****

**Rosie D. *E-*News & Feature Article     October 2014**

**Court Again Extends Monitor’s Term**

As expected, at a status conference held in Springfield on Oct. 14, 2014, US District Court Judge Michael A. Ponsor once again extended the Rosie D. Court Monitor’s term for another six months. Citing the Commonwealth’s scheduled production of crucial reports and data over the next several months, Judge Ponsor issued an order from the bench extending Karen Snyder’s appointment as Court Monitor at least through June 30, 2015.

Snyder, who was appointed in 2007 when the Court issued its Rosie D. Judgment, has overseen the implementation of the remedial services, and more recently, has been facilitating meetings between the parties regarding disengagement issues, including service access, service utilization and system effectiveness. Her initial five-year appointment has been extended numerous times.

As noted in their respective reports to the Court ([Plaintiffs’ 25th Status Report](http://rosied.org/Resources/Documents/Pls%27%2025th%20Report.doc) and [Defendants’ Report on Implementation](http://rosied.org/Resources/Documents/Defs%27%2021st%20Report.pdf)), the parties are awaiting data and analyses – all due by the end of March 2015 – that address outstanding program issues, such as the low rate of community-based mobile crisis interventions (MCI); service coordination challenges for outpatient therapists who provide service coordination to youth with SED; the static enrollment in intensive care coordination (ICC); and clinical outcomes through Child and Adolescent Needs and Strengths (CANS) assessments. The Court Monitor also is planning a review of youth transitioning from residential placements to determine if they are being linked to remedial services in the community.

Both the plaintiffs and the defendants supported the extension of the Monitor’s appointment, but the Commonwealth suggested setting a “presumptive date” for the end of monitoring and court oversight. The defendants argued that data collection and reporting fall under the general rubric of quality improvement and system maintenance, and do not warrant continued court oversight or monitoring. “Do we need to be under active court supervision when data collection and analysis are ongoing?” asked Asst. Atty. Gen. Daniel Hammond.

However, the plaintiffs distinguished between the data being generated in response to the discrete program challenges, cited above, like crisis intervention venues and ICC enrollment, and the more global agreed-upon disengagement criteria regarding access, utilization and effectiveness of services. Steven Schwartz, lead counsel for the plaintiffs, reminded the Court that suspension of monitoring and oversight is only appropriate after all of these disengagement criteria have been satisfied. And Kathryn Rucker, plaintiffs’ attorney, pointed out, strategies and solutions must be clearly defined with “a preliminary indication they are likely to be successful” before any determination can be made about switching from court oversight to a state-managed quality improvement system.

**Actions Designed to Increase Mobile Crisis Intervention in the Community**

One of the key remedial services ordered by the Court in 2007 still is failing to achieve its primary purpose: to evaluate, intervene, and treat youth in the community so as to avoid unnecessary hospital admissions. But despite five years of development, increased funding, and technical assistance, at best, only about 50 to 60% of the mobile crisis interventions (MCIs) occur in the community. In some areas, that rate is below 30%. In an effort to promote community-based MCI encounters, the parties have agreed to take a number of remedial actions designed to reduce the unnecessary use of emergency departments for crisis services. These actions include collecting data concerning the source of referrals to hospitals, a comprehensive evaluation of MCI programs and concomitant recommendations for reform by a national expert Kappy Maddenwald, and the development of administrative policy changes that are designed to increase the delivery of MCI in the community.

 **Proposed Reforms for Outpatient Therapists**

Despite the Court’s finding that service coordination was the critical service to ensure that youth with SED remain in their homes and communities, and despite the creation of ICC as the core service for providing such coordination, the Commonwealth insisted that traditional outpatient therapists should also be allowed to provide service coordination and act as a clinical hub for youth with SED. Under the State’s model, outpatient therapists are supposed to provide all necessary care coordination, work closely with schools and state agencies involved with youth, ensure that youth in their care access all needed remedial services, and then coordinate the providers of these services with other entities involved with youth. Substantial evidence from Monitor’s reports and the Commonwealth’s own data demonstrates that this has not happened.  There are significant questions about outpatient providers’ knowledge of remedial services, and more importantly, their interest and investment in coordinating all aspects of a youth’s care.

The plaintiffs have proposed that outpatient providers should be expected to refer youth to all medically necessary services and an appropriate provider of care coordination, instead of simply giving information and extending offers of assistance. Outpatient therapists would be expected to refer youth to ICC, absent an objection by the youth or family, when a Child and Adolescent Needs and Strengths (CANS) assessment indicates that he or she meets the medical necessity criteria for ICC. Families would then have an opportunity to interact with the ICC provider and to make an informed decision about the potential benefits of participating in this service.

While there is no agreement as yet on this proposed policy change, the parties have agreed that outpatient therapists must conduct regular assessments of youth and family’s care coordination needs as well as their need for referrals to other remedial services. Among the agreed-upon activities are proposed revisions to the CANS tool and its training and certification curriculum, new outpatient guidelines, and other directives from MassHealth’s managed care entities. The success of these strategies hinges directly on outpatient providers’ compliance with the CANS process and the new standards.

In addition, the parties are awaiting the state’s revised Outpatient Study, and an analysis of outpatient therapists’ collateral contact claims data, both expected in December 2014. This information will be used to determine additional reforms to outpatient therapy system for SED youth.

 **Increase Utilization of Intensive Care Coordination**

The Court’s Judgment requires that youth who meet the medical necessity criteria for ICC have prompt access to this core service. But in recent years, ICC enrollment has been plateaued, while enrollment in In-Home Therapy spiked, creating what the Court has called a “puzzling trend” away from ICC, the Judgment’s core remedial service.

The plaintiffs are concerned about the system’s capacity to deliver quality intensive care coordination. In order to get a “look behind” the numbers, the defendants have asked the managed care entities to identify the Community Services Agencies (CSAs) with the lowest ICC enrollments and to provide an overview of the reasons for the low numbers. The MCEs also will report to the state on CSAs with ICC caseloads exceeding 16 youth. This data should be available to the parties and the Court Monitor this fall.

In addition, anticipated changes to the CANS tool as well as updates to IHT service guidelines should prompt IHT providers, like outpatient therapists, to regularly assess youth and family’s care coordination needs, and to make referrals to ICC when medically necessary. If these enhancements are effective, outpatient and IHT providers are expected to shift youth and families who need more intensive, team-based wraparound care to ICC. This change in referral patterns will require ongoing, statewide efforts to ensure CSA providers are capable and ready to serve increasing numbers of youth and families.


 **Assess Clinical Outcomes for Youth through CANS Data**

The Court’s Judgment requires the Commonwealth to assess the effectiveness of the remedial services and to assess whether they generate improved clinical outcomes for youth. To date, the Commonwealth has not generated and disseminated this outcome data nor demonstrated that youth and families are benefiting from the services. At the Court’s urging, the parties recently agreed that CANS data will serve as the primary mechanism for measuring and aggregating service outcomes for class members. MassHealth has agreed to produce a semi-annual report that focuses on the three CANS domains: youth functioning, symptoms and risk. The report will incorporate data collected at the items level as well as a domain analysis using John Lyons’ Reliable Change methodology. The State will use these public reports to measure the clinical impact of home-based services.