health condition or disability; the health status and social, educational and financial resources of the youth's family; and the social, educational and recreational resources of the youth's community.

14. The CSR process does not evaluate MassHealth's implementation of the Rosie D. Remedy. For example, the CSR does not evaluate whether MassHealth has required primary care clinicians to provide behavioral health screenings in primary care; whether MassHealth has required behavioral health clinicians to use the Child and Adolescent Needs and Strengths (CANS) tool as an aid to assessment and treatment planning; and whether class members have sufficient access to the remedy services. At best, the CSR examines a narrow selection of the system improvements made by MassHealth (i.e. two Remedy Services, ICC and In-Home Therapy).

15. The CSR was not developed to evaluate Wraparound. Specifically, the language and expectations embedded in the CSR overlap with, but are not entirely consonant with, the model of case practice MassHealth requires the ICC providers to use, for which the providers have been trained, and on which MassHealth is evaluating them, using the Wraparound Fidelity suite of assessment tools. For example, some of the Practice Performance Indicators fail to sufficiently acknowledge the role of family/caregiver/youth choice in designing the care plan. Instead, the care plan is evaluated solely against a clinical standard of practice, as reflected in the language of the CSR and the evaluator's opinion. A central, foundational insight upon which the Wraparound model is based, is that clinicians, no matter how well trained, often perform poorly in devising or judging plans for children and families with serious and complex needs. Wraparound seeks to develop a clinically sound plan that meets other requirements of implementability: it engages the family in interventions the family wants and for reasons the family can understand; it builds a sustainable system of supports for the child and family (often finding resources in places that clinicians would not know to look); and it teaches families to evaluate and manage their own care. It is for this reason that we have chosen to build evaluation of Wraparound fidelity into our quality improvement process.

16. The CSR reviewers are not experts in Wraparound and some are neither trained in nor familiar with Wraparound services at all. As a result, they may not assess Care Coordinator performance accurately.

17. The CSR is very resource intensive. It requires a distinct infrastructure that is not sustainable for the State. Each case review requires one reviewer to spend a 10-12 hour day reviewing the written file, interviewing up to six people, scoring the CSR and writing a brief summary, and reviewing the findings with a senior reviewer. To conduct the 144 reviews in each one year "wave" of the project, the Court Monitor needs a cadre of 20 certified reviewers. There are two sources of reviewers: paid consultants and paid staff of provider agencies and the Parent Professional Advocacy League, and state agency staff. To become certified, a reviewer must participate in a two-day training and four days of case reviews, requiring six full days out of the office. The Court Monitor had hoped to train a sizable group of in-state reviewers to help the Commonwealth continue to use this methodology as a quality management tool. Two staff from DMH have been trained and participated in the pilot CSR in April and will participate in the September reviews. The Court Monitor recently asked DMH to make them available for a second week of reviews in November. Joan Mikula, Assistant Commissioner for Child and Adolescent Services, who supervises the two staff reviewers, reluctantly agreed, stating that making them available "was a considerable hardship on DMH." The one DCF staff member who participated in the April pilot reviews will be unable to participate in the September reviews, due to staff cuts in DCF. Two staff from DPH participated in the April reviews, but only one will be able to continue. MassHealth made one staff available, who has since been laid off. Another OBH staff member will participate in the September reviews.

18. The CSR does not use, or help to improve, the Defendants' methods of quality improvement. The CSR process does not use existing resources, such as CANS data, nor does it strengthen the existing quality improvement activities, for example by performing "field audits" of various data elements or data reports. This will be discussed further below, in "The Defendants' Alternative Proposal for Quality Improvement Activities."

19. Available independent analysis of the CSR supports the Defendants' concerns: Researchers from the Louis de la Parte Florida Mental Health Institute at the University of South Florida conducted a field test in 2002 of the "Quality Service Review," an earlier, but substantively similar version of the "Community Service Review," for the Florida Department of Children and Families[5]. A copy of the article is attached hereto and incorporated by reference as Exhibit 3. These researchers expressed the following concerns about the CSR, particularly in the context of a tool to evaluate Florida's performance under a court order:

    - The report states: that "Reviewers…reported particular discomfort with the subjectivity included in the assessment of needs assessments, service plans, and placement stability and permanence. A major part of this discomfort was attributed to the fact that the current protocol does not include specific interview questions; rather, interviewers are instructed to 'get' answers to certain questions…. Some standardization is needed in the interview format and file review protocols prior to reconsideration of inclusion of the QSR as a methodology in the evaluation." Further, the "QSR is likely most appropriate for use in a QI (Quality Improvement)

[5] Kershaw, M., Armstrong, M., Vargo, A., Styles, M., & Whitlock, A. (2002): Quality service review field test report and recommendations for future use (submitted as a report to the Office of Mission Support & Performance, Florida Department of Children and Families).

model that is focused on practice refinement or improvement as opposed to a QA (Quality Assurance) model focused on compliance."

20. On August 4, 2010, I contacted the Principal Investigator of the field test, Mary I. Armstrong, by telephone in her office at USF. I asked her if the concerns expressed in the field test report of the QSR pertained to the CSR and she said that they did.

THE DEFENDANTS' ALTERNATIVE PROPOSAL FOR QUALITY IMPROVEMENT ACTIVITIES

21. The Defendants have designed and implemented a comprehensive plan for quality improvement. The elements of our quality improvement plan align with best practices documented in a 2008 Issue Brief published by the Research and Training Center for Children's Mental Health at the Louis de la Parte Florida Mental Health Institute at the University of South Florida. (The Research and Training Center is a national resource and center of excellence for evaluation of systems of care for children with mental health needs.) Issue Brief #6 (April 2008), attached hereto as Exhibit 4, summarizes six "Lessons Learned" for systems of self-evaluation and monitoring from six highly regarded "systems of care" selected through a national nomination process. The systems of care studied were: the State of Hawaii; Marion County, IN; Placer County, CA; Region 3 of Santa Cruz County, CA; and Westchester County, NY.

22. MassHealth's quality improvement approach reflects these six "Lessons Learned":

- **Understanding System Intent Determines the Type of Data Collected**

- **Relevant Indicators Engage Partners**

  The Executive Committee of the Children's Behavioral Health Initiative drafted a Strategic Plan and CBHI Logic Model with Outcomes. The Executive Committee worked with stakeholders through the Children's Behavioral Health Advisory Council to review the Strategic Plan, Logic Model and Outcomes. The table in Exhibit 5 lists the Outcomes we anticipate monitoring as well as anticipated monitoring methods and implementation status.[6]

- **Multiple Measures Inform System Performance: System Outcomes, Service Outcomes and Child/Family Outcomes**

  In addition to the **Child, Family Outcomes** and **System Outcomes** described above, we are collecting data and reporting on over 40 indicators of **System Outcomes** and **Service Outcomes**. This information is available through five reports, four of which are produced quarterly, and one, the CSA Monthly Report, which will be produced monthly, starting in September, 2010. These data indicators have been reviewed and commented on by the Plaintiffs and the Court Monitor. The reports include indicators such as:

  - Numbers and percentages of youth receiving **standardized behavioral health screens** in primary care and numbers and percentages of children whose screens indicate a potential behavioral health condition

[6] I note that outcome measures have been developed in accordance with paragraph 46.e. of the Judgment and that, in accordance with that provision, such outcome measures are solely for the purpose of program improvement and may not be used for arguing that the Defendants are not complying with any order of the Court, including the Judgment itself.

- Numbers and percentages of youth receiving **clinical assessments including the CANS** in Outpatient Therapy and the numbers and percentages of those youth for whlom CANS data indicate that they have a Serious Emotional Disturbance
- Use of Mobile Crisis Intervention and Psychiatric hospitalization or other 24-hour levels of care **by youth receiving ICC**
- **Mobile Crisis Intervention** response times, length of intervention, site of intervention and disposition
- **Numbers of youth being served in each of the remedy services** and the **average number of units of services** being received
- **ICC** access, access data by race and primary language, staffing, caseloads, wait times, referral sources, referral disposition, length of stay, site of service, and discharge reasons
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Finally, we have just completed our first annual review of the fidelity of ICC provider practice to the ten principles of Wraparound, using the Wraparound Fidelity Index. At the direction of MassHealth, the Massachusetts Behavioral Health Partnership (MBHP) contracted an independent consumer-operated research, evaluation and quality improvement organization, to conduct phone interviews and to complete the WFI-4 for families of children receiving Intensive Care Coordination. CQI interviewers completed 540 telephone interviews of parents/caregivers of youth receiving ICC. The sample included parents/caregivers of youth being served by all 32 ICC providers. In addition, ICC providers have used the "Team Observation Measure" to review the work of Care

Coordinators. Vroon Vandenburg coaches and MassHealth's health plan technical assistance teams are reviewing the WFI and TOM data with the ICC providers.

- **Cost-Monitoring Supports Long-Term Viability of the System**

  Cost and utilization data are reported and analyzed quarterly.

- **A Quality Improvement Approach Supports System Development**

  The process of creating a positive, open, "data culture" is in various stages of development across the remedy services. It is well established among the Mobile Crisis Intervention providers, who are experienced in using data on response times, location of service and outcome of service, to manage their programs. ICC providers have just been given their first data from the Wraparound Fidelity Index, which will be used to inform the Vroon Vandenberg coaching and the MassHealth health plans' technical assistance to these providers. We are planning to share the analyses of aggregate CANS data this fall with providers, and the next release of the CANS IT application, due in November, will make it easier for provider agencies to download and analyze their own agencies' CANS data.

- **A Quality Improvement Approach Supports System Development**

  These quality measures, as the reports become available, are shared with the Court Monitor, the Plaintiffs, the Children's Behavioral Health Advisory Council and the Council's Data, Trends and Outcomes Committee, as well as other stakeholders.

CASE STUDIES

23. The court has expressed an interest in obtaining case specific information. The most useful type of case study is one that can help us to interpret and validate our quantitative data. One of our many concerns about the CSR is that it may provide us with a lot of stories, but stories that are unique in their themes, so that we would not have useable or generalizable feedback on the operation of our system. Therefore, we propose working with the Monitor to develop case study methods, within her existing budget, that would build on our quantitative quality improvement activities. There are many potential areas of inquiry, for example:

- "Outliers" - while the WFI scores are strong across CSAs, there are certainly some CSAs with higher scores and others with lower scores. Interviews and/or focus groups at these locations may help inform our understanding of how and why that difference occurs.
- youth with a positive BH screen but no claims for BH services
- youth with a CANS indicating SED who is receiving only outpatient care
- youth with a CANS indicating SED who is receiving ICC or IHT, to learn about pathways into care

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The advantages of this approach are that it is a methodologically sound use of case studies and it would inform us about the strengths and limitations of our data reports and inform development of those methods.

24. One of our principal concerns as we engage in the implementation process of the Rosie D remedy is creating quality improvement approaches that will remain sustainable once the

start-up infrastructure is removed. We see outcome measurement and continuous quality improvement activities as a vital area for the long-term success of the Children's Behavioral Health Initiative. It is our priority to find sustainable, efficient and effective ways to engage in outcome measurement and continuous quality improvement using existing and local resources that can remain engaged in these efforts over the long term.

SIGEND UNDER THE PAINS AND PENALTIES OF PERJURY:

/s/ Emily Sherwood
Emily Sherwood

August 20, 2010