UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs,	)	
v.	)	C.A. No. 01-30199-MAP
DEVAL L. Patrick, et al.,	)	
Defendants	)	

DEFENDANTS' 15TH 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"). This Report covers the period since December 3, 2013, the date of the Defendants' most recent prior status report. It describes progress on key activities, including those detailed in the parties' joint Disengagement Criteria document, with an emphasis on five areas: Practice Guidelines, System of Care Practice Review ("SOCPR"), CANS implementation, the study of outpatient services as a Hub, and the "access reports" described in the Disengagement Criteria document. The report then briefly reviews the status of other deliverables. The report concludes with a section on Sustainability and a preview of the Commonwealth's framework for replacing external monitoring with a robust, durable and transparent system for internal monitoring and quality management of the structures and processes mandated by the Judgment.

As noted in the last report to the Court, the parties acknowledged that obtaining the data and creating the data reports Plaintiffs seek has proved more complex (and time-consuming) than initially anticipated. Defendants have continued to work diligently to complete the work of the "Disengagement Criteria," as described below.

1. **Practice Guidelines** (Part IV of Disengagement Criteria):

Guidelines for In-home Therapy ("IHT"), Mobile Crisis Intervention ("MCI"), and Therapeutic Mentoring ("TM") have passed through numerous revisions reflecting comment from many stakeholders, including the Court Monitor and the Plaintiffs. The guidelines are currently undergoing near-final revisions, primarily in response to Plaintiffs' comments, and are in the process of being reviewed to enhance consistency across the documents. The Defendants anticipate that these three sets of documents will be available to the Court Monitor and the Plaintiffs in late March in essentially final form. While Defendants will remain amenable to accepting further comments at that time, their intent is to issue these guidelines formally, and to use them with providers, as soon as possible. Putting the guidelines into practice will undoubtedly reveal other ways to improve them in the future.

As previously noted, the guidelines for In-home Behavioral Services ("IHBS") has lagged the others. The Defendants anticipate sending an advanced draft for IHBS to the Plaintiffs and Court Monitor in late April.

2. **System of Care Practice Review** (SOCPR – Section I #5, Section II #1, and Section V #4 of Disengagement Criteria):

The Commonwealth has now completed three waves of case reviews using the SOCPR: Boston /Metro in June of 2013, the Northeast region in October 2013, and the Central region in January 2014. Defendants will complete the Southeast region in March and the Western region in

May. As occurred with the Court Monitor's Community Service Review ("CSR"), with experience the Defendants are becoming more skilled in managing logistics, the reviewers are becoming more comfortable and adept in use of the review protocol, and the Defendants are refining their approach to analysis and reporting. Largely as a result of prior experience with the CSR, the Defendants have moved quickly to the point where direct assistance from the University of South Florida ("USF," the developer and proprietary owner of the SOCPR tool) is no longer needed; by mutual agreement the plan is to adapt the protocol over the summer of 2014 so as more clearly to focus the SOPCR on some of the Commonwealth's key quality concerns, such as assessment of needs and strengths, and of service impact. (At that point the protocol will be renamed "Massachusetts System of Care Practice Review," per the Commonwealth's agreement with USF.)

3. CANS (Section V #2, Section III of Disengagement Criteria):

CANS compliance data, broken out by remedy service, are summarized in Exhibit A, attached hereto. Current CANS compliance activities are as follows.

- For IHT and ICC, MassHealth's Managed Care Entities ("MCEs") continue to work with providers through network management activities to ensure completion of the CANS. While the most recent report on compliance in these levels of care appears to show somewhat lower rates of compliance relative to prior periods, Defendants believe this is due to changes in MassHealth's reporting instructions to the MCEs, which directed them to disregard multiple CANS submitted for the same member in the same service. The current figures have removed all duplications.
- For Inpatient and CBAT, the MCEs made intensive efforts in summer and fall of 2013 to improve CANS compliance at Inpatient and CBAT programs. One MCE convened a provider webinar; other MCEs have followed up with providers in monthly phone calls.

Defendants have provided data from the CANS database comparing Inpatient and CBAT CANS entered into the Virtual Gateway during each month of 2012 and 2013, showing clear improvement in 2013 for both levels of care, and especially for Inpatient providers. MCEs will continue to work with these providers on CANS compliance.

- For Department of Mental Health Residential Programs, the next cycle of DMH audit data on compliance with CANS requirements will take place in early 2014.
- For Outpatient clinicians, MassHealth and its MCEs plan to deny payment to outpatient providers who bill for a diagnostic assessment without submitting a CANS. The target date for this initiative is June 1, 2014. The CBHI office (Office of the Compliance Coordinator) is currently in the process of hiring a part-time IT specialist to provide customer support for CBHI users, so as to remove any technological barriers that might impede Outpatient providers' ability to comply with this requirement.

4. **Study of Outpatient as a hub** (Comprehensive Outpatient Study – Section I #6 in Disengagement Criteria):

In negotiating the Disengagement Criteria document, the parties agreed to utilize a study being prepared by the Massachusetts Behavioral Health Partnership ("MBHP") to gain insight into the effectiveness of Outpatient providers when serving as "hubs" for the provision of remedy services. The Defendants have subsequently concluded, however, that MBHP's initial Comprehensive Outpatient Study had an irreparable defect in its sampling methodology. MBHP is currently preparing a replacement study. Defendants, Plaintiffs and the Court Monitor have had numerous discussions regarding the design for the new study, in an attempt to apply lessons learned in the first effort while maintaining the agreed-upon scope of work. Parties at this time are still in communication about these plans. The new study will require all new data from chart reviews,

caregiver interviews, and clinician interviews. The new study methodology is informed by lessons learned from the previous attempt, as well as lessons learned through SOCPR implementation and the feedback of the Court Monitor. Defendants currently expect that the study will be complete and the report available by the end of July 2014.

5. Access Reports (Section I, #1 - 4 in Disengagement Criteria):

"Access reports" refer to reports of MassHealth behavioral health service utilization for youth in 24-hour levels of care, or youth receiving certain state agency services including out-of-home placement. Reports relating to utilization by youth receiving certain services from DCF and DMH, youth detained in DYS facilities, and youth committed to DYS have been shared with Plaintiffs and the Court Monitor, and staff representing the relevant state agencies (on February 19 for DMH and DCF, and on February 26 for DYS) have conducted intensive informational sessions with the parties and the Court Monitor.[1] A report on utilization by youth experiencing the CBAT and Inpatient levels of care will be sent to the parties before the end of March, with a plan to discuss that report by phone.

While these high-level reports do not, in the view of the Defendants, yield a clear picture of the processes by which high-risk youth served by state agencies move (or do not) into remedy services, the Defendants have always had a strong interest in understanding this process and in acting to improve it where possible. From the point of view of the Commonwealth, meetings of MassHealth and CBHI staff with partners in other state agencies have provided insight into the robust array of services available to children, and the contexts within which members and their families choose from among those services.

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[1] The Commonwealth is investigating a question about the DYS data report and will report any corrections to this and any other reports to the Plaintiffs in early March.

For example, Defendants' preliminary meetings with DYS and their February 26 meeting with DYS, Plaintiffs and Monitor provided a wealth of detail related to the work of DYS, Probation, the Juvenile Court and other stakeholders to reduce and find alternatives to pretrial detention for young people, based on the understanding that detention can increase the likelihood of later commitment to DYS. Similarly, DYS described intensive coordination of services for committed youth, with caseloads of twelve to fifteen youth per case worker, and frequent meetings of DYS area staff with MBHP and with local providers to ensure that services are appropriate to the needs of this challenging population, even when remedy services might not be.[2] DYS also discussed the increasing numbers of delinquency-committed youth who are electing to continue to receive services from DYS beyond their term of commitment.[3]

6. Other Data Requests in Part V of the Disengagement Criteria

The status of other data requests is detailed in Exhibit B, attached hereto.

7. Service Updates

MassHealth continues to monitor and address access, MCI performance, screening rates, and service utilization.

The Court Monitor has identified and addressed with the Commonwealth and DMH specific concerns regarding MCI performance in the Southeast region, where MassHealth and DMH share responsibility. DMH has developed an extensive plan for quality assessment and improvement and has shared this with the Court Monitor and MassHealth, and will continue to share information on

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[2] For example, many DYS-committed youth do not return to live in a family setting upon release. For some of these young people, the best way to meet behavioral health needs might be through other interventions, such as individual or group therapy, through substance abuse services provided by the Department of Public Health, or through an employment program that provides mentoring and skill building to enhance executive functioning and impulse control.

[3] In DYS, this is referred to as "Assent of Ward."

its progress in assessing and improving performance. MassHealth plans to apply lessons learned in this region, where applicable, in working with MCI programs statewide.

Access to services has many determinants, including external factors affecting the size and training of the workforce. MassHealth regularly interacts with MCEs regarding network enrollment, always seeking to balance appropriately the frequently opposed poles of access and quality. In the long run, access and quality depend on attracting better qualified and better trained individuals into the Behavioral Health field. Although the Defendants do not (indeed, cannot) control this societal process, they believe that in working with stakeholders such as the Children's Behavioral Health Advisory Council, MassHealth can exert incremental impact on the workforce supply.

8. **Sustainability**

The Court Monitor currently performs many activities which provide surveillance on system performance.Many of her activities extend, or in some cases overlay, the Defendants' data gathering. The Defendants have been examining and, where necessary, augmenting, internal data-gathering processes to ensure that as the Court Monitor withdraws, the system can continue to gather and use all necessary intelligence.

Some of these processes are sustainable within the current budget. These include:

<u>SOCPR</u>:

MassHealth continues to improve the use of the case-review process (logistics, data gathering, analysis and reporting) and working to maximize the benefit of this process. For example, MassHealth is considering repeating a standard SOCPR every two years to trend system changes, while focusing the SOCPR in off-years on special populations (e.g., transition-aged youth, court-involved population) or processes of concern (e.g., outpatient, MCI). Many of the questions

that the parties have struggled to understand through high-level data reports would be more successfully understood through a case-review process. In future years MassHealth and CBHI intend to gather more data of specific interest to state agency partners, which will help to reduce redundancy in quality management and simultaneously reinforce their collaboration in the process.

Coaching and training:

Until now the focus of coaching and training activities has been on improving Wraparound fidelity. Early findings of the SOCPR suggest that while the investment in Wraparound fidelity has paid off in relatively consistent practice in ICC, there is more variability in practice within IHT. As MassHealth evaluates the first year of the internal Wraparound coaching program, it will also examine the need for coaching and other supports in other levels of care, including IHT.

CANS training and certification:

The last report to the Court described the plan for extensively revising the CANS training and certification process to include more emphasis on how to use the CANS in family-driven collaborative practice. CANS training and certification is a particularly promising approach to influencing practice in the outpatient level of care. Defendants anticipate the rollout of the new training and certification process by the end of calendar 2014.

Reinforcing interagency collaboration in improving quality for SED youth:

CBHI staff are developing a plan to continue on a regular schedule the bilateral meetings with key state agencies, beginning with a survey of how agencies access remedy services for their specific populations. This bilateral process with various partners will also encompass revision of interagency protocols, currently underway with DMH. The Defendants will review how existing quality improvement loops work – the flow of information and the lines of accountability for improvement – and whether additional processes of this kind need to be established (such as at a regional level, or with existing behavioral health specialists situated within the agencies). In

addition to the planned series of meetings, CBHI and MassHealth jointly convene a meeting of child-serving agencies to review access issues for children with behavioral health needs. This meeting provides a vehicle for quality improvement for specific processes that affect SED youth, such as maximizing community resources to stabilize youth with behavioral health crises. Similarly, the ongoing CBHI Interagency Implementation Team process going forward will focus on improving the effectiveness of remedy services (e.g., IHT) for special populations. Given the state of the behavioral health clinical workforce, which consists in large part of early-career clinicians, the Defendants seek to maximize collaborative opportunities for training, and for benefitting from the considerable expert resources of sister agencies. As noted in the prior report, the Defendants expect an increase in interagency service communication and collaboration following the eventual rollout of the DCF /DMH Caring Together system, which is highly aligned with the principles underlying the remedy services, and which serves a population of youth that overlaps significantly with MassHealth.[4] Service navigation and coordination and interagency collaboration will also be an imperative of the Commonwealth's implementation of a new referral and service system for juvenile status offenders (now termed Child Requiring Assistance, or "CRA").

Reallocating monitoring resources.

During Fiscal Year 2014 the Court Monitor used funds from her EOHHS budget to support EOHHS development of the Practice Guidelines. The Defendants propose to ask for further reassignment of funds to EOHHS surveillance and quality management activities during the upcoming year, in connection with reductions in the intensity of monitoring. The Defendants propose using those funds to improve the CANS system; for IHT coaching and practice monitoring;

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[4] Caring Together is a joint DMH /DCF reprocurement of residential services and is a major reorganization of the services of these agencies, whose populations include many SED and EPSDT children and youths and their families.

for a workforce development project; for studies and QI activities related to outpatient practice with youth; and for many other, smaller projects.

Given the current timetable for remaining deliverables in the Disengagement Criteria document, the Commonwealth anticipates that the Court will extend Court Monitoring beyond its current sunset date of June 1, 2014. In their next report the Defendants will provide further detail on their self-monitoring, both in the current-day context and in the wake of anticipated reduced intensity of external Monitoring and Court reporting beyond June.

Respectfully submitted,

MARTHA COAKLEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond BBO #559475
Assistant Attorney General
Government Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2078
dan.hammond@state.ma.us

Date: March 3, 2014

CERTIFICATE OF SERVICE

I, Daniel J. Hammond, hereby certify that I caused a true and accurate copy of the attached Report to be served upon all parties listed on this Court's ECF system via simultaneous electronic service on March 3, 2014.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General

Attachment A

CANS Compliance by Service
Source of the Data: MCE individual reports
Dates: 7/1/13-9/30/13

CANS compliance rates in each of the following services[i] were as follows, in order of the largest to smallest plan.:

In-Home Therapy

A	74%
B	49.30%
C	51.42%
D	39%
E	41.79%
F	38.0%

Weighted average: 60%.

Intensive Care Coordination

A	83%
B	67.07%
C	63.10%
D	70%
E	71.43%
F	45.5%

Weighted average: 75%.

Inpatient

A	20%
B	16.67%
C	20.59%
D	20%
E	0.00%
F	20.0%

Weighted average: 20%

CBAT

A	51%
B	44.79%
C	43.28%
D	44%
E	37.50%
F	0.0%

Weighted average: 50%

Outpatient Therapy
Source of Data: MassHealth claims
Date: Oct 2013
58.6 % of clinical assessments in Outpatient Therapy included completion of a CANS.

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[i] As of July 2013 the MCEs reported only one CANS per member per service, even if there were multiple CANS assessments in the service during the reporting timeframe.

Attachment B

Status of Outstanding Data Requests in "Disengagement Criteria" Document

No.	Criterion	Description	Status	When expected
Section 5, #1	% of youth with a + screen who receive follow up BH services within 90 days of the screening	MassHealth's Primary Care Clinician (PCC) Plan collects this data point and shares it with large primary care providers.	The last two cycles of data were reported in the December 2013 Court Report.	The next cycle covering April 1, 2013-September 30, 2013 will be available after April 1, 2014.
Section 5, #2	CANS compliance data	MassHealth receives reports from each of the MCEs on CANS compliance by service.	See Attachment A for FY 2014, Q1 (July-September 2013) data.	FY 2014, Q2 data anticipated in May 2014.
Section 5, #3	WFI/TOM	Measure of ICC teams adherence to principles of quality Wraparound and facilitation of Wraparound process.	FY 2013 report provided to Plaintiffs and Monitors in Dec 2013.	FY 2014 report anticipated September 2014.
Section 5, #4	SOCPR Reports on ICC/IHT	Commonwealth case review process of IHT from June 2013-May 2014.	Plaintiffs and Monitors received Boston Metro report in November 2013 and Northeast report in February 2014.	Central report anticipated end of April 2014.
Section 5, #5	MCI Pre/Post Report	BH service utilization prior to and following an MCI encounter,	Last report covering FY 2013, Q4 (April-June 2013) provided Jan. 24, 2014	FY 2014, Q1 data anticipated end of March 2014.
Section 5, #6	CBAT Length of Stay (LOS)	MassHealth receives reports from each MCEs on average LOS in CBAT.	Delays in MCEs submitting this data to MassHealth.	FY 2014, Q1 data anticipated end of March 2014.
Section 5, #7	MCI Length of Encounter (LOE)	MassHealth receives reports from each MCE setting out the average length of encounter (LOE) in MCI	FY 2014, Q1 (Jul-Sept 2013): Average LOE in MCI was 2.15, 1.79, and 1.7 days in the three larger health plans and 1.9, 1.5, and 2.33 days in the three smaller health plans	FY 2014, Q2 data anticipated in May 2014.
Section 2, #2	*In the previous court report this criterion was mislabeled as Part V, no.2* Length of stay in IHT, TM and IHBS	Youth receive other remedial services with the intensity and duration their conditions require	The key indicator report for IHT was provided to Plaintiffs and the Monitor on February 26, 2014.	MBHP does not currently produce reports showing length of enrollment in IHBS and TM. MassHealth is discussing with MBHP whether it will be possible to obtain this data on a regular basis. FY 2014, Q2 anticipated May 2014.