****

**Rosie D. News Stories March 2016**

**Parties to Discuss Plaintiffs’ Proposal for Enhanced Outpatient Therapy for SED Youth**

At the March 4, 2016 status conference, US District Court Judge Michael Ponsor called upon the parties to review the plaintiffs’ proposal for an enhanced level of Outpatient Therapy, with coordination mandates and higher reimbursement rates to better ensure youth with Serious Emotional Disturbance receive the care and services they need.  The plaintiffs and defendants will discuss the proposed Enhanced Outpatient Service with the Court Monitor several times this spring and report back to the Court in mid-May.

The plaintiffs have long raised concerns about outpatient therapists’ failure to provide adequate care coordination to youth with SED, as envisioned under the*Rosie D*. Judgment.  Last December, Judge Ponsor asked the parties to submit memoranda about the Outpatient system and its capacity to serve as a clinical hub and coordinate needed services for youth and families.  The defendants’[**Memorandum**(**Doc. 727**)](http://www.rosied.org/resources/Documents/Defs%27%20Memo%20on%20Outpatient%20Therapy.pdf)defends the Commonwealth’s three-tiered system of care coordination: Intensive Care Coordination (ICC), In-Home Therapy (IHT), and Outpatient Therapy (OP).  The plaintiffs’[**Proposal**(**Doc. 723**)](http://www.rosied.org/resources/Documents/Pls%27%20Memo%20on%20Outpatient%20Therapy.pdf)requires MassHealth to strengthen Outpatient Therapy by creating Enhanced Outpatient Services (EOS) – a more intensive level of Outpatient Therapy with specific coordination requirements and higher reimbursement rates that to ensure that youth with SED receive needed services and care coordination.  EOS would target youth with SED who need or receive one or more remedial services, such as Therapeutic Mentoring or In-Home Behavior Supports, or who are involved with state agencies such as the Departments of Mental Health, Youth Services, or Children & Family Services, yet do not need or want ICC or IHT.

Judge Ponsor said he was “drawn to” the plaintiffs’ proposal to strengthen Outpatient Therapy.  Noting that the defendants themselves acknowledge outpatient services must be “beefed up,” the judge suggested that plaintiffs’ plan could make “outpatient strong enough and adroit enough to make coordination work” for the thousands of youth – at least 37,000 as of last November – who rely on outpatient therapists as their clinical hub for services.

As the plaintiffs explain in their proposal, Outpatient Therapy has not been an effective model thus far.  A 2013 study of a sample of youth with SED who had Outpatient Therapy as their only source of care coordination found that nearly 60% of the youth’s records indicated they were not receiving appropriate levels of service coordination.  A subsequent study of youth with SED who relied on outpatient therapists for coordination found strikingly low levels of referral to CBHI services: there was zero use of IHBS or FS&T and low levels of collateral contact and case consultation among providers or agencies.  The second study concluded that caregivers who relied on Outpatient therapy for care coordination were “under-informed” about CBHI services.

Plaintiffs’ attorney Steven J. Schwartz told the Court that the plaintiffs were cautious about submitting a proposal that built on such an ineffective service system – the very system that the*Rosie D*litigation challenged as inadequate for, and irrelevant to, SED children.  But he said this is not the time to abandon Outpatient Therapy altogether, given the vast number of therapists who serve thousands of youth in communities throughout the Commonwealth.  While increased training and education to ensure outpatient therapists refer youth to remedial services was needed, Schwartz argued that a far more fundamental reform was necessary if the goals of this case, and the mandates of the Court’s Judgment, were to be achieved.  Specifically, he insisted that there must be clear programmatic standards which require care coordination activities for all youth who are receiving services from multiple agencies – youth for whom care coordination is “critical.”  Moreover, he said outpatient therapists must be compensated for care coordination activities – just like their counterparts in ICC and IHT.  Schwartz cited an internal survey conducted by the Associated Behavioral Health, which reported that 75% of providers are losing money on outpatient services and 68% are cutting back, instead of expanding, outpatient programs.

Under the plaintiffs’ proposal, EOS providers would be responsible for service planning and monitoring, collateral contacts, face-to-face meetings and case consultations with caregivers, remedial service providers, and as warranted, state agency staff.  EOS providers would be reimbursed for all care coordination activities at a rate comparable to individual therapy, and also receive reimbursement for service planning, educating families about remedial services, identifying appropriate remedial service providers, and facilitating the intake process.

Jack Simon, CBHI director, told the Court that the parties appear to be in agreement regarding improvements to the Outpatient service system, adding, “There’s a very good chance we can reach some agreement.”  He acknowledged “things need to be done” to enhance Outpatient Therapy as a clinical hub, and to ensure youth have access to the right services.

**Latest Court Reports Highlight Persistent Problems with Access and Implementation**

The plaintiffs’[**30thStatus Report**](http://www.rosied.org/resources/Documents/Pls%27%2030th%20Report..doc)outlines ongoing concerns about the implementation of the*Rosie D.*Judgment and the Commonwealth’s stalled efforts to meet outstanding disengagement criteria designed to ultimately end the Court’s oversight of the case.  The plaintiffs cited problems with Outpatient Therapists providing care coordination (*story above*), as well the State’s delay in producing outcome data and reports that are needed to assess the effectiveness of remedial services, including a long-promised report on CANS outcome data and proposed guidelines for Outpatient Therapy.  The defendants indicated in their latest[**Implementation Report**](http://www.rosied.org/resources/Documents/Defs%27%2026th%20Report.pdf)that these outstanding data and documents should be circulated later in March.  The State’s delayed report on findings from 38 case reviews conducted last October (*story below*) was released March 3rd.

As in prior status reports, the plaintiffs’ current report highlights persistent waitlists for ICC and IHT.  Recent monthly data from Community Service Area agencies suggest a slight improvement in ICC wait times, but IHT wait lists continue to grow.  As of December, 481 youth and families were waiting for an appointment with the first available in-home therapist.

**State to Continue Collecting, Sharing MCI data**

At the March 4, 2016 status conference, Judge Michael Ponsor sought reassurance that the Commonwealth’s Mobile Crisis Intervention (MCI) services can be sustained without Court oversight.  The Judge echoed the plaintiffs’ request, set forth in their current status report, for ongoing monthly and quarterly data on the number of youth served through MCI and the number seen in emergency departments, as well as periodic narrative reports on the implementation of recommendations made by consultant Kappy Maddenwald in March 2015.  According to the plaintiffs, these data and status reports “are the only source of information on the overall functioning of the MCI system.”  The defendants, who argued in their latest Implementation Report, that they have completed all outstanding disengagement activities regarding MCI and should no longer have to report on MCI activities, agreed in court to continue promulgating, collecting, analyzing and sharing MCI outcome data with the Court, the plaintiffs and the Court Monitor.  In addition, Asst. Atty. Gen. Daniel Hammond said the defendants are developing a protocol to address potential issues raised by MCI data, which the defendants will discuss in their next court report, due in May.

**Commonwealth Releases First of Three MPR Reports for FY2016**

A client review of 38 youth enrolled in In-Home Therapy found multiple, significant service delivery deficiencies, including inadequate care coordination, according to the Brief Summary Report released March 2, 2016 by the Commonwealth.

The sample, conducted last October, is the first of three case studies using the Massachusetts Practice Review (MPR), the protocol the State selected to assess the effectiveness of the Children’s Behavioral Health Services.  As part of the MPR process, trained reviewers examined medical records and conducted interviews with multiple informants, including the youth, the caregiver and the IHT provider.   The MPR scoring methodology examines service system performance and youth progress across multiple domains, rates them on a scale of 1 to 5, and then uses aggregate scores to determine whether the clinical practice experienced by youth and families is adverse, poor, fair, good or exemplary.

The Review found a few strengths in the IHT delivery system, including providers’ responsiveness and the community-based nature of the service.  However, providers scored below expectations in many other categories, including assessment, team formation, care coordination and transition planning.  For instance, only 30% of youth received assessments rated “good” or better, and only 24% of team formation was rated as good practice.  Where assessments were lacking in depth and detail, so too were service planning documents.  Review findings also raised serious concerns about the adequacy of care coordination delivered to youth in IHT, concluding that in 69% of cases sampled, youth were not receiving the level of care coordination their situation required.  Transition planning received the lowest score across all domains, with good practice found in only 18% cases, adverse care in 16% of the cases.

Based on these findings, the Summary Report concludes that the means score for all youth and families reviewed (3.0) across both practice and progress rating scales suggests fair practice overall that “does not consistently meet established standards.”   Additional MPR reviews are scheduled to take place in the Spring of 2016.

The complete[**October 2015 MPR Report**](http://www.rosied.org/resources/Documents/MPR.Oct2015.%20Brief%20Report.pdf)can be found in the Rosie D document library under “Implementation.”