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**Rosie D. News Stories August 2012**

**Defendants File Proposal for Court Disengagement**

The [**Commonwealth’s Proposal Regarding Disengagement Criteria**](http://rosied.org/Resources/Documents/Disengagement%20Criteria.defs%20proposed.pdf) outlines its plan to promptly end judicial oversight, but contrary to the Court’s directive, offers no concrete disengagement criteria by which the Court can measure compliance. Instead, the defendants’ 25-page filing reiterates their contention – which the plaintiffs dispute – that they substantially have complied with all their obligations under the Rosie D. Judgment. Moreover, the defendants maintain that several obligations in the Rosie D. remedial plan are ongoing program improvement and management initiatives that will continue indefinitely, and need not be subject to court oversight or supervision.

The defendants’ Proposal responds to the 13 disputed compliance issues which the plaintiffs identified in their [**18th Status Report**](http://rosied.org/Resources/Documents/Pls%20Eighteenth%20Report.doc) filed in June. The Proposal asserts that the defendants have satisfied all of their obligations under the EPSDT provisions of the Medicaid Act, which mandate that the Commonwealth provide children with serious emotional disturbance the medically necessary services to correct or ameliorate their mental health condition within a reasonable time frame. It also claims that the Commonwealth has complied with the provisions of the Judgment on the availability and utilization of the CANS assessment tool; access to and implementation of Intensive Care Coordination throughout the state; inter-agency roles and responsibilities linking youth to the Rosie D. remedial services; the effectiveness of services such as mobile crisis intervention and the nascent crisis stabilization services; provider performance specifications; and data collection.

The defendants frame most of their responses to these issues as legal disputes. Citing service utilization data and individual CANS assessment scores over time, they contend their tracking obligations are met even though they do not have in place a methodology or system to report on outcome data demonstrating the effectiveness of the remedial service system.

The Proposal opposes using the Court Monitor’s Community Service Review (CSR) as a compliance measure to evaluate the core remedial service, ICC, and instead promotes two other tools, the Wraparound Fidelity Index and the Team Observation Measure, on which the state scored above national norms. Significantly, the Monitor’s [**Statewide CSR Report**](http://rosied.org/Resources/Documents/2011%20report.Statewide.pdf), released this summer, concluded that children across the Commonwealth are not receiving all the home-based services they need and called for focused improvements in multiple system / practice areas.

Over the next few weeks, the parties will confer, and then have an opportunity to file revised plans which will be discussed at the upcoming status conference before Judge Michael A. Ponsor on October 10, 2012.

**Plaintiffs’ Proposal for Disengagement Criteria**

The [**plaintiffs’ Proposal Regarding Disengagement Criteria**](http://rosied.org/Resources/Documents/Pls%20Response%20to%20Defs%20Disengagement%20Criteria.doc) identifies the Commonwealth’s outstanding tasks to satisfy the Rosie D. Judgment and delineates disengagement criteria to assess compliance with the court order.

The plaintiffs note that the defendants have not offered any outcome data as evidence of the effectiveness of the mandated remedial services. They maintain that the Judgment and the EPSDT provisions of the Medicaid Act demand a showing that the services, as implemented by the defendants, are having some positive impact on youth before the Court can relinquish its oversight.

Under the plaintiffs’ proposed disengagement criteria, youth with SED must receive medically necessary home-based services with the needed frequency, duration and intensity to correct or improve their mental health condition. ICC care coordinators and teams must accurately assess youth needs and identify and arrange for services to meet those needs. MCI and crisis services must be provided in the community. Moreover, the defendants must develop an effective monitoring system and collect data on the effectiveness of their services on the youth, the provider and the systemic level.

These criteria dovetail with key outstanding tasks the plaintiffs identified in their 18th Status Report. Citing the Judgment, the Commonwealth’s service utilization data, and the Court Monitor’s discouraging findings from the Statewide CSR Report, the plaintiffs propose specific disengagement criteria, including:

* at least 50% of youth enrolled in each Managed Care Entity have behavioral health screens;
* youth in residential and in-patient programs and those served by out-patient therapists have a CANS and are referred when appropriate to ICC;
* intensive care coordinators and care planning team perform the functions outlined in Judgment;
* youth receive comprehensive mental health assessments to guide care plans;
* care plans set forth individualized treatment goals describing all medically necessary services, as well as transition and crisis plans;
* 85% of youth who receive Mobile Crisis Services are evaluated and served in the community locations; and
* 85% of youth who need crisis stabilization services receive it at home or in a CBAT setting.

In addition, the plaintiffs’ disengagement criteria calls upon the defendants to develop performance standards for In-Home Therapy, In-Home Behavior Therapy, Therapeutic Mentoring, Mobile Crisis and Crisis Stabilization services, and to develop a data collection system that collects reliable information on the timely provision of home-based services with requisite frequency, intensity and duration, as well as youth outcomes, provider outcomes, and system outcomes.

**ICC enrollment drops in June**

Enrollment in Intensive Care Coordination dropped by more than 100 in June, based on the most current available data. According to service utilization data, 3,753 youth were enrolled in ICC – the core Rosie D. remedial service – at the end of June, down from 3,868 in May. The drop reverses a modest upward trend since last September when the enrollment figure dipped to 3,552. Significantly, the June 2012 enrollment is only slightly above the 3,710 enrolled at the end of June 2011.

On the plus side, youth and families waited an average of seven days in June 2012 from the time they sought ICC services to the offer of an initial appointment. This marks a dramatic difference from July of 2011, when the average wait was 20 days.

**ICC referrals down but data fairly consistent**

During the 2012 fiscal year (July 1, 2011 - June 30, 2012), 7,397 youth were referred to ICC – 274 fewer than in fiscal year 2011. Based on FY 12 service utilization data, self-referrals comprised the largest percentage – 23%, followed by the Department of Children & Family Services at 19%. Last year, DCF referred 24% of the youth to ICC and youth / families had a 20% self-referral rate.

DCF appears to be the only state agency that truly interacts with the Children’s Behavioral Health Initiative. For the past two fiscal years, the Departments of Mental Health and Youth Services each had a 1% referral rate; the Department of Developmental Services had a 0% referral rate; and the Probation Department had a 2% referral rate.

Referrals to ICC from outpatient providers dipped from 16% in FY 11 to 15% in FY 12, but edged up from Mobile Crisis services from 6% to 7%, and from In-Home services from 5% to 7%. In both FY 11 and FY 12, schools accounted for 7% and primary care physicians for 1% of the referrals. Hospitals made 6% of the referrals in FY 12, down slightly from 7% in FY 11. Acute settings and CBATs accounted for 3% of the ICC referrals in FY 12, up from 2% in the previous year. In both years, 8% of the referrals came from an undefined ‘other’ source.

**MCI community encounters still below 60%**

The number of Mobile Crisis Intervention (MCI) encounters that occur in the community and not in emergency departments continues to hover in the upper 50% range. Based on the most current monthly data (May 2012), 1,340, or 58%, of 2,325 MCI encounters took place in a community setting. According to the Commonwealth, this is the second highest recorded number of MCI encounters since the service was rolled out three years ago in July 2009, and highlights the cyclical trend of high demand for services in the spring. A total of 425 of these encounters - about 18%, resulted in inpatient admission.

Quarterly data from January through March 2012 indicates that 57% of MCI encounters took place in the community and about 20% of them resulted in inpatient admission.

The average response time from when a youth was ready to begin an intervention and the time it began was about 36 minutes in May, up slightly from a low of 33 minutes in March. About 83% of the encounters had a response time under the contractual requirement of 60 minutes.