UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

ROSIE D., ***et al.,*** **Plaintiffs,** **v.** **DEVAL PATRICK,** ***et al.,*** **Defendants.**	**CIVIL ACTION NO. 01-30199-MAP**

DEFENDANTS' REPORT ON INTENSIVE CARE COORDINATION, CRISIS STABLIZATION AND IMPLEMENTATION

The Defendants hereby submit this Report on Implementation ("Report") pursuant to paragraphs 37(c)(i), 38(d)(i), 39(c)(i), and 47(b) of the Judgment dated July 16, 2007 in the above-captioned case ("Judgment"). This Report details the steps that the Defendants have taken since the last Report on Implementation, submitted to the Court in May, 2011.

A. REPORT ON ACCESS TO INTENSIVE CARE COORDINATION (ICC)

I. EOHHS Establishment of a Medicaid Access Standard

Federal law requires a state Medicaid agency to set standards for the timely provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services that meet reasonable standards of medical practice. 42 CFR §441.56. The law further requires the Medicaid agency to establish the standards after consultation with recognized medical organizations involved in child health care. Accordingly, MassHealth consulted with the New England Council of Child and Adolescent Psychiatry (NECCAP), whose members include psychiatrists familiar with high-fidelity Wraparound, to seek the Council's view on a

medically reasonable time standard for enrollment in ICC. The NECCAP Board considered this question at its regular meeting on November 29, 2011. Peter Metz, M.D., current president of NECCAP, conveyed the Council's recommendation to EOHHS, stating that "[t]he Board recommends that an outside limit of 10 business days between time of request for ICC and the first meeting with ICC staff to establish enrollment be instituted. The current 3-day limit should be adhered to whenever possible, recognizing that there is evidence that engagement in services is most likely to occur if the response to a request can occur as soon as possible after the need is first expressed."

On December 22, 2011, Emily Sherwood spoke with Dr. Metz by telephone, and he confirmed that 14 calendar days was equivalent to the 10 business days recommended by NECCAP. The MassHealth Medical Director, David Polokoff, M.D., has reviewed and approved the ICC access standard proposed by NECCAP and, accordingly, EOHHS plans to adopt a 14-day Medicaid access standard for ICC.

EOHHS conveyed this information to the Plaintiffs on January 3, 2012. In a conversation with Plaintiffs' Counsel on January 12, 2012, EOHHS also conveyed its thoughts regarding how it intends to manage its contracted managed care entities (MCEs) to ensure that services begin not only within the 14 days, but as rapidly as possible after member request. EOHHS invited the Plaintiffs to consider and make suggestions regarding its management plan, and Plaintiffs reported that they would do so, as well as to potentially suggest an alternative access standard.

II. MCEs' Network Management Plan to Achieve ICC Program Access Standards

The MCEs developed a coordinated Network Management Plan, approved by EOHHS, which was communicated to the Community Service Providers (CSAs) on November 23, 2011 and became effective on that date. The plan was developed prior to EOHHS's decision to establish a 14-day Medicaid access standard, and therefore the plan is based on the 3-day contractual requirement. Accordingly, the MCE goal was to achieve a statewide average length of time of three days between a CSA's first contact with the family and the date of the first appointment offered. EOHHS has not yet altered the MCE goal to reflect its decision to establish a 14-day Medicaid access standard.

The MCEs' plan includes interventions that fall into two categories: more aggressive outreach by the MCEs to CSA providers who are outliers based on the criteria described below, and strengthened network management and technical assistance activities for all CSAs. For a more detailed description of the Network Management Plan, see Exhibit 1, The MCEs' Network Management Plan to Achieve ICC Program Access Standards.

III. Access Data

The most recent CSA Monthly Report, for November, 2011, is attached as Exhibit 2, CSA Monthly Reports, July through November, 2011. Report 3 of the November CSA Monthly Report presents the average and median times, across the CSAs, between the CSAs' first contact with the family and the date offered for the first appointment.

The table below summarizes these data:

	July	Aug.	Sept.	Oct.	Nov.

Average Time (Days)	20.1	14.4	14.6	10.5	11.6
Median Time (Days)	6.0	4.0	5.0	4.0	4.0
Number of Youth	369	377	328	366	408

Report 4 shows the distribution of time between first contact with the family and first offered appointment, for the youth enrolled during the month. The table below summarizes key data elements from July through November:

Youth Waiting:	July	Aug.	Sept.	Oct.	Nov.
30 to 60 days before first appointment	74	61	35	23	43
61 to 90 days before first appointment	31	5	7	7	3
Over 90 days	2	3	4	1	4
Total youth waiting over 30 days	107	69	46	31	50
Total youth enrolled during the month	369	377	328	366	408
% of youth enrolled during the month waiting 30+ days	29%	18%	14%	8.5%	12%

The Monthly CSA Access Reports by Provider, for July through November, 2011, is attached as Exhibit 3. The table below presents the number of CSAs in each month with waitlists:

Number of CSAs:	July	Aug.	Sept.	Oct.	Nov.
With youth waiting > 30 days	9	8	10	6	3
With youth waiting 11-30 days	7	5	3	5	7
With youth waiting 1-10 days	2	6	2	7	2
With no youth waiting	14	13	17	14	20

B. REPORT ON CRISIS STABILIZATION

As previously reported, MassHealth is implementing the aspects of crisis stablization described in the Judgment for which FFP is available (1) by expanding the availability of Mobile Crisis Intervention (MCI) services from the previous maximum of 72 hours to a new ceiling of seven days, and (2) by ensuring that Community Based Acute Treatment (CBAT) providers address the length-of-stay needs of class members and provide linkage to other community-based services.

I. Crisis Stabilization Within MCI

A. MassHealth staff have met with the Emergency Services Providers (ESPs) and consulted with the MCEs and with consultant Kappy Madenwald, MSW. These meetings have helped to clarify the following issues:

1. MCI providers currently deliver MCI services beyond the 72 hours, often without billing for it. The MCEs claims payment systems currently do not deny MCI billing for services that extend beyond the 72-hour time period.
2. The proposed enhancement of MCI has two distinct components:
    a. The first is to extend the length of time the MCI team can work with a youth and family from the 72 hours to up to seven days. The ESP providers and Ms. Madenwald report that the majority of families and youth who require more than 72 hours of MCI would most likely want the MCIs to link youth and families to ongoing services, as well as to provide telephonic support. In their experience, few families want MCI to have an extended presence in their home.
    b. The second component is to enhance the capacity of MCI providers to deliver ongoing, onsite crisis intervention and stabilization services as a potential diversion from hospitalization or referral to a CBAT program. Ms. Madenwald suggests that providers conceptualize this component as potentially occurring on "day two through seven" of the service, following the initial crisis intervention.

B. Tasks to Implement CS Within MCI

1. Modify the MCI program specification to extend the length of the service to up to 7 days.[1]
2. Determine whether it is necessary to change any coding or authorization procedures for services. Such changes would make it possible to track the delivery of the extended service more accurately; however, it would lengthen the time needed for implementation and might unduly complicate operations. EOHHS is evaluating the option of starting the expansion with no changes in codes or authorization procedures, with the possibility of developing them at a future time. For measuring utilization of the extended service, EOHHS may direct MBHP to use claims logic to identify length of stay. [2]
3. Prepare budget projections for increased utilization of units of MCI services.
4. Analyze current MCI rates..
5. Develop member notice and member handbook inserts for MassHealth's Primary Care Clinician plan, and require the MCOs to update their member communication materials to reflect the availability of extended MCI service.
6. Train MassHealth's customer service vendors' staff and the MCEs' customer service staff on the availability of the service.

[1] There is no need to otherwise alter the definition of MCI. Pursuant to MassHealth's MCI State Plan language, the services delivered through MCI must be "therapeutic…for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management safety plan, if any."

[2] This is not a 100% accurate way of reporting - logic assumptions are made to group claims together into an episode of care -- but it is not possible to determine through the data whether two claims a day apart represent a continuation of the service or a new call into MCI with a new crisis.

7. Train MCI staff how to effectively deliver the service and how to recognize when in-home crisis stabilization would be an appropriate alternative to CBAT or hospitalization.

By following the incremental implementation process described above, EOHHS will be able to implement crisis stabilization services within the MCI service by May 30, 2012.

II. Community-Based Acute Treatment (CBAT) programs

The MCEs are preparing, for MassHealth's review, written communication to be sent to all CBAT providers by the end of January. The purpose of the communication is to highlight two existing components of CBAT program specifications:

1. Delivery of CBAT must be individualized according to what is medically necessary for a particular child or youth. A child or youth must receive the intervention he or she needs from the CBAT, neither more nor less.
2. CBAT staff must consult with community-based providers currently working with the child or youth.

C. REPORT ON IMPLEMENTATION

I. Informing Families, Providers, and Others of EPSDT Services for SED Children – Education and Outreach (Judgment, paragraphs 2-7[3])

A. Members (paragraphs 3, 4, 5)

1. **Informing EPSDT-eligible MassHealth Members[4] upon enrollment of: 1) the availability of EPSDT services, 2) the inclusion within EPSDT of services focused on the needs of children with SED, 3) the enhanced availability of screening services and 4) ICC.**

[3] Paragraph references in this section refer to paragraphs in the Judgment.

[4] Medicaid-eligible individuals enrolled in MassHealth ("MassHealth Members" or "Members"),

MassHealth informs members under age 21 enrolled in Standard or CommonHealth and their families of the availability of EPSDT services (1) when Members are first enrolled in MassHealth; (2) when Members are reenrolled in MassHealth after a break in coverage; and (3) annually, on or around the Member's birthday.

2. **Training of MassHealth and MCE Customer Service Representatives (CSRs)**

During Summer and Fall, 2011, MassHealth, its Customer Services contractor and MCEs reviewed and revised CBHI training and resource materials for their respective Customer Service staffs.

3. **Update and distribute, in the normal course of communications with MassHealth Members, Member education materials.**

MassHealth members and their families are also informed of program improvements through quarterly member newsletters published by the MassHealth PCC Plan and the MassHealth MCOs.

Since the last Report to the Court, the following newsletter articles have been published:

Network Health Member Newsletter, *Peace of Mind for Parents: Behavioral health screenings* Fall, 2011 (attached as Exhibit 4).

Neighborhood Health Plan Member Newsletter, *Preventive and Well-child Care for All Children*, Fall/Winter 2011 (attached as Exhibit 5)

a. Participate in Public Programs, Panels and Meetings

Since the last Report to the Court, EOHHS staff have presented at and participated in numerous public programs, panels and meetings in order to inform families about the program improvements pursuant to the Judgment:

- May 10, 2011 MA School Nurses Organization
- May 27, 2011 Understanding Services, workshop for the Dept. of Public Health
- September 22, 2011 MA Association of Middle Schools
- September 30, 2011 MA Elementary School Administrators Association
- October 4, 2011 The Learning Center, meeting with schools for the Deaf and Hard of Hearing
- October 11, 2011 MA School Psychologists Association
- October 27, 2011 MA Administrators of Special Education annual conference
- November 11, 2011 MA Association of School Committees/MA Association of School Superintendents Joint Conference
- November 30, 2011 Assabet Valley Educational Collaborative

B. MassHealth Providers (paragraph 6)

1. **Drafting and distributing special provider communications related to the program improvements described in the Judgment, including how to assist MassHealth Members to access the home-based services described in the Judgment.**
2.
   a. For a description of provider communications to behavioral health clinicians regarding the CANS, see Section IV of this report.
   b. For a description of provider communications to behavioral health providers regarding remedy services, see Sections IV and Section V of this report.

c. EOHHS informs MassHealth providers of program improvements through quarterly providers newsletters published by the MassHealth PCC Plan and the MassHealth MCOs. Since the last Report to the Court, these articles have been published:

- Beacon Health Strategies[5] (BHS) e-Bulletin-*Authorization requests and discharge notification for In-Home Therapy Services through the online eServices portal*, July, 2011
- BHS e-Bulletin-*Clarification regarding access to Family Support and Training*, September 2011
- BHS, *Hubs Roles and Responsibilities Cheat Sheet*
- BHS Guidelines for Obtaining FS&T When the Hub Is Not an ICC in your CSA, August 2011 BHS Bulletin Clinical, Clarification of the Use of Collaterals, August 2011 BMCHP Provider News, *Billing for a Behavioral Health Screen for a Member*, August 2011
- BMCHP Provider News, *Guidelines for Pediatric Care*, November 2011
- NHP Provider e-News, *Behavioral Health Screening Reimbursement Change*, July 2011
- Network Health Provider Update *Behavioral Health Assessments for Children*, Jan 2012 PCC Plan Provider Quarterly, *Billing for a Behavioral Health Screen*, Summer 2011

3. Hold special forums for providers to encourage clinical performance activities consistent with the principles and goals of this Judgment

[5] Beacon Health Strategies is a subcontracted Managed Behavioral Health Plan providing BH services to MassHealth and commercial members enrolled in Boston Medical Center's HealthNet Plan, Fallon Health Plan and Neighborhood Health Plan.

4.

See Section V of this report.

5. Prospective Members and the General Public (paragraphs 4, 7)

a. **Create New Outreach Materials**

"Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for School Personnel" is a resource guide for teachers, school nurses, health educators, psychologists, social workers, adjustment counselors, and others who interact directly with students and their families. This guide, attached as Exhibit 6, provides information on program improvements and information for connecting MassHealth-eligible students with remedy services. It also provides information on how school personnel can collaborate in ICC and further offers guidance for school administrators and others interested in building systematic behavioral health supports for students by participating in local SOC Committees. The guide has been available as a download from the CBHI web site since October 2011.

"How to Apply for MassHealth for Your Child," provides step-by-step instructions for parents and caregivers applying to MassHealth for their children. The guide's objective is to provide "tips," or advice, to ensure a smooth application process for families seeking MassHealth or CommonHealth enrollment for their children, in order to access the remedy services. This publication has been available as a download since October 2011, and is attached as Exhibit 7.

"**CANSNews"** is a quarterly newsletter that offers information to providers, administrators, data entry staff and others who use the Child and Adolescent Needs and Strengths (CANS) application on the Virtual Gateway. Launched in January 2010, the newsletter disseminates news and information to nearly 10,000 CANS users. The most recent August 2011 issue is attached as Exhibit 8.

b. Develop and implement training programs for line staff at the Departments of Mental Health, Social Services (now Children and Families), Youth Services, Mental Retardation (now Developmental Services), Transitional Assistance, and the Office for Refugees and Immigrants on how to access MassHealth services for children with SED.

See Section III of this Report.

c. Distribute outreach materials in primary care settings, community health centers, and posting electronic materials on the EOHHS Virtual Gateway that are designed to provide information to MassHealth Members and to public and private agencies that come into contact with or serve children with SED or their families.

EOHHS continues to distribute the following materials:

(i) Materials available to PCCs through the Primary Care Clinician Plan's Health Education Materials Catalog:

- Primary Care Behavioral Health Screening Toolkit
- EPSDT Billing Guide
- Brochure "Worried about the way your child is acting or feeling?", in English, Spanish and Portuguese

(ii) Materials Available on EOHHS' CBHI Website(www.mass.gov/masshealth/cbhi

- Primary Care Behavioral Health Screening Toolkit
- EPSDT Billing Guide
- Brochure "Worried about the way your child is acting or feeling?", in English, Spanish and Portuguese
- CBHI: A Guide for Staff Who Work With Children and Families
- Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for School Personnel
- How to Apply for MassHealth for Your Child

d. **Work with Department of Early Education and Care (DEEC), Department of Elementary and Secondary Education (DESE) and the Executive Office of Education (EOE).**

e.

(i) New CBHI Resource Guide for School Personnel

"Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for School Personnel" was published in October 2011, along with a new fact sheet: "How to Apply for MassHealth for Your Child".

EOHHS worked with Taskforce members and DESE staff to create a resource guide specifically for school personnel. Like the original CBHI Staff Guide, the School Personnel Resource Guide contains background information on MassHealth and descriptions of each of the services. It also includes guidance on using MCI in schools and how schools can collaborate with ICC teams.

EOHHS informed its entire mailing list that the above materials are available on the CBHI website. The Commissioner of Elementary and Secondary Education shared this announcement via an email to all school superintendents. EOHHS worked with school professional associations, such as the Mass Elementary School Principals Association, the Mass Association of School Superintendents and the Mass. Administrators of Special Education to distribute the guide to their members. EOHHS also distributed copies of the School Personnel Guide and the "How to Apply" guide, along with instructions for how to find the documents on the CBHI website, at the December CSA statewide meetings, and through regional CBHI Level of Care meetings (see Section V of this report for a description of these meetings).

The CSAs and other CBHI providers can use the School Personnel Guide as an outreach tool in their respective communities.

(ii) EOHHS staff continue to present to various audiences of educators:

- May 10, 2011 MA School Nurses Organization
- September 22, 2011 MA Association of Middle Schools
- September 30, 2011 MA Elementary School Administrators Association
- October 11, 2011 MA School Psychologists Association
- October 27, 2011 MA Administrators of Special Education annual conference

- November 11, 2011 MA Association of School Committees/MA Association of School Superintendents Joint Conference
- November 30, 2011 Assabet Valley Educational Collaborative

f. Working with the Department of Public Health and Public School Districts to educate school nurses and other school personnel on how to access MassHealth Services.

In October 2011 and again in December, the Director of School Health Services provided the link to the School Personnel Guide to DPH's 150 School Nurse Leaders across the state.

II. Standardized Behavioral Health Screening in Primary Care (paragraphs 8, 9, 10, 36, 46)

A. Selecting the Screening Tools (paragraph 8)

Each year MassHealth convenes representatives of the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) and a panel of pediatric behavioral health screening experts to review the list of MassHealth's approved behavioral health screening tools to assess whether there are any new tools that should be added to the list, or any tools that should be removed. The screening tool committee is currently considering a new tool developed by Boston-based pediatricians and researchers in Boston for children 0-6 and is gathering more information before making a decision.

B. Data Tracking (paragraphs 10, 46)

The most recent Quarterly Behavioral Health Screening Report is attached as Exhibit 9. For a summary and discussion of the data, see Section VI of this report.

C. Quality Improvement Activities (paragraph 10)

1. Staff of MassHealth's Office of Clinical Affairs have conducted interviews with a small sample of providers who have **high screening rates for youth 18-20** to learn about best practices for screening this group of youth. An article sharing these practices has been written to be published in future Provider Newsletters.

2. The Screening QI Workgroup learned that the data that appear to show **low rates of claiming for BH screening in hospital outpatient departments are, in fact, an artifact of how MassHealth pays hospitals, in "bundled" payments.** MassHealth plans to change its IT system to allow individual tracking of services that are "bundled," which will provide more accurate information regarding screening. The changes are scheduled to be complete in Spring 2012.

3. **As of July 1, 2011, the MassHealth claims system began to deny claims for BH screening if the claim did not include the required billing "modifier."** For BH screening, billing modifiers are used to indicate the outcome of the screen, i.e., whether a potential behavioral health need was identified. This change affected PCC Plan and Fee For Service providers. The MCOs implemented this change in July and now see that nearly 100% of behavioral health screenings claims correctly use the modifier.

4. **Appropriate clinical follow-up for children and youth with a positive BH screen.** MassHealth, through its regulations and contracts with health plans, requires primary care providers performing BH screens on children and youth to respond to a potential need identified by either: (1) ascertaining that the youth is receiving behavioral health services; (2) directly providing a follow- up service; or (3) referring the youth to a

behavioral health service. The latest PCC Plan Provider Profile report data on clinical follow-up to positive behavioral health screens can be found in Section VI of this report.

III. Identification of Behavioral Health Needs – The Role of Other EOHHS Agencies, and other Public and Private Agencies (paragraphs 11, 12)

A. **EOHHS will provide information, outreach and training activities for these providers and agencies.** See Section I of this report.

B. In addition, EOHHS will develop and distribute written guidance that establishes protocols for referrals for screenings, assessments and services and will work with EOHHS agencies and other providers to enhance the capacity of their staff to connect children with SED and their families to behavioral health screenings, assessments and services.

1. EOHHS staff drafted CBHI Protocols for the Massachusetts Commission for the Blind (MCB) and the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), currently being reviewed by respective agency leadership.
2. EOHHS staff held a second training for DPH Care Coordinators on April 14, 2011.
3. April 6, 2011 - Meeting of EOHHS/CBHI staff and Juvenile Court Clinic Directors, DMH Division of Forensic Mental Health (DFMH) Manager of Juvenile Court Clinics, Dr. Tina Adams, DFMH Director, Dr. Debra Pinals and DMH Assistant Commissioner for Child and Adolescent Service, Joan Mikula in Worcester. The

purpose of the meeting was to discuss the successes and challenges of implementing the new MassHealth services as they affect the Juvenile Court population.

4. August, 2011 – Meeting of DMH Commissioner Barbara Leadholm, Asst. Commissioner Joan Mikula, Asst. to the Compliance Coordinator, Jack Simons, and Ron Corbett, Commissioner of the Office of Probation. This was a first meeting with Commissioner Corbett since his appointment and participants identified several steps to enhance collaboration between the Office of Probation and remedy services. Subsequently, the Office of Probation staff attended the December statewide Wraparound trainings conducted by Vroon Vandenberg for EOHHS, and other state agency staff.

IV. **Assessment and Diagnosis (paragraphs 13-16, 37, 46)**

The Judgment requires the Commonwealth to ensure that "EPSDT services include a clinical assessment process for eligible children who may need behavioral health services," and to "connect those assessments to a treatment planning process" in a specified fashion. The Commonwealth implemented the Child and Adolescent Needs and Strengths (CANS) tool, and its progress in each area from July 1, 2011 through December 31, 2011 is described below.

A. Modifying and revising the CANS tool to be suitable for MassHealth

New "*Cultural Considerations*" Section of the CANS

The CANS originally contained a domain entitled *Acculturation,* which was designed to capture information about cultural factors that a Provider needs to understand

in order to provide effective treatment. Feedback from clinicians during CANS training, as well as analysis of Acculturation ratings in the CANS database, suggested that MassHealth could improve the questions in this section to more accurately capture information about race, ethnicity, language and culture. Accordingly, MassHealth replaced the *Acculturation* domain with a revised domain, known as *Cultural Considerations,* on November 30, 2011. The *Cultural Considerations* section of the CANS is attached as Exhibit 10.

The development of the new domain began in 2010 when EOHHS staff convened a work group to revise the Acculturation Domain. Staff worked with the Committee on Reducing Health Disparities of the Children's Behavioral Health Advisory Committee and others, to develop a work group consisting of culturally diverse clinicians who regularly work with culturally diverse clients and/or are familiar with the research literature on culture in the provision of Behavioral Health services. The work group undertook this task over a lengthy series of meetings, with great thoughtfulness and care. The revised domain was successfully piloted with three groups of clinicians in the spring of 2011. The proposed revision of the domain was also vetted with state agency staff and with John S. Lyons (developer of the CANS). It was approved by the CBHI Executive Committee in the summer of 2011, and presented at the October CBHI Advisory Council meeting.

B. Building and maintaining a web-based system to collect and report CANS data, and an associated system for tracking member consent

Because the CBHI CANS system provides a critical function, contains Protected Health Information, and must meet high standards for accessibility, every software revision requires a long process of testing -- including security and accessibility testing. The lengthy design / development / testing cycle means that updates require much planning and are relatively infrequent.

During the current reporting period, EOHHS updated the system by replacing the "Acculturation" domain with the "Cultural Considerations" domain as previously described, with the changeover occurring November 30, 2011, in concert with training and with publication of revised documentation. Additional IT enhancements included a date stamp in comment fields to make it apparent when new comments are appended to old ones.

C. Training and periodically certifying a large behavioral health workforce to rate the CANS accurately

1. **Ongoing CANS Training** - The Judgment requires the Commonwealth to "train providers to use the CANS tool, including EOHHS-required data gathering techniques." During the current reporting period, a total of 1,231 clinicians were trained and 1,953 were certified or recertified. The majority of clinicians getting CANS training and certification now use the web-based training system. Face-to-face training was offered on a quarterly basis through 2011. Effective July 2012, it will be available exclusively online.
2. **Cultural Considerations training -** The UMass CANS training team, in consultation with Dr. Kenneth V. Hardy, Ph.D., of Drexel University, developed an on-line

training module for the Cultural Considerations domain. The training offers a rationale for culturally informed clinical work, and guidance for clinicians about how to conduct a discussion with clients about race, ethnicity, language and culture. Both the on-line training and in-person training have been revised to incorporate the new material, effective November 30, 2011.

3. **Training for practice beyond CANS ratings -** Learning how to rate the CANS does not guarantee that a clinician will use the CANS effectively in collaborative practice with families, which is MassHealth's ultimate goal. MassHealth's discussions with providers have suggested a need for more training for CANS users on practice issues: how to integrate information from multiple sources and perspectives, how to use the CANS in the treatment planning discussion with the family, and how to use the CANS to track progress in treatment. Accordingly, the UMass CANS Training Program is developing an online training module that uses hypothetical case material to demonstrate excellence in these aspects of practice. Using video segments produced by Vroon VanDenBerg LLC, the training shows how an in-home therapist might capture information for the CANS in the course of an interview with a parent. The training is intended to help clinicians understand how the CANS supports a family-driven collaborative model of care. The release of this new training module will be in early 2012.

D. Implementing the CANS requirement in regulations and contracts

As described in previous reports to the Court, the Commonwealth implemented the CANS requirement through changes to MassHealth's provider regulations and its MCE contracts.

Implementation of the CANS required much work from individual clinicians and provider agencies: clinicians had to participate in training, pass a certification test, gain consent from parents before entering the CANS data in the CANS application on the Virtual Gateway and, probably most importantly, alter their own clinical assessment practice. Provider agencies had to ensure staff became certified and maintained certification, and had to manage the technical interface with the VG and manage the security requirements of the system. For many providers, individuals and organizations, this was an unprecedented level of intrusiveness into the details of provider practice. It was clear from the outset that many providers regarded the CANS as a burdensome, bureaucratically motivated change.

Implementation of the CANS has required tremendous amounts of technical assistance on technical, organizational and practice issues. While compliance with the CANS requirement is very high in certain services, such as ICC, EOHHS will continue to monitor and improve compliance in other services. Accordingly, during this reporting period MassHealth directed its MCEs to submit proposals for monitoring and enforcing CANS compliance in all levels of care, including twenty-four-hour levels of care and in outpatient. MassHealth is currently reviewing these proposals and will issue final directives to the MCEs on this topic early in 2012.

E. **Informing and educating providers, MCEs, consumers and other stakeholders**

1. <u>Provider information, education, and support</u>

The following sections describe the newsletter, revision of the CANS section of the CBHI website, the help desk or customer service functions, and a series of provider conference calls and meetings known as CANS Community of Practice.

a. *CANSNews* – CANS Newsletter – See Section I above.

b. Reorganization of the CBHI CANS page. Due to the complexity of the CANS requirement and the procedures involved in training, certification and use of the CANS application on the VG, it is essential for users to have easy access to training and reference materials. The CBHI CANS pages contain extensive documentation as well as links to other resources including interactive training modules. In 2011 it became apparent that the existing FAQ and CBHI CANS web pages could be revised and reorganized to be more useful. During the reporting period EOHHS launched a new CANS section on the CBHI website, which contains more material and is better organized. EOHHS also has an easy-to-use URL, www.mass.gov/masshealth/cans.

2. Help desks / Customer service

Both the CANS Training Program and the VG provide customer service support by telephone and online, phone and email response to user questions. Between July 1, 2011 and December 31, 2011 the UMass CANS Training Program Helpdesk responded to 1,516 phone calls and email requests. Between July 1, 2011 and December 31, 2011 the Virtual Gateway (VG) Customer Service Helpdesk responded to 574 requests for help, primarily by phone. The volume of calls and emails has steadily declined over time as most providers now understand the basics and go to the CBHI website and the UMass website for CANS information as needed.

V. Intensive Care Coordination and Other Covered Services (paragraphs 19-33, 38)

A. Remedy Service Implementation Overview (paragraphs 19, 31, 32, 33)

Utilization of remedy services has increased since implementation, both in terms of numbers and percentages:

- The number of children and youth receiving ICC in State Fiscal Year (SFY) 2011 was 9,056, up 40% from SFY10 when 6,479 children and youth received ICC.
- The number of children and youth who received any remedy service in SFY11 was 25,684, up 39% from SFY10 when 18,473 children and youth received at least one remedy service.
- "Penetration," the number of children and youth receiving services as a percentage of total number enrolled in MassHealth, has also increased:
  - For youth receiving any remedy service, the percentage has increased from approximately 3.5% of MassHealth-enrolled youth in SFY10, to approximately 4.7% of MassHealth-enrolled youth in SFY11, a 32% increase.
  - For youth receiving ICC, the percentage has increased from approximately 1.35% in SFY10 to 1.85% in SFY11, a 37% increase.

State Fiscal Year 2010 (July 1, 2009 – June 30, 2010) Utilization		
Average # Members < 21 in Standard & CommonHealth		478,661
CBHI Services	**# Members who Received Service**	**% Members < 21 who Received Svc**
ICC	6,479	1.35%
FS&T	5,281	1.10%
IHBS	242	0.05%
Therapeutic Mentoring	2,735	0.57%
Average # Members < 21 in all Eligibility Categories but Limited		521,321
CBHI Services	**# Members who Received Service**	**% Members < 21 who Received Svc**

IHT	7,492	1.44%
Youth MCI	9,727	1.87%
ALL CBHI Services	18,473	3.54%

State Fiscal Year 2011 (July 1, 2010 – June 30, 2011) Utilization		
Average # Members < 21 in Standard & CommonHealth		490,661
CBHI Services	**# Members who Received Service**	**% Members < 21 who Received Svc**
ICC	9,056	1.85%
FS&T	7,608	1.55%
IHBS	942	0.19%
Therapeutic Mentoring	6,284	1.28%
Average # Members < 21 in all Eligibility Categories but Limited		550,282
CBHI Services	**# Members who Received Service**	**% Members < 21 who Received Svc**
IHT	12,529	2.28%
Youth MCI	11,194	2.03%
ALL CBHI Services	25,684	4.67%

Data Source: FY 10 & 11 CBHI Service Utilization Reports

B. ICC For Children With Multiple EOHHS Agency Involvement (paragraph 30)

Paragraph 30 of the Judgment requires EOHHS to ensure that a representative of each involved state agency will participate as a member of a child's ICC care planning team and will coordinate any agency-specific service planning process or treatment plan with the ICC care planning process; develop protocols to guide the coordination of agency-specific planning processes or treatment plans with ICC care planning; and develop a conflict resolution process for resolving disagreements among members of the team.

EOHHS has worked with leadership of all of the child-serving state agencies within EOHHS to develop agency-specific "Children's Behavioral Health Initiative (CBHI) protocols." The protocols all require state agency staff to participate in the ICC Care Planning Teams for children and youth they serve, in order to coordinate agency service plans with the youth's Individual Care Plan. Participation by state agency staff on CPTs is monitored through the MCE TA discussions with CSAs, and is also a topic discussed at the CSAs' monthly SOC meetings. The two remaining protocols to be finalized are for the Massachusetts Commission for the Blind (MCB) and the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH). Drafts are currently being reviewed by agency leadership.

C. Project 3: Development of Service Delivery Network (paragraphs 31 and 38)

1. Network Development

a. **Geographic Access** – To ensure that each city and town in Massachusetts has access to IHT, TM, and IHBS, MBHP in 2011 created a "CBHI Service Capacity by Town/City" report.The report indicated that the majority of cities and towns have access to providers of IHT, TM and IHBS, within a 20-mile radius, and, when using a 30-mile radius, all cities and towns have access to providers of these three services

MBHP used the report to create a spreadsheet ("CBHI 20 Mile Tracking Sheet") of communities without access to these providers within 20 miles. MBHP then contacted nearby providers, within the 30-mile radius, to ensure

that all providers understood that they were responsible for delivering services to members in these outlying areas.

b. **Expansion of Family Support and Training (FS&T) -** In 2011, MassHealth and the MCEs expanded the availability of FS&T to include children and youth receiving In-Home Therapy (IHT) and/or Outpatient Therapy. (Initially, due to the need to hire and train an entirely new workforce, FS&T was limited to children and youth receiving ICC services.) The MCEs issued provider alerts and informational emails in September to inform providers of the availability of FS&T and how to access it for children and youth receiving IHT or outpatient therapy. The MCEs developed and distributed a "Tip Sheet" for outpatient providers on CBHI and their roles and responsibilities, as well as reminders of how to bill for consultation and collateral contacts. The MCE TA teams worked with the CSAs to prepare for and implement this change.

c. **Increased Capacity to Provide Services for Deaf and Hard of Hearing Children, Youth and Families –** During 2011, the MCEs convened two meetings with the Walden School, the Specialty CSA for the Deaf and Hard of Hearing population, to explore how to increase access to CBHI services for this population. The MCEs have provided, and continue to provide, extensive technical assistance to the Walden School, designed to help this particular provider to serve more Members, including expanding the remedy services it delivers. The MCEs invited representatives from various other Schools for the Deaf in Massachusetts to the second meeting. The Beverly School for the

Deaf attended, and as a result, the MCEs are currently working with School for the Deaf to become a CBHI provider.

2. Engaging in a public process to involve stakeholders in the development of the network and services.

Ongoing Meetings –

a. The Office of Behavioral Health holds regular meetings with relevant provider trade associations, including a monthly meeting with the Association for Behavioral Healthcare.

b. Staff from the Office of the Compliance Coordinator meets monthly with senior staff of the Parent/Professional Advocacy League and are in regular contact with the Federation for Children with Special Needs.

c. Staff from the Office of the Compliance Coordinator and the Office of Behavioral Health attend the bi-monthly Children's Behavioral Health Advisory Council, consisting of a comprehensive array of children's behavioral health stakeholders.

d. Staff from the Office of the Compliance Coordinator regularly attend meetings of the Children's League, an association of child welfare and behavioral health providers serving children, youth and families.

e. The MCEs convene monthly CBHI Provider Stakeholder meetings, consisting of a group of providers delivering CBHI services from across the state, including representatives from the Association for Behavioral Healthcare, to identify strengths and needs in areas such as communication, authorization

processes, and access to care, and to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system.

3. Designing strategies to educate providers, MassHealth Members, and the general public about the new services offered.

This work is described in Section I of this report.

4. **Network Management, Consultation, Training and Technical Assistance**

a. **Network Management Meetings: An Overview**

Together, the MCEs have developed and use a variety of meeting types and venues to support and oversee the work of the remedy service providers. These include **Technical Assistance (TA) meetings** between MCE Network Management staff and individual provider agencies; **statewide and regional meetings for providers of a particular service**, such as ICC or MCI; and **regional CBHI "level of care"[6] meetings** that include providers of remedy services in that geographic area. Clearly, each of these meeting types facilitates different work: individual TA meetings focus on provider-specific issues and goals; meetings of providers of one service allow for shared learning and problem-solving related to that service; and "level of care" meetings focus on the coordination and smooth operations *between* services in a region.

[6] In the language of managed care, the remedy services constitute various "levels of care" in the new service delivery system. The MCEs regionally convene all of the remedy providers – all of the "levels of care" – to focus on coordination between services and collaboration among providers.

During the reporting period of May 1, 2011 – October 31, 2011, the MCEs conducted **744** network management, consultation, training, and technical assistance (TA) meetings and activities with providers of all of the remedy services.

The purposes of these meetings were to manage the provider network, improve quality of care, promote collaboration, foster best practices, and support the sustainability of CBHI levels of care.

In addition to these meetings, the MCEs hold monthly joint meetings to coordinate their management of their common provider networks. The MCEs also meet bi-weekly with MassHealth.

b. Individual Provider Technical Assistance Meetings

The MCEs collaboratively manage the networks of providers of ICC, FS&T, IHT, IHBS and TM. Each service provider has a two-person Technical Assistance (TA) Team, consisting of one MBHP representative and one other MCE plan representative (from Fallon Community Health Plan, Boston Medical Center HealthNet Plan, Neighborhood Health Plan, Network Health or Health New England). The goal of these meetings is to increase the TA teams' awareness of provider challenges and accomplishments as well as

to identify areas for provider improvement and develop action plans as needed.

During the reporting period of May 1, 2011 – October 31, 2011, the MCEs conducted:

- 177 TA meetings with IHT providers
- 172 TA meetings with TM providers
- 53 TA meetings with IHBS providers
- 95 TA meetings with CSA providers of ICC and FS&T
- 20 TA meetings with MCI providers (note: both MBHP- and DMH-managed ESP/MCI providers)
- 100 network management meetings with MCI providers (note: MBHP-managed ESP/MCI providers only)

c. Local/Regional provider meetings

- 5 Regional trainings ("Crisis Planning Tools Training for Managers") with ESP/MCI, CSA/ICC, and IHT providers
- 5 Regional Crisis Systems Levels of Care meetings with ESP/MCI, CSA/ICC, and Urgent Outpatient Services (UOS) providers
- 5 Regional trainings ("Crisis Systems of Care – Building Competencies Across Services") with ESP/MCI, CSA/ICC/FS&T, IHT, UOS, and Child Outpatient providers

- 21 Regional ESP/MCI level of care meetings
- 10 Quarterly Regional CBHI Level of Care Meetings, including all CBHI services
- 69 local Systems of Care Committee meetings were attended by MCE representatives

d. **Statewide provider meetings**

- 2 statewide CSA meetings
- 1 Promising Practices Forum with all CBHI providers and outpatient providers
- 2 Training/orientation sessions on the CSA Child and Adolescent Psychiatrist Guide
- 3 Wraparound Online Data Entry and Reporting System (WONDERS) Webinars with CSAs
- 5 statewide meetings with ESP/MCI providers

e. **Network Management Activities by CBHI Service**

The section below summarizes the network management activities completed with each CBHI level of care during the reporting period. In addition to these network management meetings, MCEs provided other clinical/quality support and review activities relative to these levels of care.

(i) Community Service Agency (CSA): ICC and FS&T

(i) **Statewide Meetings** - The MCEs convened two statewide meetings with representatives from the 32 CSAs including CSA Directors, senior Intensive Care Coordinators (ICCs) and senior FS&T staff. Standing invitations for attendance were extended to the following MCE system partners: Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Developmental Services, Department of Mental Health and the Department of Public Health. Technical assistance, support and training topics presented during these statewide meetings included:

- Furthering Systems of Care (SOC) committee development and the inclusion of family voice
- Tip sheet for inpatient staff who work with ICC-enrolled youth
- Crisis planning tools and process
- The provision of FS&T in conjunction with the Outpatient (OP) and IHT hubs
- Collaborative practices with OP and IHT hubs
- Transition of youth and families from the ICC Service
- Transfer of hub role to Outpatient provider post-ICC transitions out
- FS&T program & staff development & resources
- MA Wraparound Fidelity Assessment System
- Promoting positive outcomes through fidelity monitoring

(ii) **Individual Provider Technical Assistance Meetings –** The MCE Technical Assistance (TA) teams facilitated 95 individual TA meetings with directors of the 32 CSAs. These TA meetings addressed issues such as:

- Ensuring provision of FS&T for youth ages 18 thru 20
- Ensuring provision of monthly System of Care Committee meetings
- Adolescent substance abuse screening
- Guidelines for ensuring timely access to care
- Capacity and waitlist data entry compliance into MABHAccess system
- Access to care outliers (see the Report on Access to ICC at the beginning of this report for more detail.)
- Percent of CANS on paper in past 90 days
- Compliance with fidelity monitoring system and review of provider specific Wraparound Provider Practice Analysis (WPPA) Report
- Effective crisis planning with families
- Requirements for use of the new crisis planning tools and a chart review of safety plans
- Family Partners with physical and behavioral health care needs
- Success/barriers to accessing/partnering with MCI

- Ensuring continuity of care when ICC or FS&T staff take leave from their position
- Ensuring staff training & supervision to the Wraparound model
- Quality assurance of CSA's subcontractors in the areas of: record keeping, fidelity monitoring, training, adherence to performance specifications
- MCE CBHI health record documentation standards
- Ensuring provision of CBHI services for youth with autism or pervasive developmental disorder
- Utilizing consumer satisfaction surveys
- Guidelines for addressing provider to provider concerns and how to raise concerns to MCEs
- Ensuring effective, family-friendly referral and intake procedures
- Ensuring intentional/successful transition of youth and families
- Determining effective ICC and FS&T caseload ratios
- Ensuring access to and the provision of FS&T in conjunction with the other hubs

(iii) The CSA Child and Adolescent Psychiatrist Guide and Training Session

The MCEs collaborated with Dr. Peter Metz, to develop a guide for CSAs regarding the role of CSA child and adolescent psychiatrists.

This guide was finalized and disseminated to all CSAs in October 2011. A training was held twice in October to orient CSA directors, supervisors and CSA child and adolescent psychiatrists to the following topics:

- Roles for the child and adolescent psychiatrist in the CSA
- Psychiatrist as coach and trainer
- Psychiatrist consultation to enrolled youth, families, and their teams
- Psychiatrist outreach to the community
- Psychiatrist role in practice-based learning and continuous quality improvement
- Administrative and process considerations
- System of care values and principles
- CBHI services overview
- Wraparound "skill sets"

(iv) Wraparound Online Data Entry and Reporting System

Webinars on the Wraparound Online Data Entry and Reporting System (WONDERS), were held three times in October, as a refresher for current CSA administrators and data entry operators and orientation for new staff not familiar with the process.

(v) System of Care Committee Meetings

To support, monitor and sustain collaboration in the larger system of care, MCE representatives have participated in 69 System of Care Committee meetings, convened by the CSAs, in the past 6 months.

(ii) In Home Therapy (IHT)

The MCE TA teams conducted 177 onsite provider-level TA meetings with IHT providers. These meetings addressed opportunities for improvement, as well as accomplishments and updates in the following areas:

- Guidelines for ensuring timely access to care
- Capacity and waitlist data entry compliance into MABHAccess system
- Access to care outliers: providers with over 10 youth waiting
- CANS compliance: percent of initial CANS completed in relation to number of families starting services during the past 90 days; percent of updated CANS in relation to number of active families served during the past 90 days; percent of CANS on paper in past 90 days
- Effective crisis planning with families
- Requirements for use of the new Crisis Planning Tools and chart reviews of safety plans
- Success/barriers to accessing/partnering with MCI
- Quality assurance of in network provider's sub-contracts in the areas of: record keeping, fidelity monitoring, training, adherence to performance specifications
- MCE CBHI Health record documentation standards

- Provision of CBHI services for youth with autism or pervasive developmental disorder
- Consumer satisfaction surveys
- Ensuring effective, family-friendly referral and intake procedures
- Ensuring continuity of care when staff take leave from their position
- Guidelines for addressing providers to provider concerns and the process for raising concerns to MCEs
- Integration and collaboration with other services
- Successes and challenges with other services (behavioral health, physical health, community agencies etc.)
- Ensuring intentional/successful transition of youth and families
- Consistent provision of the IHT model in accordance with performance specifications and family-driven approach
- Provider infrastructure for self-management/monitoring of quality of care standards
- Success and challenges as a hub working with FS&T

(iii)Therapeutic Mentoring (TM)

The MCE TA teams conducted 172 TA meetings with TM providers at program locations across the State with the directors of each

TM program. In these meetings, MCEs addressed opportunities for improvement and learned of accomplishments and updates in the following areas:

- Guidelines for ensuring timely access to care
- Capacity and waitlist data entry compliance into MABHAccess system
- Access to care outliers: providers with over 10 youth waiting
- Success/barriers in integrating care with hub providers
- Integration and collaboration with other services
- Successes and challenges with other services (behavioral health, physical health, community agencies etc.)
- Infrastructure to train/supervise staff
- Guidelines for addressing provider to provider concerns and the process for raising concerns to MCEs
- Ensuring effective, family-friendly referral and intake procedures
- Ensuring continuity of care when staff take leave from their position
- Quality assurance of in-network provider's subcontracts in the areas of: record keeping, fidelity monitoring, training, adherence to performance specifications
- MCE CBHI health record documentation standards

- Provision of CBHI services for youth with autism or a pervasive developmental disorder
- Consumer satisfaction surveys
- Ensuring intentional/successful transition of youth and families
- Consistent provision of the TM model in accordance with performance specifications and family-driven approach
- Provider infrastructure for self-management/monitoring of quality of care standards

(iv) In-home Behavioral Services (IHBS)

The MCEs conducted 53 TA meetings with IHBS providers at their program locations with the director of each IHBS program. The teams addressed opportunities for improvement and learned of accomplishments and updates in the following areas:

- Guidelines for ensuring timely access to care
- Capacity and waitlist data entry compliance into MABHAccess system
- Access to care outliers: providers with over 10 youth waiting and providers with any number of youth waiting over 8 weeks
- Success/barriers in integrating care with hub providers
- Successes and challenges with other services (behavioral health, physical health, community agencies etc

- Infrastructure to train/supervise staff
- Guidelines for addressing provider to provider concerns and the process for raising concerns to MCEs
- Quality assurance of in-network provider's subcontracts
- MCE CBHI health record documentation standards
- Provision of CBHI services for youth with autism or a pervasive developmental disorder
- Consumer satisfaction surveys
- Ensuring effective, family-friendly referral and intake procedures
- Ensuring continuity of care when staff take leave from their position
- Ensuring intentional/successful transition of youth and families
- Consistent provision of the IHBS model in accordance with performance specifications and family-driven approach
- Provider infrastructure for self-management/monitoring of quality of care standards

(v) Mobile Crisis Intervention

The network management of MCI continues to be a data-driven process with robust data shared with MCI providers on a monthly basis. These data are a foundation for the network management meetings

conducted with these providers on the individual, regional and statewide levels. MBHP network management staff engaged in ongoing network management activities, conducting approximately 100 network management meetings (approximately one meeting per month) with each of the 17 MBHP-managed ESP/MCI providers. In many cases, MBHP staff had weekly and sometimes even daily contact with these providers. MBHP regional network management staff also conducted regional ESP/MCI meetings on a monthly basis, totaling approximately 21 meetings. MBHP continued to host monthly statewide ESP/MCI meetings with all ESP Directors and MCI Managers of both the MBHP- and DMH-managed teams, totaling 5 meetings, with the exception of July 2011, when no meeting was held. These statewide meetings include all of the MassHealth contracted MCEs, both in development of the agenda and participation in the meetings. The focus of these individual, regional and network management meetings included:

- Review of data measuring progress toward the goals for the Quality Indicators: location of the MCI intervention (community-based vs. hospital ED), response time and disposition (inpatient vs. diversionary services), and development of strategies to improve performance
- Emergency Department diversion and increasing the number of MCI interventions occurring in the community
- Roles within the crisis continuum of care
- MCI collaboration with CSAs/ICC and other CBHI levels of care

- Integration with child-serving state agencies, DYS and ESP/MCI collaboration, Court clinic protocols and DYS youth
- Network management follow-up on issues raised through the TA sessions with the MCI consultant
- Crisis Planning Tools for Families
- Differential use of 24-hour levels of care

MBHP continued to offer extensive training and technical assistance to each of the 21 ESP/MCI teams across the state (both MBHP- and DMH- managed ESP/MCIs), in provider- specific, regional and statewide venues. This training and TA has continued to be provided by consultant, Kappy Madenwald, MSW. She conducted 20 individual TA sessions with MCI providers during this six-month period, through which the following topics were addressed:

- Utilizing the new Crisis Planning Tools for families
- Emergency Department diversion, increasing community- and home-based interventions
- MCI triage and family engagement
- Outreach to and education of families on the MCI service
- Collaboration with and education of various non-MCI providers and stakeholders on what the MCI service is
- Review of past MCI interventions – what went well, what could have been improved

- Family Partner recruitment and development, including training and support, how to share without making the intervention about you
- Role of the Peer Specialist within the MCI intervention
- MCI and mandated reporting
- Educating agency leadership regarding systemic ESP/MCI issues
- Infusing recovery model philosophy into MCI/CBHI
- Promoting staff safety during MCI community based interventions
- Promoting efficiencies to maximize the utilization of the MCI team
- Best practices in triage, staffing, team assignment, prioritizing referrals, and utilization of the 72-hour time frame
- Increasing community tenure and inpatient diversion
- Addressing challenges in engaging family and providers in discussion of all possible treatment and support options for the youth and family
- Crisis Systems of Care – educating providers on their role within the crisis continuum of care
- MCI collaboration with all CBHI services
- MCI staff development and training recommendations; best practices in supervision
- MCI 101 for new ESP/MCI leadership
- Challenges faced by youth and families involved with multiple providers
- Outreach and education of school systems regarding MCI service
- Addressing issues with Transitional Age Youth (TAY)

- MCI education of and collaboration with providers who do not embrace family voice and choice
- Achieving consensus disposition for high risk youth
- Addressing needs of youth involved with multiple systems

(vi) **Quarterly Regional CBHI Level of Care Meetings**

The MCEs hosted 2 CBHI Level of Care meetings in each of the five regions, totaling 10 meetings in the past 6 months. In attendance were program directors from the following levels of care: MCI, ICC, FS&T, IHT, IHBS, and TM.

The first series of CBHI level of care meetings was held in June of 2011. In addition to updates from the MCEs and providers, this meeting provided a regional forum for presentation from and discussion with the Parent/Professional Advocacy League (PPAL), the focus of which was on the History of the Family Movement, PPAL's history and mission, effectiveness of family partners, supporting emerging parent leaders, and family-driven care planning.

The second series of CBHI Level of Care meetings was held in September of 2011. In addition to updates from the MCEs and providers, this meeting provided a regional forum for a presentation and discussion with the Black Mental Health Alliance (BMHA), the focus of which was

on enhancing provider cultural competence in the delivery of CBHI Services, with an emphasis on Black youth.

(vii) **System-wide Network Management, Consultation and Training Activities**

The MCEs also implemented various initiatives and efforts to support network management and quality across the CBHI system of care, including but not limited to the following:

(viii) CBHI Promising Practices Forum

In May 2011, the MCEs held a statewide forum for program directors of all CBHI providers as well as outpatient providers. The full-day event covered a broad range of topics and highlighted exemplary practices in the following areas:

- Promoting families' strengths
- Transitions and sustainability/upholding the culture of the family
- IHBS - everything you need to know
- The integration of psychiatry within CBHI services
- Family-driven care planning
- Working with Transition Age Youth (TAY)
- CANS milestones and promising practices
- Systems integration within the CBHI services/lessons learned from families

(ix) Regional Crisis Planning Tools Training for Managers

In June 2011, the MCEs held 5 regional trainings (1 in each region) facilitated by Kappy Madenwald. ESP/MCI, CSA/ICC and IHT providers attended and the trainings focused on the following topics:

- Utilization of the new Crisis Planning Tools for Families
- Assistance with developing staff training plans on the Crisis Planning Tools
- How to implement the crisis planning process within and among the CSA, MCI and IHT providers

(x) Regional Crisis Systems Level of Care Meetings

In September 2011, the MCEs held 5 regional Crisis Systems Level of Care meetings (1 in each region) with ESP/MCI, CSA/ICC and Urgent Outpatient Services (UOS) providers. These meetings were led by Kappy Madenwald and focused on the following topics:

- Current status of the Crisis System of Care within the region
- How to engage others in the Crisis System of Care and move the system forward
- Planning for the crisis system of care trainings to be held in October 2011

(xi) Crisis Systems of Care – Building Competencies Across Services

In October 2011 the MCEs held 5 regional trainings (one in each region) for ESP/MCI, CSA/ICC/FS&T, IHT, UOS, and Child Outpatient providers. These trainings were facilitated by Kappy Madenwald. The trainings focused on the following topics:

- Roles providers across the service continuum have in helping children and families navigate crisis situations
- Strengthening the crisis continuum
- Identifying roles, responsibilities, strategies and opportunities for the system to collectively offer a stronger safety net for children and families

(xii) MBHP Outpatient Provider Practice Analysis Meetings

In February, July, August and September, 2011, MBHP sponsored Outpatient Provider Practice Analysis (OPPA) meetings with individual outpatient provider agencies in each of its five regions, in which CBHI was part of the agenda. Specifically included was the role of the outpatient provider as a hub service, including care coordination and treatment planning, the role of the outpatient provider as part of a Care Planning Team, and how to access the Common Network of CBHI providers. During these meetings the regional staff also educated outpatient providers on the role of the outpatient provider as a first responder in crisis and use of ESP/MCI services.

(xiii) **MBHP Substance Abuse Provider Practice Analysis Meetings**

These same CBHI agenda items were also incorporated into similar regional meetings for Substance Abuse Providers, in February, July, August and September 2011.

(xiv) NHP, BMCHP, Fallon Outpatient Chart Review Meetings

Outpatient providers were given information about billing for collateral contact and clinical hub responsibilities during chart review meetings.

(xv) NHP, BMCHP, Fallon – Other Provider-Level Meetings

One-to-one education provided to Outpatient providers as Network Managers identified the need for education or as the CBHI TA team see a need. The need is most often identified through provider report during a telephonic review.

(xvi) MBHP Regional Outpatient Meetings

In July, 2011, MBHP held regional Outpatient Provider meetings with outpatient providers in the Western and Central regions. During these meetings CBHI education was part of the agenda, specifically the role of the outpatient provider as a hub providing care coordination and treatment planning that informs hub dependent services, as well as the role

of the outpatient provider as a first responder and how to access and coordinate with MCI services.

(xvii) NHP, BMCHP, Fallon CBHI Regional Quarterly Meetings

Outpatient providers were invited to a round of these meetings, early in the year.

(xviii) Quarterly Regional MBHP/Outpatient/DYS Meetings

All regions have quarterly meetings with DYS and outpatient providers, in which system integration with CBHI is addressed. These meetings were held during January through February, 2011 and April through May, 2011.

D. **Wraparound Training and Coaching**

In this third year of the Vroon VanDenBerg (VVDB) training and coaching contract, priorities for the year include:

- additional training for CSA line staff in recognition of the expansion and turnover within CSAs
- workforce development for Family Partners. The VVDB expert on Family Partners, Susan Boehrer, developed and provided a series of introductions to the Family Partner role in eleven session across the state, targeted to individuals interested in becoming Family Partners.

- trainings (ten morning sessions across the state) on Wraparound for stakeholders, including staff from state agencies, courts and schools. Dr. Jim Rast, the principal VVDB trainer and coach, then trained CSAs on how to present this training to local stakeholders.
- Other training topics for CSAs have included a "webinar" on the use of an updated format for the Individual Care Plan.
- For January through June of 2012, the contract plan includes trainings for IHT and Outpatient providers on applying System of Care principles in care coordination, on how to coordinate care as "hub" service, and on how to collaborate as a Wraparound team member for children and youth involved in ICC.

VI. Data Collection (paragraphs 39-46)

Paragraph 46 requires reporting on potential tracking measures. Accordingly, this report includes data from the current reporting period, as well as actions the Commonwealth has taken to track and report data, on (A) screenings, (B) BH assessments (using the CANS in multiple levels of care), (C) intensive in-home assessments in ICC, (D) services provided, and (E) child and system outcome measures.

A. Behavioral Health Screening

The Judgment requires reporting on the following screening measures:

1. Number of EPSDT visits or well-child visits and other primary care visits.

2. Number of EPSDT behavioral health screens provided. An EPSDT behavioral health screen is defined as a behavioral health screen delivered by a qualified MassHealth primary care provider.

3. Number of positive EPSDT behavioral health screens. A positive screen is defined as one in which the provider administering the screen, in his or her professional judgment, identifies a child with a potential behavioral health services need.

   a. The Commonwealth uses MMIS claims data and MCE encounter data to report on all three of these measures. This report presents data for the quarter January-March, 2011 and April-June, 2011:

Quarter	number of well-child visits	number of screens	% of visits with screens	% of screens positive
Jan - Mar 2011	119,486	80,802	66%	7.5%
Apr - Jun 2011	125,731	86,663	67%	8.0%

As has been reported previously, screening rates vary by age:

	Jan - Mar 2011	Apr - Jun 2011
<6 mos	43%	44%
6 mos to 2 year	73%	73%
3 to 6 yrs	76%	77%
7 to 12 yrs	77%	78%
13 to 17 yrs	71%	72%
16 to 20 yrs	34%	34%

The most recent Quarterly Behavioral Health Screening Report is attached as Exhibit 9.

B. Clinical Assessment

1. **Number of clinical assessments performed**

The vast majority of clinical assessments are performed in outpatient therapy. Outpatient therapy providers file distinct claims for assessments. Production problems have delayed this quarter's CANS report from claims. The CANS application database shows that for the period July 1, 2011 through November 11, 2011, there were 16,598 CANS assessments completed. Of this total, 85% of these CANS subjects had consent from the parent or guardian to enter the CANS data into the database, and 96% were for children and youth ages five through twenty, with 4% ages birth through four.

2. **Number of clinical assessments that meet SED clinical criteria and indicate that a member could benefit from ICC.**

The data show that 97% of CANS clinical assessments completed by all types of providers find that the child meets either of the definitions of Serious Emotional Disturbance (SED) used in the Judgment.

C. ICC and Intensive Home Based Assessment

1. **Number of intensive home-based assessment performed. Such assessment processes shall result in the completion of CANS.**

Every youth in ICC receives an intensive home-based assessment, referred to in the language of high-fidelity Wraparound as the "Strengths, Needs and Culture Discovery" (SNCD). Preparation of the SNCD provides information that informs the completion of CANS for the youth. ICC staff are over 99% compliant with the requirement of completing the CANS through the CANS IT application. This is an increase from slightly over 90% in the last reporting period.

2. Number of Members who receive ongoing ICC services.

The most recent CSA Monthly Report, for November 2011, reports that 3,679 children and youth were receiving ICC as of the last day of the month. The most recent CBHI Service Utilization Report, covering State Fiscal Year 2011 (SFY2011) (July 1, 2010 through June 30, 2011), reports that 9,056 children and youth received ICC during this period, a significant increase from SFY2010, in which 6,479 children and youth received ICC.

D. Intensive Home Based Services Treatment

1. Member level utilization of services as prescribed under an ICP, including the type, duration, frequency and intensity of home based services

MassHealth is currently working with its MCEs on a methodology to collect this information, which EOHHS will implement in early 2012.

2. **Provider and system-level utilization and cost trends of intensive home-based services.**

See the current Quarterly CBHI Service Utilization Report, covering the period from January 1, 2011 through June 30, 2011. (Attached as Exhibit 11.)

E. Child and System Outcome Measures

Member level outcome measures will be established to track the BH health of a MassHealth Member with SED who has been identified as needing ICC, over time. Defendants will consult with providers and the academic literature and develop methods and strategies for evaluating Member-level outcomes as well as overall outcomes. Member-level outcome measures would be tracked solely for the purpose

of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

The Commonwealth has worked diligently to develop approaches to understand the implementation and its impact, using administrative data, fidelity data, assessment data and other available sources of information.

1. CANS and child outcomes

Because the CANS is the closest thing EOHHS has to a longitudinal measure of child status, the Commonwealth has focused considerable effort on understanding the characteristics of the Massachusetts CANS tool and identifying ways to use CANS data to measure service impact. In May 2011 CBHI, MassHealth and DMH staff met with Dr. Carl Fulwiler of the UMass Center for Mental Health Services Research, followed in this reporting period by three consultation sessions (8/3, 11/2, 12/14/2011) with a team of research methodologists from the Center for Mental health Services Research and the Department of Quantitative Health Sciences. These experts included Carl Fulwiler MD PhD, Bruce Barton PhD, Valerie Williams PhD, and Milena Anatchkova PhD. EOHHS also revisited the academic literature regarding CANS and outcomes measurement.

In addition, EOHHS collaborated with Hannah Karpman LICSW and John Hull PhD who conducted a study of CANS reliability using certification examination data, and confirming an acceptable level of interrater reliability for the Massachusetts CANS.

Ms. Karpman is focusing her dissertation research at the Heller School for Social Policy and Management at Brandeis on the CANS as a CBHI outcome measure, as mentioned in previous reports. She is also actively involved in the data consultations with UMass Medical School.

This is an ongoing effort. For a number of reasons -- some relating to sensitivity of CANS items, others related to the complexity of services and the number of unmeasured factors affecting outcomes -- EOHHS does not anticipate simple answers about service impact from the CANS. As of the end of 2011, EOHHS has examined the CANS data from an outcomes perspective and its finding at this time is that EOHHS has not yet identified methodologies, subgroups of children, services or providers, or item sets that show predictable change over time.

If, and when, EOHHS dentifies CANS items and analytic methods that can sensitively detect the effect of services, then EOHHS will also need to have accrued several years of data from established services. EOHHS is only now, two to two-and-one-half years from the start of the new services, at a point where EOHHS can expect to see increasing numbers of "completed cases."

2. Wraparound Fidelity Measures – WFI, DRM and TOM

The Commonwealth has reported on its use of elements of the Wraparound Fidelity Inventory 4.0 (WFI-4),[7] the Team Observation Measure (TOM),[8] and the

[7] The WFI-4 is a 40-item instrument used to assess adherence to the Wraparound model. In Massachusetts, the WFI-4 is completed through brief, confidential telephone interviews with the parent or caregiver. The WFI-4 interview is organized by the four phases of the Wraparound process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition). In addition, the 40 items of the WFI interview are keyed to the 10 principles of the Wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interview is intended to

Document Review Measure (DRM)[9] to assess the fidelity of Wraparound practice in ICC. Massachusetts has now completed two cycles of measurement with all three tools.

The raw data for all three tools were reported to Eric Bruns, PhD, the developer of the instruments, who analyzed the data and prepared reports for the MCEs. As previously reported, Massachusetts providers' overall WFI score for the first cycle was 78 (out of 100), four points above the current national average. Massachusetts scored above the national average in nine out of the ten Wraparound Principles measured by the WFI. TOM results were comparable, with an average score of 83, six points above the national average of 77, and above-average scores on nine out of ten Wraparound Principles. Eric Bruns concluded by describing Massachusetts'

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assess both conformity to the Wraparound practice model and adherence to the principles of Wraparound in service delivery. The CQI telephone interviews and ratings are conducted by Consumer Quality Initiatives (CQI) a consumer-run vendor contracted by MBHP. Each cycle involves calls to 600 randomly selected families and results in over 400 completed WFI-4 records.

[8] The TOM is a 20 item instrument used to assess adherence to standards of high-fidelity Wraparound during care plan team meetings. The TOM is used by the CSAs, whose staff (typically care coordinator supervisors), have been trained in rating the instrument. The TOM includes two items dedicated to each of the 10 principles of Wraparound. Each item consists of 3-5 indicators of high-quality Wraparound practice as expressed during a care plan team meeting. Trained raters measure whether or not each indicator was in evidence during the care plan team meeting. These ratings are translated into a score for each item as well as a total fidelity score for the session overall. The MCEs require the CSAs to ensure that every individual facilitating a Care Plan Team (CPT) meeting be observed twice (at minimum) during each annual TOM cycle. The second cycle of TOM data included observation of 658 team meetings across CSAs.

[9] The Document Review Measure (MA DRM) is a 26 item measure used by MCEs in CSA chart reviews. MCE raters are trained to assess conformance to principles of Wraparound as evidenced by materials present in medical record (e.g. individual care plan; strengths, needs, culture discovery documentation; risk management safety plan; CANS; transition plan, meeting notes, etc.) Although the MA DRM is derived from a standard template, it has been modified for Massachusetts and scores on the MA DRM cannot be used to compare Massachusetts to national norms. The second cycle of DRM data included data from 322 chart reviews.

implementation of High Fidelity Wraparound as “the fastest implementation of Wraparound in the history of Wraparound!”

Results of the second assessment cycle are reported in the MBHP WFI Presentation, attached as Exhibit 12. Briefly, there were some modest gains and losses in fidelity in the second cycle as compared to the first, but overall fidelity scores remained high compared to national norms. Massachusetts is rated especially strong in Family Voice and Choice, Collaboration, and Cultural Competence. These principles align strongly with central CBHI values. Perhaps the most concise summary is a comment from a parent from the WFI-4:

“I have never felt as empowered or as listened to as I have in this program.”

Opportunities for improvement include better development of natural supports, engagement of older youth, and preparing families to sustain gains beyond ICC (transition phase of Wraparound).

3. Additional data on system performance

The Commonwealth has considered anecdotal data collected through a range of avenues, both opportunistic and systematic, to understand and improve the quality of service implementation. Sources include the reports of MCE Technical Assistance Teams, feedback from group meetings of providers and from training sessions, CSA coaching reports, meetings with various stakeholders, and the Court Monitor's CSR process (in which employees from MassHealth, EOHHS, and DMH participate as reviewers). Although most of these data do not get reported to the Court, it is nonetheless of great importance to the Commonwealth in improving services.

4. Ad hoc reports completed in the reporting period

a. Court Monitor's Request for MCI Follow-up Data

This report studied data on 4142 MCI encounters with children and youth between 10/1/2010 and 12/31/2010 to learn how many of them had received behavioral health services in the 90 days prior to and post the MCI intervention. The study found that 69% of the children and youth had received a BH service in the 90 days prior to the MCI intervention and that 89% received a BH service in the 90 days following the encounter.

(i) Study of Average Length of MCI Encounter in Days

This report studied data from the fourth quarter of State Fiscal Year 2011 (April 1, 2011 through June 30, 2011). The average length of encounter, by provider, ranged from 1.2 days to 3.4 days, with a statewide average of 2.4 days.

(ii) Study of BH Service Utilization by MBHP Members Prior to Receiving ICC

This study reviewed the data of 480 MBHP Members who started receiving ICC in July, August or September 2011. Of these 480 youth, 462 (96%) received either outpatient therapy, IHT, IHBS, TM or a non-24 hour diversionary service (does not include MCI) before entering ICC.

(iii) MBHP Study of Units of 24-Hour Care Consumed by MBHP Members 0-18

In this study, MBHP tracked utilization of Inpatient Care, Community Based Acute Treatment (CBAT) services and Intensive Community-Based Acute Treatment (ICBAT) over State Fiscal Years 2007 through 2010 (July 1, 2006 through June 30, 2010). During this period, utilization of all of these

services declined by 25.5%. Inpatient care declined by 15.5%. Interestingly, there were minimal declines between 2007 and 2008 (2.1%) and between 2008 and 2009 (.5%), but a large decline between 2009 and 2010 (13.2%). EOHHS cannot state definitively the reason or reasons for the decline, except to say that it coincides with implementation of the remedy services. It is also interesting to note that a national study of inpatient use by adolescents showed a "dramatic" increase over the period from 1996 to 2007.[10]

5. Member Satisfaction Measures

Defendants will develop sampling methods and tools to measure Member satisfaction of services covered under this Judgment. Member satisfaction would be measured solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

a. The MCEs are encouraging providers of all remedy services to conduct consumer satisfaction surveys, if they do not already do so. The MCEs are currently surveying the CSAs to learn how many currently conduct consumer satisfaction surveys.

b. While the WFI-4 is a measure of Wraparound Fidelity and is not technically a measure of Member satisfaction, it is based on caregiver interviews and EOHHS believes certain scales overlap heavily with key elements of consumer satisfaction. In particular, Family Voice and Choice as measured by the WFI-4 is

[10] Blader, J.C., Acute Inpatient Care for Psychiatric Disorders in the United States, 1996 Through 2007, *Archives of General Psychiatry,* August 1, 2011.

very relevant to family satisfaction. EOHHS's CSA providers have consistently ranked especially high on this dimension of the WFI-4.

c. EOHHS notes also that high member satisfaction and high family engagement have been consistent findings of the Court Monitor in her qualitative studies of children and families involved in ICC and IHT through the Community Service Review.

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Date: January 13, 2012

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond

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