UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

ROSIE D., ***et al.,*** **Plaintiffs,** **v.** **Charles Baker,** ***et al.,*** **Defendants.**	**CIVIL ACTION** **NO. 01-30199-MAP**

INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the March 9, 2015 status conference, in preparation for the hearing scheduled for May 14, 2015.

The Defendants hereby report as follows:

Since the last status conference, the Defendants, the Plaintiffs and the Court Monitor have met three times, on March 19th and on April 9th and 28th. The parties have continued to review and discuss the reports and activities listed on the schedule of CBHI Disengagement Activities, attached as Exhibit 1. The parties' meetings focused exclusively on these activities, as will the instant Report.

I. Mobile Crisis Intervention ("MCI")

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

The Defendants implemented changes to the MCI Encounter form in November and now collect monthly data on the *source* of referrals to Emergency Departments (EDs). The first four months of data, November 2014 through February 2015, show a consistent pattern: by far the largest percentage of referrals to the Emergency Department are self-referrals by the youth or family (ranging during this time from 48% to 55%). The next two largest sources of referrals were the police (11% to 13.4%) and schools (9% to 13.5%).

There is also a consistent direct correlation between higher proportions of MCI encounters conducted in Emergency Departments and the age of the youth. For example, in January:

- For children ages 0-14, 71% of the encounters were in the community and 29% in EDs.
- For youth ages 15-18, 49% of the encounters were in the community and 51% in EDs.
- For youth ages 19-20, 33% of the encounters were in the community and 67% in EDs.

Ms. Kappy Maddenwald, MSW, completed her site visits with all of the MCI programs and submitted a written report to the parties. It is attached as Exhibit 2. Ms. Maddenwald's overall impressions, as described in her report are:

- "MCI teams across the state are established, functional and well out of 'implementation' phase. There is clear MCI/ESP system maturation. The pace of this change is good and ongoing and is where I would expect it to be in a continuous improvement environment."[1]

[1] Exhibit 2, page 1

- "Teams have advanced their understanding of 'youth and family-centeredness' in service delivery. On the whole, deeply held beliefs about youth in crisis and their parents have shifted in pro-family fashion."[2]
- "In contrast to other mental health treatment programs, crisis intervention teams are highly reliant on decisions made by the broader system and the greater public both UPSTREAM of a crisis episode and DOWNSTREAM of a crisis episode….Each team's performance must be evaluated, and performance improvement initiatives implemented within the context of the dynamic community it serves."[3]

Ms. Maddenwald made a number of recommendations, emphasizing that MassHealth should:

1. Work with MBHP to develop a "package of changes" regarding which data are collected and disseminated to the MCI programs and community partners. The purpose of the changes would be to equip the MCI teams and MBHP with data to guide both day-to-day practice and further development of the crisis system of care.
2. Develop specific materials for various referral sources (schools, police departments, residential programs) to educate them about the risks of hospitalization, particularly for certain youth, and the benefits of proactive crisis planning and use of MCI in a community setting.
3. Explore whether MassHealth could add the MCI/ESP access number to the back of health plan membership cards for MassHealth members.

The Defendants are taking steps to implement each of these recommendations.

II. Outpatient (OP) as a Hub

[2] Exhibit 2, page 3
[3] Exhibit 2, page 3

GOAL: For children or youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider: 1) regularly assesses the child/youth's need for more intensive care coordination or other remedy services; 2) expeditiously discusses the need for other services with the parent or caregiver; 3) offers to either make a referral to needed services or assist the caregiver to make the referral; and 4) with the caregiver's permission, participates in phone calls and/or meetings with the family and the new provider(s). In particular, if the outpatient provider becomes aware that the youth appears to meet medical necessity criteria for IHT and/or ICC, the outpatient provider must inform the youth's caregiver(s) about these services and offer to help the caregiver access one or both services for the youth. [4]

Outpatient Hub Services Evaluation

Conducted by the Massachusetts Behavioral Health Partnership at the request of EOHHS, the study has been completed and reviewed by the parties.

The study analyzed the claims of 8,822 members who had received at least eight OP visits between December 1, 2012 and November 30, 2013, and not received either Intensive Care Coordination (ICC) or In-Home Therapy (IHT) during the same period. It also conducted record reviews and interviews with caregivers and therapists of a sub-sample of 50 youth.

[4] This is the Defendant's formulation of the appropriate goal for outpatient-as-a-hub. The Plaintiffs' preferred language is: "For children or youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider regularly assesses the child/youth's need for more intensive care coordination or other remedy services. If the youth meets the medical necessity criteria for IHT or ICC, the outpatient provider must: 1) inform the youth's parent/guardian about these services; 2) make the appropriate referral on their behalf, unless the parent/guardian declines; and 3) with the parent/guardian's permission, participate in phone calls and/or meetings with the family and the new provider(s)." (Emphasis supplied.) As the underscored language makes clear, the parties' lingering dispute turns on whether an outpatient clinician should (a) refer a child/youth to an ICC or IHT provider at the direction of a parent or caregiver who has been briefed on the benefits of those services and whom the outpatient clinician has offered to help in making such arrangements ; or (b) make that referral as a matter of course upon finding that the child/youth meets the medical necessity criteria for the service, unless specifically directed not to do so by the parent or caregiver.

Key findings:

- The 50-youth sub-sample appears to be comparable to the larger universe of 8,822 member claimants, based on gender, age and use of various behavioral health (BH) services.
- The 8,822 youth receiving OP as a hub are at *significantly* less clinical risk than a sample of 875 youth receiving ICC, based on a comparison of their respective levels of use of Mobile Crisis Intervention (MCI), psychiatric inpatient treatment, Community-Based Acute Treatment (CBAT), Intensive Community-Based Acute Treatment (ICBAT), and medication management. This finding suggests that families are appropriately stratified within the behavioral health services continuum -- that is, that children and youth with more acute behavioral health needs are receiving coordination through the more intensive therapeutic hubs (ICC and IHT), and that youth and children with lesser needs are likely to use Outpatient Therapy as a hub.
- Of the 50 youth in the sub-sample, 12 (24%) received Therapeutic Mentoring and 7 (14%) used MCI. No youth received In-Home Behavioral Services or Family Support and Training.
- Of the 8,822 youth in OP, for 5,206 (59%), the therapist also billed for collateral contacts or consultations. In the smaller sample, 34 youth (68%) also received collateral contacts or consultations.
- Of the youth in the sub-sample, 34 (68%) caregivers reported that the therapist assisted them in accessing other services and coordinating services with state agencies. The remaining 16 caregivers were asked if such care coordination would have been helpful and only three said it would have been.

- Therapists were uniformly familiar with CBHI services:
    - IHT 49 (98%)
    - TM 49 (98%)
    - ICC 47 (94%)
    - MCI 47 (94%)
    - FS&T 46 (92%)
    - IHBS 44 (88%)

- Families were significantly less familiar with CBHI services:
    - IHT 39 (78%)
    - TM 34 (68%)
    - MCI 33 (66%)
    - IHBS 20 (40%)
    - ICC 18 (36%)
    - FS&T 13 (26%)

- Both caregivers and therapists were asked whether the CBHI services the youth had not received would have been helpful. There is a significant difference in two sets of responses, perhaps related to the therapists' knowledge of medical necessity criteria.

Service not received, but might have been helpful.	Caregivers: Yes	Therapists: Yes
ICC	20 of 49 (41%)	5 of 47 (11%)
IHT	19 of 46 (41%)	14 of 43 (33%)
TM	31 of 36 (86%)	11 of 35 (31%)
MCI	9 of 47 (19%)	6 of 41 (15%)
IHBS	12 of 49 (24%)	9 of 48 (19%)
FS&T	18 of 48 (38%)	8 of 48 (17%)

The report made several recommendations, which the Defendants are implementing:

1. Ensure that caregivers know about CBHI services and how to access them, by providing OP therapists with training and educational resources.

2. Hold OP therapists accountable for informing caregivers about CBHI services by requiring them to have caregivers sign a form attesting to having been given an overview of the CBHI services by the therapist.
3. Develop a "toolkit" for OP therapists, including information on parent support groups, CBHI materials, and a description of what caregivers should expect from outpatient therapists serving as a CBHI Clinical Hub.
4. The fact that none of the 50 youth in the sub-sample were reported to be involved with substance use disorder services is notable and merits further investigation with providers to ensure that they are screening youth for substance use disorder.

Written Guidelines for Outpatient Therapy as a CBHI Clinical Hub

The Defendants have drafted the Guidelines and revised them once, incorporating many of the Plaintiffs' comments and suggestions. The Plaintiffs are seeking additional changes. The parties continue to discuss the best methods for achieving the goal of ensuring that OP therapists inform caregivers about CBHI services and regularly reassess a family's need for care coordination. At the April 28, 2015 meeting of the parties, the Court Monitor suggested some supplementary data analysis to help further define the problem and the Defendants offered to conduct a meeting with CBHI provider representatives to obtain their suggestions for achieving this goal.

Prompts for OP therapists to regularly reassess a family's need for care coordination

The parties agree that OP therapists should not make a one-time assessment of whether a youth in treatment would benefit from more intensive care coordination, but rather should revisit such assessment periodically. To that end, the parties have agreed that the Defendants should compel OP therapists to fill out a form, at least every six months, reassessing the youth's need for care coordination. The Defendants have prepared a draft of such form and the Court Monitor and Plaintiffs have offered comments. The Defendants propose holding off on finalizing the form until they have met with CBHI provider representatives.

Launch of the new CANS training and certification

This project is on track for an October 31, 2015 launch.

Revise Protocol Documents

The first redraft has just been sent to the Plaintiffs.

III. Intensive Care Coordination

GOAL: Ensure access to ICC for children and youth who meet medical necessity criteria for the service and ensure that ICC providers deliver high-quality ICC services.

MCE Reports on CSAs with low enrollment and/or with high caseloads

The parties have discussed these issues at several meetings. The Defendants' understanding of the issue, based on discussions with CSA managers, Wraparound coaches and MCE Network Management staff, is that, for CSAs with patterns of either low enrollment or high caseloads per clinician (or, in some cases, both), the root cause of these patterns is the difficulty the CSAs have with respect to hiring clinical staff. This problem appears to have worsened since spring 2014, when the Department of Children and Families began hiring substantial numbers of new staff. The Defendants also suspect that the improving economy may have further tightened the labor

market. The Defendants are hopeful that the DCF hiring pressure will ease and that the Alternative Payment Methodology pilot, on track for implementation July 1, 2015, will help CSAs attract and retain clinical staff.

SFY2014 Final SOCPR Report

The parties have reviewed and discussed the findings and recommendations of this report, attached as Exhibit 4.

Key findings[5] include:

- Across the five service regions, SOCPR mean domain scores ranged from 4.9 to 6.4.
- Providers performed best on the domain Community-Based (6 to 6.4), followed by Culturally Competent (5.3 to 5.9), Child-Centered and Family-Focused (5.3 to 6).
- Areas needing improvement included assessment (5.2 to 5.9) and service planning (4.9 to 5.8)
- The statewide Impact score of 5.4 equates to "Good" impact.

Recommendations include:

- Creating a Massachusetts-specific version of the SOCPR protocol
- Clarifying practice standards for IHT and investing in IHT workforce development
- Developing clear policies and procedures for clinical consultation and review of care
- Promoting greater inclusion and use of natural supports and "hub-dependent" services
- Improving planning for transitions (e.g. from hospital to home, from child to adult services, from one level of service to another)
- Improve strategies to engage families in ICC

[5] SOCPR scores range from a low of 1 to a high of 7.

The Defendants have informed the Plaintiffs and the Court Monitor of a wide range of quality improvement activities underway to respond to the issues identified in these case reviews.

Development of the Massachusetts Practice Review (MPR)

The Plaintiffs and Court Monitor have reviewed the Defendants' recently revised MPR, with no outstanding issues of concern or dispute.

Upcoming MPR case reviews and reports

The Defendants will conduct another pilot of the revised MPR in June, 2015, conducting ten case reviews. A consolidated report of the October and June reviews will be completed by September 1, 2015.

Planning is underway and on track to complete 120 case reviews in state fiscal year 2016. The Defendants will conduct reviews in October, March and June. Reports on each "wave" of reviews will be produced three months after the reviews are completed, with a final, comprehensive report produced in Fall 2016.

IV. Clinical Outcomes

GOAL: Implement a regular cycle of analysis of CANS data to monitor the demographic and clinical characteristics of children and youth using CBHI services and the clinical impact of those services.

The Defendants produced a proposed plan for an annual analysis of CANS data and reviewed it with the Plaintiffs at meetings on March 4th and April 28th. The Defendants have incorporated the few changes requested by the Plaintiffs and Court Monitor and are putting the plan into production. The report setting forth the Defendants' first annual analysis of CANS data will be available by July 15, 2015.

V. Additional Items from the Disengagement Criteria

DMH Chart Reviews

The Defendants have worked closely with the Court Monitor and staff from the Department of Mental Health (DMH) to understand the DMH service data and help the Court Monitor design the chart review methodology. The reviews are expected to be completed by late summer.

Practice Guidelines

As previously reported, the **MCI** and **IHT Guidelines** have been completed and distributed to providers. One round of regional, half-day trainings on the IHT Guidelines have been completed and a second round is underway. All IHT providers are required to send staff to these trainings.

The parties have completed work on the **TM Guidelines** and they are currently in production through the MassHealth Publications Unit.

The **IHBS Guidelines** have gone through three rounds of comments and revision. The parties are in substantial agreement and the Defendants expect to produce a final version by the end of May.

The Defendants have produced one draft and one revision of the Outpatient Therapy as a CBHI Clinical Hub Guidelines. The Plaintiffs and Court Monitor are seeking additional changes and the Defendants will produce a further revision by the end of June.

Clinical Topic Review 2013 – Behavioral Health Screening Among MassHealth Children and Adolescents

The parties reviewed and discussed this study in meetings held on March 4th and April 9th and 28th.

Respectfully Submitted,

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Date: May 1, 2015

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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