UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
WESTERN DIVISION

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

DEFENDANTS' INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the May 14, 2015 status conference, in preparation for the hearing scheduled for September 22, 2015.

The Defendants hereby report as follows:

Since the last status conference, the Defendants, the Plaintiffs and the Court Monitor met twice, on July 7 and on September 8. The parties continued to review and discuss the reports and activities listed on the schedule of CBHI Disengagement Activities, revised since the parties' most recent reports to the Court and attached as Exhibit A.

The parties' meeting focused on these enumerated activities. Adjustments to the schedule were also discussed as a consequence of the Office of the Compliance Coordinator (i.e. the CBHI office) losing the equivalent of two (out of a total of five) full-time positions. One position was left open through the promotion of Emily Sherwood from CBHI Director to Director of Behavioral Health at MassHealth, and one through retirement under the Executive Branch's Early Retirement Incentive Plan, which has also resulted in many departures of key staff from sister agencies. As of this writing, it is the Commonwealth's plan to fill both vacated positions, but the temporary loss of staff has affected delivery of certain projects, as reported below.

This report follows the convention of the defendant's prior status report, in which disengagement activities are organized under main headings, with a stated goal for the activities under each heading. Except where noted, Plaintiffs and Defendants are in agreement regarding these goals.

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.

As noted in the their last report, the Defendants implemented changes to the MCI Encounter form in November and now collect monthly data on the source of referrals to EDs. Also as previously reported, Ms. Kappy Madenwald, MSW, completed her site visits with all of the MCI programs and submitted a written report and recommendations to the parties. Ms. Madenwald joined the meeting of the parties on July 7, 2015, by telephone and reiterated her

findings that quality of the MCI system continues to mature at an appropriate pace and that individual teams are working to find appropriate solutions to meet local needs. She again stated, as she did in a meeting of the parties on March 5, 2015, that she does not believe the system would benefit from MassHealth promulgating more MCI provider requirements at this time.

Ms. Madenwald made several recommendations. Those recommendations are set forth below, along with an update on Defendants' activities to address each recommendation:

1. MassHealth should 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. One element of this package would be to "unblind," or identify, the provider organizations in MCI reports for greater transparency.

Activities: Defendants have already moved to unblinded MCI reports. Defendants and MBHP met by phone with Ms. Madenwald on August 19, 2015, to discuss other elements of her recommendations. Defendants have provided highlights of this meeting to the Court Monitor and Plaintiffs. Ms. Madenwald offered four areas to focus upon in the long term. The primary immediate action step will be a meeting with a representative group of MCI directors on November 13, 2015, to discuss ways in which MassHealth could assist providers to use data more effectively in managing their programs.

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.

Activities: Ms. Madenwald has collected materials developed by local Emergency Service Programs (ESPs) and MCI programs as a starting point. MassHealth is investigating options for funding Ms. Madenwald to continue work on this project. In the meantime, the ED referral reports indicate that for youth up to age 14, a substantial fraction of members who end up

being seen by MCI in an ED were directed there by school personnel. MassHealth staff have begun meeting specifically with staff from DPH to ascertain whether some of these referrals are coming from DPH's school-based health centers, and if so, to devise strategies to reduce those referrals.

3. Explore whether MassHealth could add the MCI or ESP access number to the back of health plan membership cards for MassHealth members.

Activities: Information on member cards is regulated by the Division of Insurance. MassHealth will explore this option at a later time.

Of note, DMH has asked MBHP to procure ESPs to replace the programs currently run by DMH in the Southeast region. MBHP issued a Request For Proposals on July 6, 2015, with applications due September 15, 2015, with bidders to be notified by October 13, 2015, and contracts to be implemented within ninety days of final contract awards. Consolidation of all ESPs offers an opportunity for more effective quality management of MCI in the long run, although recontracting may present short-term operational challenges.

II. Outpatient (OP) as a Hub

GOAL: For children or youth receiving outpatient therapy but not receiving In-Home Therapy (IHT) or Intensive Care Coordination (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.[1]

Outpatient Hub Services Evaluation

As previously reported to the Court, MBHP reported to the parties its extensive study of how Outpatient (OP) services were performing as hubs, resulting in several recommendations. Those recommendations are set forth below, along with an update on Defendants' activities to address each recommendation:

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

Activities: The Defendants are developing a new Child and Adolescent Needs and Strengths tool (CANS) training into which all OP clinicians (as well as clinicians in other levels of care) must enroll when becoming newly CANS certified, or when their current CANS certification expires. The University of Massachusetts CANS training team has created raw video material which will be integrated into the new online video training of approximately six

[1] As noted in the previous report to the Court, this is the Defendant's formulation of the appropriate goal for outpatient-as-a-hub. The Plaintiffs' preferred language is slightly different: "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.

hours, and a matching certification process. The scope of the new training and certification will include sections on the CBHI array of services, responsibilities of hub providers, and how to use the CANS to facilitate coordination. Originally scheduled to launch in October 2015, the large scope of this project has required more time and it is currently expected to launch by the end of February 2016.

2. Hold OP therapists accountable for informing caregivers about CBHI services by requiring them to have parents/caregivers sign a form attesting to having been given an overview of the CBHI services by the therapist.

Activities: MassHealth and Managed Care Entities (MCEs) met with provider representatives to discuss options for ensuring that OP providers discuss ICC referral with families of children who meet medical necessity for ICC. Providers were concerned about the OP clinical process being overburdened with paperwork requirements, and suggested MCEs could instead send a letter to families of children identified as meeting Serious Emotional Disturbance (SED) criteria, to inform them about ICC. MassHealth met with MCEs on August 18. MCEs note that around 25% to 50% of member mailings are returned due to outdated addresses; in addition, hearing from a trusted clinician is likely to have much more impact than receiving a mailing from the MCE (especially given the volume of mailings that many families already receive from health care providers). As a result, it appears that a form, signed twice a year by a parent or caregiver for youth in OP with SED, is the best current option for ensuring that families have been informed about ICC. (MassHealth does not believe it is reasonable or meaningful to seek attestation about education about the entire array of remedy services. OP providers are already required to distribute the CBHI brochure to all caregivers.) MassHealth's MCEs have submitted plans for how they will audit OP providers to ensure that the form is being completed twice annually as required. The new requirement will be effective December 31,

2015. The assessment of need for ICC must be completed within 30 days of the initial visit, or by December 1 for children already in OP treatment, and at six-month intervals thereafter.

In addition, Defendants believe that high quality video introductions could play a strong adjunctive role in informing families about services such as ICC. Defendants are exploring means to develop such video materials, which could be accessed from any computer or smartphone, either with the OP clinician or independently. The Children's Behavioral Health Knowledge Center has offered a resource to develop this video through the University of Massachusetts Donahue Center; CBHI staff will meet with Donahue staff on November 4, 2015, to plan this project.

3. Develop a "toolkit" for OP therapists, including information on parent support groups, CBHI materials, and a description of what parents/caregivers should expect from OP therapists serving as a CBHI Clinical Hub.

Activities: Defendants have integrated this information into written Guidelines for Outpatient Therapy as a CBHI Clinical Hub (see below).

4. The fact that none of the 50 youth in the sub-sample reviewed by MBHP in connection with its Outpatient-as-a-Hub study 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 disorders.

Activities: MassHealth has sent information to all providers regarding the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and toolkit. The Office of Behavioral Health will also be working to implement relevant initiatives from the Opioid Epidemic Action Plan issued by the Governor on June 22, 2015. Although details are not yet clear, MassHealth anticipates ongoing efforts to increase awareness of substance abuse by behavioral health providers.

Written Guidelines for Outpatient Therapy as a CBHI Clinical Hub

Responding to extensive comments by Plaintiffs regarding an initial draft of *Guidelines for Outpatient Therapy as a CBHI Clinical Hub,* Defendants have produced major revisions and submitted these to Plaintiffs on September 4, 2015. Timing did not permit the parties to discuss this draft at their meeting on September 8, 2015. Defendants expect to have received and reviewed Plaintiffs' comments by the time of the status conference on September 22, 2015.

Launch of the new CANS training and certification

As mentioned above, the launch date for this project has been changed from October 2015 to February 2016.

Revision of Protocol Documents

Plaintiffs' comments on the Defendants' first draft have been incorporated into a version sent to state agencies to use in revising their agency-specific protocol sections. The CBHI office is currently contacting the agencies to develop timelines for each agency to revise its materials. Staff retirements at the agencies due to the Early Retirement Incentive Plan may affect these timeframes.

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.

<u>MCE Reports on Community Service Agencies (CSAs) with low enrollment and/or with high caseloads</u>

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 been having 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 (discussed extensively in the Defendants' May 2015 status report) will help CSAs attract and retain clinical staff

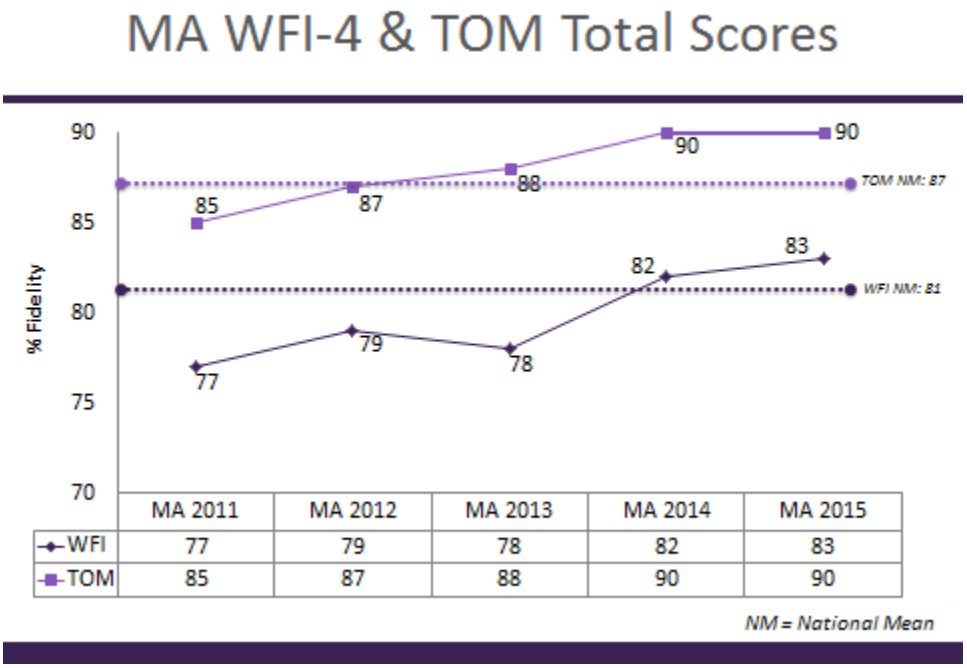
MassHealth, its MCEs, and providers have continued to plan for the APM pilot, but launch has been delayed due to the complexity of rate determination and contract language. A launch date in December 2015 appears likely.

SFY2014 Final SOCPR Report and 2014 Wraparound Fidelity Report

Findings from the SFY2014 System of Care Practice Review (SOCPR) report were discussed in Defendants' previous report to the Court. (Updates regarding the new Massachusetts Practice Review will be discussed below.) This report, consistent with data from other sources, has emphasized for the Defendants the importance of developing more robust supports for quality IHT.

Dr. Eric Bruns reported to MassHealth and the MCEs on August 11, 2015, on Wraparound Fidelity from the 2014 -2015 cycle of Wraparound Fidelity Index (WFI) and Team Observation Measure (TOM) reviews. These findings will be shared with the CSAs at a statewide meeting on September 18, 2015, and will be publicly released at that time. In brief, they show an increase in fidelity over the last three years, with Massachusetts' overall fidelity

scores surpassing national norms. The figure below shows Massachusetts WFI and TOM scores from 2011 through 2015, compared to national norms. (National norms have increased during this period as well; 2011 scores for Massachusetts actually surpassed the national norms at this time, although they fall below today's Massachusetts norms.)



During FY2016 MassHealth is conducting pilot testing of new versions of both the WFI and the TOM, in the expectation of finding increased validity for the TOM and more efficient data collection for the WFI. Scores on the new tools are not comparable to scores on the old tools, but will be comparable to national norms established for the new tools.

In response to findings from sources such as the SOCPR and Wraparound fidelity assessment, MassHealth has a number of projects in place to support ongoing improvement of quality, especially in ICC. The Wraparound Coaching program using in-state coaches for ICC

and Family Partners in FY2015 undoubtedly contributed to the continuing increase in Wraparound Fidelity in CSAs. This program will continue in FY2016 with a shift in emphasis from coaching of individual CSAs to more work with CSAs as regional groups, and a yearlong emphasis on use of quantitative data for management and quality improvement. MassHealth is also piloting new versions of the WFI and TOM that promise better measurement and in some cases more rapid collection of data.

Strengthening IHT:

The CSR, SOCPR and now the Massachusetts Practice Review (MPR, the successor to the SOCPR) have consistently shown more opportunities for improvement in IHT than in ICC. This is not surprising, given the amount of implementation support that MassHealth has provided to the CSAs compared to the level of support provided to IHT practitioners.

In response, MassHealth has initiated several projects, some in collaboration with state partners, to strengthen IHT. These include two projects focused on IHT supervisors. In the first, Ken Hardy, PhD, from Drexel University, has worked with IHT programs on supervisory issues, notably, how to develop a dialog in supervision and treatment about race and trauma. In the second project, Lizzy McEnany, PsyD, has worked with IHT programs on supervisory issues related to working with families with young children, who make up an increasing proportion of the IHT population. Both of these projects are ongoing into calendar 2016.

In addition, the Children's Behavioral Health Knowledge Center, in collaboration with MassHealth, has supported development of curricula for IHT on Family Talk with William Beardslee, MD, an evidence-based model that supports parents who experience depression in having family conversations about the impact of their condition on the family. IHT providers

have described the training as extremely helpful. In a larger project, MassHealth and the Knowledge Center have contracted with Judge Baker Children's Center to train two IHT providers (in Greenfield and in Boston) in MATCH, a modular evidence-based approach to treating children who may have any combination of four presenting problems (anxiety, trauma, depression and conduct issues). Children with MassHealth often have multiple concerns and the MATCH protocol will provide useful information on quality improvement in IHT through the use of modularized evidence-informed approaches. Modularized approaches promise a better fit for the MassHealth population than evidence-based treatments that address only one condition or diagnosis.

Finally, MassHealth and the Knowledge Center have placed strengthening IHT within a systematic "active implementation" framework developed by the National Implementation Research Network (NIRN), which will be providing consultation during the upcoming year as MassHealth and NIRN engage jointly in a major effort to define the best practices for IHT, developing what is termed a "practice profile" for that service. All of the IHT improvement projects mentioned above will be fodder for this larger initiative. Defendants are strongly committed to bringing IHT to a high level of practice, comparable to the existing standard for ICC, through a planned and integrated process.

Upcoming MPR case reviews and reports

The Defendants conducted two pilot rounds of the revised MPR in June, 2015, conducting ten case reviews. A consolidated report of the October 2014 and June 2015 reviews will be completed by October 1, 2015.

Defendants will conduct 120 case reviews in state fiscal year 2016 using the new tool. As with the SOCPR, the Technical Assistance Collaborative (TAC) will manage the review process and the analysis and reporting of findings. Reviews are scheduled for October 2015, March 2016 and June 2016. Reports on each "wave" of reviews will be produced three months after the reviews are completed, with a final, comprehensive report produced in fall of 2016. Partly in response to fewer state employees being available as reviewers as a result of the Eearly Retirement Incentive Program, TAC has recruited a number of new reviewers for 2016, including employees of MassHealth's MCEs. Defendants continue to look for opportunities to improve the validity of the tool, to increase their learning and dissemination of findings from the process, and to link MPR with other quality measurement and improvement processes.

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 4, 2015 and April 28, 2015. Defendants incorporated the few changes requested by the Plaintiffs and Court Monitor. MassHealth is committed to issuing CANS reports twice a year.

The report will include item-level analyses as well as analyses of groups of related items (that is, CANS domains). MassHealth has completed data runs and will provide to the Plaintiffs a report chapter on the item-level analysis by September 23, 2015. Defendants will present to

Plaintiffs a second report chapter including domain-level analysis and a synthesis of findings by October 21, 2015.

As noted in that report, the most interesting and potentially useful outcomes findings result from item-level analysis of CANS data and CANS change data, and the most productive use of CANS data will be at the individual and program level. Defendants believe that several actions are moving MassHealth's system toward more effective use of the CANS to improve quality and outcomes. These are:

1. Ongoing Information Technology (IT) defect fixes and performance enhancements over the last two years that have reduced obstacles to compliance and use of the CANS application on the Virtual Gateway.

2. Pending revision of the CANS training and certification system, to be released in February 2016, in which much more information is provided about the use of the CANS in working with families, in collaboration, and in serving as a hub.

3. Pending IT upgrades which will give clinicians and provider organizations enhanced reporting. Clinicians will be able to show families and collaborators graphical displays of a child's past and present CANS scores, helping them to visualize priority areas for intervention as well as progress made in treatment. IT funding for this purpose was added to the FY16 budget, and hiring of additional IT development staff is currently underway.

V. Additional Items from the Disengagement Criteria

DMH Chart Reviews

The Defendants and staff from the Department of Mental Health (DMH) met multiple times with the Court Monitor to promote understanding of the DMH service data and to help the Court Monitor design the chart review methodology. The fact that DMH administrative data do not map exactly to DMH services actually received has required many iterations of DMH analysis. In addition, the complexity of understanding which MassHealth behavioral health services a child receives through analysis of encounter data is greater than anticipated. Defendants are in the process of engaging an expert from the University of Massachusetts Medical School to assist with this issue. They anticipate that the Court Monitor will have a sample of forty (40) members drawn in early fall, and that chart reviews of those members will occur in October and November of 2015. Follow-up analysis of MassHealth data may take up to the end of January 2016.

Therapeutic Mentoring Practice Guidelines

The Therapeutic Mentoring ™ Guidelines were published in June and are available on the CBHI website at http://www.mass.gov/eohhs/docs/masshealth/cbhi/practice-guidelines-tm.pdf. Defendants engaged Marci White, MSW, to provide training on the guidelines. (Ms. White consulted with the parties on the initial design of the TM service and is a nationally acknowledged expert on the service.) The schedule of trainings appears below. Nearly two hundred provider staff attended and evaluations for the training were strongly positive.

Date	Time	Region	Hotel	#

				Attendees
6/17/15	9:00 AM – 4: 00 PM	Northeast	Wyndham Boston Andover	**43**
6/18/15	9:00 AM – 4: 00 PM	Central	Hampton Inn	**25**
6/19/15	9:00 AM – 4: 00 PM	Southeast	Holiday Inn, Taunton-Foxboro	**53**
6/24/15	9:00 AM – 4: 00 PM	Western	Hilton Garden Inn	**30**
6/25/15	9:00 AM – 4: 00 PM	Metro-Boston	Boston Marriott Newton	**47**
Total				**198**

IHBS Guidelines

The In-Home Behavioral Services (IHBS) Guidelines have gone through three rounds of comments and revision. The most recent draft from the Defendants was sent to Plaintiffs on August 28, 2015, and returned by the Plaintiffs with suggested edits on September 5, 2015. The parties are in substantial agreement and the Defendants expect to have a final version produced by MassHealth Publications by the middle of October. Defendants are also developing a plan for disseminating the guidelines and supporting their implementation by providers.

Guidelines for Outpatient Therapy as a CBHI Clinical Hub

As mentioned previously, Defendants submitted to the Plaintiffs extensively revised draft Guidelines for Outpatient Therapy as a CBHI Clinical Hub on September 4, 2015.

VI. Emerging Access Issues

Demand for Behavioral Health (BH) services is seasonal and dynamic, usually peaking in the fall and spring, with a low point in summer. In addition, certain services such as ICC have historically reported difficulty in hiring Masters-level staff.

CBHI access reports suggest that there is currently a more pervasive and lasting problem with access to services, particularly ICC and IHT, than at previous times, or than can be readily explained by seasonal fluctuations. MassHealth views this as a serious concern and has conducted many discussions with MCEs and providers to understand the origins of this problem, to determine whether it is temporary or likely to continue, and to evaluate possible interventions to resolve the problem. Regarding cause, Defendants do not have a definitive answer but identify two (perhaps three) likely causes. First, an improving economy has provided many alternative careers for young people who might have entered the BH workforce. Other business sectors, including teaching and the restaurant industry, are reporting similar workforce shortages for entry-level employees.[2] Second, extensive and ongoing hiring at DCF offers salary and benefits that are difficult for behavioral health service providers to match. In addition, an

[2] "Chef shortage leaves restaurants vying for help," by Megan Woolhouse, Boston Globe Metro Section, August 12, 2015; "Where have all the teachers gone?" Eric Westervelt for NPR, March 3, 2015, http://www.npr.org/sections/ed/2015/03/03/389282733/where-have-all-the-teachers-gone

increased emphasis on primary care integration may result in clinicians being hired away from BH organizations to work in healthcare settings, serving more commercially insured clients.

Thus, Defendants believe that access problems, to the extent that they are enduring and pervasive, are related to larger shortages in the BH workforce. One remedy to a shortage of supply is to pay more for a service, and MassHealth has raised rates for non-CSA CBHI services effective July 1, 2015. Rates for CSA services were increased substantially approximately two years ago, and another rate review for those services (ICC and Family Support and Training (FS&T)) is currently underway, with an implementation target of January 2016. While periodic rate adjustments are certainly needed, MassHealth and its providers will always face challenges in attracting and retaining the best possible candidates to work in BH services.

As a result, while MassHealth does not control the labor market, Defendants are looking for ways to support providers in attracting staff and in reducing excessive turnover. These will necessarily be long-term strategies, and none will be a panacea. Interventions under consideration include:

1. Communications strategies that will help prospective clinicians understand how to plan for tuition forgiveness for graduate school. Clearly, loan burden will have powerful influence on young clinicians' choice of jobs. Defendants believe there is potential here, especially for students using federally funded student loans. Recognizing that this challenge affects multiple state agencies, the Children's Behavioral Health Knowledge Center at DMH has developed informational materials on loan forgiveness, which MassHealth has disseminated to providers using multiple channels.

2. Providing additional supports for students in CBHI clinical placements, so that candidates in social work, counseling, psychology and marriage and family therapy programs can feel informed and ready to enter into the CBHI workforce upon graduation. SOCPR and other sources of information suggest that inadequate preparation for the complexities of CBHI clinical roles may be a source of high job stress and turnover. MassHealth is exploring models for providing additional supervision for students in final-year clinical placements in CBHI services, in collaboration with graduate training institutions and host provider agencies.
3. Working with providers to support clinicians' experience of their work as meaningful and effective. Much anecdotal experience supports the view that clinicians, while not indifferent to compensation levels, are also highly motivated by their helping mission, by human contact and teamwork with families and collaborators, and by the intellectual challenge, mastery and satisfaction of their work. While MassHealth does not control the climate of provider organizations, Defendants believe that MassHealth can support positive work experiences through such measures as:
    a. reduction in paperwork and related administrative requirements that take clinicians and their supervisors away from their focus on children and families;
    b. reduction in administrative requirements for billing (for example through the Alternative Payment Mechanism pilot for Intensive Care Coordination, which would move from fifteen-minute units to a day rate); and
    c. provision of training and tools that facilitate success in clinical work (such as the quality improvement projects underway in IHT, cited above).

Respectfully submitted,

EXECUTIVE OFFICE OF HEALTH
AND HUMAN SERVICES

By its attorney,

MAURA HEALEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General
Government Bureau
BBO # 559475
One Ashburton Place, Room 2014
Boston, Massachusetts 02108
(617) 727-2200, ext. 2078
dan.hammond@state.ma.us

Dated: September 10, 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.

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