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**Rosie D. News Stories March 2014**

**Court Monitor's Term Extended At Least Until December 31, 2014**

US District Court Judge Michael A. Ponsor once again extended the term of Court Monitor Karen Snyder another six months, this time through Dec. 31, 2014, following reports from the plaintiffs and the defendants about delays in the implementation of *Rosie D*. remedial service ystem.  *See* [**Defendants’ 15th Report on Implementation**](http://rosied.org/Resources/Documents/Defs'%2019th%20Report.pdf); [**Plaintiffs’ 23rd Status Report**](http://rosied.org/Resources/Documents/Pls'%2023d%20Report.doc)**.**

At the March 21st status conference, Judge Ponsor indicated he would consider an even longer extension until the Commonwealth demonstrates that the new system is both reasonably effective and sustainable.  The Monitor’s current term, which already has been extended several times, was scheduled to end June 30, 2014.

In addition, the defendants, who supported the term extension, assured the Court that the Monitor’s budget and responsibilities would remain unchanged.  Asst. Atty. Gen. Daniel Hammond said that state’s Medicaid office eventually would assume greater monitoring responsibilities, but said there was no pending motion or present intention to reallocate the Monitor’s budget or role at this time.

Plaintiffs’ attorney Kathryn Rucker told the Court the data the Commonwealth has produced thus far as part of the agreed-upon disengagement criteria is “sobering,” indicating problems in both access to and utilization of remedial services.  She said that remarkably small percentages of the state’s neediest youth, including those involved with the Departments of Mental Health, Child & Family Services, and Youth Services, are accessing remedial services.  Citing the data, Rucker said that many of these youth – who are most likely to be at risk of out-of-home placements – do not access Intensive Care Coordination (ICC) or In-Home Therapy (IHT) services.  Instead, they rely only on traditional outpatient therapy, despite their multiple system-involvement and special education needs.

The defendants countered that each of the state agencies operate its own service network, including some form of case management, and suggested that some youth opt to stay within a known agency instead of seeking ICC or IHT within the community-based remedial service system.  “We don’t think these kids are falling through the cracks,” said Jack Simons, acting director of the Children’s Behavioral Health Initiative that oversees the remedial services.

According to Rucker, youth who sought community-based acute treatment (CBAT) services represented a “bright spot” amid the data.  She said that 47% of CBAT youth accessed remedial services in the 12 months prior to their admission, and 73% in the 12 months after they left.  “That’s more in line with what we were expecting,” Rucker said.

She also cited data showing that providers consistently fail to administer the Child and Adolescent Needs and Services (CANS) assessment tool – a critical problem because CANS outcome data is the only measurement used by the defendants to assess youth outcomes from remedial services under the *Rosie D*. Judgment.

The defendants, who acknowledged this problem, are now making CANS assessments mandatory.  According to Hammond, providers will not be paid unless they administer the CANS to youth at designated intervals.  “It’s not an expectation, but a requirement,” he said.

Judge Ponsor, who described the hearing as a “really unusually helpful hour and a half,” scheduled the next conference on June 27th.

**State Agency Access Reports Show Low Utilization of Remedial Services**

In the context of ongoing disengagement activities, the Commonwealth has compiled three data reports designed to measure access to remedial services by Medicaid-eligible youth involved in the Departments of Mental Health, Child and Family Services, and Youth Services.

These access reports, presented in late February, 2014, showed unexpectedly low levels of remedial service utilization.  Based on claims data for the sample of [**DMH**](http://rosied.org/Resources/Documents/DMH%20report%20corrected%2020140316%20(1).pdf)-involved youth, only 40% accessed a remedial service other than Mobile Crisis Intervention (MCI).  This percentage was significantly smaller for youth leaving hospital and residential care in the DMH system.  Of this cohort, only 17% accessed a remedial service other than MCI in the 12 months following discharge.  In the [**DCF**](http://rosied.org/Resources/Documents/DCF%20Access%20Report.2.14.pdf) system, 30% of youth accessed remedial services in the 12 months following their discharge from residential care.  Youth leaving [**DYS**](http://rosied.org/Resources/Documents/DYS%20report%2020140316%20(2).pdf) residential settings on a grant of conditional liberty had the lowest levels of utilization, with only 9% having claims for one or more remedial service in the 12 months following their last release.  Across all three state agencies, youth had lower utilization of remedial services in the period after their out-of-home placement.

Also remarkable is the extent to which state agency youth continue to rely on outpatient clinicians to act as their clinical “hub” service, even after periods of out-of-home placement.  The reports document limited utilization of IHT and ICC among these youth, including those who have met DMH clinical eligibility criteria and/or experienced traumatic disruptions in their family life and development.   These results are especially troublesome given the significant needs of these youth and families, their multi-system involvement, and ongoing concerns about the quality of care coordination and access to remedial services for youth with only outpatient therapy.

The plaintiffs are consulting with national experts to assist them in a further analysis of these access reports, as well as in the development of any specific corrective actions which should be taken to ensure state agency youth have meaningful access to remedial services.  In the coming weeks, the parties will discuss the results of two additional reports examining whether youth experiencing Community Based Acute Treatment ([**CBAT**](http://rosied.org/Resources/Documents/CBAT%20Access%20Report.2.14.pdf)) or inpatient admissions are accessing remedial services.

**Outpatient Therapy Evaluation Indicates Poor Service Coordination But Must Be Redone**

In designing the new children's behavioral health system, the defendants designated three distinct services to provide various levels of care coordination and to serve as authorization "hubs" for other remedial services: ICC, IHT, and outpatient therapy.  It was assumed that youth needing the most intensive level of care coordination -- and particularly those requiring coordination with other state agencies -- would utilize ICC, while those with the least needs, and no state agency involvement, could receive adequate coordination through outpatient therapy.  The Commonwealth expected all three services would ensure adequate care coordination based upon system of care values and principles.

Due to mounting evidence that outpatient therapists were not using the CANS as required by the Judgment, were not referring youth to needed remedial services, and were not providing adequate care coordination, the defendants designed and implemented a study of their outpatient therapy program for youth with SED.  The results of the [**initial outpatient study**](http://rosied.org/Resources/Documents/Outpatient%20Review%20(1).pdf), completed in August 2013, revealed that the clinician reviewers believed that 58% of the cases in a random sample did not demonstrate adequate care coordination.  This was particularly disturbing given the high level of state agency involvement for the youth in the sample.

The more recent access reports (see above) indicate that far more youth served by DMH, DCF, and DCY use outpatient therapy as their sole form of mental health treatment than those who use all remedial services combined.  This alarming finding substantially elevates prior concerns with the role of outpatient therapy as a hub, and as the only source of care coordination for youth with significant needs.

Due to design and sampling errors, the Commonwealth has concluded it must redo the outpatient study, which will be completed in June 2014.

**Utilization of ICC Remains Static for Third Straight Year**

After a trajectory of increasing enrollment during its first year of operation, the number of youth participating in ICC plateaued, and has remained relatively static for the past three years.  See [**CSA Report, December 2013**](http://rosied.org/Resources/Documents/Copy%20of%20CSA%20Monthly%20Report%20-%2012.13.xls).  Similarly, the number of staff (care coordinators with various levels of training -- associate, bachelor, and master level clinicians, as well as family partners) has not increased significantly in three years.  Furthermore, the number and source of referrals, reasons for discharge, and length of stay have remained persistently the same.  The only significant change in ICC data is a decrease in the waiting list and a concomitant increase in the average caseload of ICC staff.

**Persistent Problems Remain in Community Evaluations by Mobile Crisis Teams**

Like ICC, there was a significant increase in the utilization of emergency services, as well as in the community location of mobile crisis intervention, during the first year of implementation.  Since then, while the number of youth served by this program fluctuates seasonally, the percent of youth who receive MCI services in the community -- as opposed to a hospital emergency room -- has varied little over the past three years.  Efforts to increase community encounters have had limited impact, with more than 40% of all MCI visits still occurring in hospitals.  Moreover, there is substantial variation by provider, with several programs offering community interventions almost 70% of the time, with others providing MCI community services less than 40% of the time.  The one encouraging note is that the poorest performing providers increased their percentage of community interventions from 30% to 40% in the past year.