

**Rosie D. News Stories September 2015**

**Court Again Extends Oversight as Disengagement Deadlines Are Delayed into 2016**

At the recent status conference on September 22, 2015, U.S. District Court Judge Michael A. Ponsor again extended the *Rosie D*. Court Monitor’s term for another six months.  Karen Snyder, who has served as Monitor since 2007, will continue in this role at least through June 30, 2016.  The defendants did not object to the extension, which the plaintiffs had recommended in their[**28th Status Report**](http://www.rosied.org/resources/Documents/Pls'%2028th%20Report.doc), although Assistant Attorney General Dan Hammond suggested that the parties revisit this issue in the spring to determine if the Court Monitor’s term should be further extended.  Judge Ponsor reaffirmed the importance of the Monitor’s role in “educating me and keeping me up-to-date” on initiatives and findings.

The Court explained that the extension was necessary because several disengagement deadlines have been delayed to 2016, due in part to staffing shortages, ongoing training projects, and difficulties obtaining requisite data from various state agencies.  The defendants also are re-instituting the statewide review of service delivery and effectiveness, which had been halted for almost a year in order to focus on system improvements.  The first round of the revised Massachusetts Practice Review is scheduled for October 2015, with subsequent reviews in March and June of 2016.  The final statewide report is not expected until October 2016.

Other issues addressed at the status conference included the growing waitlists for services, enhancements to In-Home Therapy, and challenges posed by the Commonwealth’s designation of outpatient therapy as a hub that is supposed to link youth and families with remedial services. **See stories below.**

**Access Problems Increase as More Youth Wait Longer for Home-Based Services**

The numbers of youth waiting for In-Home Therapy (IHT) and Intensive Care Coordination (ICC) have increased significantly over the past year – a trend Judge Ponsor described at the Sept. 22ndstatus conference as “puzzling and disturbing ... and a little discouraging.”  As plaintiffs noted in their [**28th Status Report**](http://www.rosied.org/resources/Documents/Pls'%2028th%20Report.doc), 228 youth were waiting for an appointment with the first available IHT provider in July of 2015, the last month for which data is available.  An additional 355 youth were waiting for a specific provider.  In June 2015, more than 300 youth were waiting for the first available IHT provider, and 473 were waiting for a specific provider.  Approximately 40% had been waiting more than four weeks for the start of service.  In contrast, in July 2014, 130 youth were waiting for their first available IHT appointment and 258 were waiting for a specific IHT provider.

ICC data is similarly troubling.  In July 2014, 91 youth were waiting for an ICC appointment.  By March of 2015, the number was up to 211; in April, 256 youth were waiting for an ICC appointment, and even more – 314 – were waiting in May 2015. In July, the average wait times for appointments spiked far beyond the 14-day Medicaid access standard. Youth waited more than 22 days on average in June, and more than 24 days in July, with over 44% of youth waiting in excess of the standard.  Notably, CSA enrollment is at its lowest level in 13 months (July 2014 through July 2015), yet these youth and families are waiting longer for their first ICC appointments.

Access issues also continue for IHBS and TM. In July, 76 youth were waiting for the first available TM provider, with another 204 waiting for a specific provider.  The numbers of youth waiting for IHBS in July were 29 and 56, respectively.  For both services, between 40% and 50% of youth had been waiting more than 30 days.

The defendants acknowledged the growing waitlists in both in court and in their [**Report on Implementation**](http://www.rosied.org/resources/Documents/Defs'%2024th%20Report.pdf).Asst. Atty. Gen. Daniel Hammond said the numbers reflect a “worsening” trend that has been accelerating over the past year. “The waitlists are going in the wrong direction,” he said.

According to Hammond, the waitlists are a workforce issue linked to the inability of CSAs to hire and retain clinicians in ICC and IHT.  The state has implemented rate increases for clinicians and is instituting changes such as reduced paperwork and improved billing mechanisms to enhance the workplace environment.  Other proposed interventions include tuition loan forgiveness and ongoing trainings.

Nonetheless, as plaintiffs’ attorney Kathryn Rucker said, “It feels like we’re moving backwards… This is one piece of the disengagement puzzle that has not fallen into place.”  She cited the 2012 Court Order setting a 14-day access standard for a youth’s first meeting with an ICC coordinator, and noted how the defendants pledged at that time to ensure appointments within the mandated limit.  However, based on the most current data (July 2015), more than 40% of youth currently are waiting longer than the Medicaid access standard for their first appointment for services.  Rucker said is critical that youth have expeditious access to ICC and IHT, since these services are the gateways to the other remedial services.

**IHT Improvement Projects Underway, But Capacity Issues Remain**

In response to In-Home Therapy deficiencies consistently cited in case reviews, MassHealth is undertaking several training and coaching projects to strengthen and improve the service – one that enrolls thousands of youth statewide. There is “a shallowness to this service that gives us pause,” said Asst. Atty. General Daniel Hammond at the Sept. 22 status conference.

Over the past few years, case reviews have found that IHT providers did not adequately coordinate care for youth on their caseloads, many of whom need or receive services from multiple providers, state agencies and special education.  These youth should have been referred to Intensive Care Coordination (ICC), where a care planning team coordinates in-home supports and school services with provider agencies.  Yet more than half of the IHT youth reviewed were not even told about the option of enrolling in ICC. [*See March 2015 news feature*](http://www.rosied.org/resources/Documents/Statewide%20SOCPR%20Confirms%20IHT%20Youth%20Not%20Getting%20Needed%20Services.docx).

According the Defendants’ Interim [**Report on Implementation**](http://www.rosied.org/resources/Documents/Defs'%2024th%20Report.pdf), outside consultants have initiated two projects that target IHT supervision.  These projects, which will continue into 2016, address issues of race, trauma and families with young children.  Another project provides training to IHT clinicians on an evidence-based, family therapy model dealing with parents suffering from depression.  In addition, two IHT providers – one in Boston and one in Greenfield – are being trained in a Modular Approach to Treatment of Children (MATCH) who present with anxiety, trauma, depression or conduct issues.  Finally, MassHealth and the National Implementation Research Network are engaged in a year-long process to define best practices for IHT.  “We have a clear idea of what is good practice and what is unacceptable practice,” Jack Simons, director of the Children’s Behavioral Health Initiative (CBHI), told the Court.

Kathryn Rucker, plaintiffs’ attorney, acknowledged the defendants’ efforts to improve IHT, but pointed out that hundreds of youth will continue to wait for services unless capacity issues are addressed.  The latest available data (July 2015) indicates that IHT providers were operating at over 97% capacity, and 228 youth were waiting for the first available appointment, with an additional 355 youth waiting for an IHT provider of choice.  ICC capacity is also at issue:  If the trainings are effective and IHT clinicians refer more children with significant needs to ICC, as intended by the CBHI system, those youth could wait an even longer time for an appointment. The average wait-time for a first ICC appointment exceeded 24 days in July.

**Some Progress But Much Skepticism on Outpatient Initiatives**

The defendants reported at the Sept. 22ndstatus conference that they are making headway on their initiatives to ensure outpatient therapists fulfill their roles as hub providers by linking youth with, and coordinating the delivery of, other remedial services.  The plaintiffs, however, continued to voice skepticism about whether outpatient providers should be retained as a hub in within the remedial service system.

Asst. Atty. Gen. Daniel Hammond informed the Court that trainings are ongoing to educate outpatient providers about their responsibilities “as gateways to ancillary services.” In addition, Hammond said outpatient therapists will not be reimbursed for their services without documentation they have discussed ICC and IHT with families.  Under this policy, which goes into effect December 31, 2015, parents or caregivers must sign a form twice a year indicating their child’s outpatient therapist discussed the services with them.

Both Hammond and Kathryn Rucker said the parties are making progress drafting outpatient guidelines – a collaborative undertaking.  As the plaintiffs noted in their [**Status Report**](http://www.rosied.org/resources/Documents/Pls'%2028th%20Report.doc), the latest draft reflects “a willingness to direct outpatient therapists to refer families to ICC when it appears they may meet medical necessity criteria and are interested in learning more about the service.”  But Rucker told the Court that it is too early to tell if youth and families relying on outpatient therapy as their hub will have access to the services they need. “We remain skeptical,” Rucker said.

The documentation requirement and the outpatient guidelines are among the systemic components that must be in place before that determination can be made.  Another component is pending changes to the CANS certification and training program, now set to begin in February of 2016.

**CBHI Now Integrated into MassHealth**

At the September 22ndstatus conference, the State announced that the Children’s Behavioral Health Initiative (CBHI), which was created as an interagency initiative of the Executive Office of Health and Human Services as a direct result of the *Rosie D*. lawsuit, has been integrated into the Behavioral Health Unit within MassHealth.    According to Hammond, this structural change ensures the sustainability of the Initiative when the Court eventually relinquishes its oversight of the case.  Notably, Emily Sherwood, who served as the CBHI director since its inception until early 2015, is now Director of the Behavioral Health Unit at MassHealth.