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**

REPORT ON 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").

EXECUTIVE SUMMARY

This Report on Implementation covers the period since November 30, 2010, when the last Report on Implementation was filed.

- The Defendants' most recent data, as of March 31, 2011, reports that 3,729 youth are currently receiving Intensive Care Coordination (ICC). In the first six months of State Fiscal Year 2011 (July 1, 2010 through December 31, 2010), 6,083 youth received ICC, 5,015 received Family Support and Training, 7,839 received In-Home Therapy, 489 received In-Home Behavioral Services, 3,903 received Therapeutic Mentoring and 5, 929 received Mobile Crisis Intervention. A total of 16,602 unduplicated youth received one or more of the remedy services during this six month period.

- In the past six months, MassHealth's Managed Care Entities (MCEs) conducted 618 network management and technical assistance meetings with providers of the remedy services, continuing a previously unprecedented level of technical assistance and network management activity for MassHealth, its MCEs and providers.
- Screening rates continue to climb through the defendants' twelfth quarter of collecting data. The most recent data, from October 1, 2010 through December 31, 2010, reports an average screening rate across all age groups of 66% (up from 63% reported in the November 2010 Report on Implementation).
- The National Academy for State Health Policy invited Massachusetts to present on its implementation of standardized behavioral health screening for MassHealth-enrolled children and youth. The webinar, entitled "Addressing the Behavioral Health Needs of Children: State EPSDT Strategies," was held on May 18, 2011 for state EPSDT Coordinators.

REPORT

This Report details the steps that the Defendants have taken since the last Report on Implementation, submitted to the Court on November 30, 2010, to implement the tasks in Projects One through Four in the Judgment.[1] This Report does not include paragraphs describing tasks that were previously reported as completed, in order to eliminate unnecessary and repetitive language, although it does report ongoing activities. What follows is a description of the most significant, but by no means all, ongoing or new activities since November 30, 2010:

***Paragraph 3*: The Defendants will inform all EPSDT-eligible MassHealth Members (Members under age 21 enrolled in MassHealth Standard or CommonHealth) and their families about the availability of EPSDT services (including services focused on the needs of**

[1] For this purpose, the Defendants construe Projects One through Four to include all tasks described in paragraphs 2 through 46 of the Judgment.

children with SED) and the enhanced availability of screening services and Intensive Care Coordination as soon as the EPSDT-eligible child is enrolled in MassHealth.

As previously reported, MassHealth mails notices to members under the age of 21 upon (1) initial enrollment in MassHealth, (2) reenrollment after a break in coverage, and (3) annually, on or around the member's date of birth. These identical notices inform members about preventive health-care services, including EPSDT services, and the availability of MassHealth's new behavioral health services.

Paragraph 4: The Defendants will take steps to publicize the program improvements they are required to take under the terms of this Judgment to eligible MassHealth Members (including newly-eligible MassHealth Members), MassHealth providers, and the general public. As part of this effort, the Defendants will take the actions described below and will also provide intensive training to MassHealth customer service representatives, including updating scripts used by such representatives to facilitate timely and accurate responses to inquiries about the program improvements described in this Judgment

The Defendants continue to publicize and distribute the brochure "Worried about the Way Your Child is Acting or Feeling?" to schools, hospitals, advocacy agencies, child-care organizations, MassHealth providers and other community-based organizations. Since the last Report on Implementation, close to 40,000 copies have been mailed, free of charge, to over 500 organizations. The brochure is currently available in English, Spanish and Portuguese and it will become available in Haitian-Creole by Fall 2011.

In addition, MassHealth's publications unit recently redesigned this brochure in black and white (English, Spanish and Portuguese) for the Department of Transitional Assistance (DTA). DTA will print the brochure and make it available to DTA employees and recipients.

Since the last report, the customer services contractor has continued to train new CSR hires and provide on-going training for existing staff.

Additional activities MassHealth has undertaken to inform eligible MassHealth members, providers, and the general public about the program improvements are described in the paragraphs below.

Paragraph 5: MassHealth Members - The Defendants will take the following actions to educate MassHealth Members about the program improvements they are required to take under the terms of this Judgment:

a. Updating and distributing EPSDT notices to specifically refer to the availability of behavioral health screening and services and to describe other program improvements set forth in this Judgment.

See the response to paragraph 3 above.

b. Updating and distributing (in the normal course of communications with MassHealth Members) Member education materials, including Member handbooks created by MassHealth and MassHealth's contracted managed care entities, to include description of these improvements, and how to access behavioral health screenings and services including the home-based services described in Section I.D.

Member Handbooks

Member Handbooks were previously updated to include information on the remedy services.

Member Newsletters

PCC Plan Member Newsletters – The PCC Plan continues to inform members of the behavioral health program improvements through its Member Newsletter. Last winter, the PCC Plan Member Newsletter included an article entitled: "Emergency Services, Right When You Need Them" (attached hereto as Exhibit 1). Additionally, the PCC Plan maintains a website that includes pertinent information related to the remedy services for members.

MassHealth's Managed Care Organizations' (MCOs') Member Newsletters – Each

MassHealth MCO publishes a Member Newsletter. Listed below are the most recent articles regarding program improvements. Each MCO also maintains a website that includes information on the remedy services for members.

Health New England

• "In-Home Therapy," Winter 2011 (Attached hereto as Exhibit 2)

Network Health

• "Peace of mind for parents: Behavioral health screenings," Winter 2011 (Attached hereto as Exhibit 3)

"Get Help During an Emergency," Winter 2011 (Attached hereto as Exhibit 4).

d. Participating in public programs, panels, and meetings with public agencies and with private advocacy organizations, such as PAL, the Federation for Parents of Children with Special Needs and others, whose membership includes MassHealth-eligible children and families.

Since the November 30, 2010 Report on Implementation, the Compliance Coordinator or her staff have held or participated in the following forums and meetings:

- December 6, 2010 - Children's Behavioral Health Advisory Council Meeting, Boston
- March 12, 2011 – Federation for Children with Special Needs - Visions of Community Annual Conference
- April 25, 2011 - Autism Commission (including representatives of family organizations and advocacy organizations concerned with Autism Spectrum Disorders), Boston
- May 2, 2011 - Children's Behavioral Health Advisory Council Meeting, Boston
- May 7, 2011 - Roxbury YMCA Healthy Kids Day
- May 17, 2011 - Boston Promise Initiative, Dudley Street Neighborhood Initiative, Boston

Paragraph 6: MassHealth Providers – The Defendants will take the following actions to educate MassHealth providers about the program improvements they are required to take under the terms of this Judgment.

c. Drafting and distributing special provider communications related to the program improvements described in this Judgment, including how to assist MassHealth Members to access the home-based services described in Section I.D.

Information on the Remedy Services and How to Help Members Access Them

Last year, the Defendants released a color brochure for families entitled, *"Worried About the Way Your Child is Acting or Feeling?* Although the brochure was designed for families, and is primarily distributed to families, many provider organizations, including primary care practices and outpatient mental health clinics, have found it to be a useful tool to inform staff about the new services and how to help families access them.

As previously reported, the Defendants have also developed a comprehensive companion publication to the brochure: *"Helping Families Access MassHealth Behavioral Health Services for Children and Youth Under Age 21: A Guide for Staff Who Work with Children and Families.* It is available for download from the CBHI website. The guide continues to serve as an important informational resource for providers and community partners who work with MassHealth-enrolled and MassHealth-eligible youth and their families. The Defendants continue to distribute these materials to targeted audiences via email, the CBHI website and in-person meetings.

CANS Newsletter

As reported in the November 2010 Report on Implementation, the Defendants launched an e-newsletter, known as, "*CANS*News," in January, 2010. *CANS*News is published quarterly and is

another means by which the Defendants can disseminate news and provide resources to support the use of the CANS. The most recent edition of *CANS*News is attached hereto as Exhibit 5.

Other Communications With Providers Regarding CANS Assessments

See paragraph 16.

d. Updating and distributing existing provider education materials to reflect the program improvements described in this Judgment.

PCC Plan Provider Newsletters – This spring, the PCC Plan provider newsletter included an article entitled, "Massachusetts Sets New Benchmark for Child Mental Health Screening." (Attached hereto as Exhibit 6). In addition, the PCC Plan maintains a website that includes pertinent information for providers related to the remedy services.

MassHealth's Managed Care Organizations' (MCOs') Provider Newsletters – Each MassHealth MCO publishes a Provider Newsletter. Listed below are the most recent articles regarding program improvements. Each MCO also maintains a website that includes information on the remedy services for providers.

Boston Medical Center HealthNet Plan

• "Behavioral Health Screens Required for Kids, Adolescents," May 2011 (Attached hereto as Exhibit 7)

Neighborhood Health Plan

• "CBHI Improves Access But Increases Cost," Spring 2011 (Attached hereto as Exhibit 8)

Network Health

• "Help for Your Patients During a Behavioral Health Crisis," Winter 2011 (Attached hereto as Exhibit 9)

e. Expanding distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Judgment.

The Defendants maintain a website for the Children's Behavioral Health Initiative that is accessible through Mass.gov, and directly through the Home pages of the Executive Office of Health and Human Services, MassHealth, the Department of Children and Families, the Department of Mental Health and the Department of Youth Services. The CBHI site contains information for MassHealth providers, members, the broader community of human service providers, stakeholders and members of the general public about EPSDT and the program improvements undertaken by the Defendants in response to the Judgment. The Defendants have developed a completely redesigned website that is scheduled to go live this spring. The site is designed to be easier to navigate, especially for families and youth. It will also include new material of interest to people in the fields of Early Education and Care, Pre K -12 Education, and Higher Education. The Defendants continue to develop and maintain e-mail distribution lists for the dissemination of timely information relevant to the remedy services.

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

This section reports on meetings organized by CBHI staff. An extensive array of meetings and training forums has been held by the MCEs, as reported in paragraph 38.

<u>Meetings with Behavioral Health Providers Regarding CANS Assessments</u>

The Defendants continue to meet with providers in person and by conference call to support skillful use of the Child and Adolescent Needs and Strengths tool in the clinical assessment process, in treatment planning and to track clinical progress. As reported previously, beginning in September, 2009, the Defendants initiated a series of conference calls and face-to-face meetings, known as CANS Community of Practice (CoP) meetings, designed to facilitate the sharing of best practices for using the CANS. Eleven of these sessions have been held since September 2009, the most recent of which was held on April 26, 2011, at Wayside Youth and Family and Support Network in Framingham. Staff of the UMass CANS Training Program are identifying and documenting best practices culled from these calls and meetings, to be disseminated to certified CANS assessors (i.e., clincians who have passed the CANS certification test).

***Paragraph 7*: The Public - To improve public information about the program improvements the Defendants are required to take under the terms of this Judgment, the Defendants will take the following actions to present the terms of this Judgment to public and private agencies that serve children and families:**

b. Creating new pamphlets, informational booklets, fact sheets, and other outreach materials describing these improvements.

See the response to Paragraph 6(C), above.

The Defendants recently signed an Interdepartmental Service Agreement (ISA) with the Department of Mental Health, to purchase services from a DMH contractor, the Parent/Professional Advocacy League (PPAL). PPAL is the state organization of the Federation of Families for Children's Mental Health, a national family-run organization that provides national children's mental health policy leadership. Through this ISA, the Defendants will work

with PPAL during the remainder of State Fiscal Year 2011 and during SFY12 to design, test and implement additional strategies for informing families and youth about the remedy services.

c. Developing and implementing training programs for line staff at the Departments of Mental Health, Social Services, Youth Services, Mental Retardation, Transitional Assistance, and the Office for Refugees and Immigrants on how to access MassHealth services for children with SED.

December 2, 2010 – Management meeting between CBHI staff and staff of the Department of Public Health's Bureau of Substance Abuse Services (BSAS), to respond to questions from BSAS contracted providers regarding coordination with remedy services.

February 24, 2011 – CBHI staff met for the first time with DMH's statewide "Service Integration Specialists"; DMH Child and Adolescent Services staff assigned to each of the 32 Community Service Agencies. Each Service Integration Specialist is assigned to work with two CSAs to, among other things; serve on Care Planning Teams for children and youth receiving both ICC and DMH services; facilitate referrals to DMH child or adult services from the CSAs, provide access to other DMH resources, such as specialty clinical consultations, and serve on the local System of Care Committee. The purpose of the meeting was to exchange feedback and review together their first year in the role. The defendants and their agency partners are discussing establishing a standing, semi-annual meeting between CBHI staff and the DMH Service Integration Specialists.

April 14, 2011 - Department of Public Health Care Coordinators, Tewksbury. Orientation to the remedy services and Wraparound care planning, for DPH case managers who serve children and youth with special health care needs.

April 6, 2011 - Juvenile Court Clinic Directors and DMH Div of Forensic MH Manager of Juvenile Court Clinics (Dr. Tina Adams) and DFMH Director (Dr. Debra Pinals) and Deputy Director Joan Mikula. Worcester. Meeting to discuss successes and challenges of implementation of new MassHealth services as they affect the Juvenile Court population.

May 26, 2011 – CBHI training for Children and Family Law attorneys from Barnstable, Bristol, Dukes and Nantucket counties. Dartmouth.

May 27, 2011 - Department of Public Health, Understanding Services Workshop. Leominster. Briefing on the remedy services for DPH Case Managers and other DPH staff interested in services for children with complex medical needs.

Interagency Protocols and Protocol Trainings

Defendants are in the process of developing protocols for the Commission for the Blind and the Commission for the Deaf and Hard of Hearing, both of which should be completed this summer. Completion of the Commission for the Blind protocols were previously delayed because of staff shortages at the Commission and loss of a CBHI consulting contract.

As previously reported, the Defendants trained Department of Children and Families' field managers and supervisors in the DCF CBHI Protocols in 2009. DCF disseminated the Protocols to line staff in 2009, but put staff training on hold through 2009 and 2010, as it implemented a new practice model for all staff. CBHI and DCF have recently developed a

plan for Fall 2011, in which CBHI and DCF will jointly develop a training presentation for DCF field managers and supervisors to deliver to line staff in DCF Area Staff Meetings. The format of the training includes time for line staff to provide feedback and suggestions on MassHealth Behavioral Health Services for children and youth.

d. Distributing outreach materials in primary care settings, community health centers, and community mental 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 in contact with or serve children with SED or their families.

See the response to Paragraph 6(c), above.

e. Working with the Department of Early Education and Care to educate preschools, childcare centers and Head Start Programs on how to access MassHealth services for children with SED.

CBHI staff are finishing a general CBHI Resource Guide for School Personnel (see paragraph 7.f.), and have been working with DEEC staff to create a specialized Resource Guide for providers of early care and education. The Guide will be distributed electronically by DEEC to providers in the Fall.

f. Working with the Department of Education, the Department of Public Health and Public School Districts to educate school nurses and other school personnel on how to access MassHealth services for children with SED.

The Defendants have been collaborating with the Department of Elementary and Secondary Education (DESE), and parent organizations, to produce a downloadable CBHI Resource Guide for School Personnel, describing the MassHealth behavioral health services and how to help children and youth access them. At the beginning of the 2011/2012 school year, DESE

will notify all public school districts of the Guide and make it available to download from the DESE website.

Paragraph 10: ***There will be a renewed emphasis on screening, combined with ongoing training opportunities for providers and quality improvement initiatives directed at informing primary care providers about the most effective use of approved screening tools, how to evaluate behavioral health information gathered in the screening, and most particularly how and where to make referrals for follow-up behavioral health clinical assessment. Additional quality improvement initiatives will include improved tracking of delivered screenings and of utilization of services delivered by pediatricians or other medical providers or behavioral health providers following a screening and use of data collected to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule and more often as requested (described in Section I.E.2).***

Implementation Activities

Since implementation of standardized BH screening in pediatric practices December 31, 2007, MassHealth, through regulation and contracts with its health plans, has required primary care clinicians seeing MassHealth-enrolled youth under 21 to offer to perform a BH screen during well-child visits and to report the result of the screening by using certain billing modifiers on the claim. The percentage of claims not including a modifier has dropped from 35% during the first quarter of 2008, to 16% during the last quarter of 2010. MassHealth recently announced that, as of July 1, 2011, it will deny screening claims that do not include a billing modifier to indicate the outcome of the screen. This includes claims paid through MassHealth's "fee for service" and Primary Care Clinician programs. MassHealth's MCOs will follow suit later in 2011.

Quality Improvement Activities

As previously reported, MassHealth created an internal CBHI Screening Quality Improvement Workgroup. The Workgroup coordinates quality improvement (QI) activities associated with

behavioral health screening across MassHealth's three service delivery systems: Managed Care Organizations, the Primary Care Clinician program and fee-for-service Medicaid.

Data Infrastructure

Since the last Report on Implementation, the Workgroup has worked with MassHealth's Department of Data and Analytics to design and build a "data cube" of screening data to permit MassHealth quality improvement staff to analyze screening data to support screening quality improvement activities.

Project to Increase Screening Rates

The Workgroup reviewed the screening rates by age grouping of the youth and decided its first quality improvement project would be to increase screening rates for youth 18 through 20. Since implementation of BH screening, the screening rate for this age group has been one half to one third the rate of screening for youth 6 months through 17. Staff have pulled a sample of providers with unusually high or unusually low rates of screening of youth in this age range, and developed a set of questions about best practices and barriers to screening these youth. The questions were mailed to the providers, and now staff are calling these providers to conduct telephone interviews. Findings from the interviews will be reviewed with various clinical advisory groups, in order to develop recommendations or interventions to improve screening for this group.

Data on Follow-up Services for Youth with Positive BH Screens

MassHealth, through its regulations and contracts with health plans, requires primary care clinicians performing BH screens on children and youth to respond to a positive screen by either: ascertaining that the youth is receiving behavioral health services; directly providing a follow up service; or referring the youth to a behavioral health service.

MassHealth's Primary Care Clinician (PCC) Plan

The PCC Plan is a MassHealth-operated program in which MassHealth contracts directly with PCCs to provide care and care coordination for MassHealth members. Every six months, the PCC Plan prepares "Provider Profiles" for PCCs with 180 or more MassHealth members on their "enrollment roster" or "panel." Beginning in 2008, the Provider Profile reports have included data on the provider's rate of BH screening, the percentage of screened youth with a positive screen and the percentage of those youth for whom a provider has submitted a claim for follow-up service within 90 days after the screen. A follow-up service for the purposes of the Provider Profile is defined as a claim for a behavioral health service or a visit with the PCC for which the PCC bills and uses a behavioral health diagnostic code. These "claims data" do not capture all PCC responses to a positive screen; they only capture responses for which a provider files a claim within the 90 day window.[2] In addition to these data, the Provider Profile reports also provide to PCCs a list of MassHealth members with a positive BH screen for which a provider has not made a claim for a follow up behavioral health service within 90 days.

[2] Note that in some cases, after speaking with the child and/or the parent, the clinician realizes that there may be no need for follow-up; for example, the clinician may determine that a child had a positive screen as a result of what appears to be normal grief process due to the death of a grandparent. In such a case, the clinician may counsel the family to call if the child does not improve within a certain period of time. In addition, the clinician may (1) determine that the child is already receiving services; (2) schedule another visit to talk more about the issues; or (3) decide to monitor the situation within the pediatric practice in conjunction with medical needs, which follow-up care would not be tracked unless the clinician uses a behavioral diagnostic code.

Due to the incompleteness of claims data, the Defendants are assessing the feasibility of conducting a chart audit on a sample of primary care medical records of youth with positive BH screens. Chart audits provide access to the PCC's notes in the youth's medical record and include information not captured in billing claims. For example, a note in the record might document that the PCC made a referral to a BH provider on behalf of the youth, while, because the family did not follow up on the referral, claims data do not record a claim for the BH service.

The aggregated results from these Provider Profile reports indicate that a significant number of children and youth who receive a positive screen also receive follow-up services that result in the submission of a claim:

Measures	1/1/10-6/30/10	7/1/09-12/31/09	1/1/09-6/30/09	7/1/08-12/31/08	1/1/08-6/30/08
% WCC Visit with BH Screening	68.68	64.97	62.22	49.74	48.89
% BH Screening with need identified	8.17	7.95	9.45	9.15	9.17
% of those with positive screen for whom a claim for a follow-up service was filed within 90 days	53.20	53.57	55.16	60.15	57.45

MassHealth's Managed Care Organizations (MCOs)

MassHealth requested its MCOs to conduct a screening Quality Improvement Project (QIP) in 2011. Each MCO is independently designing and implementing a data collection strategy to learn more about follow-up services to children and youth with a positive BH screen. The MCOs will be presenting their findings to MassHealth in September.

Paragraph 12: ***The Defendants will provide information, outreach and training activities, focused on such other agencies and providers. In addition, the Defendants will develop and***

distribute written guidance that establishes protocols for referrals for behavioral health EPSDT screenings, assessments, and services, including the home-based services described in Section I.D., 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 EPSDT screenings, assessments, and medically necessary services.

See response to paragraphs 6(c) and 7(c) above.

Paragraph 16: ***The Defendants will implement an assessment process that meets the following description:***

a. In most instances, the assessment process will be initiated when a child presents for treatment to a MassHealth behavioral health clinician following a referral by the child's primary care physician based on the results of a behavioral health screening. However, there are other ways for children to be referred for mental health services. A parent may make a request for mental health services and assessment directly to a MassHealth-enrolled mental health provider, with or without a referral. A child may also be referred for assessment and services by a provider, a state agency, or a school that comes into contact with a child and identifies a potential behavioral health need.

b. Assessment typically commences with a clinical intake process. As noted, Defendants will require MassHealth providers to use the CANS as a standardized tool to organize information gathered during the assessment process. Defendants will require trained MassHealth behavioral health providers to offer a clinical assessment to each child who appears for treatment, including a diagnostic evaluation from a licensed clinician.

Recertification

Recertification is required every two years, which means that any assessors providing services have now been recertified. The new format for the CANS certification exam, described in the last report to the Court, was designed to provide a more accurate assessment of assessor knowledge of each CANS item. The improved assessment process also has resulted in a much higher pass rate, consistently well over 90 percent.

New “Cultural Considerations” Section of the CANS

The CANS currently contains a section entitled Acculturation, which is 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 actual Acculturation ratings in the CANS database suggested to the defendants that MassHealth could improve the questions in this section to more accurately capture the necessary information. The Defendants worked with the Committee on Reducing Health Disparities, of the Children’s Behavioral Health Advisory Committee, to develop a work group consisting of clinicians who regularly work with culturally diverse clients and clinicians who are familiar with the research literature on culture in the provision of BH services. The work group undertook this task with great thoughtfulness and care and the result is a new CANS section called “Cultural Considerations" that is clearer and more clinically relevant than the old Acculturation section. The Defendants have successfully piloted the new section with a few groups of clinicians. They anticipate that the new items will make it easier for clinicians to gather relevant data, to rate the items, and to incorporate them in treatment planning. Release of the new item set requires orchestrated communications, user training opportunities, and release of an IT update. The defendants currently expect this to occur in Fall 2011.

Because discussion of culture -- including, but not limited to race, ethnicity, and language -- may be challenging for clinicians and families, Defendants are also planning to provide training on the new items and how to rate the new items, as well as training for clinicians on how to have conversations with families about culture. Dr. Ken Hardy from Drexel

University is an expert in this area and will be consulting to CBHI and the UMass CANS Training Program later this spring on training design. Training offerings will include a distance learning video module as well as written materials. As always, CBHI will also provide phone and email technical support to users, and anticipates addressing Cultural Considerations on the agenda of CANS Community of Practice meetings.

New CANS training module

The Defendants have provided extensive training and support to CANS users in rating the CANS, and are now focusing 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. The defendants anticipate release of this new training module in early autumn 2011.

CANS Community of Practice

In Spring 2011 the UMass CANS Training Program conducted a telephone survey of key informants who had participated in CANS Community of Practice meetings during the past two years. The respondent sample is small, and therefore the results should be considered anecdotal. But the responses suggest that providers have finally overcome, to a significant degree, the initial hurdle of understanding the complexities of the CANS tool, consent, and the use of the application on the Virtual Gateway. Most respondents indicated, for example, that they no longer participated in CANS TA conference calls because they already understood the material typically covered in the calls. This is consistent with CBHI's

impression in providing technical assistance to CANS users by phone and email, as well as CBHI's CANS Community of Practice meeting at Wayside Family Services on April 26, 2011, which showed, in contrast with past meetings, that providers were more focused on clinical use of the CANS and less focused on technical obstacles.

CANS Compliance

The Defendants have asked the MCEs to focus on the remedy services to increase provider compliance with the CANS requirement . MassHealth's Managed Care Entities' (MCEs)(the five Managed Care Organizations and one BH Managed Care Company) technical assistance teams review CANS compliance in their regular meetings with CSAs and with IHT providers. The MCEs expect these providers to obtain reports and to use them in managing staff compliance with completing CANS assessment. A recent increase in provider inquiries to CBHI and to Virtual Gateway Customer Service about how to obtain these reports reflects this heightened level of supervision by MCEs. As a further effort to support CANS implementation at all levels of care, including outpatient, MassHealth's MCEs sponsored a Promising Practices Forum on May 23, 2011, that provided a CANS presentation to the entire Forum audience, containing a "best practices" presentation by a provider. This Forum will be disseminated to providers via DVD, as a distance learning option with the opportunity of obtaining CEUs. In 2010 and 2011, MCEs are more frequently asking providers for CANS data in the course of clinical reviews for service authorization purposes. This emphasizes to providers the importance of the CANS as a key source of information for MCEs on medical necessity.

CANS IT Update

In February 2011,MassHealth released an update to the CBHI CANS system and an additional technical update is expected in June. The February release significantly improved the timely performance of the online CANS application. Defendants' IT focus with the CANS in the past six months has been to enhance the performance of the application, rather than to create important new features. New features are planned for the next one to two years, including: a revision of consent to permit sharing of CANS among providers working with a youth; new reports for providers that will increase the clinical utility of the CANS; and an electronic interface for provider electronic health systems, which would allow organizations with such systems to build the CANS into their electronic record and eliminate the need for staff to log onto the Virtual Gateway to input CANS data.

Paragraph 30: ***Intensive care coordination services are particularly critical for children who are receiving services from EOHHS agencies in addition to MassHealth. In order to assure the success of the care planning team process and the individualized care plan for a child with multiple agency involvement, EOHHS will ensure that a representative of each such EOHHS agency will be a part of the child's care planning team. Operating pursuant to protocols developed by EOHHS, EOHHS agency representatives will coordinate any agency-specific planning process or the content of an agency-specific treatment plan as members of the care planning team. EOHHS will develop a conflict-resolution process for resolving disagreements among members of the team.***

See the response to Paragraph 7, above.

Paragraph 38: ***Development of a Service Delivery Network***

c. Tasks performed will include:

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

In addition to the activities reported in previous Reports on Implementation, the Defendants are engaged in the following current, ongoing, consultative processes:

- The MassHealth Office of Behavioral Health (OBH) holds regular meetings with relevant provider trade associations, including a monthly meeting with the Association of Behavioral Healthcare.
- The MCEs meet monthly with a group of provider stakeholders, consisting of a group of providers delivering CBHI services from across the state, representatives of the Association for Behavioral Healthcare, and MassHealth. The purpose of this group is to work collaboratively to identify areas of strength and need and to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system.
- CBHI and OBH staff attend the Children's Behavioral Health Advisory Council, an Advisory Council established by state statute and convened by Barbara Leadholm, the Commissioner of the Department of Mental Health. The Council consists of representatives of a comprehensive array of children's behavioral health stakeholders.
- CBHI and OBH staff meet regularly with the Parent Professional Advocacy League.
- CBHI staff regularly attend meetings of the Children's League, an association of child welfare and behavioral health providers serving children and youth.

iii) Planning concerning anticipated need and provider availability.

Provider Network Management, Consultation, Training and Technical Assistance

Overview

The Managed Care Entities (MCEs) conduct provider network management at the **individual**, **regional** and **statewide** levels, with providers of all of the remedy services. During the reporting period of November 1, 2010 – April 30, 2011, the MCEs conducted **618** network management, consultation, training, and technical assistance (TA) meetings with providers of all of the remedy services. The purposes of these meetings were to manage MCE's networks of providers, to improve quality of care, promote collaboration, and support the sustainability of the remedy services.

A. Individual Technical Assistance Meetings With Providers

Each provider of Intensive Care Coordination (ICC), Family Support and Training (FS&T), In-Home Therapy (IHT), In-Home Behavioral Services (IHBS) and Therapeutic Mentoring (TM) has a consistent Technical Assistance team, comprised of one MBHP representative and one other MCE plan representative (FCHP, BMCHP, NHP, or Network Health). Through meetings with providers, the TA teams learn about provider-level and system-level accomplishments, broaden MCE awareness of provider challenges, establish areas for improvement and develop action plans as needed.

Mobile Crisis Intervention (MCI) providers are managed by the Massachusetts Behavioral Health Partnership (MBHP). The TA processes for MCI will be addressed at the end of this section.

Topics that were common to the individual TA meetings with providers of Intensive Care Coordination (ICC), Family Support and Training (FS&T), In-Home Therapy (IHT), In-Home Behavioral Services (IHBS) and Therapeutic Mentoring (TM) include:

- Integrating information from the CANS assessment into care/treatment planning
- Using the CANS to assist in referring the youth/family to appropriate services
- CANS compliance and reporting
- Ensuring timely access to care, including insuring ongoing organizational capacity to recruit, hire and train additional staff
- Utilizing Massachusetts' BH Access system (MABHAccess) to improve timely access to CBHI services for youth and families
- Documentation
- Effective crisis planning with families
- Coordination with Mobile Crisis Intervention, successes and barriers
- Ensuring that providers have policies and procedures in place for ensuring that youth/families continue to receive services as outlined in the treatment plan when staff vacate their position for any reason.

1. Community Service Agencies (CSAs)

The MCE Technical Assistance (TA) teams facilitated 104 individual TA meetings with directors of the 32 CSAs. In addition to the topics listed above, these meetings also addressed:

- Fidelity to the Wraparound model
- Effective transition planning for youth and families leaving ICC
- CSAs' use of Vroon VanDenBerg's training and coaching curricula to train new and existing staff

- Collaborating with medical providers to ensure integration of behavioral and medical services.

2. In-Home Therapy (IHT)

The MCE TA teams conducted 136 provider-level TA meetings with IHT providers. Meetings were held at program locations across the state and included the directors of each IHT program.

3. Therapeutic Mentoring (TM)

The MCE TA teams conducted 103 TA meetings with directors of TM providers at program locations across the state. In addition to the topics listed above, these meetings also addressed coordination of the TM service plan with the treatment or care plan developed by the "clinical hub service" (ICC, IHT or Outpatient Therapy).

4. **In-Home Behavioral Services (IHBS)**

The MCEs conducted 33 TA meetings with IHBS providers at their program locations with the director of each IHBS program. In addition to the topics listed above, these meetings also addressed:

- Coordination of the IHBS treatment plan with the treatment or care plan developed by the "clinical hub service" (ICC, IHT or Outpatient Therapy).
- Adherence to performance specifications

5. Mobile Crisis Intervention (MCI)

MBHP directly manages 17 of the 23 Emergency Services Providers (ESPs), who provide Mobile Crisis Intervention services to MassHealth-enrolled youth under age 21. The four remaining ESPs are operated by the Department of Mental Health. MBHP collects performance data from DMH and includes it in the regular MCI report.

The contract management activities described below are those conducted by MBHP with the 17 providers in its network.. As noted below, DMH ESP programs are included in training forums and statewide ESP meetings.

MBHP's management of MCI has continued to be a data-driven process with robust data that measure progress increasing the percentage of visits that occur in the community, meeting the one-hour response time requirement, and reducing unnecessary hospitalizations.

These data are a foundation for the network management meetings conducted with MCI providers at the individual, regional and statewide levels.

Throughout this reporting period, MBHP network management staff conducted ongoing network management meetings with each of the 17 MBHP-managed ESP/MCI providers, on approximately a monthly basis, totaling approximately 91 such meetings. 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 approximately a monthly basis, totaling approximately 26 meetings during this

reporting period. MBHP also continued to host monthly statewide ESP/MCI meetings with all ESP Directors and MCI Managers of both the MBHP- and DMH-managed teams, totaling 6 during this reporting period. These statewide meetings include the other MassHealth -contracted MCEs, both in developing the agenda and participating in the meetings. The focus of these individual, regional and network management meetings has included but not been limited to:

- Fidelity to the MCI model and adherence to the performance specifications
- Review of data measuring progress toward the goals for the Quality Indicators related to location of the MCI service (community-based vs. hospital ED), response time and disposition (inpatient vs. diversionary services)
- Utilization of the 72-hour MCI timeframe
- Integration with ICC and other CBHI levels of care
- Integration with child-serving state agencies
- Follow up on stakeholder feedback regarding MCI services
- Network management follow up on issues raised through the TA sessions with the MCI consultant

Also during this reporting period, 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 18 individual TA sessions with MCI providers during this six month period, through which the following topics were addressed:

- Integration within the ESP and MCI team
- Expanding and integrating the role of the Family Partner within the MCI team
- Family voice and choice
- Engaging and collaborating with families in MCI services
- Risk Management & Safety Planning, utilizing best practices
- Triage/dispatch – maximizing efficiencies and increasing flow to the community
- Resolution-focused interventions
- Utilization of the 72-hour timeframe
- Use of community based levels of care in MCI disposition planning.
- Short term behavior plans
- How to find resolution when community providers want youth to be placed in higher levels of care than MCI is recommending
- Interventions for youth who are transitioning to adulthood
- Strategies to engage and educate hospital EDs about MCI
- Collaboration with other CBHI levels of care
- Establishing Memoranda of Understanding (MOUs) with individual schools and the school system as a whole to memorialize the relationship beween the school and the MCI
- Review of interventions and plans for specific youth and families served

B. <u>Quarterly "Level of Care" Meetings</u>

In the language of managed care, the six 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.

Over the past six months, the MCEs have hosted two meetings in each of the five regions (total of 10 meetings) of providers of all of the remedy services. The first set of meetings was held in December, 2010. In addition to updates from the MCEs and providers, these meetings focused on successful system partnering regarding transitioning youth and families to and from the various levels of service and the need to focus on the sustainability of the youth and family in their community. The discussion centered on what each of the system partners (ICC, IHT, TM, IHBS, MCI) can do to improve the transition experience for youth and families, including concrete steps to be implemented by the providers. The MCEs held the second series of CBHI Level of Care meetings in March of 2011. In addition to updates from the MCEs and providers, which included an overview of the MABHAccess website, there was a presentation on "Understanding Deaf Culture and Resources." This meeting was instrumental in providing a better understanding of Deaf culture and available resources for individuals who are Deaf or hard of hearing.

C. Systems of Care (SOC) Committee Meetings

Each of the CSAs convenes a monthly SOC Committee meeting in its area. These meetings facilitate coordination and collaboration among local schools, state agencies, courts, providers, community organizations, and others. MCE representatives attended 68 of these meetings during the past six months.

D. Statewide Training Meetings for Providers

1. **Quarterly Statewide CSA Meetings -** The MCEs convene these meetings with representatives from the 32 CSAs including directors, Senior Care Coordinators and Senior Family Partners, to offer training and support. Topics presented during the two meetings held in the past six months included:

    - Incorporation of family voice and choice into ICC service delivery
    - A presentation by representatives of the organization "Parents Helping Parents" (support groups for families in the child welfare system) on helping parents whose children are in DCF foster care to gain the skills and confidence to participate more fully in their children's care.
    - CRAFFT Screening Tool overview (The CRAFFT is a tool consisting of six questions to screen adolescents for high risk alcohol and other drug use disorders)
    - Integration of behavioral and physical health services, including opening remarks by David Polakoff, MD, Chief Medical Officer, MassHealth
    - Role of the ICC care coordinator when youth enter 24-hour levels of care (inpatient mental health facilities, Intensive Community- based Acute Treatment programs, Community-based Acute Treatment Programs, and Adolescent Enhanced Acute Treatment for substance abuse)
    - Integration and collaboration between ICC and Mobile Crisis Intervention to achieve mutual goals

2. The **10 MCI Regional TA Forums**, facilitated by Kappy Madenwald and attended by MBHP staff, focused on the following topics:
    - Resolution- focused Crisis Intervention Techniques (advanced)
    - Implementation and Integration of the Family Partner/Professional (PPAL co-led the forums with Kappy Madenwald)

3. A statewide meeting for CSA psychiatrists

4. Two trainings for new and existing CSA supervisory staff on using the Team Observation Measure (TOM)
5. Two statewide trainings for providers of MCI, ICC and IHT regarding Crisis Planning Tools
6. A statewide forum for In-Home Behavioral Service providers
7. Five regional consultation sessions for CSAs to support the functioning and sustainability of the System of Care Committees

iv) Working with CMS to obtain approval of services to be offered and of managed care contracting documents.

Completed.

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

See the responses to Paragraphs 3 through 7, above.

xii) Designing a system of contract management for managed care contracts that includes performance standards or incentives, required reports, required quality

improvement projects, and utilization of management review, administrative services, and claims payment protocols.

See response to Paragraph 38 above and:

System- Wide Activities to Support Network Management and Quality of Care

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:

1. CBHI Outpatient Forum Distance Learning Activity

This initiative has been an ongoing statewide/system-level CBHI activity since January 3, 2011. Through this opportunity, the MCEs are able to educate outpatient clinicians across the Commonwealth about the CBHI services, the philosophy of Wraparound, and the role of the outpatient provider in the delivery system.

2. Revision of the CBHI Risk Management/Safety Plan (RMSP) and creation of the new CBHI Crisis Planning Tools and Companion Guide

At the request of MassHealth, MBHP led a process for revising the RMSP that had been used to develop and document Risk Management Safety Plans since the implementation of ICC and MCI on 6/30/09. MBHP engaged consultant Kappy Madenwald, MSW, to develop a revised RMSP and a companion guidebook. As part of this process, feedback was sought, at several points in the process, from those who have been actively involved in the use of these plans. This included gathering input from families; PPAL; providers of CSA/ICC, ESP/MCI and IHT services inclusive of family partners, clinicians, BA-level staff, clinical directors and managers; MCEs; and others. The goal was to develop a format that is more usable and useful for youth and families in managing future crises and reducing risk. Additionally, the process aimed to devise a planning tool that was

brief, practical and flexible for use with youth of varying ages and families with varying preferences and priorities. The resulting Crisis Plan is individualized to the needs of the particular youth and family, and includes:

- Safety Plan
- Advance Communication to Treatment Providers
- Supplements to Advance Communication and Safety Plan
- Companion Guide for Providers on the Crisis Planning Tools for Families

3. Addition of CBHI services to the Massachusetts Behavioral Health Access (MABHA) website

In June 2009, MBHP created a website for providers to use to locate capacity (i.e., openings for new patients) in 24-hour BH services (inpatient, CBAT, etc.), at the request of the Department of Mental Health and the Office of Medicaid. Emergency Services Programs (ESPs) and hospital emergency departments (EDs) have used the Massachusetts Behavioral Health Access (MABHA) website to locate beds for individuals requiring 24 hour level of care since June of 2009. During this reporting period, MABHA expanded access to the website to allow all providers, as well as families and members of the public, the ability to search availability of IHT, ICC, TM, and IHBS. As of February 1, 2011, the MABHA website was available for anyone to use to look up availability for IHT, and as of March 1, 2011, ICC, TM, and IHBS, as well. Providers of these CBHI services update their program's available capacity each week, and update waitlist related data each month. MCEs use the MABHA website to manage their provider networks in the following ways: to address access to care issues with

CBHI providers in real time; to ensure providers are compliant in entering their data in a timely fashion; to manage outliers around youth waiting (providers with 10 or more youth, or youth waiting over 2 weeks); and to address total capacity and available capacity within the region/network.

4. ***Stakeholder collaboration to support the CBHI system of care-*** The MCEs have collaborated with many stakeholders to discuss the CBHI system of care and address network management and training issues on a systemic level. In particular, the MCEs meet regularly with the following:

   - **Association of Behavioral Health and CBHI Providers**
     - 3 MCE/CBHI CEO Meetings including the Association of Behavioral Health (ABH)
   - **Black Mental Health Alliance**
     - 2 MCE/Black Mental Health Alliance Quarterly CBHI Meetings
   - **Parent Professional Advocacy League (PPAL)**
     - MBHP has involved PPAL in planning and conducting various MCI trainings and TA sessions, sometimes inviting PPAL to lead or co-lead such trainings. Meetings with PPAL during this reporting period involved planning for the 5 Regional MCI trainings in which PPAL co-led with Kappy Madenwald on the implementation and integration of the Family Partner/ Professional team.
       - 2 meetings with MBHP, Kappy Madenwald and PPAL to discuss FY 11 trainings

        - 1 meeting and 3 phone conferences with Kappy Madenwald and PPAL to work on curriculum for five Regional MCI trainings in February and March 2011.
    - MBHP continued to support the participation of Family Partners and other paraprofessionals in PPAL's monthly family partner support meetings and discussed strategies for increasing attendance in FY 11.
    - MBHP engaged PPAL to help revise the Risk Management Safety Plan which resulted in the new Crisis Planning Tools.
        - MBHP and Kappy Madenwald met with PPAL to get their input
        - PPAL wrote a forward in the companion guide
        - PPAL gave opening remarks at the two provider trainings held
    - MCE staff attended the "Getting Real About Family Voice and Choice" conference that PPAL co-sponsored with a provider agency.
    - the MCEs invited PPAL participate on a panel at the CBHI Promising Practices Conference on May 23, 2011.

Paragraph 39: ***Project 4: Information Technology System Design and Development***

For a description of updates to the CANS IT system, see paragraph 16.

Paragraph 46: ***Potential Tracking Measures***

a. EPSDT Behavioral Health Screening

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

b. 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.

c. 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.

The Defendants use MMIS claims data and MCE encounter data to report on all three of these measures. This report presents data for the quarter July-September, 2010 and October-December, 2010.

Quarter	# of well-child visits	# of screens	% of visits w/ screens	# screens w/billing modifier	% BH need identified	% of claims w/o billing modifier
Jul-Sept 2010	138,646	91,226	64.57%	77,104	7.33%	14.62%
Oct-Dec 2010	126,873	85,644	65.86%	72,249	7.82%	15.57%

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

Age Group	Jul-Sept 2010	Oct-Dec 2010
< 6 months	37.93%	41.74%
6 months through 2 years	70.54%	71.87%
3 through 6 years	73.58%	74.40%
7 through 12 years	74.78%	76.27%
13 through 17 years	70.17%	71.94%
18 through 20 years	34.76%	35.60%

b. Clinical Assessment

i) Number of MassHealth clinical assessments performed. A MassHealth clinical assessment is defined as any diagnostic, evaluative process performed by a qualified MassHealth behavioral health provider that collects information on the mental health condition of an EPSDT-eligible MassHealth Member for the purposes of determining a behavioral health diagnosis and the need for treatment.

The vast majority of clinical assessments are performed in outpatient therapy. Outpatient therapy providers file distinct claims for assessments. This report presents billing data for CANS assessments conducted in outpatient therapy during the period July through December, 2010:

Month	Unique Members Assessed	Unique Members Assessed – with billing code for CANS	% of Members Assessed w/billing code for CANS
July	3890	2078	53.42%
August	3865	2016	52.16%
September	4569	2333	51.06%
October	5014	2674	53.33%
November	5027	2716	54.03%
December	4232	2177	51.44%

ii) Number of clinical assessments that meet SED clinical criteria and indicate that the Member could benefit from intensive care coordination services.

The data show that 90 – 94% 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. Intensive Care Coordination Services and Intensive Home-Based Assessment

i) Number of intensive home-based assessments performed as the first step in intensive care coordination. Such assessment processes shall result in the completion of a standardized data collection instrument (i.e. the CANS tool). As part of the treatment planning process, that standardized tool will be used, and the resulting data collected on a Member level at regular intervals.

Every youth in Intensive Care Coordination receives an intensive home-based assessment, referred to, in the language of high-fidelity Wraparound, as the "Strengths, Needs and Culture Discovery." Preparation of the SNCD provides information that informs the completion of CANS for the youth. ICC staff are over 90% compliant with the requirement of completing the CANS through the CANS IT application.

ii) Number of Members who receive ongoing intensive care coordination services.

The most recent CSA Monthly Report for April, 2011 indicates that, as of the end of the month, there were 3,754 youth enrolled in ICC. The most recent CBHI Service Utilization Report, covering July 1, 2010 through December 31, 2010, indicates that 6, 083 youth received ICC services during this period. (The CBHI Service Utilization Report covering the first year of CBHI services, from July 1, 2009 through June 30, 2010, reported that 6,479 youth received ICC services during this 12 month period.)

d. Intensive Home-Based Services Treatment

i) Member-level utilization of services as prescribed under an individualized care plan, including the type, duration, frequency, and intensity of home-based services.

ii) 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 July 1, 2010 through December 31, 2010. (Attached hereto as Exhibit 10.)

e. Child and Outcome Measures - Member-level outcome measures will be established to track the behavioral health of an EPSDT-eligible MassHealth Member with SED who has been identified as needing intensive care coordination services 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.

Member-level Outcome Measures

The Defendants are gathering CANS data and data on Member utilization of Mobile Crisis Intervention services and Inpatient care in order to measure member-level outcomes for children and youth receiving Intensive Care Coordination

Inpatient Care

The Defendants' contractors are preparing this report, which the defendants expect to have this summer.

CANS Data Analysis

Many jurisdictions have successfully used the CANS to:

- standardize the scope of the clinical assessment process
- infuse the assessment process with "System of Care" values
- improve treatment planning
- serve as a decision-support tool to provide guidance on appropriate services
- improve communication between providers and families and between multiple providers.

There is less experience using the CANS as a measure of change in child functioning and the situation is complicated by the fact that each jurisdiction's CANS uses different sets of questions, or "items."

The Defendants are undertaking necessary analytical work to quantify the statistical reliability and validity of the CANS. Some of this work has already been completed.

CANS Inter-Rater Reliability - Hannah Karpmann, MSW, and John Hul,l PhD, analyzed CANS certification data to assess the level of reliability among CANS assessors trained in Massachusetts. By looking at multiple raters responding to a limited suite of clinical vignettes, the researchers were able to analyze the level of inter-rater consistency in rating the same vignette. Through comparison with the inter-rater reliability of established clinical

measurement tools, they concluded the raters showed a relatively high level of reliability, sufficient to support the use of the Massachusetts CANS in future quality improvement, evaluation and research studies.

CANS Construct Validity and Analysis of Item Sensitivity

Hannah Karpmann, MSW, is an intern at EOHHS and a PhD candidate at the Heller School for Social Policy and Management. With the oversight of EOHHS, she is focusing her dissertation research on characterizing the children receiving Intensive Care Coordination, and measuring the changes, as indicated in the CANS, that occur for children while in ICC. She plans to use a matched group of children receiving outpatient services as a comparison group . The defendants expect her work to be concluded Winter of 2011-12, which will enable them to examine some preliminary analyses of changes in child functioning, as a correlative of receiving ICC services, by the end of December, 2011.

2011 National CANS Conference

CBHI staff recently attended the national CANS conference in Baltimore in May 2011. This provided a good opportunity to assess the Commonwealth's strengths and weaknesses in CANS implementation, in comparison with other jurisdictions across the country. Massachusetts is a national leader in CANS training and in its IT development of the CANS application. The breadth (virtually all behavioral health services) and depth (all levels of acuity / complexity) of the Massachusetts implementation makes it far more complex than many jurisdictions that use the CANS within a single sector of children's services, or only with youth with the most significant behavioral health issues. Discussions with States that

use the CANS to measure changes in child functioning were confirming of the defendants' anticipated approaches to using these data. However, colleagues from other States also emphasized the difficulty of ascribing any change in child functioning to any particular service. Measurement in the "real world" (as opposed to a laboratory setting) tends to be confounded by impact of many factors external to the child and the service. Defendants are developing a data analytic strategy for CANS that acknowledges the complexity of the data and anticipates use of multilevel repeated-measures models. Defendants are working on plans to develop additional resources for data analysis.

System-level Outcomes Measures

MassHealth is using, through its Managed Care Contractors, two state-of-the-art assessment tools for measuring whether ICC provider practice conforms to the standards of High Fidelity Wraparound, the Wraparound Fidelity Index 4.0 (WFI-4) and the Team Observation Measure (TOM). The defendants' second annual period of data collection is currently underway. As was done in 2010,. approximately 600 families are being contacted by phone to complete the WFI-4. In addition, CSAs are required to complete two TOMs on each Care Coordinator. The data collection phase will conclude at the end of June and data reports should be available in the Fall.

f. 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.

As noted in Paragraph 7.b., the Defendants recently executed an Interdepartmental Service Agreement (ISA) with the Department of Mental Health, to purchase services from a DMH

contractor, the Parent/Professional Advocacy League (PPAL). Included in the scope of this work is consultation to help the Defendants design and implement an accurate and sustainable method of collecting data on member satisfaction with the remedy services.

Respectfully submitted,

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Date: May 31, 2011

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.

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