UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al., Plaintiffs, v. CHARLES BAKER, et al., Defendants.	C.A. No. 01-30199-MAP

PLAINTIFFS' THIRTY-SECOND STATUS REPORT

I. Introduction

At its June 8, 2016 status conference, the Court directed the parties to exchange and discuss several documents related to the disengagement process: (1) the form of a proposed Order memorializing recent agreement on the enhancement of Outpatient Therapy; (2) a sustainability framework for Mobile Crisis Intervention (MCI); and (3) the parties' respective positions on achievement of the 2013 Joint Disengagement Criteria and ongoing efforts to comply with the Court's Judgment. The defendants filed their Interim Report on Implementation (Defendants' Interim Report) on September 13, 2016. Doc. 749. Plaintiffs' Status Report responds to the Court's directives, and Defendants' Interim Report, in the context of ongoing implementation efforts.

II. Order on Outpatient Services

The Court's Findings and Conclusions, *Rosie D. v. Patrick,* 410 F. Supp. 2d 18 (D. Mass. 2006) extensively discussed the critical importance of care coordination for youth with Serious Emotional Disturbance (SED). Its 2007 Judgment, *Rosie D. v.*

Patrick, 497 F. Supp. 2d 76 (D. Mass. 2007), included an entire section on service coordination and service planning. Judgment at 11-14. Although the Judgment did not address Outpatient Services, the Commonwealth subsequently determined to rely upon outpatient therapists as one of three vehicles for providing service planning and coordination to youth with SED.[1] The parties have apparently agreed on a series of reforms designed to enhance Outpatient Therapy and enable it to provide improved care coordination for SED youth who rely upon the service for approving, authorizing, coordinating, and monitoring other remedial services. Because of the Commonwealth's decision to designate outpatient therapists as service coordinators, the agreed upon reforms to enhance Outpatient Services should be incorporated into the Court's remedial plan.

As directed by the Court, on July 29, 2016, the plaintiffs sent the defendants a proposed Order on Outpatient Services, which is attached as Exhibit 1. On August 19, 2016, and again by conference call on September 13, 2016, the defendants voiced their objections to incorporating the substantive reforms in a court order, claiming that an order is not necessary and could restrict their flexibility in providing Outpatient Services.[2] Defendants raise these objections despite their decision to use Outpatient Services as a central element for complying with the Court's liability decision without ever modifying the Court's Remedial Order, and irrespective of the fact that they have already agreed to reform Outpatient Services as described in the proposed Order.

[1] The other two programs, Intensive Care Coordination and In-Home Therapy, are specifically described in the Judgment.

[2] The defendants' August 19, 2016 draft Opposition also indicated their disagreement with the plaintiffs' description of the substantive reforms of Outpatient Services. In the September 13, 2016 conference call, the parties appear to have resolved these disagreements. That same day, the plaintiffs sent a revised proposed Order that included changes to address the defendants' concerns. Because of vacation schedules, the defendants will not be able to respond to this revised order until September 23, 2016.

The defendants' first objection – that an order is not necessary because they will soon implement the reforms to Outpatient Services – is contrary to the very purpose of court-ordered relief in general, and to the Remedial Plan in particular. In its Remedial Order, the Court adopted many of the system reforms proposed by the Commonwealth, but determined that these reforms should be reflected in an enforceable judicial decree. That the Commonwealth voluntarily adopted and has begun to implement revisions to its outpatient service system in no way undermines the appropriateness of, and indeed the necessity for, incorporating those revisions in a court order. In fact, the defendants have already *de facto* modified the Remedial Plan by having Outpatient Services act as a "hub" for coordinating other remedial services. As a result of this decision, tens of thousands of youth with Serious Emotional Disturbance (SED) have Outpatient Therapy as their only source of service coordination. That *de facto* modification of the Remedial Plan should now be formally reflected in the Plan, with the agreed-to revisions.

The defendants' second objection, that a court order will lead to the loss of flexibility in operating, monitoring and administering Outpatient Services enhancements, is both unsupported and misplaced. As evidenced by the very decision at issue – the Commonwealth's use of Outpatient Services as a 'hub' for home-based service coordination – the defendants have retained, and exercised considerable discretion in the establishment, oversight and operation of the remedial service system. The specific obligations and service requirements outlined in the Court's 2007 Judgment have not hindered this flexibility at any time in the past nine years, and they are not likely to do so in the future. To the contrary, the parties have collaboratively discussed and agreed to a host of revisions to medical necessity criteria, program specifications, authorization

procedures, evaluation methods, reporting requirements, and service system reforms over the past decade without any interference with the Commonwealth's flexibility to provide home-based services to youth with SED.[3]

Because enhanced Outpatient Services are now, and will continue to be, an important part of the Commonwealth's program for providing access to and coordination of home-based services, it is well within the Court's authority and purview to approve the proposed Order modifying its Judgment. More importantly, such an Order is necessary to ensure the completion and enforceability of these reforms which are critical to the implementation of the remedial service program and, ultimately, to successful disengagement from active court monitoring.

III. MCI Sustainability Framework

At the last status conference, the Court described its view of an appropriate sustainability framework that included standards (*i.e.* staffing, wait times), outcomes (*i.e.* number of persons served in community locations, number admitted to inpatient facilities), and an ongoing process for monitoring and implementing corrective actions, when needed. The Court emphasized that the framework should measure and ensure the effectiveness of MCI services over time.

On August 1, 2016, the defendants submitted their proposed MCI Sustainability Framework (Framework). On August 18, 2016, the plaintiffs submitted their response. As described in the defendants' Status Report, the Commonwealth then made certain modifications its proposed Framework. These changes included a paragraph listing various initiatives undertaken by the new OBH Program Manager, a sentence describing

[3] The plaintiffs' proposed Order is limited to ensuring adequate service coordination activities for certain children and youth with SED who are class members in this case, and would not preclude a future modification by the Commonwealth with respect to non-class members.

the various types of MBHP network management meetings, and a reference to the collection of quarterly Length of Episode (LOE) data.

Even with the additional details above, defendants' proposed sustainability Framework for MCI is primarily a recitation of existing data collection and network management procedures undertaken by MBHP. Doc. 749-1. Among the MCE's responsibilities are convening technical assistance meetings with providers, maintaining provider-specific quality improvement plans and, when needed, initiating corrective actions. However, the Framework provides little other description of the mechanisms the Commonwealth will employ to analyze and remediate systemic implementation problems when they are detected through existing network management and monitoring. While MCE provider meetings and ongoing data collection may provide relevant information on the MCI system, it is only the first step in the creation and maintenance of a sustainable, self-correcting, and continuous quality improvement process.

In order to demonstrate the durability of the MCI service system, and its ability to function effectively without the continuation of active Court monitoring, the plaintiffs believe the proposed Framework should include five additional elements:

1. As required by the Court's Judgment, and in consultation with Ms. Maddenwald, the Monitor and plaintiffs, the Commonwealth has developed specific service standards for the delivery of MCI. These standards focus on central features of MCI practice, including: effective community-based crisis encounters; youth and family-centered interventions; provider staff training and supervision; delivery of extended crisis services; and the coordination of MCI within the broader remedial service system. A

comprehensive MCI Framework should include specific strategies for the monitoring and assessment of provider adherence to these standards.

2. Despite years of implementation, key aspects of the MCI program, like the delivery of mobile crisis encounters, have proven difficult to improve over time. This pattern continues in the most recent quarterly MCI data showing that 30-35% of youth 0-14 and 50% of youth 15-18 have their mobile crisis encounter in an emergency room.[4] Other aspects of the MCI service have been significantly under-utilized, like the extended length of stay. Data from the first quarter of 2016 shows that among the 6 MCEs, the average length of crisis encounters were as follows: 3 plans under 2 days, 1 plan at 2.3 days, and 2 plans at 3.1 and 3.7 days, respectively. Yet data examining the receipt of behavioral health services post-MCI encounter continue to show that many children and youth could benefit from referrals to home-based services. [5]

Any MCI Framework should include specific goals and incentives for the increasing provision of MCI encounters in community locations. Specifically, there should be a goal of providing 80% of all MCI encounters in community locations. Other specific standards should be developed for measuring the appropriate utilization of extended MCI services, including the kinds of services and supports being offered to youth and families in the days following an initial crisis encounter. Effective oversight of, and quality assurance in, this aspect of MCI service delivery is particularly important given the absence of a crisis stabilization program as envisioned in the Court's Judgment.

[4] For youth in the 0-14 age range, the MCI quarterly data report notes that "[w]hile the percent of MCI encounters that have occurred in the community has slowly but steadily increased since September 2009, the percent of community encounters that are mobile versus in an ESP/CB/UCC location has remained relatively flat."

[5] The most recent data on youth and families' receipt of behavioral health services pre and post MCI encounter, covering July 1, 2015 to September 30, 2015, show that 28% of youth received diversionary or emergency services as their first behavioral health service after the crisis encounter, while only 23% received a remedial service other than MCI.

3. There must be a clear process for using data – not simply to observe the service system, but to directly inform quality oversight and improve performance. The current draft does not describe a continuous quality improvement "loop" that is customary in most systems. Nor does it set forth a clear process, with accountability, for remediating systemic problems and then assessing the impact of corrective actions.

4. Effective oversight of the MCI system depends upon the direct involvement of leadership at various levels of government, including the Office of Behavioral Health and EOHHS staff responsible for continued implementation and oversight of the Community Behavioral Health Initiative (CBHI). The Framework should describe with specificity how defendants will: (a) actively participate in and oversee quality assurance activities delegated to the contractor; and (b) ensure accountability for quality assurance outcomes and the successful performance of any necessary corrective actions.

5. The parties previously agreed to retain Kappy Madenwald to assess the performance and progress of MCI programs. She issued numerous recommendations for system improvement which plaintiffs believed would provide the foundation for disengagement, as well as ongoing efforts to ensure quality service provision going forward. Surprisingly, the defendants' proposed Framework states that many of Ms. Maddenwald's recommendations have been rejected, deemed infeasible, or are unlikely to be implemented. It is unclear from defendants' filing whether or to what extent she has modified or reconsidered these recommendations in light of the defendants' response. In areas where recommendations are being implemented, the identified action is often vague and the identified goal uncertain. This approach to the service delivery and system

improvement recommendations by Ms. Maddenwald threatens to undermine the parties' discussion of sustainability and makes the defendants' Framework deficient.

IV. Status of Disengagement

At the last status conference, the Court requested that the parties provide their own assessment of the status of disengagement, and specifically the extent to which each of the Disengagement Criteria, Outcomes, and Actions set forth in the parties' June 13, 2013 Joint Criteria for Disengagement (Doc. 620-2) have been achieved.[6]

To implement the Court's request, the plaintiffs conducted an exhaustive review of each Action the Commonwealth had previously agreed to undertake, and assessed whether the relevant data allowed the parties to make a reliable determination that the Action's stated goal, and its desired Outcome, had been achieved. Solely for the purpose of conducting this review, the plaintiffs voluntarily assumed the burden of proof in this analysis.[7] The plaintiffs also applied a presumption in favor of compliance: unless there was strong evidence that the Action and its intended Outcome had not been achieved, the defendants were considered to be in compliance with that Outcome and any related disengagement Criteria. After completing this internal review, the plaintiffs shared their findings and conclusions with the Court Monitor, in order to incorporate her unique perspective on ongoing disengagement efforts.

Recognizing the Court's interest in focusing, and where appropriate, narrowing the remaining disputed issues, the plaintiffs made an additional effort to limit or

[6] For the Court's convenience, items marked with roman numerals (I) are Disengagement Criteria; those in regular numbers (1) are Outcomes; those in small letters (a) are Actions.

[7] In voluntarily adopting burden-shifting for this internal review, the plaintiffs do not concede that future compliance assessments – either by the parties or the Court – should deviate from well-established precedents that hold that the defendants have the burden of demonstrating substantial compliance when they seek to terminate a remedial order.

consolidate any remaining Outcomes that were deemed non-compliant despite the presumption. In recognition of the progress and efforts that have been demonstrated, and due in part to the presumptions employed in their analysis, numerous Outcomes were deemed satisfied.[8] Based upon this analysis, the plaintiffs also identified six remaining Outcomes that clearly had not been accomplished. In an attempt to avoid further disputes or subjective assessments of compliance, the plaintiffs proposed an objective measure for evaluating when each remaining Outcome is met. In all cases, these measures relied upon currently available data collection methodologies, so as to avoid creating new data generation tasks. Whenever possible, plaintiffs used information from the defendants' Massachusetts Practice Review, since this methodology was designed by the Commonwealth, focuses on the individual but still generates systemic findings, and evaluates the overall impact of the Court's remedial order, and resulting home-based services, on children, youth and families. The plaintiffs' consolidated Outcome measures focus on achieving compliance with the central elements of the Judgment – timely access to professionally-adequate and medically necessary services – and on ensuring a durable and sustainable remedial service system.

In order to maximize time for the parties to reach a new agreement on outcome measures, the plaintiffs shared their Summary of Remaining Disengagement Criteria and Proposed Outcome Measures on July 12, 2016 (attached as Exhibit 2). The plaintiffs offered to meet to discuss their proposal during July, but only an exchange of emails and a brief telephone conference occurred. On August 15, 2016, the defendants responded with their proposal, which substantially revised, diluted, and reduced these outcome

[8] For instance, the entire Goal on quality and Outcomes related to Practice Guidelines for each remedial service was determined to be completed.

measures. Specifically, the defendants' proposed disengagement criteria would allow ICC providers to violate the 14-day Medicaid access standard adopted years ago by this Court for 33% percentage of youth served. This proposed measure of compliance ignores the fact that federal law requires full compliance with this standard and that defendants themselves had promised 100% adherence to the revised standard at the time it was presented for Court approval.

Similarly, despite the Commonwealth's own program standards for IHT (requiring an initial appointment within 2 days), and despite the plaintiffs' willingness to extend this access standard to 14 days (a 700% increase in waiting time), the defendants' response would allow IHT providers to violate that enlarged access standard for 33% percentage of youth served. Finally, the Commonwealth seeks to revise the rating methodology for its own System of Care Practice Review instrument, which currently defines a "fair" score as "unacceptable." [9] The defendants' response now proposes that this Court adopt this unacceptable rating as evidence of compliance with the Court's Judgment and an appropriate standard for demonstrating sustainability of the service system.

As a result of these differences, no consensus was reached with regard to the remaining disengagement outcomes or the appropriate criteria for evaluating compliance.[10] However, in recognition of the parties' prior success in negotiating acceptable disengagement criteria, it is probably useful for the parties to make a concentrated effort in the next month to see if consensus on Outcome Measures is possible.

[9] The current MPR rating methodologies for service delivery and youth progress are attached as Exhibit 3.
[10] In fairness, as a result of vacation schedules of all parties over the past month, the parties and the Monitor have not met to discuss their respective proposals on Outcome Measures.

V. Status of Implementation

Informing the plaintiffs' proposal for disengagement measures are several ongoing implementation activities centered on the delivery of timely, professionally adequate service coordination to children and families.

A. Timely Access to Remedial Services

The issue of waiting lists for ICC and IHT has been discussed repeatedly in the parties' Status Reports to the Court and remains a focus in the ongoing discussions of disengagement measures. Chronic delays in access to IHT persist across the Commonwealth. In June 2016, 555 youth were reported as waiting for a provider of their choice, while over 450 waited for the first available IHT provider. Of these 450, almost 80% waited more than two weeks for an initial appointment, and 62% waited more than 30 days, despite performance specifications requiring that an initial assessment and crisis plan occur within two days. This trend continued into July, the most recent month for which data is available, with 338 youth reported as waiting for a provider of their choice and 410 youth waiting for the first available provider. Of these 410 youth and families, 48% waited more than 30 days to receive an initial appointment.

Significant numbers of youth also continue to wait for ICC, with offers of an initial appointment occurring far in excess of the 14-day Medicaid standard. For youth starting service in June of 2016, the Commonwealth was out of compliance with its own access standard in 37% of cases, impacting almost 150 children and youth. Of the 250 youth still waiting for service at the end of June, more than half --146 children and youth - had waited 20 days or more to be offered an initial appointment.[11] In July 2016, the

[11] The ICC waiting list data measures the period of time between request for service and the "offer" of an initial appointment, not the date on which that first appointment actually occurs.

average wait time for a first appointment was 16.8 days, with 32% (139 youth) waiting longer than the 14-day Medicaid standard. Of the 152 youth still waiting at the end of July, 90 had already been waiting more than 20 days for an initial appointment.

As evident in the proposed disengagement measures, the parties disagree on two critical points: (1) whether the Commonwealth should be required to adhere to, and demonstrate compliance with, its own ICC access standards; and (2) how long the system must demonstrate the capacity to provide timely access to medically necessary services before active monitoring ends. The plaintiffs maintain that the discontinuation of active monitoring should require a demonstration of the Commonwealth's ability to comply with its own ICC Medicaid access standard for a reasonable period of time. Recognizing the access problem is even more severe within IHT, plaintiffs propose only that the majority of youth are offered an initial appointment within the 2-day standard, but that youth not wait longer than 14 days for IHT.

B. CANS Outcome Data

On July 13, 2016, Defendants issued part two of the annual CANS data report: *Changes in Child Status During Behavioral Health Services in 2013*. This second report also examined progressive CANS scores from ICC and IHT recipients between January 1, 2013 and December 31, 2014. Rather than examine individual CANS scores by item or symptom, this report measured patterns of change by examining youth outcomes in broader categories such as Life Domain Functioning, Child Emotional and Behavioral Needs, and Child Risk Behaviors.[12]

[12] Part one of the CANS Outcome Report: *Changes in Child Status During Behavioral Health Services in 2013* can be found at Doc. 706-2.

Defendants preface the report's domain score findings with an extensive discussion of the data's limitations, questioning the utility of employing the Reliable Change Index (RCI) developed by CANS creator John Lyons, and its ability to inform the parties' and the Court's understanding of class member outcomes.[13] This pessimistic view of the reliability of CANS data, and the defendants' expressed preference for the more comprehensive and contextual assessment of youth progress in the MPR, led the plaintiffs to adopt the MPR as the primary tool for assessing the effectiveness of remedial services.[14] As a result, the plaintiffs' proposed disengagement measures require that a significant majority of youth (66%) are making at least good progress, and that no youth are found to have a "worsening condition."

C. Massachusetts Practice Review

Shortly after the parties' last status conference on June 8, 2016, the defendants released findings from the second round of the Massachusetts Practice Review (MPR), conducted during March and April of 2016. The Brief Summary Report examined service delivery for 37 children and youth, from 7 IHT providers and 11 CSAs. A stratified sampling process was used to capture two distinct, randomized cohorts – youth receiving service coordination through ICC, and youth relying on IHT to meet their service coordination needs.

[13] RCI scores from 2013 CANS data report reflect that the vast majority of youth showed no reliable change when individual and aggregate domain results were analyzed, although what change there was showed a positive trend by length of enrollment. Two exceptions were seen in the transition and caregiver needs/resources domains, where CANS scores were more likely to worsen over time. When items scores were averaged across domains, youth outcomes appeared slightly better than those calculated by the RCI.

[14] Based on the parties' discussions to date, plaintiffs expect that CANS data will continue to be collected and analyzed by the Commonwealth on an annual basis, as previously agreed. It is possible that continued refinement of the data analysis, increased reliability resulting from new training and credentialing of clinicians using the CANS instrument, and increased use of CANS data at the individual and provider level will improve its reliability and utility as an outcome measure over time.

Like the October 2015 MPR review, which examined only youth with IHT services, the overall mean score for youth in the March/April 2016 review was in the 3 range (3.46 to be precise), meaning that ICC and IHT services do "not consistently meet established standards and best practices." The MPR's specific practice areas evaluate a range of critical service functions including assessments, treatment planning, service delivery, care coordination, and team formation and participation. In each of these areas, and for all of the 14 practice areas measured by the MPR, overall mean scores reflected a failure to consistently meet established standards for service delivery. When the March/April 2016 IHT practice area scores were calculated separately from ICC, 3 of the 14 areas scores dropped to "poor," meaning that service delivery did not meet "minimal established standards of practice." However, this finding was an improvement over October 2015, where 8 of 14 practice areas had mean scores in the poor range. Unfortunately, in March/April the percentage of cases with "good" practice, or better, declined across the majority of practice categories, as did the percentage youth making "good" progress.[15]

Answers to supplemental questions on IHT affirmed ongoing disparities between ICC and IHT with respect to service coordination. Despite high levels of need for coordination with schools, multiple providers and state agencies, reviewers found that 55% of youth with IHT were <u>not</u> receiving the care coordination their situation required. Most disturbing was the significant percentage of youth in IHT for whom practice was

[15] In March/April of 2016, IHT practice scores reflected the following: youth assessments were rated good or better 28% of the time. For service planning, this figure was 33%. Team formation was good or better in 17% of cases, and team participation for youth in IHT was in the good or better range only 6% of the time. Care coordination was considered good or better in only 28% of cases reviewed.

still determined to be poor or adverse: 22% for assessment and service planning, 39% for team formation, and 28% for care coordination and transition planning.

Significant and persistent deficits in delivery of IHT have recently led the Commonwealth to lower its expectations in the MPR, and to re-frame the definition of "fair" practice as an acceptable outcome. Defendants suggest that limitations like workforce inexperience justify scores in the fair range, and that these outcomes can be considered evidence of compliance with the Court's Judgment since youth derive some benefit. This revisionist approach to evaluating what has for years been a central measure of the parties' disengagement plan threatens both the integrity of the MPR process and the likelihood that the parties will reach agreement on proposed disengagement measures for the multiple outcomes which rely on this instrument.[16]

VI. Monitoring and Court Supervision

The defendants' status report presents an extended argument for dramatically reducing the role of the Court and its Monitor, to say nothing of the input of the plaintiffs. Report at 3-6. It concludes with a list of specific requests, the first being the reduction and termination of all status hearings over the next year, regardless of the outcome of current efforts or a finding of compliance. Defendants also seek to reduce the involvement of the Court Monitor to a monthly call or occasional meeting, while limiting the scope of her involvement to only two substantive issues. Communication between the parties would be limited to once quarterly. *Id.* at 9-10. This demand is misplaced, excessive, and unsupported by the status of compliance with the Court's Judgment.

[16] The plaintiffs propose that ICC and IHT services are delivered consistent with acceptable practice standards, with a significant majority of youth (66%) in the good and exemplary practice ranges (levels 4 and 5) and no youth receiving "adverse" care (level 1). Nothing about the plaintiffs' proposal is inconsistent with defendants' commitment to improving practice that currently falls in the poor or adverse range. Defendants' Report at 7-8.

While there has been and should continue to be a gradual reduction in the scope of monitoring, and the time expended on monitoring and oversight activities, the defendants' wholesale termination of most monitoring activities should be rejected without further discussion.

VII. Conclusion

The plaintiffs' consolidated outcome measures focus on achieving compliance with the most central elements of the Judgment – timely access to professionally adequate remedial services. They propose established, measurable criteria which both the parties and the Court can employ to: (1) evaluate the durability and sustainability of the remedial service system; (2) resolve remaining areas of alleged non-compliance; and (3) navigate the final phase of disengagement from active Court monitoring. The plaintiffs look forward to discussing these issues with the Court at the status conference on September 27, 2016. The plaintiffs remain willing to continue to discuss their proposed disengagement measures and proposed order on Outpatient Services with the defendants, if the Court prefers that the parties make further efforts to resolve these issues.

RESPECTFULLY SUBMITTED,
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BY THEIR ATTORNEYS,

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Dated: September 20, 2016 /s/ Kathryn Rucker