UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
WESTERN SECTION

ROSIE D., et al.,

Plaintiffs

v.

MITT ROMNEY, et al.,

Defendants

Civil Action No.
01-30199-MAP

INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the March 4, 2016 status conference, in preparation for the hearing scheduled for June 8, 2016.

Since the last status conference, the Defendants, the Plaintiffs and the Court Monitor have met three times, on March 15, March 29, and May 17, and held a conference call on April 15. The parties have continued to review and discuss disengagement activities defined in prior status reports, with a particular emphasis on care coordination activities for youth in Outpatient. This report will briefly summarize those discussions, then will turn to MassHealth's plans to strengthen In-Home Therapy, and finally will review other status issues.

I. Outpatient as a "hub"

The parties have had several productive discussions focused on two shared beliefs. *First*, for many youths, the need for care coordination cannot be met by outpatient (OP) services alone

and every effort must be made to ensure that these youth are directed, with due respect to family choice, to either Intensive Care Coordination (ICC) or In-Home Therapy (IHT), as appropriate. *Second*, for various reasons, some youths with care coordination needs will, at times, not enroll in ICC or IHT; therefore, OP should have the capacity to meet the care coordination needs of those class members. While the Commonwealth will continue to work to ensure each youth is enrolled in the "hub"[1] that best suits his or her needs, the focus of discussion for the parties has been primarily on how to enhance the current capacity of OP to provide care coordination for youths not enrolled in ICC or IHT.

The parties have discussed proposals to ensure that care coordination activities (i.e., Collateral Contact, Case Consultation and Family Consultation) in OP for members under 21 are reimbursed at levels comparable to face-to-face therapy, thus removing any disincentive for PO care coordinators to perform these critical tasks. Additionally, to minimize administrative complexity involved with authorization and billing, the parties have discussed proposals to remove daily caps on these activities, to amend the service definition for Collateral Contact to include email and voicemail communication, and to implement uniform service definitions, medical necessity criteria, and authorization parameters for these services. The parties also share a belief that changes to rates, service definitions or authorization parameters will not, alone, be sufficient to ensure that robust and effective care coordination occurs when OP has hub

[1] The "hub" service is the service responsible for conducting a behavioral health assessment, devising with the youth and family a treatment plan or care plan, and implementing that plan while coordinating with necessary services and supports. With consent of the member, such services and supports could include (for example) behavioral health service providers, primary care providers, schools, state agencies, and informal community supports. Certain remedy services ("hub-dependent" services) are only available when coordinated through a hub. The three levels of care that can perform the hub function are OP, IHT, and ICC, in order of increasing capacity for care coordination. A youth has only one hub at a given time; when a youth is involved in more than one service that could be a hub, the level with the greatest capacity for care coordination serves as the hub Thus, for a youth involved with both OP and IHT, the IHT service would be the hub and would carry the responsibility for care coordination.

responsibilities. The parties have discussed other steps that MassHealth may take to educate providers and to shape practice, including a web-based training for OP clinicians and various monitoring and feedback activities based on information from claims and from systematic chart reviews.

Defendants are hopeful that they will be able to implement many, if not all, of the aspects of the proposals discussed with the Plaintiffs. Implementation will require discussions and negotiations with MassHealth's managed care entities (MCEs), as well as obtaining all necessary approvals from CMS, neither of which has yet occurred. The Defendants will keep the Court, the Court Monitor, and the Plaintiffs apprised of their implementation efforts regarding these proposals.

II. Strengthening In-Home Therapy

IHT is a critical component of the service system, providing both treatment and care coordination (as needed) to large numbers of class members and their families. Defendants' previous status reports have documented a stubborn inconsistency in the provision of high quality services in In-Home Therapy, particularly as reflected in intensive case reviews from the Court Monitor's Community Service Reviews and the Commonwealth's subsequent System of Care Practice Reviews and Massachusetts Practice Reviews (MPRs).

As previously noted, Defendants believe that the consistency of quality generally seen with ICC was based, at least in part, on the ability to provide robust implementation supports for good Wraparound practice. For ICC these included standardized curriculum and training for ICC line staff and their supervisors; fidelity measures to provide feedback on quality, such as the Wraparound Fidelity Inventory and the Team Observation Measure; and coaching to help each

Community Service Agency improve quality over time in way that recognizes the strengths and needs of the specific agency. To date, the availability of these systemic supports to IHT providers and supervisors has been spotty, at best.

Learning from the success with ICC, Defendants are addressing the inconsistency of quality seen with IHT by developing and providing robust implementation supports to IHT to ensure that IHT is implemented as intended. A well planned program of implementation, including implementation supports of the type employed for ICC, will help to put exemplary practices in place and sustain them over the long term.

To this end, as Defendants described in their last report, they now have a program in place to develop implementation supports for IHT using a model developed by the National Implementation Resource Network (NIRN) at the University of North Carolina.[2] A core step in this process is the development of an IHT Practice Profile (IHT PP). The IHT PP is a detailed description of IHT practice -- what it looks like, concretely, not only in ideal practice (master practice) but also in normal developmental practice (at the apprentice or journeyman phase). This description can then be used to develop training, practice appraisal tools, and coaching programs to move practitioners along toward master practice.

Work on the IHT PP launched in November 2015 in collaboration with the Children's Behavioral Health Knowledge Center (the Knowledge Center) at the Department of Mental Health. The launch was followed by ten workgroup sessions, each session focused on one Core Component of IHT practice, according to the schedule described in Defendants' last status report. Each workgroup was attended by numerous IHT supervisors who worked together to develop a consensus description of the activities that constitute each Core Component. These sessions were

[2] http://nirn.fpg.unc.edu/

serious and intense, and IHT provider agencies and their staff deserve much credit for volunteering their time and labor for this purpose. A draft of the IHT PP, combining the nine core components, explaining their contribution to outcomes, and placing them in the context of behavioral science research, will be shared with providers over the summer. The Knowledge Center is arranging meetings, which MassHealth staff will attend, with IHT line staff and supervisors over the summer to assess the usability of the IHT PP. At the same time MassHealth will be looking to design appropriate intervention measures (i.e. implementation supports) to implement the Practice Profile. A draft of the prefatory section and first core component of the IHT PP is attached to this report as an exhibit (Exhibit A), to show more concretely the nature of the document. (Please note that this is one of many drafts and that a public first draft, presumably different in some respects from Exhibit A, will be disseminated to the community during the summer.)

Research on implementation of exemplary practices in behavioral health, healthcare, education and other fields demonstrates that training alone is almost always insufficient to change practice or to implement improvements. As such, concurrently for FY2017, MassHealth is planning to extend some existing activities, and beginning some new activities that the Defendants believe will be consistent with the IHT PP, and that may become part of their array of implementation supports. These include two existing programs to strengthen supervision in IHT. The first is a program focused on supervision of IHT work with families with young children. The second is a program focused on multicultural supervision, to deepen IHT clinicians' ability to conduct conversations that recognize the role of race, disempowerment and trauma in the lives of many MassHealth youths. Both programs have been well received by IHT supervisors and will be continued in FY17.

In addition, a pilot implementation of MATCH-ATDC (Modular Approach to Treatment of Children with Anxiety, Trauma, Depression or Conduct Problems) will continue with supervisor training next year. MATCH is an evidence-based treatment protocol that shows promise for the IHT population in learning to address multiple presenting problems.[3]

Also, MassHealth will run a pilot implementation of the ARC (Attachment, self-Regulation, Competency) model developed by the Trauma Center at the Justice Resource Institute. Like MATCH, ARC provides a useful structure for working with families in IHT, and its particular emphasis on understanding the role of trauma in the lives of parents as well as children makes it especially appealing for IHT.[4]

Finally, MassHealth, as part of its initiative on behavioral health workforce development undertaken in conjunction with the Knowledge Center, will again focus on IHT supervision in piloting an intervention from the Yale School of Medicine to enhance supervisory protocols and practices for selected provider agencies.

While each component of this array of pilots has some merit on its own, Defendants view these initiatives as part of a careful plan to develop and test implementation supports for IHT, which can then be scaled to support the whole system in a sustainable fashion. Defendants expect the benefits of these projects to grow over time.

MPR case reviews have been a critical source of information about quality and workforce in ICC and IHT . Defendants have somewhat revised the MPR infrastructure with a smaller pool of reviewers, as described in their most recent status report, and will continue to refine this

[3] For more information on this pilot initiative, http://jbcc.harvard.edu/sites/default/files/jbcc_match-adtc_iht_request_for_qualifications_june_2015.pdf
[4] For more information on ARC, http://www.traumacenter.org/research/ascot.php

valuable feedback process. MPR findings from this spring show similar themes to past reviews and continue to support MassHealth's decision to focus substantial resources on strengthening IHT. Defendants will produce brief reports summarizing MPR findings for the two waves undertaken in the first half of 2016, with a more extensive summary report for FY2016 in the fall of 2016.

III. Other status issues

A. Administrative infrastructure and hiring:

Staffing shortages at MassHealth have necessitated that Defendants modify their schedule of some activities for disengagement. Fortunately, the position of manager of the CANS program, which has been open since June 2015, has been posted, and candidates will be interviewed in May and early June 2016, for an anticipated start date round the beginning of the fiscal year.

In addition, the Office of Behavioral Health (OBH) will bring on a staff person through an arrangement with UMass Medical School to focus on Acute Care, which includes emergency services (and Mobile Crisis Intervention, or MCI), along with 24-hour services such as CBAT and inpatient. Filling this position will allow MassHealth to monitor and attend to improvement in MCI more effectively than is currently possible. OBH will hold interviews in June with a projected start date for the position early in FY2017. Finally, Dr. Simons was officially appointed as CBHI Director in March 2016, so MassHealth can now begin the process to fill the position of Assistant Director.

B. Mobile Crisis Intervention:

As stated at the last status hearing, MassHealth will continue to gather data on MCI performance as in the past and will share these data reports with the parties and with the Court.

Defendants continue to work actively on quality improvement in MCI but will no longer routinely report on these activities in their periodic status reports.

C. Behavioral health workforce:

The Defendants have referred in recent status reports to growing behavioral health workforce shortages that can threaten both quality and access. While Defendants believe that remedying workforce shortages is beyond the scope of disengagement, they also believe in taking all steps within their power to understand and address the phenomenon. With the Knowledge Center taking the lead, the Defendants have begun to examine possible interventions to enhance recruitment and retention at various stages in the pipeline from school to employment. There is reason to believe that supervision is one of the best places to intervene to strengthen workforce.

In addition to the pilot with the Yale Supervision Program mentioned above, and with feedback from the graduate training programs, Defendants and the Knowledge Center are considering or planning three additional interventions:

(1) The Knowledge Center plans to develop a clearinghouse of speakers -- practitioners and family members -- who can speak with first-hand knowledge about CBHI services to classes of graduate students.

(2) Based on a successful example from Connecticut, Defendants are exploring the creation of a CBHI curriculum that graduate training programs can adopt. FY17 would be a planning year for this initiative.

(3) Defendants plan to sponsor Integrative Seminars for CBHI social work and counseling interns, which would bring together trainees placed in CBHI sites under the direction of a seasoned CBHI practitioner. This would strengthen supervision as well as peer support for students during the critical phase of field

training.

From numerous sources, including provider meetings, MPR interviews, and a recent web survey of IHT clinicians, Defendants have learned that many clinicians would welcome more opportunities to build their clinical skills, increasing effectiveness and reducing attrition. As with strengthening IHT, Defendants hope to see some immediate benefits from these initiatives, with increasing effects over time.

D. CANS training:

The new and entirely revised on-line CANS training and certification exam was launched on May 18, 2016. MassHealth will monitor feedback from participants and may make revisions as a result. The training carries eight hours of continuing education credit for several disciplines and signals a much greater investment of time and effort for individuals becoming certified, as it adds much material on the clinical use of the CANS for treatment planning and collaboration, including care coordination. Defendants believe this much deeper training will be helpful to outpatient clinicians in learning to function within the CBHI system, including as a hub. MassHealth requires that CANS assessors recertify every two years.

E. CANS outcome reports:

Defendants submitted Part 1 of the first CANS outcome report in December 2015, focusing on change at the single-item level. Part 2 will focus on change at the domain level (items grouped together). Defendants believe these reports can be useful in informing improved use of the CANS and eventually in understanding better their service population and the impact of services. Defendants expect to deliver Part 2 no later than June 30, and propose to discuss a revised schedule for these reports at the next meeting of the parties, along with the special topic of the next report.

F. Family forums:

For years, the Court Monitor has met with families to hear about their experience of the service system. Although not within the scope of disengagement criteria, Defendants believe that this type of feedback is an essential component of an effective overall system for monitoring and improving services. On its own initiative, in May, MassHealth conducted two family forums (one with caregivers, one with youth) as a pilot, and currently plans to institute forums on a regular basis in FY2017. Forums will be convened by Community Service Agencies, which can use System of Care Meetings to spread family invitations to other agencies and organizations. MassHealth will provide refreshments and will use statewide Wraparound Coaches as facilitators. MassHealth staff and staff from Managed Care Entities will attend selected forums. MassHealth looks forward to engaging with families around their experience of the service delivery system.

Respectfully Submitted,

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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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