Implementation Status Report

November 15, 2017

Submitted under the

Settlement Agreement

in *T.R. v. Strange and McDermott*

Hon. Thomas S. Zilly

U.S. District Court, Seattle

No. C09-1677-TSZ

Washington State Department of Social & Health Services

Transforming lives

Washington State Health Care Authority

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Introduction

In December 2013, the State of Washington settled *T.R. v. Strange and McDermott* (formerly Dreyfus and Porter), filed four years earlier, which asked the State to provide children and youth on Medicaid with intensive mental health services in homes and community settings. In the settlement, Washington State committed to developing Medicaid-covered intensive mental health services, based on a "wraparound" model, so that eligible youth can live and thrive in their homes and communities and avoid or reduce costly and disruptive out-of-home placements. As part of the settlement, Washington State developed Wraparound with Intensive Services (WISe). WISe is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to assist their families on the road to recovery. The State is working to make WISe available in every county across the state by June 2018.

Until the exit of the settlement agreement, the State will provide the Court, the Plaintiffs, and the public with an annual Implementation Status Report that describes progress in meeting obligations under the agreement. The report is to include accomplishments, remaining tasks, and potential or actual problems, as well as remedial efforts to address any identified problems. This Implementation Status Report represents the fourth and final annual report, detailing the State's accomplishments in developing and implementing the WISe program.

On August 1, 2014, the State submitted a WISe Implementation Plan to the Court, which was subsequently approved. The Implementation Plan was organized around seven objectives necessary to accomplish the commitments and exit criteria of the settlement agreement. This report follows these seven objectives so that progress and concerns can be tracked in a logical and consistent manner, as the WISe program evolves over time. In addition, as the Implementation Plan is itself enforceable during the pendency of the case, the report allows the parties to identify to the Court any obstacles that may arise that could impede timely termination of the Settlement Agreement.

This report is organized into three sections. Section I is an Executive Summary that provides an overview on the State's progress in developing and implementing WISe over the past year. Section II has a description of the specific accomplishments made from December 2016 through September 2017, and then sets forth remaining tasks that need to be completed to exit court jurisdiction at the end of June 2018, per the Settlement Agreement. Section III identifies overarching implementation challenges and proposals for addressing those areas of concern. Section IV contains a glossary of key terms.

I. Executive Summary

Reforming the children's mental health system of care requires dedicated resources and infrastructure to support high quality providers of home-based services capable of meeting the needs of thousands of vulnerable children and youth. This report highlights the strides that have been made in Washington to achieve this goal, the key challenges that remain, and the remaining tasks for the State to complete its obligations under the Settlement Agreement. These advancements and challenges are summarized below.

Washington Has Made Significant Advances Over the Past Year

1. Increasing numbers of children and youth are getting screened for WISe services in a timely manner

Implementation data indicates that the number of referrals and screenings continues to grow. From July 1, 2014, through June 30, 2017, (SFY 2015 - SFY 2017), **6,861 WISe screens** were conducted for an unduplicated total of **5,436 youth**. The largest referral sources for the WISe program are the Behavioral Health Organizations (BHOs) (34%), self and family (21%), and Children's Administration (CA) (12%).

Of the 3,112 screens conducted in SFY 2017, **87% were conducted within 14 days of referral**, the standard for screening timeliness. This represents an improvement over prior years (which had approximately 80% timeliness). For five of the regions, screening timeliness in SFY 2017 was above 90% for the fiscal year. Three regions had timeliness rates between 85 and 90%, and two had rates below the average. Both of these regions experienced major expansions in services in SFY 2017 and are expected to improve timeliness rates as the program becomes more established.

2. More children and youth are being provided with WISe services

A total of **3,515 youth** are estimated to have received WISe services between July 1, 2014, and March 31, 2017; this is an increase from the 1,705 reported in last year's annual report. This estimate is based on currently available administrative data (Behavioral Health Services Summary, the Division of Behavioral Health and Recovery's data system, with finalized data available through the end of SFY 2017 Q3 at the time of this report).

The average amount of services varied among the regions, but the statewide average number of service encounters per month was 13.3. Across the state, services occurred in outpatient facilities (39%), at home (30%), at school (6%), and in other community settings (23%). A small number of services were delivered in hospital emergency rooms, residential care settings, and correctional facilities (1%).

The percentage of services modalities delivered in each region also varied. Statewide, the top five service modalities, by hours of WISe services are: individual treatment services (43%), peer support (13%), child and family team meeting (13%), care coordination services (12%), and family treatment (9%).

3. Children and youth are benefitting from WISe services

WISe providers are measuring substantial benefits to youth and families receiving WISe. WISe uses quantitative and qualitative feedback from its youth and family survey as well as the Child and Adolescent Needs and Strengths (CANS) tool to measure progress and need for improvement. Both tools demonstrate the effectiveness of WISe.

CANS is administered at intake and every three months while in WISe. The tool measures the number of 'need' items that require immediate attention as well as the number of current strengths that the youth and family have. Both needs and strengths show improvement as WISe services are provided. The percentage of youth with clinically significant treatment needs declined across all five of the top behavioral and emotional domains including emotional control problems, attention/impulse problems, mood disturbance, oppositional behavior and anxiety.

CANS data from youths who have received WISe shows improvement in the youths' level of functioning, including changes in needs, risk factors, and strengths. After receiving six months of WISe services, the percent of youth with actionable treatment needs related to emotional control problems decreases from 78% to 54%, and the percent of youth with decision-making problems decreases from 59% to 44%. The percent of youth with educational system strengths increases from 61% to 78% after the first six months of receiving WISe.

Some youth and families receiving WISe have also reported receiving benefits from participating in the WISe program through a voluntary survey administered by Washington State University Social and Economic Sciences Research Center (SESRC). This survey was designed to determine if services are helpful and if there needs to be changes in how WISe is administered. The survey consists of an interview over the phone available in English or Spanish. There is also a web-based option to provide feedback if the youth or family prefers. In 2016, the survey was offered to 785 youth and 1,235 caregivers. SESRC received feedback from 193 youth and 447 caregivers, with an overall response rate of 30%. More than 80% completing the survey said that the WISe team gave them useful tools and over 90% said that their team made it easy to come to the next session. In 2017, SESRC offered the statewide youth and family survey again to 1,164 youth and 2,007 caregivers. Approximately 279 youth and 784 caregivers provided feedback this year for an overall response rate of 34%. The 2017 report is scheduled to be available by January 2018.

In the coming months, the State will be reviewing additional outcome measures to analyze alongside the CANS and survey data to assess the effectiveness of WISe services.

4. The Family Youth and System Partner Round Tables (FYSPRTs) play a crucial role in supporting the development of WISe services

The current governance structure includes regional and state level FYSPRTs relaying challenges and successes related to the implementation of WISe. Currently there are ten regional FYSPRTs in addition to the state FYSPRT that act as a conduit to the Executive Leadership Team (ELT) bringing youth and family voice to the highest decision making levels in Washington State.

5. **Information for parents and youth about WISe has been developed and shared**

DSHS sought and received input from stakeholders including system partners and youth and families receiving WISe services to update the WISe information sheets. Those sheets are available in online in eight languages at: http://www.dshs.wa.gov/dbhr/cbh-wise.shtml

Information about WISe is available on the WISe implementation website www.dshs.wa.gov/dbhr/cbh-wise.shtml in addition to BHO websites. WISe has been promoted in a number of venues including behavioral health conferences, school-based conferences, and juvenile justice and children's welfare trainings.

6. **Continued financial commitment**

Washington continues to commit funding for implementation efforts. Appropriated amounts support direct services, a statewide governance structure, trainings and technical assistance, a statewide youth and family survey and the Behavioral Health Assessment System (BHAS), the data base for WISe. Additionally, this past year the State supported a WISe Symposium for practitioners and system partners focused on quality improvement within WISe. The appropriated budget for State Fiscal Year 2018 is $78.5 million.

Each year of WISe implementation the budget has increased. In State Fiscal Year 2015, the first year of WISe, the budget was $15 million, the following budget year the funds increased to $31.6 million and last year the appropriated budget was $47.5 million.

Washington Has More Work in the Coming Months

1. **Workforce issues continue to pose a challenge**

As of September 2017, 32 of Washington's 39 counties have started implementing WISe. Six of the remaining counties (Adams, Ferry, Lincoln, Okanogan, Pend Oreille and Wahkiakum) are scheduled to have WISe available in January 2018. San Juan County is scheduled to have WISe available no later than March 2018. Although the majority of counties have begun implementing WISe, the State has only achieved **58%** of the full implementation target for the mid-level service target range as of September 2017. The State has demonstrated increased capacity each year (growing from 18% in 2015, to 45% in 2016). Given this growth pattern, a push to meet identified capacity targets by June 2018 poses a steep challenge. Each region of the the state, with the exception of Thurston Mason Behavioral Health Organization who is at their capacity target, has submitted an

updated hiring plan for their region. These regional expansion plans establish clear timelines to increase WISe staff and in turn increase the number of youth and families who can enroll. The execution of regional plans is necessary to meet established capacity targets in 2018.

As indicated in previous status reports, an ongoing difficulty hiring and retaining qualified staff has presented a significant challenge for meeting regional and statewide capacity targets. Over the past year, agencies have used a variety of recruitment strategies, including some provider agencies raising salaries, conducting national searches to identify qualified staff and offering finder fees for new staff hires across most of the state. However, despite implementation of these strategies, workforce poses a considerable challenge. Ongoing review of workforce impacts will be monitored to assist efforts to rapidly increase WISe capacity.

BHOs and Managed Care Organizations (MCOs) are sub-contracting with WISe agencies to meet the mid-range target numbers by June 2018. The State anticipates having information in March 2018 on the progress towards meeting those goals. To stay on target, agencies around the state will have to continue recruitment and retention of staff at an increased level.

As noted below, Plaintiffs' counsel have significant concerns regarding the pace of the rollout and the likelihood of achieving 42% growth in the remaining months of the implementation period. The parties continue to discuss these concerns and their positions regarding the work needed to ensure that quality services become available across all regions.

2. More work needs to be done across child serving systems to ensure that Washington's most vulnerable children and youth are linked to WISe

Foster children entering Behavior Rehabilitation Services (BRS) congregate care placement may be eligible for WISe but are instead receiving services that are more restrictive than WISe due to the need for placement. Washington's algorithm to determine whether a youth's mental health needs and associated functional impairments are at or above the severity level for WISe services uses information from the CANS. The current screening process does not specify whether the needs of the youth can be managed in an outpatient setting, such as WISe, or need of a higher level of care offered in BRS facilities.

This situation has led the State to look for new ways to analyze WISe referrals. CANS screening information is captured by BHAS, the WISedatabase, but no automated report analyzes referrals that follow a WISe screen. In addition, the current BHAS system lacks a field to capture rationale for referring a child to a more restrictive level of care than WISe. BHAS was modified in October 2017 to capture this information. Cross-system partners will review this data and consult about what policy or protocol changes are needed for WISe eligible youth to access WISe services.

To further assist with ensuring that cross-system involved youth are accessing WISe, the WISe Access Protocol has been embedded within WISe trainings, shared during community presentations and included in the WISe Manual. Information about care coordination and participation on CFTs is included on WISe information sheets for staff in CA, as well as staff from systems such as Developmental Disabilities Administration, Juvenile Rehabilitation, Health Care Authority (HCA) staff and contractors, K-12 educators, and Juvenile Court personnel. Formalizing and finalizing cross-systems protocols for the various child servicing-systems, as well as drafting "framework" protocols that may be adopted by other systems, are a priority for the State over the next few months. Plaintiffs' counsel have been working with the State to advance the process of developing protocols. Plaintiffs' counsel have expressed concerns about (1) the scope of some of the proposed protocols which must address referral to WISe, participation in the CFTs, community collaboratives, and transitions out of WISe, under the parties' Settlement Agreement and (2) that implementation of these protocols has not yet begun.

3. Continued work is needed to ensure access to meaningful data

The WISe database, BHAS, is still undergoing improvements necessary to provide current and accurate feedback for quality improvement. Most of the planned reports are functional, but some need refinement. Capturing data from youth in transition from one agency to another also remains problematic. With the reports now functional, users need additional training so that data is used to drive case level and systematic improvements.

The Division of Behavioral Health and Recovery (DBHR) is working with the Praed foundation to create updated reports that better facilitate trend tracking using BHAS data. Comprehensive updated reports including data from January 2015 through October 2017 are expected to be available no later than early December 2017.

Changes in administrative data systems following the April 2016 BHO rollout have also created challenges to accessing and using encounter data. Methods are being developed to summarize encounter data from the Southwest region that will be comparable to summary information from the BHO regions housed in DBHR's data system. This work is ongoing and remains a priority for DSHS.

4. Continued efforts are needed to ensure due process protections

New grievance and appeals rules were drafted to be compliant with the Centers for Medicare and Medicaid Services (CMS) amendments to 42 C.F.R. Part 438, Subpart F. These changes became effective July 1, 2017, with the permanent rule effective on October 23, 2017. An updated Benefits Booklet was published in early November 2017and reflects these changes. Changes are also being made to contracts and a guidance has been issued on how the new rules affect youth screened for, or enrolled in, WISe.

DBHR will continue to perform ongoing monitoring of BHOs and providers' compliance with due process requirements. Quarterly, reports will be used to monitor compliance to the new state and federal regulations. BHOs and providers' policies, procedures and data

concerning notices of adverse benefit determination, grievances and appeals will be reviewed to determine adherence to the client and families receiving their due process rights.

DBHR uses our External Quality Review Organization (EQRO), Qualis Health, to review grievances, notices, and appeals. The EQRO follows CMS protocols, which is based on CFR requirements. An EQRO review is completed annually with each BHO. If there are recommendations requiring corrective action, the Contract Monitoring team issues an official corrective action request and follows up to ensure these findings are addressed. Any corrective actions issued are also followed up on by the EQRO review the following year.

Outside of the EQRO, if a BHO is not following a contract requirement or is not meeting a specific deliverable, the Contract Monitoring team provides coaching and technical assistance. If however, the BHO continues to not meet requirements, there are progressive remedial action steps utilized that are listed in section 17 of the Prepaid Inpatient Health Plan (PIHP) contract. Remedial action steps include development and execution of a corrective action plan.

Efforts are also being undertaken to ensure that BHOs are complying with the due process requirements in the Settlement Agreement, including the issuance of Notice of Adverse Benefit Determinations in all instances where they are required for children being referred to and screened/assessed for WISe. Additional monitoring of BHOs' policies and practices will be needed to ensure compliance with these requirements.

5. More work is needed to ensure a robust, sustainable, and effective Quality Management, Improvement, and Accountability (QMIA) system going forward

An effective quality framework is essential to the WISe program. Reforming system practices requires well-designed monitoring, analysis, reporting, and real-time feedback capabilities in order to be successful. The Quality Management Plan (QMP) provides a basis for measuring the implementation and performance of the WISe program. The QMP was finalized in December 2014 and amended in May 2015, but has not been systematically implemented. The QMP will be reviewed and updated via a collaborative process including Plaintiffs' counsel, expected to be completed by early 2018. New quality improvement tools specific to the WISe program are also being developed, including the WISe Monitoring Tool which will be piloted in January 2018. These tools along with guidance for their use need to be included in the QMP revisions.

6. Status of Exit Criteria Discussions

Over the past six months, the parties have been engaged in discussions regarding Defendants' progress towards meeting the exit criteria requirements set forth in the parties' Settlement Agreement. Pursuant to Paragraph 66, the parties met in September to discuss whether they anticipate a "dispute as to whether Defendants are on track to meet

the exit criteria." The parties are continuing to evaluate Implementation Plan compliance, exchange information and data, and assess their positions.

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II. Progress in Meeting Obligations Under the Settlement Agreement and Status of Remaining Tasks

Objective 1: Communication regarding WISe

Communicate with families, youth, and stakeholders about the nature and purpose of Wraparound with Intensive Services (WISe), who is eligible, and how to gain access to WISe.

Progress and Accomplishments:

WISe information sheets go through an annual review. The sheets were sent out to the various affinity groups (see list below) for comments and revisions with only minor updates suggested. During the fall of 2017 the information sheets are scheduled for an additional review to increase cultural relevance; various culturally diverse organizations and groups across the state will be invited to provide feedback. Once this review is completed, the information sheets will be sent to the DSHS Communication Division for translation into eight different languages (English, Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese).

Once translation and publication are complete, the updated WISe information sheets will be available on the DBHR website link https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/wraparound-intensive-services-wise-implementation. WISe Information sheets were updated for the following affinity groups:

- Child Psychiatrists and Advanced Registered Nurse Practitioners (ARNPs)
- Children's Administration Social Service Specialists
- Children's Long Term Inpatient Program Staff (CLIP)
- Developmental Disabilities Administration (DDA)
- Designated Mental Health Providers (DMHP)and Crisis Teams
- Families/Family Organizations
- Heath Care Authority and Contracted Providers
- Individuals Providing Mental Health Services
- Juvenile Court, Detention, and Probation Personnel
- Juvenile Rehabilitation (JR) Personnel
- K-12 Educators and Professionals
- Pediatricians, Family Practitioners, Physicians Assistants and ARNPs
- Substance Use Disorders (SUD) Providers
- Youth/Youth Organizations

WISe information sheets continue to be available at community mental health agencies, through Behavioral Health Organizations and Managed Care Organizations. Information sheets have also been shared at the statewide and regional Family Youth and System Partner Roundtables (FYSPRTs). Affinity groups and system partners, such as Office of Superintendent of Public Instruction and DDA have sent information via their listservs. Volunteers from regional FYSPRTs will be asked to share WISe materials with their local school districts. During August 2017, BHOs and WISe providers were asked to update their

websites with current information on WISe so youth, families and other interested stakeholders would have easily accessible WISe information. Information added to websites includes eligibility and referral information, and links to the WISe Information Sheets. Seven of the nine BHOs have updated their websites with WISe information (BHO webpage: http://greatriversbho.org/wise-services). Twelve WISe providers have added information to their websites (WISe provider webpage: http://www.columbiawell.biz/services/wise/). For WISe providers such as Catholic Community Services that are part of large multi-agency structure, adding WISe information to the corporate webpage will take time as there is a process the local providers must go through to get the information included on the website.

In 2018, to assist with tracking the use of the WISe information sheets, regional screening trend reports will be developed. These quarterly reports will be used to monitor number of referrals and who referred to WISe. These reports will assist with tracking and help BHOs identify which child serving system are in need of outreach and education about the availability of WISe.

Objective 1-Remaining tasks[1]:

- Revise WISe information sheets with feedback from culturally diverse organizations including one for American Indians and Alaska Natives (AI/AN) fee-for-service.
- Continue to disseminate WISe information to youth and families, affinity groups, and to system partners.
- Continue to have FYSPRTs distribute WISe communication materials.
- Continue to share information drafted and incorporated into the WISe Manual with FYSPRTs, system partners, affinity groups, and Plaintiffs' counsel.
- Continue to deliver information developed through a variety of online, print, and in-person methods, including targeted and in-person outreach to school personnel and medical providers.

Objective 2: Identification, Referral and Screening for WISe

Effectively identify, refer, and screen class members for WISe services.

Progress and Accomplishments:

WISe Access Protocol: Prior to implementation, a WISe Access Protocol was established to identify and refer class members for WISe services. The Access Protocol includes the identification, referral, screening, and intake/engagement process for WISe services. The WISe Access Protocol is included in the WISe Manual and provides uniform standards on the administrative practices and procedures for providing access to WISe and its services.

[1] The "Remaining Tasks" reflect priorities for the upcoming year, but are not intended to expand or limit the parties' obligations under the Settlement Agreement.

WISe providers and BHOs use the protocols to identify youth who might qualify for WISe and conduct an appropriate screen. The annual review of the Access Protocol is incorporated in the WISe Manual review. During this review, the manual is emailed out to BHOs, WISe providers, and the FYPSRTs for technical and programmatic review and feedback. Suggested edits are submitted to DBHR for further review and consideration. Currently there are no updates to the protocol.

WISe Manual: The WISe Manual is currently in its third annual update since 2015. This update will include the new federal regulations regarding a client's due process rights and updated program expectations based on the Quality Services Review, feedback from the Youth and Family Survey and the draft of the WISe monitoring tool. The manual is a living document that continues to be informed by those working on implementation and monitoring the progress. A list serve of individuals who have been reviewing the WISe Manual since 2014 were sent a request in late Spring 2017 to review the manual and submit feedback of revisions and changes for the annual update. Minimal changes were requested by the group. The WISe Manual is available on-line at: www.dshs.wa.gov/dbhr/cbh-wise.shtml.

WISe screening algorithm: The Washington version of CANS and the BHAS computer application reflect an algorithm that was developed to determine which youth, among those screened for WISe, will likely benefit from the service. The initial version of the screening algorithm was developed based on consultation with clinical experts, including Dr. John Lyons, prior to the availability of CANS screening and WISe service data. Using available WISe screening data, the State continues its analysis of the functioning of the algorithm. This work will continue through early 2018. Results from this work may include a recommendation for a revised WISe screening algorithm. The recommendation will available by March 2018, and any resulting changes will be made before July 2018.

Behavioral Health Assessment System (BHAS): Data from CANS screens and full CANS assessments for WISe are recorded and tracked via BHAS. A competitive process was launched in 2017 to determine if a new BHAS vendor would improve data accuracy and use. After careful consideration, the existing contractor, RCR Technologies, was chosen to continue providing the online data system. Ongoing efforts focus on improving the data quality, user experience, and reporting functions of BHAS. Recent system updates and enhancements include access to 'flat files' for data export, implementation of auto save, and additional automated reports.

All BHOs, MCOs, and agencies using BHAS have access to a 'flat file' which is an excel spread sheet showing all the data for their respective WISe clients that has been entered into BHAS. The State has provided training on how to use those flat files, how this data can be used and organized to check data accuracy, and how to run reports that are not automated in BHAS. In addition to reviews of data quality conducted by BHOs, MCOs, and agencies, the data entered into BHAS is checked for quality by both Research and Data Analysis (RDA)

and the Praed Foundation. The Praed Foundation conducted a follow-up to the 2016 BHAS users survey. Another survey is scheduled for the end of November 2017. A report from Praed is due in early 2018 and the results from these follow-up surveys will inform further adaptations and features to BHAS to increase the accuracy, reliability, and usability of CANS data.

Ongoing BHAS improvements include the October 2017 addition of a drop-down and comment box to capture and track additional information about referrals and transitions. For example, if a youth leaves CLIP but does not enter WISe services, this BHAS feature will indicate why the youth is not being referred to WISe and instead being referred to a different service. Another feature added to BHAS in 2017 is the addition of 'auto save,' which users had clearly indicated was needed in order to diminish the risk of losing data when the system times out during the data entry process. BHAS updates currently in development include improved tracking of episodes of care and multi-level reporting for cross-regional entities.

A number of new BHAS automated reports now allow agencies and clinicians to graphically analyze progress based on CANS scores at the client level. These reports also "roll up" to aggregate results for analysis at the clinician, agency, BHO, MCO, or state level. Analysis of this data in the spring of 2017 resulted in the State purchasing additional in-person CANS training from Praed to be offered statewide. Those trainings provide information on how to properly administer the CANS tool as well as how to use CANS results provided by BHAS to share with the youth, family, and Child/Family Team to inform care plan improvements as well as aggregated results that improve system quality.

WISe screens: Anyone can make a referral for a WISe screen. Family, youth, and child-serving systems, such as CA, Rehabilitation Administration (RA), DDA, Health Care Authority (HCA), BHOs, school personnel, county and community providers, and medical providers can assist in the identification and referral of youth who might benefit from WISe. Consideration for referral begins with youth who are Medicaid eligible, under age 21, and have complex behavioral health needs.

The WISe providers and referral contacts list by county can be found at: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISeReferralContactListbyCounty.pdf. In addition, referrals for a WISe screen may be made directly to a BHO or any BHO provider.

From July 1, 2014, through June 30, 2017, (SFY 2015 - SFY 2017), **6,861 WISe screens** were conducted for a total of 5,436 unduplicated youth. The table below provides the number and percentage of referral sources broken down by state fiscal years to assist with identifying changes over time. The largest referral sources for the WISe program are the BHOs (34% of screens were referred by BHOs), self and family (21%), and CA (12%). In SFY 2017, several other referral sources grew in the rate of referrals made to WISe screening. These sources include schools (6% of screens were referred by schools), mental

health inpatient services including CLIP (1%) and other inpatient settings (3%), medical providers (3%), and mental health providers outside of the BHO system (2%).

Table 1. WISe Screens, by Referral Source: July 1, 2014 - June 30, 2017

	FULL PERIOD 7/14 – 6/17		SFY 2015 7/14 – 6/15		SFY 2016 7/15 – 6/16		SFY 2017 7/16 – 6/17	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Referral Source								
MH-Outpatient/BHO	2,311	33.7%	550	35.1%	809	37.1%	952	30.6%
Self & Family	1,450	21.1%	299	19.1%	473	21.7%	678	21.8%
Children's Administration	800	11.7%	273	17.4%	221	10.1%	306	9.8%
School	400	5.8%	48	3.1%	131	6.0%	221	7.1%
MH-Crisis Services	367	5.3%	86	5.5%	154	7.1%	127	4.1%
Other	357	5.2%	100	6.4%	123	5.6%	134	4.3%
MH-Inpatient/Non-CLIP	183	2.7%	23	1.5%	22	1.0%	138	4.4%
Medical Provider	180	2.6%	17	1.1%	56	2.6%	107	3.4%
MH-Other	177	2.6%	31	2.0%	62	2.8%	84	2.7%
MH-Outpatient/Non-BHO	164	2.4%	25	1.6%	13	0.6%	126	4.0%
Community Organization	133	1.9%	55	3.5%	28	1.3%	50	1.6%
Juvenile Justice/JJRA	99	1.4%	15	1.0%	36	1.6%	48	1.5%
Juvenile Justice/non-JJRA	99	1.4%	26	1.7%	27	1.2%	46	1.5%
MH-Inpatient/CLIP	99	1.4%	10	0.6%	17	0.8%	72	2.3%
MH-Tribal	18	0.3%	2	0.1%	7	0.3%	9	0.3%
Developmental Disabilities Adm.	14	0.2%	4	0.3%	4	0.2%	6	0.2%
Substance Use Disorder Provider	9	0.1%	1	<0.1%	0	0.0%	8	0.3%
Missing	1	0.0%	1	<0.1%	0	0.0%	0	0.0%
TOTAL Duplicated Screens	**6,861**	**100%**	**1,566**	**100%**	**2,183**	**100%**	**3,112**	**100%**
TOTAL Unduplicated Youth	**5,436**		**1,381**		**1,906**		**2,734**	

NOTES: This table presents data for all screens (duplicated) for WISe between 7/1/2014 and 6/30/2017. Youth screened more than once for WISe services over this period are displayed multiple times.
SOURCE: Washington Behavioral Health Assessment System (BHAS).

WISe screening data does not reflect a universal screening effort. Rather, WISe screening data come from select groups including: (1) children referred to the WISe program; (2) children entering/exiting CLIP services or re-screening while in CLIP services; and (3) children entering/exiting BRS services or re-screening while in BRS services. Because screenings are mandatory for CLIP and BRS involved children and youth, the numbers and proportions of CLIP and BRS youth in WISe screening data are substantially inflated relative to their proportions in the overall youth Medicaid population. These are very small programs, with only 182 youth in CLIP in SFY 2016 and only 1,071 youth in BRS in SFY 2016. In the same fiscal year, there were 943,223 total Medicaid youth age 0-20. The

population of youth with indicators suggesting potential eligibility for WISe services, as described by the WISe proxy in SFY 2015, is 25,090.

It is important to critically assess what other factors may be improperly restricting access to WISe services. Moreover, the percentage of youth from CLIP or BRS may be inflated because of low referral rates from other system partners. These other system parnters need concrete descriptions to identify youth and children for referrals, as well as system-specific indicators based on the proxy class (Appendix – to the Settlement Agreement). As discussed below for Objective 3, it is anticipated that the adoption of system partner protocols will also increase the number of referrals from other sources.

As discussed in the 2015 annual report, the SFY 2015 referrals from schools was very low. With targeted outreach and training efforts, there has been improvement in the number and quality of referrals coming from schools. For example, targeted outreach in the fall of 2017 included WISe information sent to 4,432 school counselors and other educators on the "News and More for School Counselors" listserv. While the percentage is still low, the percentage of referrals from schools has almost doubled since 2015. Furthermore, just over four-fifths (82%) of youth referred to WISe by schools have a referral outcome of WISe services. This is higher than the overall average; of all screens conducted in the three-year period, 75% had a referral outcome of WISe services. Given this improvement, DBHR will be working with system partners to replicate the strategies used to increase referrals from schools to increase the number of referrals from juvenile justice, substance abuse disorder providers, community organizations, and tribal sources.

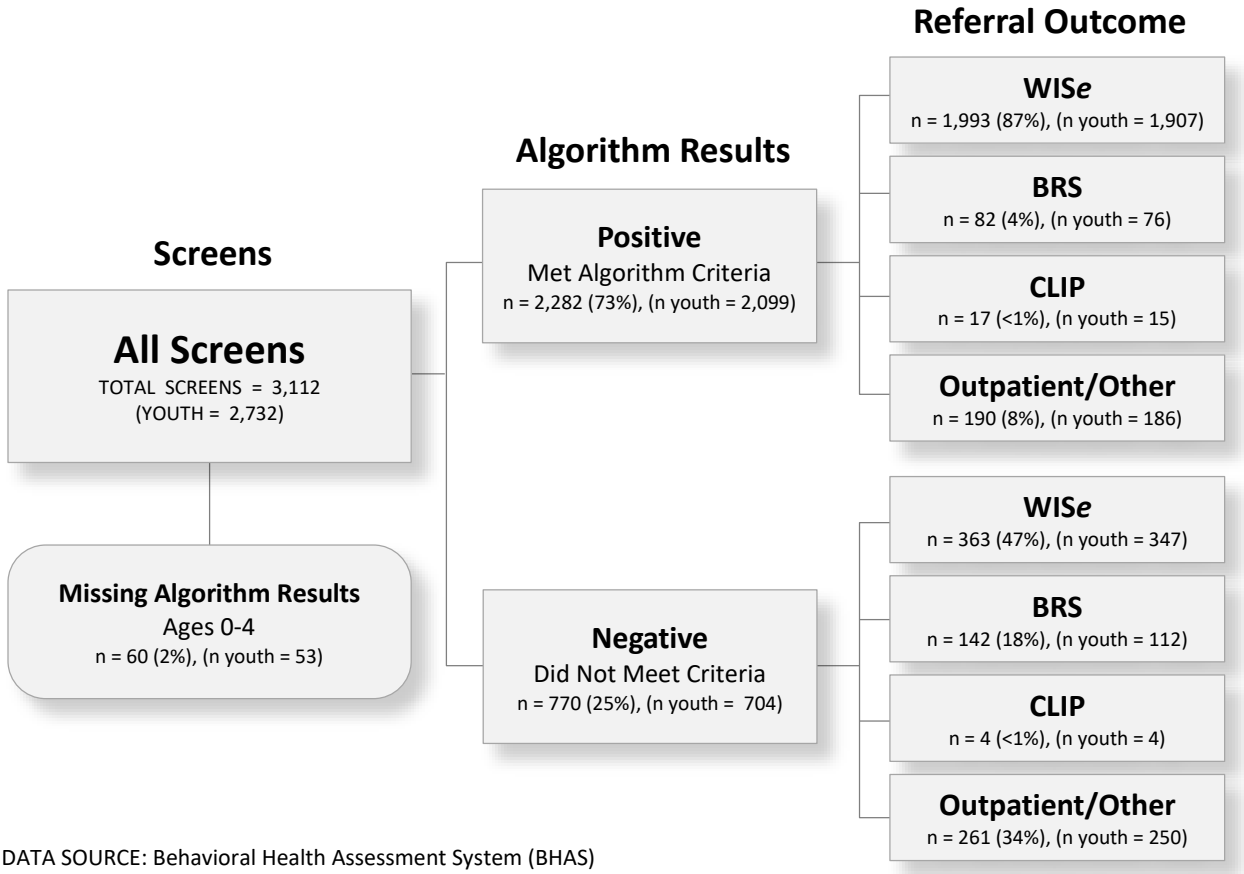
WISe screening timeliness: Of the 3,112 screens conducted in SFY 2017, **87% were conducted within 14 days of referral**. This represents an improvement over prior years (which had approximately 80% screening timeliness). For five of the regions, screening timeliness in SFY 2017 was above 90% for the fiscal year. Three regions had timeliness rates between 85 and 90% timeliness, and two had rates below the average. Both of these regions experienced major expansions in services in SFY 2017 and are expected to improve timeliness rates as the program becomes more established.

Referrals Resulting From WISe Screening: In total, 9% of the 6,861 WISe screens conducted from SFY 2015 through SFY 2017 (July 1, 2014, to June 30, 2017) resulted in a referral outcome of BRS or CLIP. For most of these screens, the person making the referral for WISe screening had originally recommended BRS or CLIP as the most appropriate service placement for the youth in question. Many of those youth whose screening resulted in a service recommendation of BRS or CLIP likely were already engaged in BRS or CLIP at the time of screening, and thus the screening represents a recommendation to continue in the current setting.

The figures below describe WISe Screening results for SFY 2017 (July 1, 2016, to June 30, 2017): figure 1(a) describes results from all screens; figure 1(b) includes reflects only

screens from CA referral; and figure 1(c) includes screens for all youth involved with CA, even if the referral source was not CA.

Figure 1(a). WISe Screening Results, SFY 2017: All Screens
July 1, 2016, to June 30, 2017



DATA SOURCE: Behavioral Health Assessment System (BHAS)
NOTE: The numbers displayed above represent screens, not consumers. Counts are duplicated where an individual has multiple screens in the time frame. Counts of unduplicated youth consumers shown in parentheses. Subgroups may not total 100% due to rounding.

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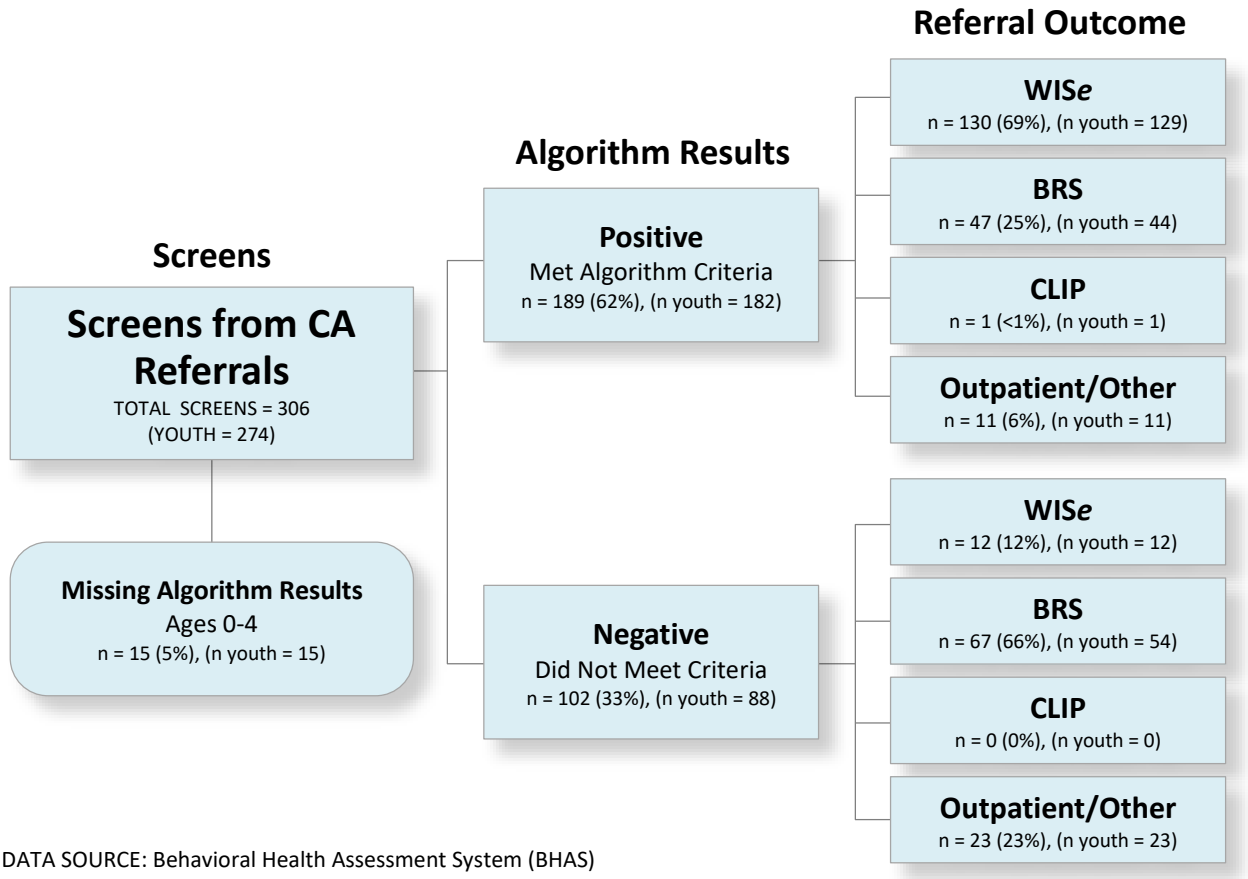
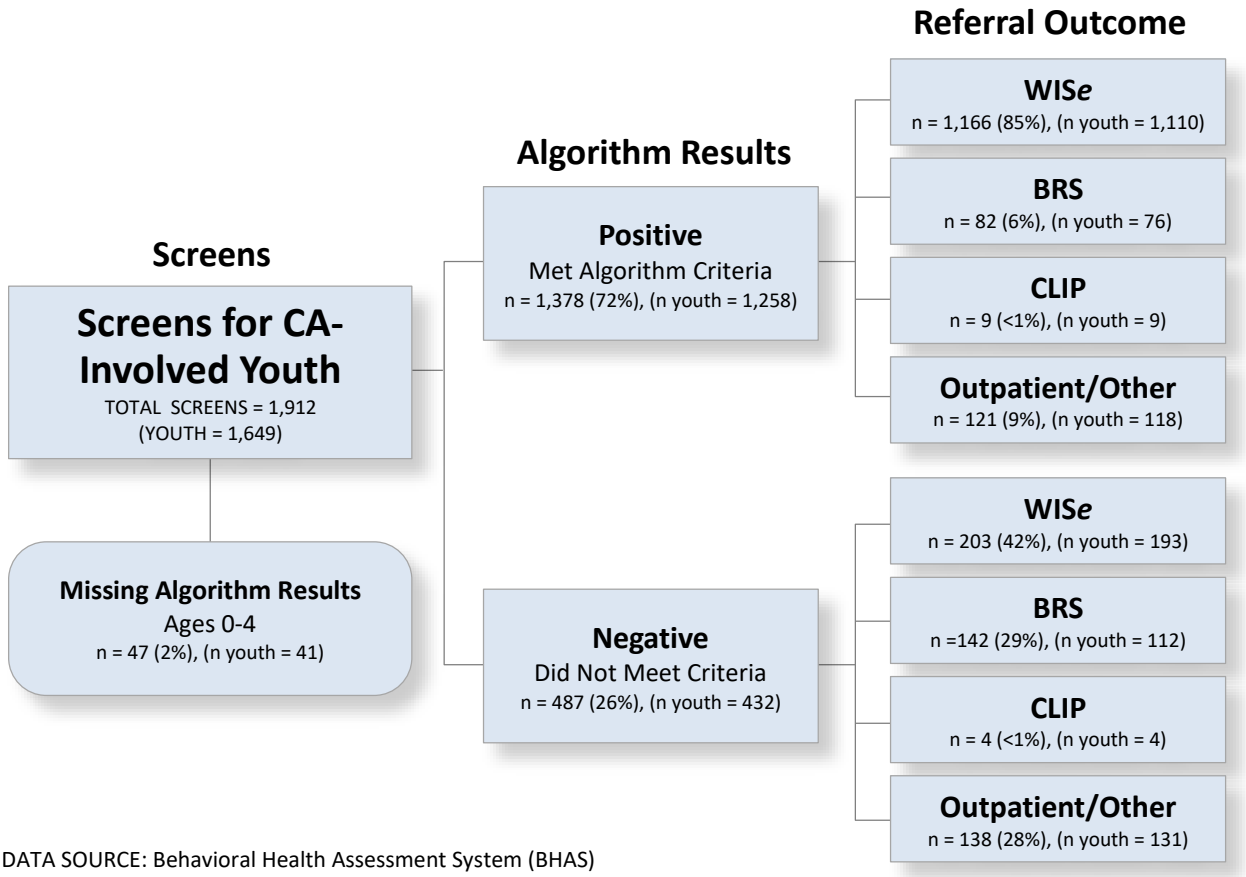
Figure 1(b). WISe Screening Results, SFY 2017: CA referrals
July 1, 2016, to June 30, 2017



DATA SOURCE: Behavioral Health Assessment System (BHAS)
NOTE: The numbers displayed above represent screens, not consumers. Counts are duplicated where an individual has multiple screens in the time frame. Counts of unduplicated youth consumers shown in parentheses. Subgroups may not total 100% due to rounding.

[The remainder of this page is intentionally left blank.]

Figure 1(c). WISe Screening Results, SFY 2017: CA-involved youth
July 1, 2016 to June 30, 2017



DATA SOURCE: Behavioral Health Assessment System (BHAS)
NOTE: The numbers displayed above represent screens, not consumers. Counts are duplicated where an individual has multiple screens in the time frame. Counts of unduplicated youth consumers shown in parentheses. Subgroups may not total 100% due to rounding.

These data show that in SFY 2017, over 60% of youth referred by CA meet algorithm criteria for entry into WISe, and 25 percent of these youth have a referral outcome of BRS (Figure 1(b)). Of all screened youth with CA involvement, over 70% met algorithm criteria for WISe entry, and only 6% of these youth had a referral outcome of BRS (Figure 1(c)).

Plaintiffs have expressed concerns that youth who are eligible for and would benefit from WISe are not receiving the services due to placement scarcity and other systemic challenges within CA. Plaintiffs have proposed additional data analysis, improved transparency, clarification of placement decision-making, and enhancements to the CANS as ideas to improve practice in this area.

A BHAS feature that will allow users to indicate why a youth may have screened into WISe but was referred to another level of care is currently being finalized. This will allow for analysis of trends and characteristics of youth who qualify for WISe but are referred elsewhere. That analysis will be shared with state FYSPRT and Executive Leadership team to drive potential policy changes ensuring appropriate referral to WISe.

Children's Long-Term Inpatient Program (CLIP): CLIP is the most intensive inpatient psychiatric treatment available to all Washington residents, ages 5-18 years of age. CLIP provides medically-based inpatient psychiatric treatment. Prior to admission to CLIP, youth receive a CANS screen or CANS full to determine whether a less restrictive level of care can meet their needs. Children and youth also receive a full CANS assessment within the first 30 days following admission to CLIP, a CANS screen every six months while in CLIP, and another CANS screen is completed within 30 days before the youth is discharged from CLIP. In addition, community WISe providers conduct a full CANS assessment for all Medicaid-eligible youth discharged from CLIP, within 30 days post-discharge. Over this past year, CLIP Programs began conducting CANS Screens at discharge versus completing a full CANS assessment 30 days prior to discharge since a full CANS assessment is also required 30 days post-discharge.

CLIP programs convene multi-faceted discharge planning team meetings in coordination with the CLIP treatment team, the youth, youth's family, system partners, school, and community providers which include WISe Team members to develop a successful discharge plan that best supports the youth and their family. When youth have a WISe team involved before admitting to a CLIP facility, some WISe team members are remaining involved throughout the youth's CLIP treatment by participating in treatment plan reviews and/or discharge planning, resulting in improved continuity of care from the community to CLIP and back to the community. For youth engaging in WISe for the first time, CLIP coordinates with WISe teams to begin working with the youth, family, and CLIP treatment teams as early as possible prior to youth's planned discharge from CLIP.

Six-month WISe screening rates for CLIP clients increased substantially in SFY 2017. During SFY 2017, a total of 53 screens and 120 full CANS assessments were conducted for youth in CLIP, compared with 7 screens and 77 full CANS assessments in SFY 2016. The majority of CLIP clients statewide transitioned into WISe services upon discharge from CLIP. During this past year, several strategies contributed to improved WISe screening rates for the CLIP system. These included CLIP Administration oversight to ensure Voluntary Medicaid-eligible youth receive a CANS screen prior to their admission into CLIP. CLIP Programs have also implemented their own processes to ensure monitoring and completion of CANS assessments. In-person technical assistance for CLIP program staff has decreased BHAS and data entry technical challenges. Finally, the DBHR CLIP Administrator has been monitoring completion of CANS assessments and providing data directly to the CLIP Directors to improve CANS assessment compliance. As the roll-out of WISe progresses, the DBHR CLIP Administrator will continue to participate in any relevant discussions involving service transitions to and from CLIP and the community as well as the administration of the CANS tool within the CLIP Programs.

Objective 2 - Remaining Tasks:

- Continue to work with system partners to further develop system-specific referral indicators based on proxy.
- By March 2018, results from the review of WISe screening algorithm and any potential recommendations will be available.
- Continue annual reviews of the WISe Access Protocol and update as needed.
- Continue to monitor WISe screens for BRS and CLIP and analyze cross-system barriers to WISe access
- Continue to resolve issues related to BHAS (see Section III, Implementation Challenges, BHAS).
- Continue to review and report timeliness standards.
- Post BHO and state level Quarterly Reports to DBHR website once all BHAS reports complete validation for accuracy. (See Section III, Implementation Challenges, BHAS.)
- Review data regarding youth who screen positive for WISe but do not receive WISe services to evaluate systemic barriers to access that should be addressed, in particular with youth in CA and Juvenile Rehabilitation, to address any barriers and engage those youth in WISe services when appropriate.
- Continue to review implementation of CANS for care planning at CLIP facilities.
- Ensure BHOs and providers are utilizing regional proxy predictors to assist with outreach and referrals to WISe.
- Consult with the Praed Foundation to determine the feasibility and logistics required to add WISe screen protocols that would allow a 'step down' algorithm from CLIP and BRS to WISe and consider what changes may be implemented so that youth who would safely benefit from WISe are not redirected to more restrictive settings or placements.

Objective 3: Provision of WISe

Provide timely and effective mental health services and supports that are sufficient in intensity and scope, are individualized to youth and family strengths and needs, and delivered consistently with the WISe Program Model as well as Medicaid law and regulations

Progress and Accomplishments:

Named Plaintiffs' Workgroup: Over the past year, one named plaintiff was involved in outpatient mental health services. The Named Plaintiffs' Workgroup collaboratively reviewed progress reports; this review will continue as long as the plaintiff remains in services. The other nine named plaintiffs have aged out, opted out or moved out of the class. Named Plaintiff Workgroups were identified in August 2014 and ongoing quarterly meetings or progress reports were provided over the course of three years.
WISe Participants: A total of 3,515 youth received WISe services between SFY 2015 Q1 and SFY 2017 Q3 (July 1, 2014, to March 31, 2017). This is an increase from the 1,705 reported

in last year's annual report. Below, table 2 identifies the demographic characteristics of WISe recipients.

Table 2.
Demographic characteristics of all youth receiving WISe services: July 1, 2014 – March 31, 2017

	FULL PERIOD 7/14 – 3/17		SFY 2015 7/14 – 6/15		SFY 2016 7/15 – 6/16		SFY 2017 PARTIAL Q1-Q3 7/16 – 3/17	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Gender								
Female	1,399	40.1%	348	37.3%	715	38.8%	920	40.6%
Male	2,094	59.9%	584	62.7%	1,128	61.2%	1,347	59.4%
Age Group								
0-4	39	1.1%	4	0.4%	19	1.0%	23	1.0%
5-11	1,236	35.4%	318	34.1%	640	34.7%	807	35.6%
12-17	2,108	60.3%	577	61.9%	1,119	60.7%	1,323	58.4%
18-20	110	3.1%	33	3.5%	65	3.5%	114	5.0%
Race/Ethnicity								
Non-Hispanic White	1,585	45.4%	435	46.7%	818	44.4%	1,039	45.8%
Minority	1,908	54.6%	497	53.3%	1,025	55.6%	1,228	54.2%
Minority Category[1]								
Hispanic	827	23.7%	188	20.2%	449	24.4%	549	24.2%
Black	584	16.7%	119	12.8%	321	17.4%	397	17.5%
American Indian/Alaska Native	477	13.7%	160	17.2%	253	13.7%	292	12.9%
Asian/Pacific Islander	233	6.7%	72	7.7%	112	6.1%	131	5.8%
TOTAL POPULATION with linked data available[2,3]	**3,493**	**100%**	**932**		**1,843**		**2,267**	
TOTAL POPULATION SERVED[3]	**3,515**		**939**		**1,854**		**2,279**	

NOTES: (1) Minority category is not mutually exclusive; categories do not sum to 100%.
(2) Some youth served in WISe could not be linked with demographic characteristics in administrative data.
(3) Youth in WISe over multiple fiscal years are counted each year that they are served; summing across a population row produces a duplicated count. The figures in the full period column for both the total population with linked data available (3,493) and the total population served (3,515) are unduplicated.
SOURCE: DSHS Integrated Client Database.

WISe Service Delivery: Of the 3,515 youth served, service encounter data is currently available for 3,421 youth, with a total of 311,236 service encounters between July 1, 2014 and March 31, 2017. On average, a youth enrolled in WISe had 13.1 service encounters during that month. This is four times as many service encounters as received on average by all youth 0-20 with any DBHR outpatient services (including WISe clients) in the same period; the average for this group is 3.4 encounters per month.

The current service location data shows that WISe services were most frequently delivered in outpatient facilities (39%; includes "office," "independent clinic," "community mental health center") and in the youth's home (30%). Six percent of services were delivered in schools, and 23% were delivered in other community settings. A small number of services were delivered in hospital emergency rooms, residential care settings, and correctional facilities (1%). In contrast, two-thirds of all DBHR youth outpatient encounters are delivered in outpatient settings.

Note that these service statistics are presented in units of service encounters rather than service hours, as shown in previous reports. DBHR transitioned to a new integrated mental health/substance use disorder data system coinciding with the BHO rollout in April 2016, and clean data on the length of mental health service encounters is not currently available. Due to the change in units of analysis, direct comparisons cannot be made between prior reports showing number of hours and the current data summary showing number of encounters in different service categories. Additionally, the apparent higher prevalence of office-based encounters in the current data summary relative to past reports, is partly an artifact of the change in units of analysis, because office-based services tend to be of shorter length than community-based services, reporting the distribution of service encounters rather than service hours makes community-based services appear less frequent. The Behavioral Health Services System (BHSS) dataset used for this summary of WISe service characteristics does not contain data on service provider types.

The available service encounter data includes DBHR-paid managed care encounters from July 2014 – March 2017, but known data issues affect the analysis as follows:

- Encounter data is not currently available for youth served in the Southwest region after March 2016 because the region transitioned to fully integrated managed care (FIMC) in April 2016. As of that date, MCOs in the Southwest region no longer reported encounters using the same set of reporting standards as BHO providers (SERI), and no longer reported encounters into DBHR's behavioral health data system (BHDS). Methods are being developed to summarize WISe encounters in Southwest available only through the ProviderOne system after the transition to FIMC that will be comparable to summary information from the BHO regions housed in DBHR's data system.
- Greater Columbia BHO data prior to March 2016 is excluded from the service location data summary, as a data issue was causing all encounters to default to outpatient facility even when provided in another setting.

The top five service modalities, by number of encounters for WISe services are: individual treatment services (43%), peer support (13%), CFT meeting (13%), care coordination services (12%), and family treatment (9%).

Table 3. WISe Service Characteristics by Time Period, July 1, 2014 – March 31, 2017

	FULL PERIOD 7/14 – 3/17		SFY 2015 7/14 – 6/15		SFY 2016 7/15 – 6/16		SFY 2017 PARTIAL Q1-Q3 7/16 – 3/17	
Program Totals								
WISe Clients (unduplicated)	3,421		936		1,841		2,128	
Service Months	23,723		5,038		8,610		10,075	
Service Encounters	311,236		72,031		116,503		122,702	
Service Encounters per Month	13.1		14.3		13.5		12.2	
Service Location - *Average number of encounters per WISe service month*								
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Outpatient	5.2	39.1%	5.1	33.8%	5.1	35.8%	5.4	44.4%
Home	4.1	30.8%	5.3	35.2%	4.7	32.7%	3.3	27.0%
Other	3.1	22.8%	3.8	25.0%	3.4	24.1%	2.5	20.7%
School	0.8	6.1%	0.7	4.8%	0.9	6.2%	0.8	6.8%
Emergency Room – Hospital	0.1	0.5%	0.1	0.5%	0.1	0.6%	0.1	0.5%
Residential Care Setting	0.1	0.4%	0.1	0.4%	0.1	0.4%	0.1	0.5%
Correctional Facility	0.0	0.3%	0.1	0.4%	0.0	0.2%	0.0	0.2%
Treatment Modality - *Average number of encounters per WISe service month*								
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Individual Treatment Services	5.6	42.5%	5.9	41.5%	5.5	40.9%	5.4	44.5%
Peer Support	1.8	13.6%	1.9	13.5%	1.8	13.2%	1.7	14.1%
Child And Family Team Meeting	1.7	12.9%	1.8	12.2%	1.9	13.8%	1.5	12.3%
Care Coordination Services	1.6	11.9%	1.7	12.0%	1.8	13.0%	1.3	10.8%
Family Treatment	1.2	8.9%	1.4	9.8%	1.2	8.6%	1.1	8.8%
Crisis Services	0.4	2.7%	0.4	2.5%	0.4	3.0%	0.3	2.5%
Medication Management	0.3	2.3%	0.4	2.7%	0.3	2.3%	0.2	2.0%
Other Intensive Services	0.2	1.6%	0.3	2.0%	0.2	1.7%	0.1	1.1%
Intake Evaluation	0.2	1.3%	0.2	1.3%	0.2	1.3%	0.2	1.4%
Rehabilitation Case Management	0.1	1.1%	0.2	1.5%	0.2	1.2%	0.1	0.8%
Group Treatment Services	0.1	0.5%	0.1	0.4%	0.0	0.4%	0.1	0.6%
Therapeutic Psychoeducation	0.0	0.3%	0.0	<0.1%	0.0	0.1%	0.1	0.6%
Interpreter Services	0.0	0.2%	0.0	0.3%	0.0	0.2%	0.0	0.1%
Medication Monitoring	0.0	0.1%	0.0	<0.1%	0.0	<0.1%	0.0	0.2%
Involuntary Treatment Investigation	0.0	0.1%	0.0	<0.1%	0.0	0.1%	0.0	0.1%
Psychological Assessment	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%
Co-Occurring Treatment Services	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%	0.0	0.0%
Engagement And Outreach	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	<0.1%

DATA SOURCE: Administrative data (BHSS).
NOTES: WISe services include all WISe mental health outpatient service encounters recorded in BHSS data system, including DBHR-paid managed care mental health outpatient services received in a month with at least one "U8"mental health service. The service location summary excludes encounters from Greater Columbia prior to 4/1/2016, as the data is unavailable for that time period. Both the service location and treatment modality summary exclude data from Southwest after 3/31/2016, as it is unavailable in the BHSS data system.

Regional Variation: On the following pages, table 4 presents descriptive statistics on WISe services for the ten service regions in Washington State from July 2014 through March 2017. The data demonstrate variation in the average number of DBHR-paid managed care mental health service encounters being provided to youth in WISe, ranging from 10.0 service encounters per month in King County to 16.6 service encounters per month in the Southwest region[2]. In addition to variation the in overall volume of services received by WISe youth, there is also variation in the package of WISe services being delivered, as indicated by the proportion of service encounters in key service modalities including care coordination (ranges from <0.1% to 29.6% of WISe service encounters), CFT meetings (ranges from 0.3% to 19.9% of WISe service encounters), and crisis services (ranges from 0.9% to 5.5% of WISe service encounters). The percentages of substantive modalities that include individual treatment services, peer support, family treatment, medication management, and other intensive services also varied significantly (combination of these five modalities ranges from 45. 1% to 86.9% of WISe service encounters) [3].

[The remainder of this page is intentionally left blank.]

[2] Note that encounter data from the Southwest region is not available after 3/31/2016 as it is unavailable in the BHSS data system.

[3] Due to formatting and space constraints, notes for Table 4 are presented here, instead of below the table.

Table 4 Notes: WISe services include all WISe mental health outpatient service encounters recorded in BHSS data system, including DBHR-paid managed care mental health outpatient services received in a month with at least one "U8"mental health service. Region information is displayed using the current Behavioral Health Organization (BHO) and FIMC boundaries. Youth served in more than one region during the report date range have been allocated to the region in which they received the greatest number of WISe "U8" service encounters in the date range. Service months and service encounters for youth served in more than one region during a month have been allocated to the region in which they received the greatest number of WISe "U8" service encounters during the month. The service location summary excludes encounters from Greater Columbia prior to 4/1/2016, as the data is unavailable for that time period. Both the service location and treatment modality summary exclude data from Southwest after 3/31/2016, as it is unavailable in the BHSS data system. Because a small number of clients participating in the Address Confidentiality Program (ACP; 20 in this time period) are included in statewide totals but not in regional breakdowns, numbers do not sum to statewide totals.

Table 4. WISe Service Characteristics by Region, July 1, 2014 – March 31, 2017 *(page 1 of 2)*

	STATEWIDE		Great Rivers		Greater Columbia		King County		North Central		North Sound	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Program Totals												
WISe Clients (unduplicated)	3,421		187		762		345		44		524	
Service Months	23,723		1,054		5,587		2,061		274		4,228	
Service Encounters	311,236		15,010		56,599		20,682		3,284		60,457	
Service Encounters per Month	13.1		14.2		10.1		10.0		12.0		14.3	
Service Location - *Average number of encounters per WISe service month*												
Outpatient	5.2	39.1%	7.3	51.4%	6.3	63.9%	6.6	65.9%	7.4	61.6%	5.8	40.3%
Home	4.1	30.8%	3.0	20.9%	1.7	17.4%	0.7	6.8%	1.9	15.6%	4.4	30.9%
Other	3.1	22.8%	2.6	18.2%	1.2	12.0%	1.7	16.9%	1.4	11.7%	3.4	24.1%
School	0.8	6.1%	1.1	7.8%	0.5	5.4%	1.0	9.5%	1.1	8.8%	0.6	3.9%
Emergency Room – Hospital	0.1	0.5%	0.1	0.6%	0.0	0.3%	0.0	0.2%	0.0	0.2%	0.1	0.5%
Residential Care Setting	0.1	0.4%	0.0	<0.1%	0.1	0.7%	0.1	0.7%	0.0	<0.1%	0.0	0.2%
Correctional Facility	0.0	0.3%	0.1	1.0%	0.0	0.4%	0.0	<0.1%	0.2	2.0%	0.0	0.2%
Treatment Modality - *Average number of encounters per WISe service month*												
Individual Treatment Services	5.6	42.5%	7.3	51.6%	5.8	57.6%	6.9	69.0%	4.7	39.3%	3.7	25.7%
Peer Support	1.8	13.6%	2.0	14.3%	0.8	7.7%	1.0	10.1%	4.0	33.1%	1.2	8.7%
Child And Family Team Meeting	1.7	12.9%	1.7	12.1%	1.3	13.0%	0.0	0.3%	1.8	15.3%	2.8	19.9%
Care Coordination Services	1.6	11.9%	0.6	3.9%	0.5	5.1%	0.9	8.8%	0.4	3.1%	4.2	29.6%
Family Treatment	1.2	8.9%	1.3	9.0%	0.5	4.7%	0.6	5.7%	0.4	3.0%	1.1	7.6%
Crisis Services	0.4	2.7%	0.4	3.0%	0.4	3.6%	0.2	1.6%	0.1	0.9%	0.4	2.5%
Medication Management	0.3	2.3%	0.3	2.0%	0.4	3.6%	0.2	2.1%	0.2	1.6%	0.4	3.1%
Other Intensive Services	0.2	1.6%	0.0	<0.1%	0.0	0.4%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Intake Evaluation	0.2	1.3%	0.2	1.7%	0.1	1.2%	0.1	1.0%	0.1	0.5%	0.1	0.7%
Rehabilitation Case Mgmt	0.1	1.1%	0.1	0.7%	0.2	2.1%	0.0	0.0%	0.1	1.2%	0.0	<0.1%
Group Treatment Services	0.1	0.5%	0.1	0.4%	0.0	0.3%	0.1	0.8%	0.1	1.0%	0.1	0.9%
Therapeutic Psychoeducation	0.0	0.3%	0.0	<0.1%	0.0	<0.1%	0.0	0.4%	0.0	0.0%	0.1	0.9%
Interpreter Services	0.0	0.2%	0.1	0.5%	0.0	0.4%	0.0	<0.1%	0.1	0.9%	0.0	0.2%
Medication Monitoring	0.0	0.1%	0.0	0.0%	0.0	<0.1%	0.0	0.1%	0.0	0.0%	0.0	<0.1%
Involuntary Tx Investigation	0.0	0.1%	0.0	<0.1%	0.0	0.1%	0.0	<0.1%	0.0	0.2%	0.0	0.1%
Psychological Assessment	0.0	<0.1%	0.1	0.5%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Co-occurring Treatment Services	0.0	<0.1%	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Engagement And Outreach	0.0	<0.1%	0.0	0.0%	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	<0.1%

Continued on next page

Continued Table 4*. WISe Service Characteristics by Region, July 1, 2014 – March 31, 2017** ***(page 2 of 2)

	STATEWIDE		Optum Pierce		Salish		Southwest		Spokane Region		Thurston Mason	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Program Totals												
WISe Clients (unduplicated)	3,421		578		50		211		191		509	
Service Months	23,723		3,893		314		1,195		1,005		3,953	
Service Encounters	311,236		57,405		5,083		19,804		15,523		54,764	
Service Encounters per Month	13.1		14.7		16.2		16.6		15.4		13.8	
Service Location - *Average number of encounters per WISe service month*												
Outpatient	5.2	39.1%	3.3	22.6%	4.5	28.0%	3.0	18.0%	7.8	50.3%	4.4	31.8%
Home	4.1	30.8%	7.1	48.1%	5.3	32.5%	5.8	34.7%	3.3	21.7%	4.7	33.6%
Other	3.1	22.8%	3.5	23.4%	4.5	27.8%	6.4	38.8%	1.6	10.1%	3.9	28.3%
School	0.8	6.1%	0.7	4.6%	1.7	10.5%	1.3	7.6%	2.2	14.4%	0.8	5.5%
Emergency Room – Hospital	0.1	0.5%	0.1	0.7%	0.1	0.7%	0.1	0.6%	0.2	1.5%	0.0	0.2%
Residential Care Setting	0.1	0.4%	0.1	0.6%	0.0	0.1%	0.0	0.1%	0.3	1.8%	0.0	0.2%
Correctional Facility	0.0	0.3%	0.0	<0.1%	0.1	0.4%	0.0	0.2%	0.0	0.2%	0.1	0.5%
Treatment Modality - *Average number of encounters per WISe service month*												
Individual Treatment Services	5.6	42.5%	5.3	36.3%	5.8	57.6%	6.9	69.0%	4.7	39.3%	3.7	25.7%
Peer Support	1.8	13.6%	3.9	26.4%	0.8	7.7%	1.0	10.1%	4.0	33.1%	1.2	8.7%
Child And Family Team Meeting	1.7	12.9%	1.8	12.0%	1.3	13.0%	0.0	0.3%	1.8	15.3%	2.8	19.9%
Care Coordination Services	1.6	11.9%	0.4	2.9%	0.5	5.1%	0.9	8.8%	0.4	3.1%	4.2	29.6%
Family Treatment	1.2	8.9%	2.3	15.6%	0.5	4.7%	0.6	5.7%	0.4	3.0%	1.1	7.6%
Crisis Services	0.4	2.7%	0.4	3.0%	0.4	3.6%	0.2	1.6%	0.1	0.9%	0.4	2.5%
Medication Management	0.3	2.3%	0.2	1.2%	0.4	3.6%	0.2	2.1%	0.2	1.6%	0.4	3.1%
Other Intensive Services	0.2	1.6%	0.0	0.2%	0.0	0.4%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Intake Evaluation	0.2	1.3%	0.3	2.1%	0.1	1.2%	0.1	1.0%	0.1	0.5%	0.1	0.7%
Rehabilitation Case Mgmt	0.1	1.1%	0.1	0.4%	0.2	2.1%	0.0	0.0%	0.1	1.2%	0.0	<0.1%
Group Treatment Services	0.1	0.5%	0.0	<0.1%	0.0	0.3%	0.1	0.8%	0.1	1.0%	0.1	0.9%
Therapeutic Psychoeducation	0.0	0.3%	0.0	0.0%	0.0	<0.1%	0.0	0.4%	0.0	0.0%	0.1	0.9%
Interpreter Services	0.0	0.2%	0.0	0.0%	0.0	0.4%	0.0	<0.1%	0.1	0.9%	0.0	0.2%
Medication Monitoring	0.0	0.1%	0.0	<0.1%	0.0	<0.1%	0.0	0.1%	0.0	0.0%	0.0	<0.1%
Involuntary Tx Investigation	0.0	0.1%	0.0	<0.1%	0.0	0.1%	0.0	<0.1%	0.0	0.2%	0.0	0.1%
Psychological Assessment	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Co-occurring Treatment Services	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0	0.0%

Engagement And Outreach	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%	0.0	0.0%	0.0	0.0%	0.0	<0.1%

DATA SOURCE: Administrative data (BHSS).

NOTES: *Due to space constraints, notes for this table are presented in a footnote on page 25*

Plaintiffs' counsel have raised concerns that regional service encounter data indicates inconsistent access to intensive services across the state. The statewide average number of monthly service hours does not indicate whether the service encounters for each region demonstrate that the full service array is being delivered consistently across the state. Class members in regions offering fewer services or a smaller percentage of therapeutic services are not receiving the intensive level of services that class members in other regions are accessing. For instance, in regions where less than half of the service modalities are substantive treatment, class members may be receiving a less intensive service array than in regions where over 85% of the service encounters are for treatment and therapy modalities.

The WISe providers across the state have all been contracted to provide the same array of services in WISe and are all required to follow the WISe program model as set forth in the WISe Manual. Starting in 2018, regions will also have additional coaching as DBHR is hiring a full time WISe system coach to increase consistent practices across the state. In addition, more analysis and consultation is necessary to ensure the full service array is being delivered in adequate amounts statewide.

Service Coordination: Care coordination has two critical components: coordination within DBHR among behavioral health providers and levels of care, and coordination with other agencies including CA, Juvenile Rehabilitation, schools, and others. This latter component is addressed in Objective 4 below.

DBHR, with system partners, reviewed requirements/protocols related to: referral to WISe, participation CFTs and transitions out of WISe. Additional work on protocols is underway. DBHR and various system partner representatives also meet regularly with RDA to review data related to service coordination.

After consultation with system partners and review with Plaintiffs' counsel in September 2016 regarding updates to the WISe Manual, the timeliness guidelines for full CANS was changed from 30 days from the CANS screen to 30 days from the first WISe service. DBHR is currently working to create a new timeliness report for BHAS that will reflect these revisions, which is being developed in consultation with the contracting agency, Praed Foundation; its subcontractor, RCR Technologies; other BHAS users, including BHO representatives; and RDA.

DBHR meets with BHO Care Coordinators on a quarterly basis. Review for updates to the protocols will continue over the next year. Additionally, BHOs are reviewing their local processes around service coordination. King County BHO is working on a protocol for contracted agencies to assist with better understanding agency coordination within the county.

WISe Outcomes: CANS data shows improvement in WISe recipients' level of functioning. This suggests that WISe is beneficial to the youth's well-being. Data gathered from

quarterly WISe dashboard reports provides information on outcomes for clinical improvements over time. The following table shows change over time in needs, risk factors and strengths for youth who entered WISe and completed an initial CANS assessment in between July 2014 and December 2016, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days).

Table 5, "Clinically Significant Improvements Over Time: Behavioral and Emotional Needs," reflects positive changes experienced over the first six months of WISe treatment for the 1,442 children and youth ages 5-20 who received an initial and follow-up CANS assessment. The top five behavioral and emotional needs, by proportion at intake/initial assessment, are shown based on the proportion of youth with an "actionable treatment need" (rating of 2 or 3 on CANS item). A decline at the time of the six-month reassessment represents improvement for these measures, i.e., a decrease in the proportion of children and youth with clinically significant treatment needs in these areas. A decline at the six-month reassessment represents clinical improvement.

Table 5. Clinically Significant Improvements Over Time: Behavioral and Emotional Needs

Top 5 behavioral and emotional needs at intake shown

Behavioral/Emotional Needs, *N=1,442*	Intake	6 Mos.
Emotional control problems	78%	54%
Mood disturbance	68%	47%
Attention/impulse problems	66%	55%
Anxiety	61%	49%
Oppositional behavior	59%	42%

Definitions of top five needs:

- Emotional Control Problems: Youth's inability to manage his/her emotions, lack of frustration tolerance.
- Mood Disturbance: Includes symptoms of depressed mood, hypermania, or mania.
- Attention/Impulse Problems: Behavioral symptoms associated with hyperactivity and/or impulsiveness, e.g., a loss of control of behaviors, ADHD, and disorders of impulse control.
- Anxiety: Symptoms of worry, dread, or panic attacks.
- Oppositional Behavior: Non-compliance with authority. (Different than conduct disorder, where emphasis is seriously breaking social rules, norms, and laws).

Other youth behavioral needs on CANS assessment that are not in the top five at intake (and not shown here): Adjustment to Trauma; Conduct; Psychosis; Substance Abuse.

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Table 6, "Clinically Significant Improvements Over Time: Risk Factors," shows the top five risk factors for youth who entered WISe and completed an initial CANS assessment between July 2014 and December 2016, and subsequently completed a six-month CANS follow-up assessment. The following chart reflects the changes experienced over the first six months of WISe treatment for 1,442 children and youth ages 5-20. The top risk factors, by proportion at intake/initial assessment, are shown based on the proportion of youth with an "actionable treatment need" (rating of 2 or 3 on CANS item). A decline at the six-month reassessment represents clinical improvement.

Table 6. Clinically Significant Improvements Over Time: Risk Factors

Top 5 risk factors at intake shown

Risk Factors, *N=1,442*	Intake	6 Mos.
Decision-making problems	59%	44%
Danger to others	44%	23%
Intended misbehavior	33%	25%
Suicide risk	25%	11%
Non-suicidal self-injury	23%	10%

Definitions of top five risk factors:

- Decision-Making Problems: Youth's difficulty anticipating the consequences of choices, and lack of use of developmentally appropriate judgment in decision making.
- Danger to Others: Youth's violent or aggressive behavior, the intention of which is to cause significant bodily harm to others.
- Intended Misbehavior: Problematic social behaviors that a youth engages in to intentionally force adults to sanction him or her (e.g., getting in trouble, suspension/expulsion from school, loss of foster home).
- Suicide Risk: Presence of thoughts or behaviors aimed at taking one's life.
- Non-Suicidal Self-Injury: Repetitive behavior that results in physical injury to the youth (e.g., cutting, head banging).

Other risk factors on CANS assessment that are not in the top five at intake (and not shown here): Medication Management; Other Self-Harm; Runaway.

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Table 7, "Strengths Development over Time: Child and Youth Strengths," shows growth in strengths for youth who entered WISe and completed an initial CANS assessment between July 2014 and December 2016, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days). The chart reflects the changes experienced over the first six months of WISe treatment for 1,442 children and youth ages 5-20. The five strengths that grew the most over the first six months in WISe services are shown, based on change in proportions of youth with "identified strength" (rating of 0 or 1 on CANS strength item). An increase at the time of the six-month reassessment represents improvement for these measures; i.e., an increase in the proportion of children and youth with noted strengths.

Table 7. Strengths Development Over Time: Child and Youth Strengths

Top 5 child and youth strengths by growth over time shown

Strengths, *N=1,442*	Intake	6 Mos.
Educational system strengths	61%	78%
Relationship permanence	61%	72%
Optimism	56%	67%
Resilience	46%	59%
Community connections	43%	54%

Definitions of top five strengths shown:

- Educational System Strengths: School works with and/or advocates on behalf of the youth and family to identify and address the youth's educational needs, or the youth is performing adequately in school.
- Relationship Permanence: Youth's significant relationships including with family members and others are stable.
- Optimism: Ability of youth to articulate a positive vision for his or her future.
- Resilience: Ability of youth to recognize his or her own strengths and use them in times of need or to support his or her own healthy development.
- Community Connections: Youth is connected to people and institutions in the community, for example through community centers, little league teams, jobs, after school activities, religious groups, etc.

Other strengths on CANS assessment that are not in the top five in terms of growth over time (and not shown here): Family; Natural Supports; Primary Care Physician Relationship; Recreation; Resourcefulness; Spiritual/religious; Talents/interests; and Vocational Strengths.

In addition, DSHS will be reviewing other outcome measures to assess the efficacy of WISe, with a report from RDA expected to be available at the end of March 2018. These measures will include indicators such as, use of emergency rooms, involvement in criminal justice system, incidence of homelessness, and use of short and long-term inpatient services.

WISe Statewide Rollout and Capacity Development: As of September 2017, 32 of Washington's 39 counties have started implementing WISe. Six of the remaining counties (Adams, Ferry, Lincoln, Okanogan, Pend Oreille and Wahkiakum) are scheduled to have WISe available in January 2018. San Juan County is scheduled to have WISe available no later than March 2018. In addition to the 48 sites currently providing WISe, 8 additional agencies have been identified and are planned to start providing WISe services by early 2018 (see Figure 2).

Figure 2. Counties with WISe Services and WISe Service Providers, as of September 2017

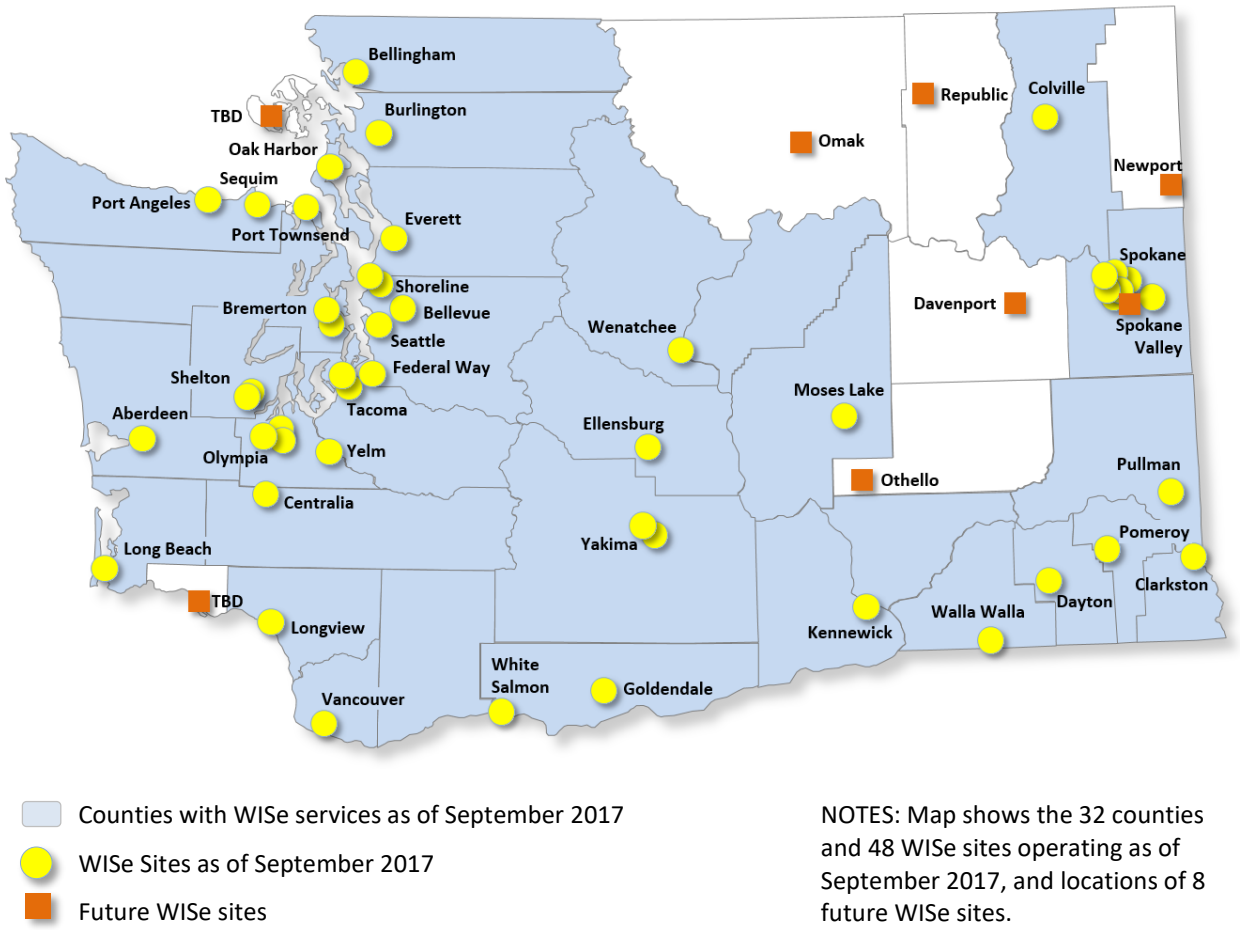

Table 8 below describes the progress of all BHOs and the Southwest Fully Integrated Managed Care (FIMC) regions have made towards the reaching the mid-level capacity targets for June 2018.

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Table 8. WISe progress to Full Implementation Capacity Targets by Region, as of September 2017 *Based on caseload counts reported directly by BHOs.*

Region	WISe Caseload September 2017 *	Mid-Level Monthly Service Target (by June 2018)	Progress to Target
Washington State Total	**1,724**	**2,985**	**58%**
Great Rivers BHO Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum	119	203	59%
Greater Columbia BHO Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	265	418	63%
King County BHO King	220	527	42%
North Central BHO Chelan, Douglas, Grant	55	90	61%
North Sound BHO Island, San Juan, Skagit, Snohomish, Whatcom	251	460	55%
Optum Health Pierce BHO Pierce	218	345	63%
Salish BHO Clallam, Jefferson, Kitsap	63	189	33%
Southwest FIMC Clark, Skamania	110	201	55%
Spokane County Regional BHO Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens	223	410	54%
Thurston-Mason BHO Mason, Thurston	200	142	>100%

NOTES: Mid-level monthly service targets reflect mid-level estimates of WISe youth projected to be served each month at full implementation. *September 2017 caseload numbers shown here were reported directly to DBHR. Due to a transition in DBHR's data collection and reporting infrastructure, administrative data on WISe services are currently incomplete after March 31, 2016.

As of September 2017, the State is at 58% of capacity needed for meeting the mid-level range implementation target. This means that statewide there is a monthly caseload capacity to serve over 1,700 youth and their families. The mid-level target is to have a monthly caseload capacity statewide to serve 3,000 youth and their families.

To meet this target, substantial increased capacity (at least 42% statewide) to serve youth and their families is needed in every region of the state with the exception of Thurston Mason BHO.

By January 1, 2018, every county in the state is scheduled to have WISe available, with the exception of San Juan. Agencies from Adams, Lincoln, Ferry, Okanogan and Pend Oreille counties started working on implementation plans with Spokane County Regional BHO this past summer. Four out the five sites have started recruiting, hiring and training staff. The last site is awaiting approval from County Commissioners and anticipate recruitment to start soon. For WISe in Wahkiakum County, Great Rivers BHO posted a Request for Proposal (RFP) and did not receive response from an interested community mental health agency. Based on this outcome, the Behavioral Health Agency associated with Great Rivers BHO will begin to cover services in the county by January 2018.

In contract as of January 2018, all BHOs and MCOs, with the exception of Thurston Mason BHO, have another required increase in their WISe capacity targets. BHOs are in the planning process for the next scheduled expansion phase. To meet the new contractual goal, some regions are hiring to bring on new teams (North Central, Optum, Salish, and Spokane County Regional BHOs). King County issued an RFP this past summer to expand capacity and will award contracts later this fall. The new King County BHO contracts will meet the mid-level capacity numbers. Catholic Community Services is currently providing WISe in Clark and Skamania Counties, and is also preparing to hire and expand the number of WISe teams. For WISe in San Juan, North Sound is meeting with community mental health agency to starting implementation plans.

DBHR will continue to monitor regional progress monthly. Statewide capacity reviews will be completed January 31, 2018, and March 31, 2018, to report our progress towards mid-level targets.

WISe Budget: Washington continues to commit funding for implementation efforts. Funds support direct services, a statewide governance structure, trainings and technical assistance, a statewide youth and family survey and the Behavioral Health Assessment System, the data base for WISe. Additionally, this past year the state supported a WISe Symposium for practitioners and system partners focused on quality improvement within WISe.

For WISe services, the Washington's actuarial contractor, Mercer, reviewed WISe encounter data to determine a Service Based Enhancement (SBE) that supports provision of WISe services. For SFY 2018, this SBE was increased from $2115 to $2721 per youth enrolled in WISe per month. This is in addition to the per member per month payment that managed care entities receive for covered lives under their responsibility.

Appropriated funding for Fiscal Year 2018 is identified in Table 9 (below).

Table 9. WISe Budget, State Fiscal Year 2018	
State	$39,902,328
Federal	$38,617,328
Total WISe Budget *(includes salaries & encounters)*	**$78,519,656**

The appropriated funding in table 9 is budgeted to provide the ramp up of services to youth and their families at the mid-level target range. The mid-level target range means 3,000 youth and their families across the state are enrolled in WISe every month.

The appropriated funding also includes the SBE for WISe provided in Fully Integrated Managed Care (FIMC) regions of the state. Currently, Skamania and Clark Counties are a FIMC region. In January 2018, Chelan, Douglas and Grant Counties will be a FIMC region. In these regions, Managed Care Organization (MCOs) receive the same monthly SBE for every youth in WISe in addition to the per member per month capitated rate. MCOs negotiate the rate with WISe providers. Starting in July 2018, the SBE for WISe will be included in the overall capitated rate and there will no longer be a separate payment for BHOs and MCOs.

Washington continues to plan a change in how it is managing the provision of Medicaid services to foster children with a single managed care organization. Coordinated Care of Washington (CCW) will provide integrated physical and behavioral health coverage to foster children. Ensuring ongoing access to WISe services for children and youth in state custody continues to require additional planning as the payment shifts from regional BHOs to a single managed care organization. This will include continued planning meetings with Health Care Authority (HCA), CA, CCW and DBHR regarding the transition of service benefits scheduled for October 2018. Currently, CCW provides physical health (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care children and youth. In October 2018, CCW will begin to provide the full continuum of outpatient mental health benefits including WISe. CWW will receive a capitated rate and will contract directly with WISe providers.

AI/AN WISe Fee-for-service: In July 2017, Fee-for-service (FFS) for mental health services was established specifically for American Indians and Alaska Natives (AI/AN). FFS is for clients who are not served in managed care receive services through the Medicaid fee-for-service program, where HCA pays providers directly for each service they provide. Federal law makes American Indian/Alaska Natives voluntary and they are exempted from managed care. They may choose to opt into BHO or MCO services.

Fee-for-service contracts are through HCA with agencies who are qualified and elect to participate. FFS agencies providing WISe are reimbursed for each service provided under WISe. In addition these agencies receive case rate. The rate was established by Mercer and

reviewed by DBHR fiscal and budget staff. The case rate is set at $1,338.38 per youth per month enrolled in WISe. This case rate is in addition to the reimbursement for each service provided to AI/AN youth enrolled in WISe. The case rate and the reimbursement for FFS would be comparable to the rate established in the PIHP and FIMC contracts.

WISe Screens are completed by staff at the FFS WISe agencies. DBHR is in the process of finalizing the AI/AN Referral list and will post on the DBHR website in addition to disseminating through distribution list. In addition, two staff at DBHR are available to provide WISe screens and referrals. Direct link to the AI/AN provider map can be found at: Fee-for-Service Providers as of October 2017

Additional information is available on the DBHR website at: https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/contractors-and-providers "For Fee-for-Service Treatment Providers."

Objective 3 - Remaining Tasks:

- Review regional service encounter data variations regarding number of service encounters, modalities, and locations.
- Continue to build sufficient provider capacity and address workforce challenges to meet the statewide need for WISe services by June 30, 2018. (See Section III, Implementation Challenges, WISe Roll Out)
- Continue to post on the DBHR website, the list of qualified WISe providers by county.
- Continue to monitor capacity/utilization through fiscal reports and the BHO bi-monthly monitoring reports.
- Continue to collect and analyze outcome measures of performance for children and youth who have received WISe services.

Objective 4: Coordinating Delivery of WISe across Child-serving Agencies

Coordinate delivery of WISe services across child-serving agencies and providers

Progress and Accomplishments:

DBHR Coordination: System partners need concrete descriptions to identify youth and children for referrals, as well as system-specific indicators based on the proxy class (Appendix – to the Settlement Agreement). It is anticipated that the adoption of system partner protocols will also increase the number of referrals from other sources. DBHR is drafting WISe "framework" protocols for the education system, county probation, substance use disorder treatment agencies and for those working with homeless youth. These protocols will be completed by February 2018 and shared with system partners. These local systems and agencies may choose to adopt the protocols as a way to support better service coordination for WISe. CA is in the final stages of completing an

administration wide policy for WISe. Juvenile Rehabilitation is drafting a WISe protocol for their staff.

Work in the coming year will also include planning meetings with HCA, CA, CCW and DBHR to guide the transition of service benefits scheduled for October 2018. Currently, CCW provides physical health (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees. In October 2018, CCW will begin to provide the full continuum of outpatient mental health benefits including WISe. CWW will contract directly with community providers for mental health services that are currently provided through contracts with BHOs and other MCOs.

Children's Administration: Over the course of the last year, the **Children's Administration (CA)** continued a focused effort on training and support for their staff. CA offered mental health trainings for new and ongoing staff with a total of 33 Regional Core Trainings and five In-Service Trainings reaching over 312 staff. The In-Service trainings were offered in Kelso, Mount Vernon, Tacoma, Ellensburg and Spokane.

Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of child(ren) from their home, placement stabilization and prevention and reunification or placement into a permanent home. The annual statewide FTDM facilitators meeting included WISe information with more than 35 FTDM facilitators in attendance. As of October 2017 CA implemented a new WISe policy which supports the identification and referral of children with complex behavioral health care needs to WISe. (Please see below for policy update.) CA HQ staff are available for technical assistance with the FTDM supervisors and facilitators.

WISe information was shared with the statewide Supervisors conference with 260 individuals in attendance. Those supervisors are able to provide guidance and direction on how to ensure WISE is appropriately offered and provided to youth in CA services Updates from CA were given to relevant staff on the WISe information sheet developed for staff working in child welfare.

Behavior Rehabilitation Services (BRS) is a temporary intensive wraparound support and treatment program for youth with high-level service needs. BRS is used to stabilize youth **(in-home or out-of-home)** and assist in achieving their permanent plan. BRS services are intended to: 1) safely keep youth in their own homes with wraparound supports to the family; 2) safely reunify or achieve alternative permanency more quickly; 3) safely meet the needs of youth in family-based care to prevent the need for placement into a more restrictive setting; and 4) safely reduce length of service by transitioning youth to a permanent home or less intensive service. There is ongoing communication on WISe updates with staff BRS contractors and Regional CA staff regarding implementation, information sheets and updated WISe referral contact lists. In conjunction with the WISe rollout schedule, when WISe is newly implemented in a county, CA provides a targeted dissemination of the CA WISe Information sheet to regional staff.

Currently all CA offices and over 2,000 workers have received CA WISe information sheet directly via e-mail attachment or a hard copy handout. There is in-person consultation with statewide BRS managers to understand local WISe implementation strengths and challenges. Ongoing implementation support is provided to BRS Contractors and CA offices regarding WISe referral requirements, BHO contacts, and overall information when WISe is newly implemented in a county.

CA provided ongoing regional and headquarters level consultation and collaboration on WISe implementation, notably WISe rollout in two major counties in Washington State with Spokane and King Counties in 2017.

CA completed an internal small sample targeted case review (N=60) to determine the potential reasons of the referral outcome for CA's BRS when children and youth meet positive screening algorithm criteria for WISe program. Based on observations made since the beginning of WISe implementation, the case review provided lessons learned and supported two assumptions: 1) in the regions and counties where WISe was neither implemented nor available due to capacity; BRS was utilized to meet the youth's immediate needs and 2) in the regions and counties where WISe was available, facility-based BRS provided around the clock supervision for youth who required a more intensive level of care and the child's needs could not be safely met in a less restrictive environment. CA will continue to train both upstream and downstream programs for early identification and referral for screening. CA will explore with DBHR to look at differences and/or local resources, preferences and practices in the screening process that may be influencing WISe versus BRS referrals in two targeted areas. Between October 2016 and January 2017, visits were completed by CA headquarter staff with six field offices and participated in staff meetings to discuss mental health services, including access to WISe and participation in CFTs in Vancouver, Shelton, Bellingham, Mt. Vernon, Spokane, Wenatchee.

Plaintiffs' counsel have repeatedly expressed concerns about the youth who screen positive for WISe, but who are placed in BRS facilities instead. The CA case review discussed above did not allay those concerns. Plaintiffs' counsel have also expressed concerns regarding whether youth who are placed in BRS placements are receiving the intensive mental health services they need. Plaintiffs have requested a data analysis from the state regarding this issue.

CA developed a WISe policy rollout that we anticipate being implemented in the fall of 2017. This policy addresses WISe referrals and screens with the goal of improving consistency of CA practice around the state. Plaintiffs have expressed concerns regarding the level of detail and scope of this policy, and will continue to work with the State to improve it and address implementation issues that may arise.

An electronic WISe Quick Tip was distributed to all CA employees. Quick Tips are brief communications on policy or practice that pop up automatically on staff computers. Quick Tips are designed to highlight practice or policy, provide hyperlinks to policy or practice tools for deeper awareness about the topic that then supports continuous quality

improvement. The WISe Quick Tip included links to DBHR's WISe Implementation site and CA WISe Information Sheet.

Additional efforts CA will undertake in the coming months**:**

- CA will finalize the new policy related to referral to WISe, participation in CFTs, and transitions out of WISe, work to implement the policy, and continue to work with Plaintiffs on needed improvements.
- CA will evaluate any changes needed to the BRS and WISe Manuals relating to adoption of the new policy.
- CA will develop a plan for initial and ongoing implementation of the new policy.
- CA will review data to assess the intensive mental health services being provided to youth in BRS placements.

Health Care Authority: **Health Care Authority** reports the following activities in the Southwest Fully Integrated Managed Care region (Clark County and Skamania County) to ensure consistent delivery of WISe over the past year:

- MCOs continue to work collaboratively with the WISe provider, Catholic Community Services (CCS), and the Behavioral Health Administrative Services Organization (ASO) to ensure the community is aware of the expanded availability of WISe.
- The MCOs continue to contract with all the behavioral health providers that had been serving youth and families before the transition, to ensure stability and a full range of behavioral health services for both providers and families. In addition to contracting with the providers that previously were under contract with the regional support network, the MCOs each had their own network of behavioral health providers as well, thus creating increased choice for clients.
- The MCOs are working closely with the ASO, Beacon, who manages the crisis system in the region. The MCOs provide lists of the WISe participants to Beacon, so that when a youth is in crisis, the crisis staff can make sure they connect the youth with their WISe team, who is knowledgeable of the youth and families' individualized crisis safety plan.

In the North Central region, which includes Chelan, Douglas and Grant Counties, substantial effort is underway between the BHO, MCOs, ASO, and HCA, in partnership with DBHR, to prepare for the January 1, 2018, transition. This includes participating in the WISe Symposium and developing processes between the MCO and the ASO for crisis contracts, and being knowledgeable of the requirements of WISe and having policies and procedures in place for their staff. MCO's in North Central will receive specific information about clients being served by WISe to ensure continuity of care at the time of transition. The region is participating in knowledge transfer meetings where MCOs learn from BHOs and HCA about new or priority programs. In the most recent knowledge transfer meeting in September, 2017, DBHR accompanied HCA to consult with all of the WISe providing agencies in the region and MCO's to ensure that protocols, procedures, roles, and responsibilities of agencies, DBHR, HCA, and MCO's are clear.

HCA continues to review and approve or develop client handbooks, letters, and other templates. HCA participates in training and technical assistance on WISe for new MCOs entering integrated care contracts.

Juvenile Rehabilitation: **Juvenile Rehabilitation Administration (JR)** has completed a number of activities to increase the use of WISe over the past year. Effective July 1, 2017, access to WISe and other community behavioral health services was increased as a result of an established agreement with Sea Mar to provide Medicaid enrollment services to institutionalized youth, and an MOU with HCA that allows services for enrolled youth to be activated thirty days prior to release. JR and HCA are implementing process changes in the fall of 2017 that will allow Medicaid enrollment to be suspended, instead of terminated, for youth who are admitted to a JR institution. JR and HCA anticipate in the winter of 2018, a practice to suspend rather than terminate Medicaid coverage will be fully implemented. This will allow coverage verification to be maintained for youth who are enrolled at intake, and can facilitate an 'enroll and suspend' process with Sea Mar that allows coverage verification to be established earlier in a youth's residence in an institution. These changes enhance WISe team engagement opportunities with youth and their families prior to the youth's release and facilitate connections to community-based services immediately following release.

JR is in the process of implementing a Medicaid/WISe eligibility and referral protocol and integrating the process in to the agency's Automated Client Tracking System (ACT), to be fully implemented in January 2018. The protocol will also address participation in Child and Family Teams, Community Collaboratives and transitions out of WISe. JR has also established inclusion of WISe Practitioners in Reentry Team Meetings (RTM) with youth who have been referred, and used Intake and Release RTMs to educate youth and families regarding WISe and other behavioral health services. This change ensures all youth eligible for WISe services will have the option to receive them the month prior to release to allow for successful transition to familiar and youth/family informed community based services.

In addition to increasing WISe awareness and opportunities for access, the RTM process JR has implemented over the last three years is based on Wraparound principles, and RTMs further support the needs and goals identified in the TR lawsuit. RTMs were adapted from the Family Team Decision Making (FTDM) process in collaboration with CA. JR will continue to place a high priority on establishing external connections with system partners and community stakeholders in support of youth and family-driven, strength-based services that support successful reentry from JR residential programs and increased access to community-based services.

Additional efforts JR has undertaken in the last year to promote WISe include:

- The Clinical Director met with BHO Coordinators statewide to discuss WISe eligibility, referral protocol and coordination.

- WISe Training Webinar has been included as a required training in the JR Training Standard, which is part of Policy 4.10, Developing Youth and Their Families.
- Continued participation in System Partner role as part of state-wide FYSPRT Tri-Lead.

Additional efforts JR will undertake in the coming months**:**

- Will incorporate information regarding WISe services in to family information packet and youth intake information in the fall of 2017.
- Regional JR offices will establish or strengthen relationships with local FYSPRTs. Coordinators in JR's three regions are in regular contact with BHOs and FYSPRTs within their region. Given the recent Medicaid enrollment enhancements for JR youth in institution, coordinators will make contact with each BHO before the end of September to inform them of the change in process and to identify with them best practices for making referrals as early as possible.
- JR coordinators, reentry liaisons, program leaders and clinicians will receive in-person training on November 15, 2017. This includes approximately 20 staff. This will be follow-up to similar training provided to this group in 2015. The training will be recorded and available for leaders and clinicians at a later time.
- All case-carrying JR counselors will complete a web-based training by the end of 2017. The training will be incorporated in to New Employee Orientation in the fall of 2017. To date, 40 JR personnel have viewed the web-based training.
- The JR Clinical Director is a contracted WISe trainer with the WSU Workforce Collaborative. The Clinical Director will continue to leverage knowledge and networks associated with this work in the service of optimizing WISe utilization among eligible class members supported by the agency.
- JR will finalize new protocol related to referral to WISe, participation in CFTs, and transitions out of WISe.
- JR will develop a plan for initial and ongoing implementation of the new protocol.
- JR will work to develop a protocol/plan to address the needs of county probation youth.
- JR and HCA will implement and monitor practice to ensure youth who are admitted to a public institution or JR institution remain enrolled in Medicaid with coverage of services suspended instead of terminated and that suspension be released as soon as the youth is no longer in that institution.

Developmental Disabilities: **Developmental Disabilities Administration (DDA)** continued to actively support related activities outlined in the T.R. Settlement agreement throughout 2017 by working collaboratively with youth, families, stakeholders, contracted providers, and other DSHS administrations to deliver coordinated person centered services to our clientele.

DDA offers positive behavior support (PBS) as a service option for individuals enrolled on the five DDA waivers including: Basic Plus, Children's Intensive In-Home Behavior Support (CIIBS), Individual and Family Services (IFS), the Core and Community Protection waivers. When behavioral health supports are not available to individuals under the state plan or private insurance, the DDA may authorize PBS to those youth. In September of 2017, the Centers for Medicare and Medicaid Services (CMS) provided clarifying guidance that waiver funding may not be authorized to use PBS unless the behavioral health need cannot be met using state plan or private insurance benefits. PBS is a service that addresses many of the same needs that state plan Medicaid benefits address. Applied Behavioral Analysis (ABA) is one of those benefits that are available in the state plan that meet the behavioral health needs of young people with developmental disabilities. Families will need to access behavioral health supports such as ABA or other state plan benefits prior to being authorized for PBS. WRAP is the DDA term for the wraparound services provided by their providers. In 2017, DDA offered WRAP and advanced WRAP training for 18 case managers whose clients are enrolled in WRAP services. Many individuals who receive WRAP services through the waiver as a component of PBS will or may be eligible for WISe services. We anticipate that this clarifying guidance from CMS will result in additional youth being referred, screened, and receiving WISe in place of WRAP. The WISe Team and DDA waiver team meet twice monthly to discuss coordination of services. DDA also meets with HCA regularly to discuss ABA trends and coordination of services.

In 2017, DDA provided guidance and direction to the field about WISe services. DDA published Management Bulletin D17-021. This bulletin provides guidance for case managers when referring a client to WISe services and when they participate in CFT meetings. It also includes a copy of the WISe county referral guide and informative flyer case managers can share with DDA youth and family members. The bulletin has been distributed to all DDA staff and posted on DDA's external website. The bulletin will be updated to provide clarification of the WISe referral process to include information that case managers will provide clients the resources to set up a WISe screen. It will also be updated to say that case managers are encouraged to participate in the CFT meetings.

Behavioral Health Organizations and contracted WISe agencies: **Behavioral Health Organization staff and their contracted WISe agency staff** continue to be critical system partners. The BHO contributions during implementation, and their sharing lessons learned has been essential to our building success. Each BHO is required to have one Performance Improvement Plan (PIP) specific to children's services; these PIPs must also reflect the Washington State Children's Behavioral Health Principles[4]. In 2014, to assist with infusing the Children's Behavioral Health Principles in the delivery of care, DBHR began to review and approve these PIPs to make them more meaningful.

[4] Key components of the principles are included in WISe, CANS assessment, and the CFT meetings. For a list and description of the principles, see https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WA%20State%20Children%27s%20BH%20Principles.pdf

- All PIPs are justified on the basis of clearly-identified needs and are relevant to the Medicaid population, include input from BHOs regarding the selection of the topic, and focus on a high-volume or high-risk population.
- BHOs must develop PIPs with a measurable outcome within three to four years; DBHR approves all PIP topics prior to BHO implementation.
- BHOs are to demonstrate that their PIP addresses barriers identified by a root cause analysis or other recognized Quality Improvement process.

BHOs are updating their Children's PIPs and the updated PIPs are sent to the DBHR Contract Manager and to the Children's Team for review. Examples of PIPs include:

- Increase in Access to Treatment for Children Residing in Rural, Underserved Areas As a Result of School-Based Outpatient Services .
- Adopting the Washington State Children's System Principles and Core Practice Model to Improve the Penetration Rate of Child and Family Team Participation for Medicaid Children Ages 0–20.

Objective 4 - Remaining Tasks:

- Continue to promote Washington State Children's Behavioral Health Principles service delivery beyond WISe and in local and regional policy development through the Family, Youth and System Partner Roundtable (FYSPRT) governance structure.
- DBHR and CA will continue to review BRS and WISe materials annually to ensure clear guidance for identification and referral for WISe, participation on CFTs and coordination of care.
- Review data regarding youth who screen positive, for WISe but do not receive WISe services, to evaluate systemic barriers to access that should be addressed, in particular with youth in CA and JR.
- Continue to refine the process to provide access and services to youth jointly served by BRS and mental health agencies consistent with WISe and the Access protocol.
- Finalize development of policies or protocols with system partners related to referral to WISe, participation in CFTs, Community Collaboratives and transitions out of WISe and a plan to ensure implementation.
- Develop plan to ensure ongoing cross-system training and technical assistance on the implementation of CANS and WISe for agencies and providers of child-serving agencies.
- Draft framework protocols for education, substance use disorder, county probation and homeless youth to be completed by February 2018. Work with HCA, CA and CCW to ensure CCW is prepared to implement WISe services for foster youth.

Objective 5: Workforce Development and Infrastructure

Support workforce development and infrastructure necessary for education, training, coaching, supervision, and mentoring of providers, youth and families.

Progress and accomplishments:

WSU Behavioral Workforce Collaborative: This past year, the Washington State Behavioral Workforce Collaborative was contracted to provide training, coaching and technical assistance for WISe across Washington State. In late 2016, the Workforce Collaborative completed a needs assessment for each region of the state to determine the anticipated frequency and demand related to training needs for each of the ten regions across the state. Table 10 below provides an overview of the number of WISe staff trained during the 2016-17 contract year by region.

Table 10. Workforce Collaborative WISe trainings, September 2016 - August 2017

Region	number of trainings	number of staff trained
Washington State Total	**16**	**320**
Great Rivers	1	11
Greater Columbia	2	55
King County	2	37
North Sound	4	78
Optum Pierce	2	52
Salish	1	4
Spokane	2	60
Thurston-Mason	2	23

Across the state a total of **320 people have been trained in WISe since October 2016**. Of those trained, most were Care Coordinators, Therapists, Family Partners, or "other" (supervisors, program managers, etc.). There were 30 Youth Partners trained during these trainings, which was triple the number of the previous reporting year. Supervisors were also trained during these trainings.

Since 2014, **1,406 individuals** have received direct training on WISe through contracts with Portland State University and Washington State University. Each region has been provided with registration materials, training materials, tri-led trainers and an opportunity to participate in the training delivery.

Seven WISe Youth and Family Certified Peer Counselor trainings were provided since November 2016. Table 11 provides an overview of the number of WISe staff trained during this contract year, by region and role; this table also includes the number of non-WISe staff trained during this contract year.

Table 11. Workforce Collaborative Peer Counselor trainings, November 2016 - July 2017

Region	Youth Track	Family Track	WISe Team Members	Non-WISe staff	Total Trained
Washington State Total	**59**	**90**	**87**	**61**	**148**
Great Rivers	12	16	18	10	28
Greater Columbia	8	12	12	8	20
Lower Elwha	0	10	2	8	10
North Sound	6	12	8	10	18
Optum Pierce *(2 sessions)*	24	28	37	15	52
Spokane	8	12	10	10	20

A total of 148 people participated in the Youth and Family Certified Peer Counselor trainings between November 2016 and July 2017. Of those trained, most were primarily WISe (59%) staff, although participants did include non-WISe members (41%) who also work in youth and family roles but not on a WISe team. Among those participants trained, roughly 40% of them attended the youth track. This is a great achievement in the area of WISe and Peer Support, with a 30% increase in youth trained peer counselors from last year.

YouthSound hosted two Youth Professional Leadership trainings and launched a coaching pilot for participants with a total of 28 youth peers, including 18 WISe Youth Partners. The primary goal of youth professional leadership coaching is to foster the leadership capacity of youth professional leaders in Washington State. While professional development is the primary goal, participating coaches and organizations will benefit from the experience, knowledge, perspectives, and insights that youth professionals are uniquely able to contribute. Specific outcomes and objectives are determined collaboratively between the participating youth professional and the coach. The primary focus is for youth professionals to be able to apply with confidence the principles of adaptive leadership as a leader in youth-serving systems. For example, one participant shared, "The training has changed the way I talk with my co-workers. I'm more confident and I'm not as confrontational when I feel like my role is misunderstood."

The Workforce Collaborative has been working closely with the regions to identify staff available and interested in participating in the "train the trainer" training and model. There are approximately 20 agency staff and BHO representatives who have expressed interest in participating in the model. North Sound and King County have staff who have participated in past the "train the trainer" and have provided staff to participate as part of the training. An additional "train the trainer" session is planned for spring 2018.

To provide ongoing support directly to WISe practitioners, monthly coaching calls started in January 2017. The design of the coaching model is to provide an opportunity to exchange knowledge, offer skills and to build the statewide capacity and awareness of our instate expertise on the WISe model. Coaching call topics are responsive to requests from the field, and have included: transition planning, clarifying WISe team member roles, engaging community team members, and operationalizing peer support. In early 2018

affinity led coaching calls will be available: this will offer separate calls for care coordinators, mental health therapists, youth peers and family peers.

The Workforce Collaborative and its training team also provides individualized technical assistance to each region. This includes the development of regional needs assessments, Regional Training plans, in-person site support, and telephone and email correspondence as well as participation with groups such as Community Connectors and presenting at their annual conference. For example, in May and August 2017 the Workforce Collaborative provided in-person technical assistance to the North Central BHO and their newest provider in Moses Lake, Grant County Integrated Mental Health. Outcomes of this technical assistance include supporting a training on safety related precautions for community based practitioners with a special focus on crisis response, as well as linking North Central BHO with the UW EBPI to access additional training for their mental health counselors.

Work for the coming year includes further development of the "train the trainer" model, further development of the coaching calls which will expand and celebrate statewide expertise, to design and collaborate with other entities to provide increased skills to the workforce and to continue to support the WISe workforce statewide.

Additional WISe training: In addition to trainings provided by the Workforce Collaborative, DBHR supports additional trainings to support WISE.

This past year, based on outcomes on the Quality Service Review (see Objective C below) and feedback back from various stakeholders, DBHR determined the previously required online CANS training was not sufficient to result in WISe regularly using that data to inform client and system level improvement. As a result, investment has been made providing in-person training on CANS provided by Praed and Chapin Hall in all 10 BHO/FIMC regions for 2017 and 2018 as well as in-person CANS/BHAS data training.

The Evidence Based Practice Institute (EBPI) at University of Washington has been funded by DBHR for several years to provide training and consultation to increase the use of evidence and research based practice in child and adolescent mental health. This year, EBPI has increased its focus on the use of evidence and research-based practices as part of the service array offered by WISe. EBPI created a reporting guide that tracks the use of ERBP's among youth mental health providers and will track use in WISe settings.

WISe Symposium: In July of 2017, DBHR sponsored a **WISe Symposium** in Yakima. The purposes of the Symposium were to:

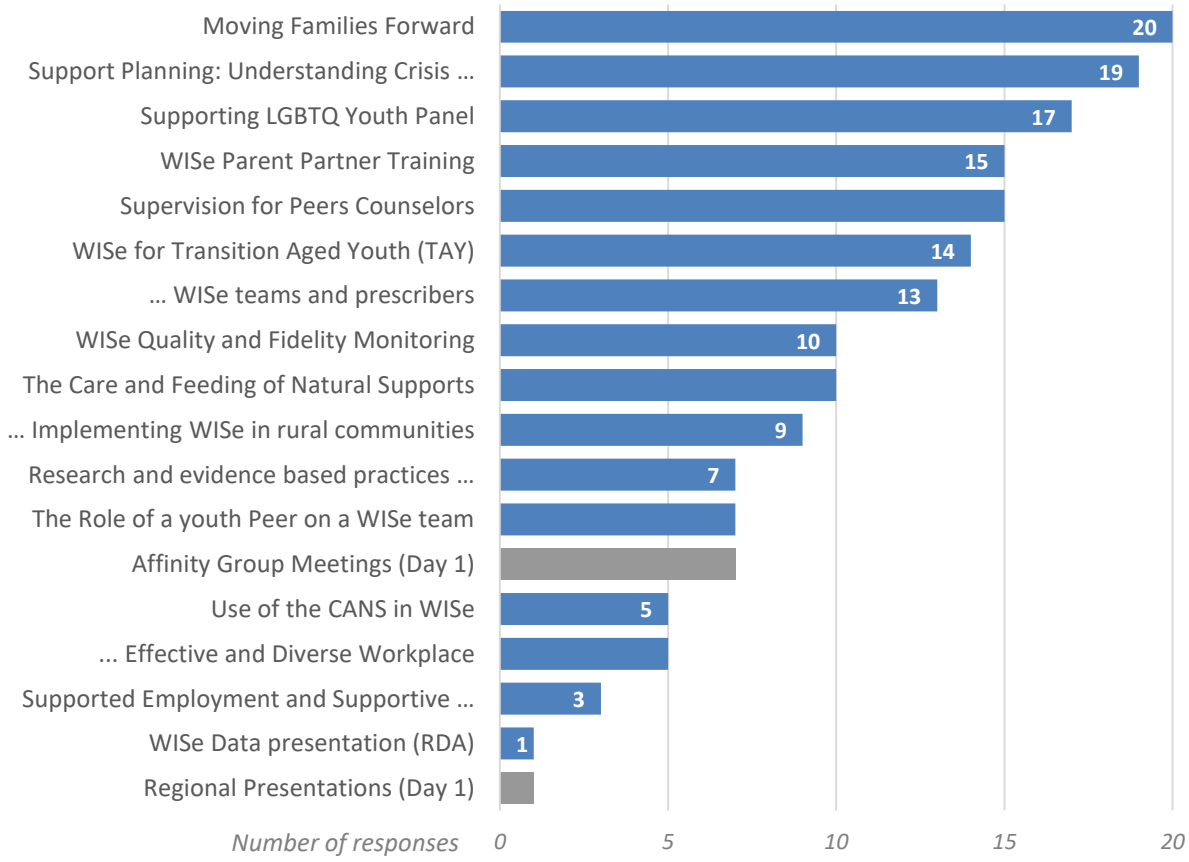
1) Celebrate successes.
2) Share experiences including what worked and what caused problems from the perspective of WISe providers.
3) Provide training and technical assistance from the state to ensure the core common elements of WISe are being delivered with consistency in all areas of Washington.

The Symposium was attended by approximately 265 WISe team members. DBHR partnered with BHOs to identify those who should attend the event and used Systems of Care grant and state funds to provide lodging and travel support for people who attended. The Symposium offered a number of interactive workshops on topics related to implementing WISe as well as opportunities for WISe teams to interact with others doing similar work around the state.

A participant evaluation conducted at the end of the Symposium asked participants to rate the conference using five point scale, with higher ratings denoting more positive. The majority of WISe Symposium participants who completed evaluations rated the conference highly; averages for each item ranged from 3.75 to 4.04. When asked which session from the Symposium will be most helpful in their future work, most respondents identified one of the breakout sessions from the second day (sessions from day two are shown with blue bars in Figure 3 below).

Figure 3. WISe Symposium 2017 Session Ratings from Participants

Participants were asked "Which session did you attend that will help you most in the future with your work goals?" *(Titles of some sessions are shortened due to space limitations.)*



Prior to the Symposium, DBHR and the other state system partners hosted a System Partner meeting to promote collaboration between local and state agencies that provide referrals and benefit from WISe; about 70 people attended the Partner meeting.

A large number of participants in both the Partner Meeting and Symposium reported that they benefited from attendance and suggested holding a similar event in 2018. DBHR is currently partnering with BHOs and regional family representatives to plan the 2018 year event. It is the intent of DBHR to open the Symposium to all WISe team members and offer a limited number of 'scholarships' for travel reimbursement while offering the symposium to WISe team members free of charge.

As noted in the section above, system partners have included WISe materials in their trainings, management bulletins, and other workforce development efforts. Some of these efforts include: HCA supports and participates in training and technical assistance on WISe for new MCOs entering integrated care contract. HCA and DSHS are providing knowledge transfer sessions with new MCOs which includes information on WISe. CA offers ongoing mental health trainings for new and permanent staff which includes a training component on WISe. JR will be updating the WISe webinar currently available to staff; all case-carrying staff will complete the new web-based training by the end of 2017. In collaboration with DBHR, JR is offering in-person training this fall. DDA has disseminated a Management Bulletin and will update to provide more information about the WISe referral process. DSHS and HCA will continue to refine training materials and identify new ways to collaborate. One key efforts is to consider expanding training strategies through the Workforce Collaborative, who oversees WISe training and technical assistance for the state.

Objective 5 - Remaining Tasks:

- The Workforce Collaborative will refine the existing WISe "train the trainer" session.
- The WISe coaching model developed in early 2017 will continue to be implemented.
- Continue to evaluate training curriculum; the Workforce Collaborative will continue to oversee contracting for training evaluation.
- Workforce development will be an ongoing agenda item at FYSPRT and TRIAGe meetings.
- DBHR will continue to consult with a national consultant to identify statewide and regional priorities and strategies to support increased workforce recruitment and enhanced service capacity.
- DBHR is hiring a WISe coach and will continue consultation with a national expert to identify ways to improve the coaching and training model.

Objective 6: Maintaining Collaborative Governance Structure

Maintain a collaborative governance structure to achieve the goals of the agreement.

Progress and accomplishments:
Family, Youth and System Partner Round Tables (FYSPRTs), part of the Children's Behavioral Health Governance Structure (Governance Structure), are designed to influence the functioning of regional and state child-serving systems. FYSPRTs promote proactive changes that will improve access to, and the quality of, services for families and youth with complex behavioral health challenges, and the outcomes they experience. FYSPRTs are grounded in the Children's Behavioral Health Principles and provide a forum for regional information exchange and problem solving, as well as an opportunity for identifying and addressing barriers to providing comprehensive behavioral health services and supports to children and youth.

Ten Regional FYSPRTs continue to be maintained across Washington with state funds. In July 2017, the Division of Behavioral Health and Recovery (DBHR) worked with Behavioral Health Organization (BHO) Children's Care Coordinators to update the contract language to a yearly cycle of deliverables, including an annual needs assessment, five-year strategic plan and work plan for the contract year, as outlined in the Regional FYSPRT Manual.

Regional FYSPRT activities during this reporting cycle include:

- Continue to update Regional FYSPRT websites and share website link information with DBHR and the Behavioral Health Workforce Collaborative.
- Continue to outreach to families, youth and system partners to build and maintain a Regional FYSPRT membership that includes at least 51% youth and families with other members representing the BHO, community system partners, and other relevant stakeholder groups from the community.
- Completion of an annual needs assessment to inform any needed updates to the five year strategic plan and develop a work plan to inform activities for the remainder of the contract year.
- Continue to meet on a monthly basis to discuss regional concerns, propose solutions, and improve coordination.

A few challenges have emerged as the Regional FYSPRTs have developed in the ten regions:

- Recruiting and sustaining family and youth Tri-Leads.
- Family and youth participation to meet the goal of 51% family and youth membership.
- Tribal engagement.

To address these challenges, technical assistance continues to be offered to the Regional FYSPRTs/BHOs. YouthSound, a youth-led program within the Workforce Collaborative, is contracted to provide technical assistance for youth engagement, voice and leadership. Washington State Community Connectors (WSCC), a family-run organization, is the contractor for the Washington State Children's Behavioral Health Statewide Family

Network and continues to provide technical assistance for family engagement, voice and leadership. In addition, YouthSound and WSCC provide activities that engage youth and family in activities that prepare them to be leaders in the Children's Behavioral Health system, including workforce preparation.

The Workforce Collaborative completed two Youth Professional Leadership trainings. The Youth Professional Leadership trainings are intended to support youth professionals, including Youth Partners working on WISe teams, Regional FYSPRT Youth Tri-Leads and other youth professionals, to support and further build their capacity as leaders. This is accomplished through interactive modules and is based on the curriculum of the Washington State Leadership Academy. Topics covered include: what is leadership, mental models, formal and informal authority, adaptive and technical challenges, and reset. Coaching on applying these skills in real life situations will be provided through the end of September 2017 to training attendees.

The Statewide FYSPRT meets on a quarterly basis. At the November 2016 Statewide FYSPRT meeting, an updated Statewide FYSPRT Charter was reviewed and approved. The updated Statewide FYPSRT Charter is available online at https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/MentalHealth/Statewide_FYSPRT_Charter.pdf

At the March 2017 Statewide FYSPRT meeting, regions shared information about how WISe is working in their area. Most regions indicated that dialogue about WISe implementation is happening at the Regional FYSPRT level, including having teams that analyze and review data regularly or having youth and families receiving WISe services attending the Regional meeting. Most regions also identified inaccuracies or glitches with the Behavioral Health Assessment System (BHAS) data. As part of follow up to this meeting, the WISe Dashboard along with a link to the Healthy Youth Survey, and summaries of the Youth and Family Survey and Quality Service Review were sent out to membership to gather and review data relevant to their regions. Dialogue and technical assistance around data and BHAS was added to the monthly Regional FYSPRT Coordinator calls as an ongoing topic for information sharing and support.

For the May 2017 Statewide FYSPRT meeting, the Statewide FYSPRT Tri-Leads requested that membership submit completed Challenge and Solution Submission Forms, a briefing template approved by the Statewide FYSPRT membership for communication from the Regional FYSPRT to the Statewide FYSPRT and when indicated, to the Children's Behavioral Health Executive Leadership Team (ELT).

At the May meeting, membership participated in an activity to prioritize which challenge would be focused on for the next Statewide FYSPRT meeting. The group voted to prioritize the challenge regarding lack of availability of respite care. The Statewide Tri-Leads then worked with the region submitting the challenge to develop questions to send to the Statewide FYSPRT membership to gather information to share resources and solutions and/or to move the challenge forward to the ELT. At the August 2017 Statewide FYSPRT meeting, after sharing information gathered from the regions and state system partners,

the members present voted to move the challenge regarding respite care forward to the ELT. A briefing form summarizing the information presented at the August meeting has been drafted and approved by the Statewide FYSPRT Tri-Leads. The briefing form has started routing through DBHR leadership as part of preparation to add this topic to an ELT agenda.

Different members of the ELT have attended Statewide FYSPRT meetings during the past year including Assistant Secretaries from Rehabilitation Administration, Behavioral Health Administration, DDA and CA. This is in alignment with the ELT Charter which identifies that one ELT members will attend the Statewide FYSPRT meeting to create a connection and line of communication between these levels of the Governance Structure. Statewide FYSPRT Tri-Leads have also attended ELT meetings to highlight what is working well in the Regional FYPSRTs and what challenges are being addressed in the regions, in addition to sharing WISe success stories and FYSPRT system change or system improvement stories. At the July 2017 ELT meeting, Regional FYSPRT Tri-Leads were also invited to share a WISe success story and FYSPRT system change or improvement story from their region.

DBHR has recently collected templates from all ten regions outlining how each community is linking with the Governance Structure, around barriers and solutions expressed at CFTs. After identifying barriers or solutions at the CFT level, they will then take the following steps to determine:

1) Whether the solutions found by CFTs could benefit others.
2) Whether the community can find solutions for barriers experienced across CFTs in their region.
3) Whether there are barriers the community is unable to resolve.

If the community is unable to resolve the barrier, then linkage to the Regional or Local FYSPRT occurs to problem solve. Solutions found can also be shared at the Regional or Local FYSPRT to facilitate sharing solutions across the state.

The intent of this objective is to further establish meaningful partnerships between family, youth, and system partners throughout the state at every level of the child-serving system. Through the identified strategies, family, youth, system partners and providers will have the opportunity to work together cooperatively and collaboratively to build a delivery system with effective services and supports for youth and families across the state.

<u>Objective 6 - Planned activities for the coming year</u>:

- Continue to review and approve BHO reports and other deliverables summarizing Regional FYSPRT progress on contract requirements.
- Maintain similar Regional FYSPRT contract language in the BHO contracts and with the Fully Integrated Managed Care regions to ensure consistent language and deliverables across the state.

- Continue to promote and refine the process for the Regional and Statewide FYSPRT to bring challenges forward to the Executive Leadership Team and receive timely responses.
- Move forward the briefing form regarding respite services to the Executive Leadership Team and provide a response and/or next steps back to the Statewide FYSPRT.
- Continue to support activities through the contractor for the Washington State Children's Behavioral Health Statewide Family Network to promote family engagement and leadership.
- DBHR Youth Liaison will develop a regular call/meeting for Regional FYSPRT Youth Tri-Leads to provide support and technical assistance around the Youth Tri-Lead role.
- DBHR Youth Liaison will start participating in the Regional FYSPRT Coordinator calls making it a Tri-Lead call in partnership with the DBHR Family Liaison and Children's Unit staff.
- Continue Youth Professional Leadership trainings and coaching to support Youth Partners on WISe teams, Regional FYSPRT Youth Tri-Leads and other youth professionals in leadership development.

Objective 7: Affording Due Process to Class Members

Afford due process to class members by adopting legally appropriate, federally compliant due process rules and policies; modification of the Washington Administrative Code (WAC) that addresses Medicaid due process requirements for Medicaid enrollees; inform class members of their rights to due process; and monitor compliance with due process requirement and address noncompliance.

Objective 7 Strategies - Progress and Accomplishments:

Over this past year, a substantial amount of technical assistance was offered by DBHR staff to staff with Behavioral Health Organizations. Due process policies and procedures for all nine BHOs were reviewed to ensure compliance with contract, federal regulation, and WAC. This audit was an important foundational step, to ensure a uniform and consistent understanding of contract requirements. DBHR met with the Quality Managers of the BHOs to directly offer training and technical assistance. Many of the BHO staff were new and not employees of the previous Regional Support Networks.

In addition to the review of all policies and procedures, Qualis Health conducted an External Quality Review of the Grievance and Appeals as part of their first year review. This review followed Center for Medicare and Medicaid Services protocols and reviewed specific Grievance and Appeal files onsite, as well as reviewed the BHOs overall adherence to CFR.

Meetings with the Quality Leads are held bi-monthly and include a Grievance and Appeals learning collaborative, where the group discuss and address specific areas that are confusing or not consistent between the BHOs. Reporting guidelines and instructions for reporting were completed and provided to the BHOs. DBHR also produced a guidance document (#04-17) that describes how changes in the federal regulations affect WISe applicants and enrollees. Finally, DBHR has completed and disseminated an updated sample template for Notices of Adverse Benefit Determination.

Over the summer of 2017, work was completed to amend administrative rules and other due process provisions to be compliant with federal Centers for Medicare and Medicaid Services (CMS) rules governing Medicaid managed care, grievances, and appeals, which were effective on July 1, 2017. The permanent rule became effective on October 23, 2017. Updates to the Benefits Booklet were finalized in early November. The updated Benefits Booklet is currently being printed and in the process of being posted to the website. Additional contract amendments are also planned to achieve better alignment with new federal regulations.

DBHR recognizes the need for continued technical assistance and quality improvement in the grievance and appeal system.

Objective 7 - Remaining Tasks:

- Continue to provide BHOs technical assistance on due process requirements outlined in the DBHR contract, Guidance Documents, and the updated WISe Manual for WISe-enrolled and WISe-referred BHO beneficiaries.
- Continue to establish and implement a protocol to monitor BHO and MCO reports on grievances, appeals and administrative hearings and to correct instances of non-compliance.
- Monitor BHOs for compliance with due process requirements in the Settlement Agreement, contract, Guidance Documents, and the WISe Manual, including the issuance of notices of adverse benefit determination in all instances where they are required for youth being referred to and screened/assessed for WISe, but do not meet WISe eligibility criteria.
- Analyze and use the data as part of the WISe quality improvement program, and for monitoring compliance with notice and appeal rights of beneficiaries.
- DBHR will continue to provide technical assistance and offer the recently convened Learning Collaborative on the Grievance System to the BHOs.
- DBHR will continue to provide technical assistance and offer the recently convened Learning Collaborative on the Grievance System to the BHOs.

Objectives A-E: An Accountability Structure that Ensures Ongoing Quality Assurance and System Improvement

To ensure that progress towards meeting all objectives in the implementation plan is well described, this status report includes a summary of progress to date on Objectives A-E (Section II of the Implementation Plan).

Objective A: Report on progress on Settlement Agreement Requirements

Consistently and accurately monitor and report on progress in achieving the Implementation Plan Objectives and the Settlement Agreement Commitments and Exit Criteria.

Objective A Strategies - Progress and Accomplishments:

WISe Quality Management Plan: The WISe Quality Management Plan (QMP) was adopted in December 2014 and amended in May 2015. The QMP provides tools, resources, and processes for measuring the implementation of WISe and the success of the goals and commitments of the T.R. Settlement Agreement. An overview of the reporting processes, measures, and operationalized criteria included in the QMP can be found in the Action Information Matrix (AIM), which is Appendix B of the QMP.

Progress has been made on implementing the QMP, with all but one of the BHAS reports specified in the AIM now available for use at both the client and the system level. The remaining BHAS report specified in the AIM is currently in development. A copy of the QMP can be found online at:
https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/QMP.pdf

Given recent development of new quality improvement tools and processes, including the WISe Monitoring Tool (WMT), DBHR anticipates reviewing, updating, and amending the QMP in consultation with Plaintiffs' counsel and other stakeholders in early 2018. The planned update to QMP will include a new protocol and guidance for using the WMT, which is expected to provide valuable data to inform continuous quality improvement. Also planned for the update are format changes to both the quarterly and annual reports to better facilitate trend tracking, in response to recent feedback from Plaintiffs' counsel and other stakeholders.

WISe Statewide Measures of Performance: The second annual WISe Statewide Measures of Performance "dashboard" was completed in January 2017, and is available online at:
www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe_Dashboard.pdf

This dashboard is designed to provide an overview of demographics and characteristics of the youth who are screened for and who receive WISe, the types of services provided in the WISe program, and outcomes. Quarterly updates on specific measures were completed in May 2017 and August 2017. Another quarterly update will be disseminated in November

2017, and a third annual update will be completed in January 2018 and posted to the DBHR website.

The WISe "dashboard" indicates:

- Over 3,000 youth received WISe services between July 1, 2014, and December 31, 2016.
- WISe continues to grow, and growth is accelerating – both in terms of the number of youth screened for WISe and the number of youth served in WISe.
- WISe services are now available to youth in all ten regions of Washington State, and one region caseload has met the full implementation target for number of youth served in a month.
- In general to date, youth served in the WISe program have more severe mental health needs and associated risk factors than youth in the WISe proxy. This indicates that the program is appropriately serving youth with among the most severe mental health needs in the state. The WISe proxy is best thought of as the target population to be screened for WISe services and represents a much broader population than the WISe service population; those youth served by the program are expected to be among the most severe youth included in the proxy.
- There are additional opportunities to link youth with WISe services in some areas (e.g., youth with co-occurring substance use disorders or juvenile justice involvement).
- Youth in WISe services are frequently served in home-and community-based settings in addition to office settings.
- Youth in WISe services experience measurable reductions in actionable treatment needs (e.g., emotional control problems, suicide risk) and measurable increases in identified strengths (e.g., resilience, optimism) over their first six months in services, based on CANS data. These positive changes are observed in every region operating the WISe program.

Implementation status reports continue to be presented annually, including this report. Additionally, the T.R. Implementation Advisory Group (TRIAGe) meets monthly to ensure consistent and ongoing communication about implementation between parties.

As detailed in the QMP, DBHR has established a quarterly data review process to address WISe access and utilization, including screening and outcomes. (See Appendix B of the QMP.) DBHR staff and Quality Improvement (QI) representatives from the BHOs meet on a monthly basis to discuss WISe data and progress on QI projects, and DBHR also offers one-on-one technical assistance for WISe-related QI projects.

<u>Objective A – Remaining tasks:</u>

- Produce annual updates of the Statewide Measures of Performance for WISe, and quarterly updates for some measures in order to improve consistency and trend analysis.

- Update the Quality Management Plan consistent with new quality improvement tools, including the WISe monitoring tool and Plan-Do-Study-Act (PDSA) projects.
- In collaboration with Plaintiff's' counsel and other stakeholders, review the QMP to assess implementation progress and identify areas needing updates and remediate gaps or shortfalls in QMP implementation to date.
- Further develop the processes used to assess and refine estimates of service need and actual use, including service utilization data, to better identify:
    - Out-of-home placements of youth with mental health needs who are not provided WISe after screening (Objective A Item 7-b in the Implementation Plan).
    - Youth who may meet medical necessity for WISe are not being screened, and make data-informed adjustments to algorithm or identification and referral processes as needed (Objective A Item 7-c in the Implementation Plan).

Objective B: Improve core system and cross-system competencies

Determine and measurably improve core system and cross-system program administration and management competencies necessary for successful implementation of the Settlement Agreement.

Objective B Strategies - Progress and Accomplishments:

As described in Objectives 4 and 5 above, DBHR and its system partners are implementing a range of strategies to address core and cross-system competencies, including workforce development. Additionally, DBHR and its agency partners have worked extensively with the Praed Foundation to develop and use a TCOM (formerly "Total Clinical Outcomes Management", now "Transformational Collaborative Outcomes Management"") approach to developing and implementing the WISe program. The QMP includes a Supplement (pp. 62-64) that details how the TCOM framework is used to guide and improve the WISe program.

To ensure that the TCOM structure is appropriately used, the State of Washington has committed to, and continues to provide, certification training on the use of the CANS, as well as other TCOM tools and the overall framework. Ongoing training, coaching, and other technical assistance is offered to WISe providers, supervisors, system partners, and others involved in the administration and management of WISe. (See also Objectives 4 and 5 above.) The State of Washington has both hired staff and contracted resources to provide the capacity needed to successfully implement and operate a quality system.

Objective B – Remaining tasks:

- Ensure consistent evaluation of system and infrastructure strengths and needs under the TCOM framework, with supporting documentation to be included in the updated QMP.

- Incorporate Lessons Learned from the Quality Service Review in training and clinical practice to improve core practice.

Objective C: Monitor, measure, assess, and report system information

Monitor, measure, assess, and report information on system accessibility, performance, outcomes, quality, and cross-system collaboration.

Objective C Strategies - Progress and Accomplishments:
Managed Care Entities (the BHOs and MCOs) have been completing individualized Performance Improvement Projects (PIPs) related to WISe services, as described in Objective 4 above. Ongoing monitoring of implementation progress, per the QMP, is in place (see also Objective 3 above).

As described above, DBHR works closely with RDA to produce data reports consistent with the requirements of the QMP; this information is also shared in annual implementation status reports. Measures related to WISe implementation and system performance are reported via annual "dashboards" that are posted online. The Children's Behavioral Health Measures of Statewide Performance were reported on in November 2014; as was noted at that time, changes to available data sources have delayed subsequent updating. Newly updated Measures of Statewide Performance are expected to be available in early 2018. DBHR continues to improve its communication and outreach process, including progress toward meeting goals, status of service delivery, system improvement, and outcomes.

The WISe screening process has been incorporated into the BHAS. DBHR, in conjunction with RDA and other system partners, periodically review data associated with the algorithm to ensure that appropriate class members are being identified. As noted in Objective 2 above, updates to the screening process are ongoing, including a review of the algorithm that is expected to be completed in early 2018.

As detailed in the QMP, DBHR uses a quarterly data review process to address outcomes monitoring and continuous quality improvement (CQI) using BHAS data. Recent feedback from WISe program stakeholders, including the FYSPRTs and BHO Children's Care Coordinators, suggests that additional work is needed to make sure that this information is useful and actionable to those receiving it, so that it can effectively drive CQI. DBHR is currently working with consultants from the Praed Foundation to improve the quarterly reporting process, with revised reports expected to be available no later than December 15, 2017.

Fidelity monitoring: The WISe Manual provides a fidelity model for the WISe program. The WMT is currently in development, and will form the basis of the fidelity monitoring approach for WISe. A draft WMT instrument has been shared with stakeholders, and will be pilot tested and finalized in early 2018. The protocol for implementation and use on an

annual basis is also currently in development, with revisions expected following the pilot testing phase. The WMT builds upon the lessons learned from the Quality Service Review (QSR – see Objective D below), and the draft protocol incorporates both a file review component and structured interviews with youth and family involved in WISe services.

Youth, Family and Caregiver WISe Survey: In 2016, DBHR contracted with the Social and Economic Sciences Research Center (SESRC) to conduct a statewide survey of children and youth, and their caregivers, who are participating in WISe to gain direct feedback about their experience. The survey instrument was developed and pilot tested in 2015 based on the Multi-Cultural Engagement Scale (MCES) and the Wraparound Fidelity Index Short Form (WFI-EZ). SESRC staff conducted telephone interviews with a total of 605 respondents, with an overall response rate of 30%.

Table 12. Response Rates for 2016 Youth, Family, and Caregiver WISe Survey

Respondent group	Starting population	Completed	Completed and partially completed
Youth (age 13-21)	785	180 (at 23%)	193 (at 25%)
Caregivers of youth age 13-21 and children under age 13	1,235	425 (at 34%)	447 (at 36%)

The majority of WISe participants reported having a positive experience throughout the WISe process. According to participants, WISe teams were able to help them identify strengths and needs, achieve treatment goals, and build confidence for the future.

Highlights from the survey from youth and caregivers who were in WISe over 60 days included:

- Youth almost unanimously (97%) indicated WISe teams helped them understand how WISe services would assist them in setting realistic goals, ninety-two percent of caregivers agreed.
- Youth and caregivers overwhelmingly agreed WISe teams assured them they are able to get help if and when they need it.
- Eighty-three percent of youth and eighty percent of youth and caregivers asserted WISe teams assisted them in developing confidence to manage future problems.

In 2017 the statewide youth and family survey was again conducted by SESRC. A total of 279 youth and 784 families provided feedback this year, with an overall response rate of 34%. The 2017 report is scheduled to be available by January 2018.

<u>Objective C – remaining tasks:</u>

- Ensure all reports described in Appendix B of the QMP are available and functional to users (1 report is currently still in development).

- Continued development of the WMT and protocol for use, to be available for system-wide use in early 2018. Current timeline includes a pilot test process in December through mid-February, with a revised tool available in spring 2018. Timeline for dissemination is still in development.
- Review, update, and amend the QMP, in consultation with Plaintiffs' counsel and other stakeholders in early 2018. This will include a new protocol and guidance for using the WMT.

Objective D: Improve clinical and program quality

Improve clinical and program quality.

Objective D Strategies - Progress and Accomplishments:

Data Access and Dissemination: As described in Appendix C of the QMP, data are regularly shared with the Statewide FYSPRT, BHO Quality Leads, BHO Children's Mental Health Committee, BHO Children's Care Coordinators, DBHR Quality Improvement Committee, and other system partners. BHAS includes on-demand reporting capability that allows users to run ad-hoc checks on CANS data tailored to specific regional, agency, or provider-level needs.

Quality Improvement PDSA Projects: DBHR is working closely with the MCEs to implement new CQI projects based on a Plan-Do-Study-Act (PDSA) framework, using CANS data to identify and track targets for improvement.

During the previous round of PDSA projects (7/1/16 to 6/30/2017), each regional BHO designed and implemented a tailored plan with individualized targets. A new round of PDSA projects began in July 2017, and is focused on a unified statewide target: increasing natural and formal supports on WISe teams. With this approach, BHOs and agencies from each region have identified specific strategies that are tailored to address needs identified in the client populations that they serve. All areas are using CANS data from BHAS to track the impact of these projects on client outcomes; some BHOs and agencies are also tracking additional sources of information to help monitor the progress of their QI work.

Promising strategies from the projects, as well as challenges and other findings, are shared during monthly statewide QI calls. PDSA progress is also tracked via quarterly updates submitted by each region. The PDSA approach has proven to be particularly useful for organizing and implementing quality improvement work across system levels, with overall positive responses from staff at multiple BHOs and WISe agencies.

Quality Service Review: In 2016, the Quality Service Review (QSR) was completed on 30 files in three agencies, with analysis and dissemination of results in the "Lessons Learned" report completed in early 2017. The QSR employed a specific sampling strategy to select

30 cases across organizations with diverse outcomes, with the goal of capturing as wide a range of practices as practically possible. The goal of this approach was to describe the range of practices being used in WISe during the study time frame, not necessarily their prevalence. Key findings from the QSR focus on program performance, fidelity, and practice improvement.

Program performance in WISe is best understood in terms of its ability to result in clinical, functional, and strength development improvements for children and youth. Overall trends in BHAS data demonstrate relatively large declines in actionable treatment needs: average reductions of 5.3 needs at six months, 7.2 needs at nine months, and 8.5 needs at 12 months. BHAS data from SFY 2016 (July 1, 2015-June 30, 2016) for all entering WISe participants indicated that for youth with six months of treatment or more, meaningful clinical or functional improvement is likely to occur.

In contrast, among the QSR sample a nine-month length of stay was associated with much greater likelihood of improvement. Half of all clients in the QSR sample who were discharged had a length of stay that met or exceeded nine months. These findings from the QSR suggest that aggregating data to track statewide averages may inadvertently mask the fact that improvement is unevenly distributed across participants and throughout the time course of treatment. Subgroup analyses may be required to adequately identify and track improvement trajectories.

Fidelity describes the extent to which wraparound and clinical practices provided to WISe recipients were consistent with best or empirically supported practices. Overall, the files assessed in the QSR exhibited great variability with respect to fidelity. Persons who received WISe services reported high rates of program accessibility, with generally short wait times from referral to program eligibility determination. However, rates of timely CANS assessment completion and service receipt post-entry were substantially lower. Wraparound meetings tended to have primarily formal service system participants, but even these were often limited to the care coordinator and therapist. Less emphasis on engaging external system partners and natural supports offer clear areas for improvement of fidelity to the WISe model.

In terms of clinical practice, during the sampled time frame therapists consistently and regularly delivered treatment to clients throughout their episode of care, indicating that the volume of treatment being provided is likely appropriate. However, analysis of the content of treatment, as well as data from caregivers and youth, indicate concerns over the ability of treatment to provide sufficiently effective care. This suggests that the type of treatment being provided may not include the kind of structure needed to create lasting behavioral or functional change.

The key **practice improvement** opportunities identified by the QSR are training and coaching on both core clinical and wraparound competencies. Areas for particular emphasis include a focus on early engagement and collaborative assessment strategies, as well as strategies to expand the CFT beyond the child's immediate family, therapist, and care coordinator to include a broader array of formal and particularly informal partners.

Clinically, coaching and training are indicated to more clearly focus treatment on the ongoing development of emotional and behavioral skills particular to the person's clinical profile and desired strength-based and functional outcomes.

These findings are actively being used to improve WISe implementation; for example, one of the key practice improvement findings, the need to increase natural supports, was selected to be the target of the current statewide PDSA. The QSR findings have also shaped the ongoing development of the WMT.

Objective D – remaining tasks:

- Use the (currently in development) WMT to identify promising practices and support CQI.
- Integrate the use of PDSA projects into the QMP (during revision process in early 2018) to ensure sustainability of QI projects.
- Identify and implement additional quality improvement strategies to address key findings from the QSR.

Objective E: Multi-Level Communication

Regularly communicate with managers, decision-makers, supervisors, clinicians, young people and families, the public, the T.R. Implementation Advisory Group, and the Court about the accessibility, performance, outcomes, quality, and cross-system collaboration.

Objective E Strategies - Progress and Accomplishments:

In addition to the communication activities described in several sections above, DBHR has established a quarterly data review process to address outcomes monitoring and continuous quality improvement (CQI) using BHAS data. Recent feedback from WISe program stakeholders, including the FYSPRTs and BHO Children's Care Coordinators, suggests that additional work is needed to make sure that this information is useful and actionable to those receiving it, so that it can effectively drive CQI.

Children's Behavioral Health Data and Quality Team: Feedback from stakeholders and system partners has also highlighted the need for additional structure to support this review process, including ensuring that the Children's Behavioral Health Data and Quality Team regularly reviews, disseminates, and provides guidance related to this data. This group moved to a semi-annual meeting in 2016, but will return to quarterly meetings in 2018. Additionally, meetings will now be coordinated with the statewide FYSPRTs so as to better engage youth, family, and system partners from across the state in the data review process.

Objective E – remaining tasks:

- Formalize the standard template for quarterly data reports, develop guidance for reporting to ensure the information provided is useful and actionable, and

post aggregated quarterly reports online to ensure public access to WISe quality improvement data.

- The Children's Behavioral Health Data and Quality Team will meet quarterly, or more frequently if needed, to ensure review of quality data and indicators is sustainable, and will coordinate with Statewide FYSPRTs to facilitate communication with youth, family, and system partners.

III. Implementation Challenges

In addition to the issues and concerns raised above, we anticipate several broad challenges in the remaining seven and a half month time frame before the State is required to meet the exit criteria set forth in the Settlement Agreement. The categories below are current areas of focus for WISe implementation:

WISe Roll Out:

As of September 2017, the State is at 58% of capacity needed for meeting the mid-level range implementation target.. The state has demonstrated increased capacity each year (growing from 18% in 2015, to 45% in 2016). Given this growth pattern, a push to meet identified capacity targets by June 2018 poses a steep challenge. Each region of the the state, with the exception of Thurston Mason Behavioral Health Organization who is at their capacity target, has submitted an updated hiring plan for their region.

As reported in past court reports, problems with building and maintaining an adequate workforce to staff the projected WISe caseload continue to exist. Agencies report considerable vacancy rates among all WISe team member categories including therapists, family partners, youth partners, care coordinators, and coaches/supervisors. They also indicate that staff turnover is problematic in a number of locations. The current job market offers a number of employment options for people with the skill set and experience required for WISe team members as the social service sector continues to have a number of openings in both the private and public sector.

This past year DBHR consulted with nationally prominent subject matter experts as well as with regional BHOs to determine what steps can be taken to address the workforce shortage. In response, a number of strategies were implemented, including BHOs and agencies authorizing increased pay, offering finder's fees for qualified staff, conducting national searches and providing work flexibility to enhance recruitment efforts. These efforts boosted capacity by as many as 100 new youth each month over the summer for a total of 300 new WISe participants. Nonetheless, capacity growth for WISe across the state has not met the pace required.

Plaintiffs' counsel have also expressed concerns that the WISe capacity target set in 2011 needs to be updated. A second estimate was made in 2015 that showed an increase in

Medicaid eligible youth, but no significant increase in WISe-eligibility, a somewhat controversial result. In preparation for exiting jurisdiction, the case-load estimate must be brought current. In addition, further research may be needed to estimate the length of service that is appropriate for WISe recipients. An estimate was made at the outset of the case, but data now exists to verify what is an appropriate period. The average length of time children receive services has a direct impact on the service capacity needed to treat the population.

Plaintiffs' counsel have requested that the WISe capacity targets set in 2013 be reviewed to determine if Medicaid population growth has yielded increased need for WISe services. RDA has advised DBHR that it is unlikely that the target needs to be adjusted because growth was included in the initial needs estimate. It is expected that further discussion among the parties will clarify this issue.

WISe services are expanding geographically with all counties scheduled to start implementing WISe by January 2018 with the exception of San Juan County. For Wahkiakum County, Great Rivers BHO posted a Request for Proposal (RFP) and did not receive response from an interested community mental health agency. Based on this outcome, the Behavioral Health Agency associated with Great Rivers BHO will begin to cover services in the county by January 2018. Northeast counties in the state are in the process of implementing WISe. Development of WISe in rural and frontier counties will need to be adaptive and responsive to the lessons learned at local and regional level and these needs will become known over the coming months.

In addition to implementing WISe in our frontier counties, there is the ongoing need for capacity expansion. With the exception of Thurston Mason BHO, all other regions continue to focus on recruitment and hiring. BHOs and MCOs are aware of contract expectations and have sub-contracted these capacity requirements. To keep up with the expansion requirements some WISe agencies have had to lease new office space.

In the coming year, the state will continue to support regional efforts and monitor progress. Strategies used to support hiring and retention will continue. DBHR will continue contracting with a national consultant to assist with problem solving for the rural and frontier counties. Starting in 2018, DBHR will have a WISe System Coach on staff who will provide additional support to on-boarding new staff and be response to in-person or on the phone to assist with WISe orientation as regions work to hire and expands teams.

For capacity enrollment numbers, regions have submitted WISe expansion plans linked to their contracts and the mid-level capacity targets. DBHR will continue to monitor regional progress monthly. Statewide capacity reviews will be completed on January 31, 2018 and in March 31, 2018 data to report our progress towards mid-level targets. DBHR will review the planned expansion targets with Plaintiffs' Counsel during the ongoing Exit Criteria discussions.

Plaintiffs and Defendants have conferred regularly throughout implementation and, with even greater frequency in 2017, to discuss the status of the State's efforts to meet all exit

criteria. Plaintiffs' counsel have requested, and continue to request, information and data regarding the rollout of WISe, and plans for reaching the target capacity level. Plaintiffs also wish to discuss contingency strategies in case target levels will not be achieved by June 2018. Defendants believe that they have provided Plaintiffs with all available information, or a timeline of when such information can be provided. Defendants' strategies for increased capacity, including training, workforce development, and contracting for the mid-range targets by January 2018, have all been discussed and are being implemented. Defendants believe that it is premature to discuss contingencies now until it is clear that target levels set for early 2018 have not been achieved.

Inter- and Intra-Agency Implementation

As discussed above, the parties' Settlement Agreement requires Washington to develop and use "cross-system protocols . . . to coordinate services and participate in CFTs". More than four years into implementation, these protocols remain under development. Both agency-specific, as well as cross-agency policies and protocols need to be finalized and implemented in order to ensure that within and across agencies, implementation is comprehensive. Further, once policies are in place, ongoing oversight will be needed to ensure that policies are followed and modified when needed.

Algorithm

The CANS screening algorithm assists clinicians in determining whether youths meet the minimal medical necessity for WISe. As a cut-off score, however, the existing CANS screening algorithm does not adequately evaluate the severity of a child's needs above the threshold, or whether a higher more intensive or more restrictive level of care is indicated. CLIP and BRS facilities are more intensive and restrictive alternatives to WISe, and may be appropriate treatment for some children who meet the CANS minimum threshold test. The CANS screening algorithm alone does not adequately inform providers when WISe would not safely meet their needs. As a result, it is challenging to make consistent decisions about when WISe should be provided as a way to divert and discharge very high needs children and youth to in-home and community based settings. Data gathered to date shows that some children are being referred to more restrictive services than CANS scores alone would indicate. DSHS will seek further consultation and explore whether creating additional algorithms could help facilitate transitions between services and levels of care.

TCOM Data Collection and Dissemination:

There continue to be some remaining challenges with data; specifically, the current BHAS system does not allow for a youth's case to be open in two agencies at the same time. This makes it difficult to record work being done as a youth transitions from one agency to another including those who are transitioning from CLIP to WISe. Praed and its BHAS vendor, RCR Technologies, anticipate that this obstacle will be remedied by the end of calendar year 2017. In addition, there are reports that continue to be in development. While reports on client level data are functional, the challenges with the system's ability to handle concurrent and consecutive episodes where a child moves from one agency to

another in a transition, has caused difficulty in creating reports that attribute work to the appropriate clinician and agency. We anticipate the concurrent and consecutive episode issues to be resolved by December 2017.

Plaintiffs' counsel have expressed a number of data concerns, including the lack of encounter data since early 2017, gaps in reporting and inconsistency in reports that are produced, a lack of consistent timeframes that makes it very difficult to assess trends, a lack of regional or county-level data, and the failure to produce needed reports, including the vital annual proxy. There is also concern that the potential of the BHAS data has not nearly been tapped for quality improvement purposes.

DSHS has been working with Praed to improve the consistency and structure of reports that use BHAS data, including providing for trend tracking. The new report format including data going back to January 1, 2015, to current will be available by the end of November. As noted above in Objective 3, the transition in the Southwest region to FIMC and associated changes in how encounters are reported resulted in a lack of comparable data. DSHS is working to create a method to allow for comparison of data. Because data hasn't been available for all regions, analysis of encounter data broken down by region has been delayed. Timelines are under review to generate reports.

Quality Management:

Quality management and improvement is a priority in the coming months. A full review and update of the QMP will form the foundation for a robust, sustainable, and effective Quality Management, Improvement, and Accountability (QMIA) system going forward. Additionally, the WMT will be pilot tested and finalized in early 2018. During the WMT pilot, face to face interviews will be conducted with youth and families receiving WISe. The protocol for implementation and use on an annual basis is also in development. Other QMIA related tasks include improving data communication, improving the CANS reports available in BHAS, formalizing the use of the PDSA framework to drive CQI, and more effectively disseminating quality, process, and practice improvements.

Due Process Protections

DBHR will need to monitor BHOs and providers' compliance with due process requirements (notice and appeal rights), in particular with respect to WISe services, taking into account the requirements in the Settlement Agreement, as well as the new state and federal regulations.

IV. Glossary of Key Terms

Definitions: The words and phrases listed below have the following definitions:

1. **"Behavioral Health Assessment System" or "BHAS"** is an online data system to store and report on Child and Adolescent Needs and Strengths (CANS) data for Wraparound with Intensive Services (WISe).

2. **"Behavioral Health Organizations" or "BHOs"** are created by state law to purchase and administer public mental health and substance use disorder services under managed care. BHOs are single, local entities that assume responsibility and financial risk for providing substance use disorder treatment, and the mental health services previously overseen by the Regional Support Networks (BHOs).

3. **"Behavioral Health Services Summary" or "BHSS"** is a database maintained by the Division of Behavioral Health and Recovery that stores and reports information on service encounters provided through the Washington state public behavioral health system.

4. **"Behavioral Health Administration" or "BHA" is** an administration of the Department of Social and Health services and provides prevention, intervention, in-patient treatment, outpatient treatment, and recovery support to people with addiction and mental health needs. In addition, BHSIA operates three state psychiatric hospitals: Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center.

5. **"Behavior Rehabilitation Services" or 'BRS"** is a temporary intensive wraparound support and treatment program for youth with high-level service needs. BRS is used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. These services are offered through contracts under the Children's Administration.

6. **"Children's Administration or CA"** is an administration of the Department of Social and Health Services and the public child welfare agency for the state of Washington.

7. **"Child and Adolescent Needs and Strengths" or "CANS"** is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

8. **"Child and Family Team" or "CFT"** includes the youth, parents/caregivers, relevant family members, and natural and community supports.

9. **"Children's Long-term Inpatient Program" or "CLIP"** is the most intensive inpatient psychiatric treatment available to all Washington residents, ages 5-18 years of age; offers a medically based treatment approach providing 24-hour psychiatric

care staffed by psychiatrists, Master-level social workers, RNs and other clinical experts.

10. "**Culturally and Linguistically Appropriate Services" or "CLAS"** – the national standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these standards will help advance better health and health care. https://www.thinkculturalhealth.hhs.gov/content/clas.asp

10. **"Developmental Disabilities Administration" or "DDA"** an administration of the Department of Social and Health Services that provides programs for state residents with developmental disabilities and their families.

11. **"Division of Behavioral Health and Recovery" or "DBHR"** means the DSHS-designated state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

12. **"External Quality Review Organization" or "EQRO"** provides external quality review and supports quality improvement for services provided to Medicaid enrollees in Washington; the work supports the state of Washington Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery.

13. **"Family Youth and System Partner Round Tables" or "FYSPRTs"** provide an equitable forum for families, youth, systems, and communities to strengthen sustainable resources by providing community-based approaches to address the individualized behavioral health needs of children, youth, and families.

14. **"Fiscal Year"** is the state fiscal year running from July 1, through June 30.

15. **"Full partners"** are persons or entities who play an active role in the development and implementation of activities under the *T.R. v. Strange and McDermott* (formerly Dreyfus and Porter) Settlement Agreement. Full partners have the same access to data and equal rights in the decision-making processes as other members of the Governance structure.

16. The **"Governance Structure"** consists of inter-agency members on an executive team of state administrators, the statewide, regional, and local FYSPRTs, an advisory team, and various policy workgroups who inform and provide oversight for high-level policy-making, program planning, and decision making in the design, development, and oversight of behavioral health care services and for the implementation of the *T.R. v. Strange and McDermott* settlement agreement.

17. "**Health Care Authority" or "HCA"** purchases health care for more than 2 million Washingtonians through two programs — Washington Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program.

18. **"Quality Management Plan" or "QMP"** prescribes the quality management goals, objectives, tools, resources, and processes needed to measure the implementation and success of the commitments set forth in the *T.R. v. Strange and McDermott* settlement agreement.

19. **"Regional Service Areas" or "RSAs"** as directed by E2SSB 6312, the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) have jointly decided on common Regional Service Areas (RSAs) for Medicaid purchasing of physical and behavioral health care, beginning in 2016. Map as of June 2015: http://www.hca.wa.gov/hw/Documents/2016rsa_boundaries.pdf

20. **"Rehabilitation Administration's (RA), Juvenile Rehabilitation" or "JR'"** is an administration of the Department of Social and Health Services which serves Washington State's highest-risk youth.

21. **"System of Care" or "SOC"** is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.

22. **"T.R. Implementation Advisory Group" or "TRIAGe"** is a group comprised of the Plaintiffs' counsel, Attorney General representatives, and representatives of DSHS child-serving administrations (BHSIA, CA, DDA and RA) and HCA who have knowledge relevant to the services and processes identified in the WISe Implementation Plan. TRIAGe is used as a communication mechanism between parties to enable implementation.

23. **"T.R. v. Strange and McDermott (formerly Dreyfus and Porter) Settlement Agreement"** is a legal document stating objectives to develop and successfully implement a five-year plan that delivers Wraparound with Intensive Services (WISe) and supports statewide, consistent with Washington State Children's Behavioral Health Principles.

24. **"Tri-Lead"** is a role, developed to create equal partnership, among a family, a transition age youth and/or youth partner, and a system partner representative who share leadership in organizing and facilitating FYSPRT meetings and action items.

25. **"Washington State Children's Behavioral Health Principles"** are a set of standards, grounded in the system of care values and principles, which guide how the children's behavioral health system delivers services to youth and families. The Washington State Children's Behavioral Health Principles are:

- Family and Youth Voice and Choice
- Team Based
- Natural Supports
- Collaboration
- Home- and Community-based
- Culturally Relevant
- Individualized
- Strengths Based
- Outcome-based
- Unconditional

26. "**Wraparound with Intensive Services" or "WISe**" means intensive mental health services and supports, provided in home and community settings, for Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families, in compliance with the *T.R. v. Strange and McDermott* (formerly Dreyfus and Porter) settlement agreement.

27. "**Workforce Collaborative**" means a staffing infrastructure that operates independently and is tri-led by youth and families, state systems, and partner universities to develop sustainable local and statewide education, training, coaching, mentoring, and technical assistance.