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 Report on Status of Implementation of Judgment and Remedial Order

At the direction of the Court, 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 May 31, 2013. It describes progress on key activities including those detailed in Disengagement Criteria, with an emphasis on five areas: Practice Guidelines, System of Care Practice Review (SOCPR), CANS implementation, the study of outpatient as a "Hub," and the "Access reports." The report then briefly reviews the status of other deliverables and finally provides updated service data.

Most of the tasks enumerated in the Disengagement Criteria are more complex than either of the parties anticipated. As a result, while the Defendants are working diligently to provide deliverables as quickly as possible, they have extended many of the timelines. The Defendants' goal is not only to produce the data, but also to use the experience to inform its own planning and capacity for ongoing self-monitoring and quality improvement, post-disengagement. Accordingly, the

Defendants in several places in this document refer to data and activities that will occur in the future, after active monitoring and reporting are expected to end.

1. **Practice Guidelines** (Part IV of Disengagement Criteria):

The service practice guidelines for In-home Therapy ("IHT"), In-home Behavioral Services ("IHBS"), Mobile Crisis Intervention ("MCI"), and Therapeutic Mentoring ("TM") are among the most important of the Disengagement Criteria activities, from the point of view of improving and sustaining effectiveness of practice. The guidelines can be used for many key purposes, including enhancing training and supervision of staff, assessing and planning interventions to improve program quality, and educating other stakeholders about the services. Production of these documents involves two stages: using subject matter experts (seven in all) to develop appropriate service-specific content, then editing for consistency across documents. Since material written for one service often can inform guidelines for other services, this is inherently an iterative process. In drafting these documents, the Defendants are also soliciting comment from many stakeholders. At this time the guidelines for all four of these remedy services have been drafted and are in various stages of revision. Plaintiffs and the Monitor have reviewed the MCI guidelines and it is essentially complete and exemplary. TM and IHT guidelines are well-developed and Defendants are in the process of responding to numerous suggestions from the Monitor. The draft of the IHBS guidelines requires substantial rewriting, which will be done in December; all four documents will then require editing for stylistic consistency prior to publication. All the guidelines will be sent to plaintiffs in early January for additional comment. The Defendants anticipate issuing final guidelines in early March.

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

Case reviews have proven to be an invaluable source of rich qualitative information about how services work. In consultation with the University of South Florida, the Defendants made minor adaptations to the SOCPR tool and conducted reviewer training in June. They then completed SOCPR reviews in the Boston/Metro regions in June, and in the Northeast region in October. The regional report for June was completed in November. The time required for data entry, analysis and reporting was much longer than expected and the Defendants have since implemented a number of changes to make this process more efficient, going forward. They are now analyzing October's data and anticipate that the Northeast regional report will be released by the end of February. While SOCPR quantitative results are not directly comparable to results from the Monitor's Community Service Review ("CSR"), both reviews report positive patterns of practice overall, while illuminating opportunities for improved provider practice. The Defendants have shared, and will continue to share specific feedback from SOCPR with the provider organizations that they review. They also will issue regional reports to provide general feedback to all providers, state agency partners, Wraparound coaches, and MCE Technical Assistance teams to ensure that lessons from the reviews flow back into practice.

3. **CANS** (Section V #2, Section III of Disengagement Criteria)

The CANS should be a major tool for providers to use to implement the collaborative, family-driven approach to practice that underlies the Children's Behavioral Health Initiative "CBHI"). Defendants have been working to improve provider use of the CANS; beyond this, they

are working to improve coordination, treatment planning, and monitoring of child outcomes at the provider level. Most recent CANS compliance data are as follows.

a. **Outpatient Therapy –** In September 2013, 58.5 % of clinical assessments in Outpatient Therapy included completion of a CANS. For SFY 2013, Quarter 4 (4/1/13-6/30/13) CANS Compliance rates in each of the following services were as follows:

b. **IHT** - For the three larger plans: 72%, 86%, and 94%. For the three smaller plans: 61%, 100% and 51%. The weighted average was 90%[1]

c. **ICC –**For the three larger plans: 84%, 100%, and 100%. For the three smaller plans: 72%, 87% and 44%. The weighted average was 79%.

d. **Inpatient -** For the three larger plans: 18%, 18% and 17%. For the three smaller plans: 5%, 0%, and 0%. The weighted average was 17%.

Community Based Acute Treatment (CBAT) – For the three larger plans: 49%, 61% and 49%. For the three smaller plans: 12%, 42%, and 0%. The weighed average was 50%.

CANS Quality Improvement Activities are as follows:

a. **For Outpatient –** In early November, MassHealth released a software update to the CANS application, intended to resolve long-standing but difficult-to-diagnose performance issues that affected some providers' ability to use the application. The evidence suggests that this update has been effective, but the Defendants will collect and examine user complaints through the end of December to ensure that the problem has finally been resolved. MassHealth and its health plans ultimately intend to deny payment for any clinical assessment made in an outpatient setting that does not include a CANS.

---

[1] The weighted average for IHT, ICC, Inpatient and CBAT excludes one of the smaller plans which submitted percentages but not total counts.

b. **For IHT and ICC –** MassHealth's health plans continue to work with providers through network management activities to ensure completion of the CANS.

c. **For Inpatient and CBAT –** MassHealth's health plans made intensive efforts in summer and fall of 2013 to improve CANS compliance by staff of Inpatient and CBAT programs. The impact of these efforts will not be evident in standard CANS compliance reports until June of 2014, due to the long lag in reporting of encounter data, upon which these reports are based. In the interim, Defendants will review the CANS database to compare Inpatient and CBAT CANS volume for the Fall of 2013 to that from 2012, with the expectation that 2013 volume will be notably higher. Defendants anticipate that this report (detailing the differential in volume between those two periods) will be available in early January.

d. **Department of Mental Health Residential Programs** – The last review conducted was for youth discharged from residential care between April 2011 and November 2012. During that time there were 96 discharges for whom 64 (67%) had a completed CANS in their clinical records. Since then, DMH has ensured that clinical staff have been trained and subsequently retrained on the use of the CANS. Programs have been and will continue to be intermittently audited. In addition, CANS compliance was embedded into the new semi-annual performance-based contracting measures to be completed by the IRTPs and the CIRT. The next cycle of DMH audit data on compliance will be in early 2014.

e. **New CANS training and certification**. At Defendants' direction, in 2013 the UMass CANS training program conducted an extensive evaluation of the existing training and

certification process, resulting in numerous recommendations for improvement. A revamped process is now in planning, which will focus not just on how to rate the CANS items (as in the current training), but on how to use the CANS at all levels of care to promote the collaborative, family-driven approach to care that underlies the CBHI. Defendants will also be putting in place new resources to help provider organizations improve their clinical use of the CANS, such as in communicating with families, in collaborating with other services and supports, and in staff supervision and program improvement. CANS training and certification is a particularly promising approach to influencing practice in the outpatient level of care, where CBHI principles are perhaps least well understood and practiced at this time. Defendants anticipate the rollout of the new training and certification process by the end of calendar 2014.

f. **Using CANS data** – CANS outcome reports were previously provided to the Plaintiffs and Monitor per Section II #2 of the Disengagement Criteria (see Exhibit A). While Defendants believe the use of domain scores has potential in looking at change in children's status over time, at this point it is relatively uninformative for evaluation purposes. While Defendants continue to hope that CANS will provide insight into system-level effects, the greatest potential of the CANS is for tracking youth and family outcomes at the child- and program-level. New reports that EOHHS hopes to make available to providers through the CANS application will make this task easier by showing, for example, how a child's CANS profile changes over time. We will also evaluate methods (such as reporting domain scores) that might allow provider organizations to track outcomes for groups of youth over time, and to use these data for program improvement.

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

The outpatient study by MBHP to collect data on the functioning of Outpatient providers as "Hubs" (i.e., the locus from which referrals to remedy services are made) rresulted in an initial report that was confusing in many respects. MBHP is in the process of reorganizing and rewriting the report to clarify the methodology and clearly answer the Plaintiffs' questions. The Defendants expect to provide the revised report to the Plaintiffs and Monitor by early January, 2014. It is now apparent that this project would have been better approached with a longer timeline, which would have allowed MBHP to pilot various components, and the report will therefore address lessons learned regarding the evaluation methodology. Regardless of the specific findings of this report, the Defendants anticipate that assessing the performance of Outpatient as a hub, and training Outpatient providers about the Hub role, will be ongoing efforts. As noted above, a revamped CANS training and certification process will offer new opportunities to improve Outpatient provider practice. Once EOHHS has received the revised report from MBHP, it will formulate next steps.

5. Access Reports (Section I, ##1 - 4 in Disengagement Criteria):

"Access reports" refer to reports of MassHealth behavioral health service utilization for youth in 24-hour levels of care, or youth receiving certain state agency services including out-of-home placement. MassHealth has performed an initial analysis based on data submitted by DYS, DCF, and DMH. Given the complexity of the study designs and the need to present each report in a way that is understandable and that reflects the context of each agency, the Commonwealth will arrange meetings, including the Plaintiffs and the Monitor, with each agency, to discuss the

meaning of the data. In December the Defendants will set dates for these meetings, which they expect to occur in February 2014. Defendants do not expect that these reports will yield a clear picture of the processes by which youth in other services do, or do not, move into remedy services, but they hope that the interagency discussions associated with this project will enhance understanding of those processes, and may result in more refined data-gathering activities for the future. Defendants have multiple avenues for gathering data and improving coordination. These include interagency participation in SOCPR, revision of CBHI interagency protocols (DMH revision is underway), regular monitoring and problem-solving meetings (such as periodic meetings between EOHHS/CBHI staff and the DMH System Integration Specialists), ongoing efforts to reduce emergency department boarding, and interagency efforts to improve the effectiveness of IHT services for special populations through the CBHI Interagency Implementation Team process. Collaborative interagency program development and quality improvement is driven by the needs of all the agencies and will be a key ongoing function of the Children's Behavioral Health Interagency Initiatives office (also known, for the purposes of the present litigation, as the Office of the Compliance Coordinator). The Defendants expect an increase in interagency service communication and collaboration following the eventual rollout of the DCF/DMH Caring Together system, which is highly aligned with the principles underlying the remedy services, and which serves a population of youth that overlaps significantly with MassHealth.[2] Service navigation and

---

2 Caring Together is a joint DMH/DCF reprocurement of residential services. As stated in the Request for Response, "This collaboration began with the Children's Behavioral Health Initiative (CBHI) and now continues through the development of CARING TOGETHER. The first stage of development will be accomplished through this procurement and transformation of residential levels of service. ..Families are the center of the design, development and delivery of services and supports they need. EOHHS and the Agencies envision a system wherein Massachusetts children and families will have timely access to an integrated network of out of home and in home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully in their local communities. As the Commonwealth transforms residential levels of service for children, there is recognition that our efforts are establishing an important framework and foundation for ensuring an integrated Child Welfare and Behavioral Health 'System' of Care for strengthening families."

coordination and interagency collaboration will also be an imperative of the Commonwealth's implementation of a new referral and service system for juvenile status offenders (CHINS reform).

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

a. **Percentage of youth with a positive screen who receive follow-up behavioral health services within 90 days of the screening** (Section V #1 in Disengagement Criteria): A follow-up service is defined as either a follow-up visit in the primary care practice for behavioral health concern, or a claim for a service from a behavioral health provider. Between April 1, 2012 and September 30, 2012, 53% of youth with a positive screen received a follow-up service, and between October 1, 2012 and March 31, 2013 the rate was also 53%.[3] Massachusetts is the national vanguard[4] of well-child behavioral health screening, but there are no external benchmarks on the range of follow-up rates to be expected under best-practice circumstances. MassHealth is currently conducting a large-scale chart review of screening in approximately 4,000 well-child visits; this report will be available in June 2014 and will help to inform its understanding of what happens following a positive screen.

b. **Length of stay in IHT, TM and IHBS** (section V #2 in Disengagement Criteria): Key indicator reports for these services have been provided to Plaintiffs and the Monitor.

---

[3] Due to system upgrades being implemented within MassHealth's claims and encounter database, this data point had only recently become available beyond March 31, 2012.

[4] The November 25, 2013 Boston Globe reported that Massachusetts led the nation in the rate of screening children under age 6 in low income families in 2010-2011. The Massachusetts rate was more than twice the rate of the United States as a whole.

c. **WFI / TOM** (Section V #3 in Disengagement Criteria): See Exhibit **B.** The 2013 Wraparound Fidelity Index data show Fidelity to the Wraparound model remains strong in the fourth year of implementation. The average fidelity score for Massachusetts' providers on the WFI was 78%. TOM scores showed improvement compared to the National Mean, and WFI scores remained stable between FY2012 and FY2013. Massachusetts providers are strong in the Engagement and Planning phases of Wraparound and in the following principles: Strengths-Based, Individualized, Team-Based, Outcomes Based, and Crisis Planning. In fact, Massachusetts' weakest TOM principle in 2010 was Outcomes Based (meaning that the Team revises plans in response to monitoring of the progress of the youth), but due to Wrap Teams' increasing focus on this principle, it has become one of the greatest strengths in FY2013. Massachusetts teams have far more school representatives involved than teams in other states. EOHHS has shared WFI and TOM data with the CSAs and discussed them with the CSAs in the MCE technical assistance meetings and has followed up to ensure that each CSA is aware of and actively addressing any areas that need improvement. This activity is part of EOHHS' ongoing management and quality improvement activities.

d. **MCI Pre/Post Report** (Section V #5 in Disengagement Criteria): This report, attached as Exhibit C, displays behavioral health ("BH") service utilization prior to and following an MCI encounter, during the period between January 2013 and March 2013. As appears in previous quarters' reporting, MCI continues to appear effective as a conduit, helping families engage in BH services. While only 69% of youth using MCI had BH service in the previous 90 days, after the encounter, 90% had utilized a service within 90 days after the

encounter, 80% within 15 days. Of the utilizers who had no BH services prior to the MCI encounter, 71% engaged in services following the encounter. Receiving any remedy service (other than MCI) within 90 days prior to the MCI encounter appears to correlate with more rapid use of a service after the encounter: 97% of youth using remedy services prior to the MCI encounter subsequently utilized a follow-up service within 15 days of the encounter as compared to 58% for those who had no previous BH service utilization.

e. **Data on average length of stay for youth receiving services from Community-Based Acute Treatment (CBAT) programs** (Section V #1 in Disengagement Criteria):

i. For SFY 13 (July 1, 2012-Jun 30, 2013), the average length of stay (LOS) in CBAT programs for all children and youth under the age of 20 was, for the three larger plans, 8.3, 7.5, and 11.3 days respectively. For the three smaller plans, the average was 6.1, 4.9 and 4 days.

ii. For 0-12 years age group: the average LOS was 13.6, 8, and 10 days for the three larger plans and 9.8, 9.9, and 5 days for the three smaller plans. The last figure represents LOS for just two youth.

iii. For 13-18 years age group: the average LOS was 11.2, 8.6, and 9.9 days for the three larger plans and 4.5, 4.9, and 7 days for the three smaller plans.

iv. For 19-20 years age group: the average LOS was 6 and 14.1 days for two of the three larger plans, the third of which had no CBAT utilization for youth aged 19-20 years. Of the three smaller plans, only one had CBAT utilization for youth aged 19-20 years, of which the average LOS was 3.9 days.

f. **Data on Average Length of Encounter in Mobile Crisis Intervention** (section V #7 in disengagement criteria): Due to resource constraints, MassHealth is unable to produce data on the number and percentage of youth who receive MCI services for more than three days. It does, however, receive reports from each of MassHealth's health plans setting out the average length of encounter (LOE) in MCI: In SFY13 Q4 (April-June), the average LOE in MCI was 2.24, 1.87, and 1.75 in the three larger health plans and 2.1, 1.71, and 2.61 in the three smaller health plans.

7. **Service Updates**

a. **Timely Access to Services**: Most families obtain remedy services without delay. However, IHT, IHBS and TM providers in some regions have waiting lists. MassHealth's contracted health plans continue to add to their networks of providers for these services, including working with existing provider agencies to expand into additional service areas.

i. **Intensive Care Coordination** – At the end of September, there were 3,688 youth using ICC. Of the 345 youth enrolled in September, 95% obtained services within 14 days of their request.

ii. **In-Home Therapy** – At the end of September, there were 8,306 youth using IHT, while 70 youth were waiting, 59% for less than two weeks, 20% for two to four weeks, 20% for four to eight weeks, and 1% for eight to twelve weeks. 192 were choosing to wait. ("Choosing to wait" means that capacity exists for those children to enroll in nearby IHT providers, but the family is choosing to wait for services to become available through a particular provider agency.)

iii. **In-Home Behavioral Services** – At the end of September, there were 1,072 youth using IHBS. Eight youth were waiting, two for less than two weeks, two for two to four weeks, and four for over twelve weeks. 63 were choosing to wait.

iv. **Therapeutic Mentoring** – At the end of September, there were 6,999 youth using TM. Thirty-three youth were waiting, 55% for less than two weeks, 27% for two to four weeks, 15% for four to eight weeks, 0% for eight to twelve weeks and 3% for over twelve weeks. 186 were choosing to wait.

v. Family Support and Training (Family Partners) – At the end of September, there were 495 youth enrolled in FS&T.). The only youths waiting were seven youth who were choosing to wait.

b. **Mobile Crisis Intervention (MCI) Access and Quality Indicators:** The Monitor has brought to the attention of the Commonwealth several areas of concern regarding MCI. One of these is whether providers are consistent in providing families with mobile services whenever needed. Defendants are following up with MBHP and DMH, seeking to understand provider practice and improve it where needed. MCI performance is a critical issue for the Commonwealth because it affects downstream services such as Emergency Departments and acute levels of care. At the individual level, MCI offers the crucial opportunity to avert a child's first inpatient admission.

i. **MCI Access -** In August[5] there were 1230 encounters, with an average response time of 32 minutes. 86% of all encounters occurred within 60 minutes of the call to MCI.

ii. Location of Encounter - 49% of these encounters occurred in a community location.

iii. Disposition – 20% of the encounters in February resulted in a psychiatric admission.

[5] August 2013 is the most recent month for which MCI data reports are currently available

c. **Screening:** Exhibit D is the latest available report, FY13, Q4 (April-June 2013). The overall screening rate has reached 70%. Screening rates for children and youth from six months of age to 17 years continue to improve: for children six months to two years old, 80%; for children three to six years old, 81%; for children seven to twelve years old, 76%; and for youth 13 to 17 years old, 75%. Screening rates for infants continue to be much lower (39%) due to a lack of consensus among providers regarding the utility of screening infants this young with the currently available screening tools. MassHealth is in the process of approving a new, comprehensive screening tool that includes cognitive, language, motor, and social-emotional development as well as family risk factors, that can be used with children aged one month to five years. With the addition of the new tool, MassHealth hopes to see increased screening with this age cohort. Screening rates for young adults 19 to 20 are similarly low (36%).

d. **Service Utilization:** Personnel changes at MassHealth have allowed the Defendants to resume generating the CBHI Service Utilization report; see Exhibit E for SFY 13 data. ICC utilization is holding steady, though the proportion of clients aged 0-12 years continues to increase, as it has in the other remedy services. Between SFY 11 and SFY 13, there has been dramatic growth in TM, IHBS and IHT.

Service	**SFY 13 Unduplicated Utilizers**	**SFY 11[6] Unduplicated Utilizers**
ICC	9,095	9,056
FST	8,443	7,608
IHT	17,589	12,529
IHBS	2,067	942
TM	12,447	6,284

[6] A complete report for SFY 12 will be available by the end of December-early January. In the meantime, the last full year service utilization data is from SFY 11.

MCI	12,738	11,194

Respectfully submitted,

MARTHA COAKLEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond BBO #559475
Assistant Attorney General
Government Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2078
Date: December 2, 2013

CERTIFICATE OF SERVICE

I, Daniel J. Hammond, hereby certify that I caused a true and accurate copy of the attached Report to be served upon all parties listed on this Court's ECF service list, via simultaneous electronic service, on December 2, 2013.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General