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.

MassHealth Data

2. MassHealth has a lot of complex data that are often difficult to interpret. At times the quantity of data can obscure their overarching implications. The data we have recently collected and provided to the Plaintiffs quantify the numbers of EPSDT eligible members with SED who receive Intensive Care Coordination services, and provides a wealth of information about how quickly eligible members receive services and, for those members who wait for a CSA to become available, how many members wait and for how long. The data demonstrate that few members wait any significant length of time.

3. To accurately measure the service *capacity* of the CSAs, we count the "first appointment" as the start of ICC services, even though, in Wraparound, families may not make a formal commitment to services (indicated by signing a consent for services) until they've met a few times with their prospective Care Coordinator and Family Partner. In this, and other ways, the Wraparound model is different from conventional clinical services. It is important to note that the first visit is conceptualized in the Wraparound model as the beginning of the first of the four phases of the Wraparound process: the Engagement phase. One more note: again, to accurately represent the CSA's *capacity,* we have chosen to count the date of the first appointment *available to the family*, as the point at which the CSA has capacity to serve the family, *even if the family* asks that the first appointment be rescheduled to meet their needs.
4. Since the inception of the remedy services, at least 7,535 youth and their families have received ICC, and, as of September 30, 2010, 3,585 youth were receiving ICC services.
5. Data from the most recent Monthly CSA Report, for September, 2010, show that, for the 348 youth who began ICC services during the month, for 45% of the youth (158) a first appointment was made available to them within 3 days of the family's request for services, and for fully 79% of the youth (274), a first appointment was made available within 30 days of the family's request for services. Augus'st and July's data are similar.
6. Of the remaining 20%, 74 youth whose first appointment was offered more than 30 days from the request for services, the majority, 53, were offered an appointment within 60 days. 21 of the 348 youth enrolled during the month of September had waited a long time for services, from 61 to 100+ days.

7. Data from our first three Monthly CSA Reports, for July, August and September, 2010, show that the average time between the family's request for services and the first available appointment averaged 21.5 days in July, 16.7 days in August, and 16.3 days in September.
8. In addition to documenting how long it takes for a youth to get into ICC services, as described above, we count how many youth are waiting for appointments and how long they wait. At the end of September, there were 269 youth waiting for ICC; however, this includes 63 youth (23%) who had requested services within the last ten days and 86 more (32%) who had requested services within the last 30 days. In addition, 77 (29%) had waited 30 to 60 days and 49 (18%) had waited over 60 days.
9. Of the youth on the waiting list, well over half were waiting for services at four of the 32 CSAs. A total of 13 CSAs had no waiting lists at all. 12 CSAs had waiting lists of 1 to 10 youth and three CSAs had waiting lists of 11 to 20 youth. The four outlier CSAs had waiting lists ranging from 21 to one CSA with 80 youth waiting. Three of these four CSAs are in Central Massachusetts and one is in Western Massachusetts.
10. It is also important to understand that all youth who are put on a waiting list move off of the waiting list – none of them stay on the waiting list indefinitely. As referenced above in paragraph 9, there were 269 youth listed as waiting at the end of September. At the end of August, there were 232 youth waiting. In both cases, a substantial portion of the list was youth who had been referred quite recently and who will become enrolled in ICC during the next month. So, while at the end of September there is a waiting list of similar size to August, 269 youth, the September list contains a substantially different cohort of youth.
11. To summarize: close to 80% of youth are offered first appointments within 30 days of a request for service, 45% within 3 days. Of the youth listed as waiting at the end of

September, 23% had waited less than 10 days, 50% for less than 30 days. The 20% of youth waiting for more than 60 days are concentrated among four "outlier" CSAs. 25 of the 32 CSAs have fewer than 10 youth waiting for appointments.

12. With close contract management from EOHHS, MassHealth's Managed Care Entities (MCEs) have been using these data reports to manage the CSAs. For the past several months the plans have been actively working with the four outlier CSAs to address their problems assuring sufficient capacity, the reasons for which are different for each CSA. One CSA lost a significant number of staff in one month and has been working hard to fill the vacant positions. Another CSA was inaccurately reporting on its waitlist by keeping families on the waitlist for months after they had stopped responding to calls. One of the CSAs is working closely with the Technical Assistance ("TA") team, implementing a corrective action plan to improve intake procedures and communication with families waiting for appointments.
13. The MCEs' work with the CSAs occurs in the context of ongoing ICC Network management. In the past six months, the MCEs' TA teams facilitated nearly 150 individual TA meetings with directors of the 32 CSAs. The TA teams for each CSA consist of one MBHP representative and one other MCE plan representative (from either FCHP, BMCHP, NHP, or Network Health). Topics addressed in the technical assistance meetings over the past six months have included: use of the Wraparound fidelity monitoring data, adherence to the wraparound principles, ensuring that the CSAs have the infrastructure to provide timely access to care, appropriate staff-to-family ratios, efficient and consistent intake processes, effective eligibility verification processes, adherence to performance specifications, understanding of and documentation of medical necessity criteria in the context of family voice and choice and the wraparound model, use of Risk Management Safety Plans, use of

psychiatric consultation, compliance with administering the CANS, and integration of the CANS with the comprehensive assessment, and strengths needs culture discovery.

CSA MANAGEMENT OF THE INTAKE PROCESS AND WAITING LISTS

14. To clarify and standardize the CSA's intake and waitlist process, at MassHealth's direction, the MCEs developed, and MassHealth approved, "CSA Waitlist Guidelines" in December 2009, attached as Exhibit _A. The health plans' Technical Assistance teams[1] work with the CSAs to ensure that they operate according to the Guidelines. When a CSA lacks capacity and has a waiting list for appointments, the three objectives of the Guidelines are for the CSA to work with the family to:

    a. Determine whether the referral is appropriate for ICC. If it is, CSA staff will either refer the youth/family to another CSA with capacity or place them on the waiting list for ICC services. If the referral is not appropriate for ICC, CSA staff will refer the family/youth to the most appropriate service.

    b. Assess whether the youth is in need of a behavioral health intervention and refer the youth/family to the most appropriate service while they wait for ICC services.

    c. Inform families waiting for services about Mobile Crisis Intervention and other community resources, services and providers. CSA staff are to maintain regular phone contact with the family to assess safety concerns and the family's interest in remaining on the waitlist.

DATA ON ACCESS TO OTHER REMEDY SERVICES

[1] MassHealth's contracted health plans are collaboratively managing the CSA network, as well as the network of providers for all remedy services. Each CSA works with one two-person Technical Assistance team. Each team consists of one staff member from the Massachusetts Behavioral Health Partnership and one staff member from one of the other health plans.

15. **Mobile Crisis Intervention (MCI).** MCI providers collect detailed access information using "encounter forms" that they submit to the Massachusetts Behavioral Health Partnership (MBHP), which manages the MCI network of providers.[2] Data collected include response time, location of the intervention[3] and disposition after the intervention – whether the youth is admitted to the hospital, to a Community-Based Acute Treatment (CBAT) program, to another diversionary service, or home.
16. Access to services is measured by the MCI response time. Program standards require MCI providers to be on site with the youth/family within one hour of receiving a call for services.
17. **Average Response Time in Minutes** for the 17 contracted MCI programs, for the period July 1, 2009 – May 30, 2010, was 41 minutes.
18. **Average Response Time in Minutes by Provider** – The average response time of MCI providers ranged from 18 to 69 minutes, with two of the 17 providers having averages above 60 minutes.

    Response Time – Percent Within 60 Minutes - The percent of responses within one hour averaged 78%.

    Response Time – Percent Within 60 Minutes by Provider – The percent of response times within one hour, by provider, ranges from 63% to 90%. At the low end, eight providers have response times within one hour between 63% and 79% of the time. At the high end, nine providers have response times within one hour between 80% and 89% of the time.

[2] The DMH-operated MCI programs are not managed by MBHP, but adhere to the same program specifications and standards. The data referenced here do not include data from these sites, but such data will be incorporated into future reports.

[3] Whether the crisis intervention takes place in a community location such as a home or school, the MCI's provider's location or the Emergency Department of a hospital.

19. MBHP network management staff work with the MCI providers on an ongoing basis. In the past six months, staff conducted 102 meetings with the 17 MBHP-managed ESP/MCI providers, on approximately a monthly basis. In many cases, MBHP staff had weekly and sometimes even daily contact with these providers. MBHP regional network management staff also conducted regional ESP/MCI meetings on approximately a bimonthly basis, totaling approximately 15 meetings during this reporting period. MBHP also continued to host monthly statewide ESP/MCI meetings with all ESP Directors and MCI Managers. These meetings include the other MassHealth contracted MCEs, both in developing the agenda and participating in the meetings. Topics have included the review of statewide MCI data, access to care, response times, risk management and safety planning, MCI standardized clinical documentation, family partner and paraprofessional role clarification, MCI integration and collaboration with other CBHI services, MCI referrals to CBHI levels of care, MCI interventions in the ED, and MCI training requests.
20. In response to concerns identified through the Monitor's Community Service Review, EOHHS directed MBHP to develop an action plan to address areas for improvement. MBHP's action plan, which was approved by EOHHS, provides for specific follow up on the statewide, regional and provider level. This includes an email to all ESP/MCI CEOs informing them of the general feedback received , phone calls to several individual CEOs where warranted, addressing issues with ESP/MCI managers during statewide ESP/MCI meetings, including training protocols and staffing of MCIs, requesting data from any MCI satisfaction survey that the providers may have collected from families and other stakeholders, updating the ESP/MCI directory and remaindering providers of the 24/7/365

MCI hours of operation, and continuing technical assistance with Kappy Madenwald and statewide trainings including PAL.

21. **Access data for other remedy services.** Since data on response times and wait times is not automatically generated by the MCEs' service authorization or claims systems, EOHHS directed MBHP to develop an online application for providers to give MCEs this information. In fact, the new application will have two purposes. Not only will it track access to In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, it will function as a tool for the providers and health plans to locate providers with capacity to provide these services. Work on this application is underway and MassHealth expects that the health plans will roll out the application starting with In Home Therapy providers this winter, followed by the IHBS and Therapeutic Mentoring providers.. We anticipate that all of the data reports will be available in early March.

HELPING FAMILIES ACCESS REMEDY SERVICES

22. The affidavits by Lisa Lambert, Kathryn Rucker and Leslie Lockhart raise concerns about how families can be helped to understand the remedy services, the MassHealth eligibility requirements and how to quickly access services for their children. Their concerns grouped into three subject areas:

    a. Enough basic information about the remedy services, and especially ICC, so families can get an idea of what might help and can communicate effectively with providers that they call for help.

    b. Information about how a child's MassHealth "Coverage Type" impacts access to remedy services, and information about CommonHealth and how to apply for CommonHealth.

c. Clarification for families, providers and stakeholders about access to remedy services for children with a developmental or autism spectrum disorder.

23. Adequately informing MassHealth members, people who might become MassHealth members ,and all the people who come into contact with these groups of people through their work is a large and complex task. Some of the many strategies we use to inform these communities are summarized below, by subject area.

24. **General Information on Remedy Services and ICC**

a. When a member under 21 becomes MassHealth-eligible, and thereafter, once a year, they (or their parent) receive a notice describing the EPSDT entitlement and services. It includes a list of the remedy services and next steps for accessing services.

b. When Members enroll in an MCE they receive a Member Handbook containing a 3 page, 1000+ word insert that contains remedy services information. Use of the insert provides more exposure to the remedy information than text located within the handbook. In addition, all plans, except MBHP, also have text about remedy services incorporated into their handbooks, in addition to the insert. The Member Handbooks advise Members how to reach their health plan for help accessing services.

c. In addition, on the back of the Members' card is a statement "For help with Behavioral Health services, call XXX-XXX-XXXX." In the debrief from the CSR reviews in September, the reviewers reported that one mother described turning over her card, calling the number and having In Home Therapy in place one week later.

d. Member Newsletters – Informative articles related to remedy services have appeared in all of MassHealth's contracted health plans' Member Newsletters.

e. Other Newsletters – family organizations and providers have partnered with us to run articles for families describing the remedy services (e.g., The Guidance Center, Mass. Society for the Prevention of Cruelty to Children, Parent Professional Advocacy League, Federation for Children with Special Needs, Judge Baker Guidance Center).

f. Brochure – The MassHealth brochure provides parent-friendly descriptions of remedy services along with regionalized access information.

(Phase 1: Summer 2010) – dissemination through over 2000 stakeholders, providers and community partners (e.g., school nurses/school personnel, Early Education providers, PCCs, behavioral health providers and social service agencies). Approximately 85,000 brochures distributed between May and October 2010.

(Phase 2: Fall 2010) – dissemination through 400 targeted child- and family-serving community organizations (e.g., YWCAs, Boys and Girls Clubs, family shelters, ethnic, faith-based, legal/advocacy, adoption agencies, community associations, etc.)..

This winter, field staff of the Department of Transitional Assistance will start handing out a black and white version of the MassHealth brochure, printed in-house by DTA.

g. Ongoing training of staff from EOHHS' child-serving agencies, and other child-serving agencies in other Secretariats or branches of state government.

h. Preparation of informational articles for submission to community newspapers, school and PTA newsletters and other local print and electronic media read by families. Adding, in this fiscal year, radio PSAs for submission to community radio stations.

25. **Information about how a child's MassHealth "Coverage Type" impacts access to remedy services, and information about CommonHealth and how to apply for CommonHealth.** The MassHealth member handbook and the CBHI brochure informs families about how MassHealth "Coverage Type" affects eligibility for the remedy services and gives them resources for more information. In our standard public presentations of the remedy services, staff explain that for children who are not eligible for MassHealth Standard, CommonHealth eligibility is an important eligibility category for children with mental health disabilities, as well as the key steps in applying for CommonHealth. We are in the process of developing a one-page fact sheet summarizing key MassHealth eligibility information and describing how to apply for CommonHealth. The fact sheet will be made available to, and can be used by, families, family organizations, provider staff (including CSA and all other remedy services staff), state agency staff, school staff, and many others.
26. **Clarification for families, providers and stakeholders about access to remedy services for children with a developmental or autism spectrum disorder.** To be eligible for the remedy services, a youth must have a behavioral health diagnosis. The youth may also have a co-occuring developmental disability or autism spectrum disorder. Some people construe the definitions of SED as excluding developmental disabilities and autism spectrum disorders. MassHealth's is in the process of providing written clarification to the MCEs, to ensure that there is no confusion about the availability of Remedy Services for children with

behavioral health diagnoses, without regard to any other diagnosis they might have, including, but not limited to, developmental disabilities or autism spectrum disorders.

INDIVIDUAL CASES REFERENCED IN PLAINTIFFS' AFFIDAVITS

27. Kathryn Rucker's third affidavit describes four case vignettes. We asked the Plaintiffs for identifying information on all four youth so that we could investigate the allegations. We were provided information on just one of the youth, the Center's client who reported waiting seven weeks for ICC services and for whom, it appeared, the CSA did not follow the CSA Waitlist Guidelines. The CSA reportedly did not inform the family about other remedy services, or other ICC providers, did not inform the family about Mobile Crisis Intervention and did not maintain telephone contact with the family while they were waiting. Upon receiving the youth's information, we asked the youth's MCE to look into the allegations. They had already been working with this provider on issues related to waiting lists and had asked the provider to develop a Corrective Action Plan (CAP). They report that some of the action steps were already underway; others have been newly identified; and still others may be added as the provider continues to look into this particular case example.
28. The following is taken from the MCE's report to MassHealth:

- 11.4.10: MBHP Regional Director brought complaint to the attention of senior leadership of the provider agency and the MBHP Youth Regional Network Manager (YRNM) brought this information to the attention of the CSA Program Director and requested a corrective action plan.

- 11.5.10: Corrective Action Plan received from provider. Their response is summarized below.
    - August 18, 2010: initial referral made to CSA. Review of CSA records indicates that both the referral and the family were contacted on August 19, 2010 within the 24 hour performance specification and expectation of response. CSA acknowledges that the staff member who received the call had been on the job less than six weeks and plausibly communicated that "no one would be in touch with the family" as an attempt to try to address the availability of a care coordinator to assign and not a communication indicating when the family would be contacted. CSA acknowledges a "very poor choice of words." CSA Follow-up: we will be re-examining the CSA practices relative to who handles and responds to incoming referrals, and work to standardize the process across CSAs. Details are provided in the attached plan.
    - Re: distribution of Written Information: CSA reports that this initial conversation did provide such details but does acknowledge that the CSA does not routinely send out written material at this point in the referral process. CSA hopes to be able to elicit feedback directly from the parent about her experience with this particular staff person as the Youth is now enrolled with ICC. CSA will also work with their local MCE Team to identify what materials for families awaiting ICC would be helpful to distribute to them. It should be noted that CSA has its own materials/brochures (Spanish, Portuguese and English) and looks to have a discussion with the TA team on making appropriate materials available to families awaiting the service.

- Follow-up during the waiting period: The complaint asserts that no contact person contacted the family, and did not offer any interim supports and did not inform the family of other services or other CSA providers who may have been able to work with the family sooner. CSA reports that these assertions are "largely correct." CSA does not have evidence that their staff member stayed in touch with the family after placing them on the wait list. CSA acknowledges that their current CSA policy was not followed.
- Next contact with the family: The complaint asserts that the family was re-contacted on 10/13/10 seven weeks after the initial intake calls were made. CSA disagrees with this assertion although will need more time to track down timelines. CSA reports that at least one, perhaps more than one, contact was made to the family in September 2010, without success. The youth was placed back on the wait list and reassigned on 10/12/10. Following this, the family was successfully reached, the first appointment was offered on 10/13/10 and services began on 10/25/10.

Conclusion & Plans:

- Acknowledge that the staff who responded to this particular referral was new and hired at a time when her direct supervisor was out for an extended leave of absence. Her training could have been better. As noted above, CSA will be re-examining its practice relative to who handles and responds to incoming referrals and work to standardize the process.
- CSA will work with their local MCE TA team to provide families with written materials (i.e., a packet of materials that would be offered to families) describing

the service, etc., versus relying solely on the initial phone conversation to convey the important information about the service

- CSA reports falling "far short" of their own policy re: follow-up with families on a wait list. CSA Program Director has requested a formal review of all youth currently on the wait list to determine the needs, will share these results with the local MCE team. CSA staff will receive additional training in CSA policies, procedures and general performance expectations/specifications. The training will occur by November 18th.

29. We also asked for indentifying information on the case vignettes shared in Lisa Lambert's affidavit but did not receive any. However, one of the descriptions was recognized by MCE staff, who was aware of the complaint and that the provider had already been actively working with the mother around this specific complaint. In her affidavit, Ms. Lambert described the experience of a family in the North Central region who contacted a PAL family support specialist, reporting a total inability to access crisis services. The parents had called the mobile crisis team late on a Friday but there was no answer. The family support specialist also called MCI and even drove to their building and knocked on the door. Although there appeared to be someone there, no one responded. The parents ended up calling the police, who knocked down the girl's bedroom door and took her to the emergency room in shackles.

From MBHP's report to MassHealth:

- 11.4.10: upon receipt of the information, the MBHP Regional Director brought this complaint to senior provider management, who were aware of the complaint and had been working closely to address the issues in the complaint with the child's mother.
- 11.5.10: The provider submitted a written response to MBHP that reviews the facts and chronology of events, and is summarized below:
    - 10.15.10: The request for MCI occurred on 10/15/10 approximately 7:00 p.m. according to mother. Mother reports she called the triage line in No. County and states that she spoke with someone named "Susan" or "Stacey". She reports she was put on hold and told that MCI line was busy and that they would attempt to reach MCI and call her back. Mother called triage back approximately 45 minutes later and was told that MCI had not been reached and that she would be called back. The MCI provider reports that they have no staff with the name of Stacy or Susan did not have someone on site with that or a similar name at the time of the call . The provider does report that they had MCI staff available and in the Community Based Location on 10/15/10 at 7:00 p.m.
    - 10.15.10: After review of their telephone log the provider reports that they have no record of a call from mother on this evening at this time. All calls into the triage line are logged by the triage staff. While there were other calls logged that evening during this time frame, there were no calls logged in regard to this individual until after 8:30 pm when Henry Heywood Hospital ED called to request an intervention by ESP/MCI.
    - 10.15.10: The provider also reports that mother apparently went to 100 Erdman Way in Leominster to try to access the MCI team. MCI at the time of this

incident was located at 45 Summer Street. Additionally, the Erdman Way offices are not open at that time of night.

- 10.15.10: the provider reports that a referral had been made to ICC but that the individual did not have ICC services at this time.
- Response: the provider reports that they have clarified with mother their ESP location and walk-in capabilities. As a consequence of this issue, the provider has reviewed their protocol re: triaging calls and reviewed it with their ESP/MCI staff.
- Response: Provider managers report a very close working relationship with this mother in an ongoing way and note that her work with them has been "invaluable" in informing their work with families and the development of their service(s). For example, they note that with this parent and DMH all are working on risk management and safety planning for youth discharged from DMH residential facilities.

30. In both of these cases, and in all others that come to EOHHS's attention from whatever sources, MassHealth works closely with its contracted MCEs to ensure that they address and resolve specific problems.

Signed under the pains and penalties of perjury on this twelfth day of November, 2010.

/s/ Emily Sherwood
Emily Sherwood