T.R. v. DREYFUS, No. C09-1677 – TSZ

INTERIM AGREEMENT AND PROPOSED ORDER

2-01-2012 Negotiators' Draft Interim Agreement

TABLE OF CONTENTS

APPENDICES

I. PURPOSE AND OBJECTIVES OF THIS AGREEMENT

1. The purpose of this Interim Agreement ("Agreement") is to set forth a plan and process for the State of Washington to develop a foundation for the delivery of intensive home and community based mental health services to Medicaid eligible children and youth, in substantial compliance with Title XIX of the federal Social Security Act, and specifically the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of Medicaid, 42 U.S.C. § 1396d(r)(5). The objective of this Interim Agreement is to establish the infrastructure and necessary collaboration towards the readiness to provide intensive home and community based mental health treatment and supports that will be delivered in accordance with the principles and practices described herein, and are provided statewide in a sustained manner over time.

2. This Agreement includes three distinct components: goals, commitments, and achievements. The goals are intended to provide guidance to the overall planning and implementation of the Agreement. As guidelines, the goals are not enforceable. The commitments are items or actions that Defendants agree to do to implement the Agreement. During the pendency of this Agreement, Defendants will substantially comply with each of the commitments as set forth herein based on a phased-in period of implementation. The achievements are the sole objective measures that, when accomplished at the end of this Agreement, indicate that Defendants are in substantial compliance with the terms of the Agreement.

II. BACKGROUND

3. Plaintiffs brought this lawsuit entitled *T.R. et al. v. Susan Dreyfus et al.* (the "*T.R.* Litigation"), filed November 24, 2009, case no. C09-1677-JPD, seeking certification of

a class and declaratory and injunctive relief against Susan Dreyfus, Secretary of the Washington State Department of Social and Health Services. The lawsuit was subsequently assigned to the Hon. Thomas Zilly, Senior District Court Judge, as case number C09-1677-TSZ.

4. On July 23, 2010, this case was certified as a class action for purposes of all causes of action in Plaintiffs' Complaint.

5. The class was defined as: all persons under the age of 21 who now or in the future (1) meet or would meet the State of Washington's Title XIX Medicaid financial eligibility criteria; (2) are determined and documented by a licensed practitioner of the healing arts operating within the scope of their practice as defined by Washington state law, to have a mental illness or condition, or had a screen or an assessment been conducted by such practitioner, would have been determined and documented to have a mental illness or condition; (3) have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and (4) for whom intensive home and community based services coverable under Title XIX Medicaid and eligible for Federal Financial Participation, have been, or would have been recommended by a licensed practitioner in order to correct or ameliorate a mental illness or condition.

6. On January 6, 2011, the parties began intensive efforts to negotiate the settlement of this case. The parties conducted seven mediation sessions with the assistance of mediators Theresa Wakeen, J.D., of Seattle, and Kathleen Noonan, Clinical Professor of Law, at the University of Wisconsin Law School in Madison. Thereafter, the parties undertook direct mediation sessions without the assistance of mediators. From March 19, 2011 to October 16, 2011, the parties held approximately 21 direct sessions, achieving substantial progress.

Ms. Wakeen is no longer employed by the parties; however, Professor Noonan remains available to the parties to resolve matters where the parties are unable to reach Agreement, as set forth in the dispute resolution provisions herein.

7. Plaintiffs filed their First Amended Complaint on October 27, 2011, adding J. Douglas Porter, Director of the Washington State Health Care Authority, as a defendant. The First Amended Complaint is the operative pleading in this action.

8. This Agreement does not settle the claims in the *TR* litigation. Nonetheless, the parties agree that the best interests of the class will be substantially advanced by the implementation of the commitments reflected in this Agreement.

9. The parties acknowledge that a deep, prolonged recession has taken the greatest toll since the Great Depression on the State's economy and its revenues. As a result, the parties acknowledge that the Defendants intend to implement this Agreement within legislative appropriations. This Agreement does not require Defendants to seek, nor does it preclude Defendants from seeking, additional legislative appropriations to accomplish the goals, commitments and achievements of the Agreement. Nothing in this Agreement is intended to, nor does it, impair the rights of children to EPSDT services.

10. This Agreement is not to be construed as an admission of liability or wrongdoing by the Defendants subject to the specific admissions set forth in paragraph 20(b). The Defendants assert that they have meritorious defenses in response to the allegations of the Plaintiffs' Class. The Defendants have entered into this Agreement solely for the purpose of laying a foundation for system reform and to avoid the expense and diversion of resources caused by protracted litigation.

11. In consideration of the covenants and undertakings set forth herein and intending to be legally bound thereby, it is stipulated and agreed by the Plaintiffs and the Defendants, represented by their authorized signatories, that Defendants will undertake the commitments herein during the term of this Agreement.

III. JURISDICTION AND AUTHORITY OF THE COURT

12. The United States District Court has jurisdiction over the claims against all Defendants pursuant to 28 U.S.C. §§ 1331, 1343(a). Venue is proper in the Western District of Washington pursuant to 28 U.S.C. § 1391(b).

13. The parties to this interim Agreement acknowledge that this Agreement is not a settlement of the claims set forth in *T.R. v. Dreyfus, et al*. The parties acknowledge this Agreement establishes commitments and achievements to which State Defendants agree to be bound during the term of the Agreement. The parties acknowledge that this Agreement calls for the cessation of litigation activities in this case for the term of the Agreement. The parties further acknowledge this Court will continue to have jurisdiction over this Agreement during that period.

14. Upon execution of this agreement the parties shall file with this Court a Stipulated Motion and Proposed Order asking the Court to:

a). Enter an Order regarding enforcement of this Interim Agreement,

b). Strike the pre-trial deadlines and trial date in the current case scheduling order, and

c) Enter a new case scheduling order requiring the parties to file with this Court a Joint Status Report not later than June 15, 2013.

15. Because this Agreement is not a final settlement of the claims set forth in *T.R. v. Dreyfus, et al*, and does not bind the members of the class, the parties believe that notice to the

Class and a hearing on this proposed order are not required under FRCP 23 prior to entry of an Order regarding enforcement of this Agreement. Accordingly, the parties will ask the Court to enter its Order herein without formal notice to the Class, other than notice to the individual class representatives in this case. Should the Court determine that notice to the broader Class is required, the parties will provide said notice as directed by the Court.

16. Except as otherwise noted, the terms of this Agreement shall not take effect until the Court issues its Order regarding enforcement of this Agreement.

IV. EFFECT OF INTERIM AGREEMENT AND NEGOTIATION OF A SUBSEQUENT AGREEMENT

17. The parties anticipate that Defendants will accomplish the achievements of this Agreement on or before June 30, 2013. The term of this Interim Agreement ends on June 30, 2013. Nothing in this Interim Agreement shall obligate Defendants to enter into a second interim agreement.

18. Prior to expiration, the Parties agree to use best efforts to negotiate a second agreement to continue implementation of the reforms outlined herein. Any second agreement, known as a "subsequent agreement", may address the roll out of Washington Individualized Youth Services (WIYS)[1] statewide, and may include settlement of some or all of Plaintiffs' legal claims.

19. To negotiate the terms of any subsequent agreement the parties will:

[1] The array of services is briefly described in Paragraph 24 in this Agreement, and more fully described in Appendix A.

a) Meet and confer, no later than January 2013, to exchange information and establish a meeting schedule that anticipates the parties' best efforts to negotiate the terms of any subsequent agreement.

b) Establish milestones for the completion of specific components of any subsequent agreement and place those milestones in a timeline, the end point for which will be June 30, 2013.

c) Use their best efforts to adhere to the established negotiation schedule and timeline.

d) Initiate those steps necessary to gain approval of any subsequent agreement, if successfully developed, by their respective approving authorities.

e) Apply to the Court for preliminary and final approval of any subsequent agreement, pursuant to FRCP 23(c) in the event any subsequent agreement contains a final resolution or settlement of any claim or all claims set forth in *T.R. v. Dreyfus, et al.*

20. In the event that the Parties do not develop a subsequent agreement before July 1, 2013, the Parties may:

a) By mutual consent and with the approval of the Court extend the deadline for completing the subsequent agreement and continue to implement this Agreement in the interim; or

b) Upon 30 days notice, move the Court for appropriate relief on the underlying cause(s) of action, but not before July 1, 2013. Should Plaintiffs file such a motion, Defendants agree to the following admissions:

(1) The WIYS array is covered under Washington's Medicaid state plan to the extent the services are eligible for federal financial participation as Medicaid-covered services;

(2) Plaintiffs' First Amended Complaint is properly plead; Plaintiffs have a private right of action under 42 U.S.C. § 1983 to enforce the provisions under the Medicaid Act and the Americans with Disabilities Act; the Court has both personal and subject matter jurisdiction of this matter; and venue is proper in the U.S. District Court, Western District of Washington; and

(3) Delay in filing any motion for preliminary injunction during the negotiation or implementation periods relating to the Agreement is not evidence that there is no imminent harm or threat to Plaintiffs.

The admissions set forth in this paragraph shall be in effect throughout the term of this Court's jurisdiction of the lawsuit.

V. GOALS

21. The goals of this Agreement are to:

a) Identify the WIYS array and population to be served, and establish procedures for determining who is eligible for, and, once implemented, how they may gain access to, those services.

b) Set up practices and procedures consistent with the principles and core practice model established under this Agreement to guide interagency efforts to collaborate and coordinate delivery of care to class members in order to improve the effectiveness of services and outcomes for families and youths. Improving collaboration among child-serving agencies is intended to reduce fragmentation of services for class members, avoid duplication and waste, and lower costs.

c) Establish a consistent screening, assessment and referral (where indicated) procedure statewide that will facilitate access to services under this Agreement regardless of entry point, for all putative class members.

d) Provide the foundation for the provision of services statewide consistent with the principles and core practice model under this Agreement, and develop and maintain a comprehensive service array in order to provide class members with timely access to medically necessary services.

e) Make systemic changes in the way intensive home and community based services are delivered to eligible children and youth in order to, among other things, minimize out of home placements and maximize the class members' potential to grow into healthy and independent adults.

f) Identify quality management tools and measures to be developed in order to report on, provide, and improve quality of care, and to provide transparency and accountability to families, youths, and stakeholders under this Agreement. Provide due process consistent with this Agreement to class members denied services.

g) Arrive at Agreements based on three fundamental considerations: (1) what is required of the Defendants, including achieving substantial compliance with Commitments and Achievements, is within the Defendants' control, (2) the standards used to determine whether the State has accomplished those achievements are objective and measurable, and (3) state resources are efficiently and effectively used.

VI. COMMITMENTS

22. Defendants agree to the commitments contained within this Section:

A. T.R. Principles

23. Defendants agree to operate a Medicaid-funded mental health system that delivers services to children and youth guided by the following Principles:

a) **Family and Youth Voice and Choice**: Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.

b) **Team-based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.

c) **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.

d) **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.

e) **Home and Community-based**: Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.

f) **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.

g) **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

h) **Strengths-based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

i) **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.

j) **Unconditional**: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

B. Population And Service Definition

1) Washington Individualized Youth Services (WIYS)

24. Defendants will develop a written "crosswalk" that matches the following Medicaid covered mental health services for eligible children and youths to Washington Medicaid State Plan Modalities: (1) Mobile Crisis Intervention and Stabilization Services, (2) Intensive Care Coordination, and (3) Intensive Home and Community Based Direct Services. WIYS are more fully described in Appendix A. The crosswalk will describe the services and their components, who is authorized to provide them, and how an agency or provider may authorize and bill for them. In accordance with the Principles, Core Practice Model, Access Model, Governance Model, and existing Washington State Medicaid State Plan, Defendants will develop:

a) a funding strategy to expand capacity statewide[2] for use in any subsequent Agreement;

b) a plan to train and coach providers and Prepaid Inpatient Health Plans (PIHP) to prepare to deliver these intensive services; and

c) a plan to transition existing intensive services capacity to the WIYS array to the extent feasible using existing resources.

25. Defendants will define initial expected service utilization among PIHPs of WIYS not later than April 1, 2013.

26. Upon the Court entering an order regarding enforcement of this Agreement:

a) Defendants will offer a reassessment to each of the eight named plaintiffs currently enrolled in the WA Medicaid program within 20 days.

[2] "Statewide" means sufficient in quantity, scope, duration, and geographic distribution to meet the needs of class members in each PIHP service area.

b) This reassessment will be scheduled within 60 days or at the Plaintiff's convenience. The reassessment will determine the client's current need for intensive home and community based mental health services.

c) Defendants will provide medically necessary services to address these needs as soon as possible but no later than 90 days after reassessment.

d) Any variance to these timeframes will be documented in the client file.

27. Defendants will develop a flexible statewide communications plan for outreach and education of the community, stakeholders, and families about eligible children and youths and the WIYS array to be developed within six months of a signed agreement in concert with the implementation plan. Information will be provided with appropriate translations and other necessary accommodations to promote recipient understanding.

2) Class Member Proxy

28. The Population Proxy Model ("the Proxy") is an aggregation of historical data from actual children who had a mental illness or condition and a functional impairment that the Parties surmised would be similar to the characteristics of potential class members. The Proxy is attached hereto and incorporated herein as Appendix B. The Proxy was designed, in part, to inform the parties as to the potential numbers and characteristics of the actual class. The Proxy also informs as to potential costs and need for increased system capacity. The Proxy represents potential cross-system service utilization and helps distinguish the numbers of children and youth who are exclusively served by PIHPs, jointly served by PIHPs and allied agencies and partners, and exclusively served by allied agencies and partners. The Proxy may be refined as additional

data becomes available to Defendants, particularly with respect to children and youth who have an Individualized Education Plan (IEP).

29. Defendants will develop a plan to screen children and youth who have a mental illness or condition and functional impairment as listed in the Proxy. Defendants will develop instructions, guidance and/or technical assistance so that PIHPs, providers, allied agencies and partners are prepared to screen children and youth for the presence of the functional indicators contained in the Proxy.

C. Screening, Assessment And Access To Care

1) Access Model

30. Defendants will develop an access model to be fully implemented in any subsequent Agreement that describes access pathways to WIYS consistent with this Agreement within six months of the Court entering an order regarding enforcement of this Agreement. The Access Model will include elements that address all of the following:

a) screening all putative class members, including those children and youth who have a mental illness or condition and functional impairment as listed in the Proxy, for appropriate services;

b) identifying youth who may need WIYS;

c) providing timely access to medically necessary WIYS for class members already being served by the PIHPs;

d) developing cross-system protocols to facilitate entry from any of the child-serving agencies; and

e) providing for continuity of care[3] for children and youth receiving WIYS, particularly for those in transition.

31. Defendants will begin transitioning existing intensive services capacity to the WIYS array in accordance with the completed transition plan, subject to existing resources and PIHP capacity.

32. The Access Model developed pursuant to this subsection is not intended to, nor shall it, restrict the rights of individuals to medical assistance under EPSDT.

2) Screening and Assessment

33. Defendants will begin to implement the Child and Adolescent Needs and Strengths (CANS) tool no later than June 30, 2013. The CANS is an assessment strategy and communication tool and will be used to inform: screening, level of care decisions, standardization of referrals, clinical practice, measurement of individual outcomes, resource and program management, and improvement of service access and service coordination consistent with T.R. Principles and the Core Practice Model.

34. Defendants will train providers to recognize functional impairments commonly associated with the functional indicators identified in the T.R. class proxy criteria and evaluate if they amount to a high risk behavior, as defined under 1915(b) Waiver Access to Care Standards, and exist due to the presence of a mental health condition (Diagnosis B "Additional Criteria").

[3] Continuity of care means the provision of continuous coordinated care for class members through transitions in providers or service areas and across child serving agencies so that services are provided in a manner that does not interrupt medically necessary care or jeopardize the individual's health.

35. Defendants will train providers that screening for intensive services or WIYS, if applicable, is essential when there is a:

a) request for out of home treatment or placement due to mental health needs;

b) step-down request from institutional or group care; or

c) PIHP crisis intervention and the individual presents with past or current functional indicators in the T.R. proxy.

Eligible youth who screen positive under this paragraph shall be considered for transitioning from existing intensive services to WIYS under this Agreement, consistent with the transition plan.

36. Defendants will allow families or their representative referral sources to directly contact the PIHP or PIHP contracted Community Mental Health Agency (CMHA) to request and receive screening.

37. Defendants will provide medically necessary services or up to 14 days of medically necessary stabilization during the screening/assessment process through the contracted CMHA.

D. Service Delivery

1) Core Practice Model

38. The Core Practice Model, more fully described in Appendix D to this Agreement, is the overarching framework for providing comprehensive behavioral health services and supports for class members under this Agreement. The Core Practice Model components embrace wraparound principles employed within a System of Care[4] to the fullest extent feasible.

[4] A "system of care" (SOC) is an organizational philosophy and framework that is designed to create a network of effective community-based services and supports to improve the lives of children and youth with, or at risk of, serious mental health conditions and their families.

The Practice Model components include: (1) Engagement, (2) Assessing, (3) Service Planning and Implementation, (4) Teaming, (5) Monitoring and Adapting, and (6) Transition.

39. The Core Practice Model informs and guides the management and delivery of mental health services and supports; describes the treatment and support activities that care providers undertake; describes how services are coordinated among systems and providers; provides the means to measure and account for outcomes; provides relevant feedback to managers and clinicians in order to continuously improve system and services quality; and seeks cost-effective use of resources. Each individual case affords the class member and his or her family all of the six Core Practice Model components over the course of treatment and transition.

2) Child and Family Teams (CFT)

40. Defendants will institute contract language by October 2012 requiring PIHPs to develop Child and Family Teams (CFT) consistent with the T.R. Principles and the Core Practice Model. Class members, especially those who are served by multiple child-serving agencies, whose individualized strengths and needs (as identified by a standardized assessment process) indicate that they would benefit by having a Child and Family Team should be provided an organized Child and Family Team. In such cases the CFT drives the treatment planning process for services and supports. The role of the CFT is expressly set forth at Appendix E.

41. Defendants will establish a process for CFTs to obtain authorization by PIHPs. The process will be defined no later than November 1, 2012, whereby an organized CFT, with the participation of the Duly Authorized Provider Representative (DAPR), has the ability to access services and supports included in the class member's treatment plan.

42. In case of any disagreement between the DAPR and other CFT members regarding service recommendations, the DAPR works with the CFT to resolve any differences of opinion, with particular attention to the input and preferences of the parent(s)/guardian(s) of the enrolled child. When Agreement is not able to be reached regarding service planning at the CFT level, the DAPR helps unite the team in agreeing to try a particular service approach on an interim basis for a specified period of time during which the behavioral outcomes of the child are carefully monitored by the CFT. The team later reconvenes to consider the outcomes in relation to the services that have been provided and works together to make needed adjustments as time progresses. When deciding upon a service approach in the case of disagreement between CFT members, the DAPR gives as much or more weight to the opinions and preferences of the parent/guardian/youth as to any other member of the CFT.

43. Defendants will establish Agreements across the Department of Social and Health Services (DSHS) with child serving agencies requiring that local and regional representatives participate in CFTs (or care planning teams) for children served by multiple agencies.

44. Defendants will develop plans to provide guidance, training, supervision, and/or support to Child and Family Teams and informal care planning teams consistent with T.R. Principles and the Core Practice Model.

E. System Collaboration / Governance Model

45. Defendants will establish a sustainable interagency governance structure designed to achieve the responsibilities as outlined in the Governance Structure in Appendix C. The governance structure will establish a process for (a) high-level policy-making, program

planning, decision-making, oversight, and implementation of the intents set forth in the Agreement and (b) local engagement, including participation by families/youth and local community representatives.

46. Defendants will establish Agreements with other child-serving systems to promote collaborative and coordinated care for high needs youth consistent with the T.R. Principles, Core Practice Model, and purposes and the intents of the Agreement.

47. Defendants will include families as full partners[5] in the governance committees and groups as depicted in the Governance Structure in Appendix C.

48. Defendants will begin the process of aligning funding sources to strengthen interagency collaboration, support improved long-term outcomes, and establish systems to develop funding mechanisms for WIYS.

49. Defendants, with input from the Settlement Design Team, will undertake analyses and make recommendations to improve the integration of Children's Administration's and Division of Behavioral Health & Recovery's Title XIX services to class members. Defendants will implement their recommendations to the extent that it can be done within the term of this Agreement.

F. Quality Management And Quality Improvement Strategy

50. Defendants will begin development of a Quality Management Plan (QMP) not later than January 2013. The QMP is a comprehensive integration of the quality management

[5] Full partners are persons or entities who play an active role in the development and implementation of the T.R. activities. They have the same access to data and equal rights in the decision-making processes as other committee members.

goals, objectives, tools, and resources needed to implement the commitments set forth in this Agreement.

51. The QMP will be produced with input from the Settlement Design Team and appropriate stakeholders, and, as needed, from consultants.

52. The QMP will:

a) Enumerate the goals necessary to achieve T.R. implementation and the data used to determine progress;

b) Identify key performance indicators, and the data to be used to inform the indicators and establish procedures and timelines for measuring them; and

c) Identify tools, resources, and personnel available to perform these tasks.

53. Information and data developed pursuant to the QMP will be used to inform and improve the provision of mental health services at multiple levels: at the individual level to assess and meet the child's needs; at the agency level to monitor the provision of services and to build and maintain adequate capacity and quality; and at the regional and state levels to establish and maintain accountability within the system and monitor the systemic improvements required and/or implemented under this Agreement.

54. In support of their quality management commitments, Defendants will identify, gather, analyze and use reliable and relevant data from a variety of sources, to:

a) Inform the children's mental health system and promote transparency;

b) Guide decision-making and resource allocation;

c) Measure access to care;

d) Assess adequacy of service capacity statewide;

e) Measure and promote adherence to the T.R. Principles and Core Practice Model;

f) Evaluate and continuously improve clinical, program and system performance and outcomes for children and families; and

g) Monitor and report on implementation of the QMP.

55. Key indicators shall be established by the Quality Management Work Group in order to provide sufficient qualitative and quantitative information to assess performance of the State's commitments under the Agreement and provide sufficient evidence to affirm substantial satisfactory compliance. Indicators may include:

a) The number and characteristics of youth screened, assessed and referred to treatment;

b) The number and characteristics of youth that receive treatment;

c) The outcomes;

d) The scope and intensity of services provided;

e) The degree to which services are provided consistent with T.R. Principles and the Core Practice Model; and

f) Administrative achievements.

56. Defendants will develop the mechanisms for measuring these system and clinical performance indicators no later than June 30, 2013.

57. Defendants will develop methods and procedures for PIHPs to monitor and periodically report on the degree to which services are aligned with T.R. Principles and the Core Practice Model.

58. Defendants will use data to manage and allocate resources through the governance structure, including initiating system improvements when indicated by data.

59. Defendants will share information developed under this section with the Settlement Design Team in order to facilitate reaching any subsequent Agreement.

60. Defendants will refine the annual satisfaction survey for youth and families to include questions regarding intensive services no later than January 2013.

G. Due Process

61. Defendants will require that PIHPs provide a Notice of Action to Class members when any of the following apply:

a) The regional support network or the PIHP denies, terminates or reduces services.

b) The class member indicates to the PIHP their disagreement with specific treatment recommendations made during the development of his or her treatment plan.

62. Defendants will inform class members in the benefits booklet of the circumstances in which they have a right to receive a notice of action and request a fair hearing, including the circumstances listed in Paragraph 61 above.

63. Defendants will provide directives to PIHPs and CMHAs reflecting the limits of CMHA's authority to deny, terminate, or reduce services for reasons that are solely clinical. Defendants will train CMHAs and PIHPs as to the limited role of CMHAs.

64. Defendants will require the PIHP to monitor for CMHA reductions, terminations and denials of services, to take such actions as are necessary to correct unauthorized actions by CMHAs. Defendants will require all PIHPs to collect data that tracks Notices of Action issued and Grievances and Appeals filed and to analyze the information on grievances and appeals as part of the PIHPs' quality improvement program. Compliance will be monitored

through an Extended Quality Review Organization (EQRO) review. Defendants will address compliance concerns when they are identified.

H. Implementation

65. Defendants will implement the Agreement consistent with the T.R. Principles and Core Practice Model, and include them as appropriate in:

a) A governance plan

b) Contracts with PIHPs

c) Training materials

d) Communication materials

e) Quality review planning

f) Transition plan for existing intensive services.

1) Implementation Plan

66. Defendants will begin to develop an Implementation Plan for this Agreement once the Court enters an order regarding enforcement of the Agreement and will complete the Implementation Plan within three months thereafter. The Implementation Plan shall be developed under the direction of the Division of Behavioral Health and Recovery with input as outlined in the governance structure by the Settlement Design Team and shall:

a) identify and sequence necessary tasks;

b) set clear and accountable timelines for completing tasks;

c) assign responsibility for achieving tasks;

d) establish processes to provide feedback on implementation progress, including the need to adjust or amend the plan;

e) establish a collaborative method, to the greatest extent possible, to resolve disputes among the parties; and

f) be reasonably capable of achieving the terms of this Agreement.

67. The Implementation Plan will include a timeline for specific activities to achieve the goals set forth in this Agreement. The timeline will serve as a measurement of progress but strict adherence is not an expectation of this Agreement nor is it cause to seek judicial relief if the overall purpose of this Agreement is otherwise being met.

2) Report On Implementation

68. By June 30, 2013, Defendants will provide the Court, the Plaintiffs, and the public with a Report that describes Defendants' progress in meeting their obligations under this Agreement. The Report will include accomplishments and identify potential or actual problem issues that need attention as well as remedial efforts to address them. The Report shall also set forth a funding plan for implementing WIYS and discuss the status of negotiations towards a subsequent Agreement.

69. The parties agree that Kathleen Noonan may advise and assist the parties in the development of the Report. In providing such consultation, Ms. Noonan may communicate freely with each of the parties or their counsel and shall have access to all necessary information.

70. Thirty days prior to filing the Report, Defendants shall provide a draft of the report to counsel for Plaintiffs. Plaintiffs shall provide any feedback within fifteen days of receiving the draft. If the parties are unable to reach consensus on the final contents of the Report, they may engage Kathleen Noonan to mediate the dispute. Plaintiffs will have the option

to prepare a Reply that will be filed with the Court and attached as an addendum to the publicly available version of the Report.

VII. EXPECTED ACHIEVEMENTS

71. The Parties anticipate Defendants will complete implementation of this Agreement on or about June 30, 2013. The expected achievements of this Agreement are set forth in the five categories below (i.e., Population and Service Definition, System Collaboration, Access and Assessment, Service Delivery and Quality Management).

A. Population and Service Definition Achievements

72. Defendants have defined the WIYS array, as described in Appendix A, and produced a written "crosswalk" that matches WIYS to Washington Medicaid State Plan Modalities.

73. Defendants have described the population of youth that will be eligible for WIYS.

74. Defendants have described the population of youth that will be served by CFTs.

75. Defendants have developed a flexible Communication Plan for outreach and education of the community, stakeholders, and families about eligible children and youths and the WIYS array. The plan includes language that it will be updated per department policy.

B. System Collaboration Achievements

76. Defendants have established an interagency governance structure, substantially similar to the structure described in Appendix C, that provides for high-level policy-making, program planning and implementation, and local engagement and decision-making. Families are

full partners in governance and policy development. The Settlement Design Team is operational during the term of this Agreement.

77. Defendants have developed and adopted cross-system protocols consistent with this Agreement and have embedded those protocols in established Agreements/MOUs with child-serving agencies.

C. Access and Assessment Achievements

78. Defendants have adopted an access model as described in paragraphs 30 - 32.

79. Defendants have developed and adopted CANS as an assessment strategy and communications tool consistent with paragraph 33.

80. Defendants have established the threshold CANS criteria for access to WIYS in consultation with clinical experts agreed upon by the state and Plaintiffs.

D. Service Delivery Achievements

81. Defendants have adopted the Core Practice Model for the purpose of guiding service delivery consistent with the T.R. Principles and the Agreement.

82. Defendants have required PIHPs to develop CFTs pursuant to PIHPs' amended contracts.

83. Defendants have established a protocol that identifies the process by which a CFT may present treatment recommendations for authorization by the PIHP.

84. Defendants have developed a CFT quality tool to measure CFT voice, choice, and efficacy.

85. Defendants have defined the initial expected service utilization of WIYS among PIHPs.

86. Defendants have a written implementation plan developed for this Agreement, as described in paragraphs 66-67. This plan is created with input from the Settlement Design Team and approved through the Governance process.

87. Defendants have developed a plan, subject to existing resources and PIHP capacity, to transition existing intensive services capacity to the WIYS array consistent with the T.R. Principles and Core Practice Model.

E. Quality Management Achievements

88. Defendants have identified quality management tools and measures to be used for reporting, providing, and improving quality of care, and for providing transparency and accountability.

89. Defendants have begun development of the Quality Management Plan, as described in paragraphs 50-60.

90. Defendants have clarified Notice of Action and grievance protocols and incorporated them into the Communication Plan and Benefits Booklet. The Division of Behavioral Health and Recovery (DBHR) has in place a process to monitor and periodically report on PIHP's compliance with this provision.

91. Defendants require that at least one PIHP annual Performance Improvement Project (PIP) is focused on improving mental health services to Medicaid funded children and youth.

VIII. DISPUTE RESOLUTION

92. Any claim, dispute, or other matter in controversy ("dispute") arising out of or related to this Agreement, or the breach, implementation or performance thereof, shall be resolved according to the procedure set forth in paragraphs 93-97 below.

93. The parties agree to convene, at a mutually agreeable time and place, and use their good-faith, best efforts to discuss and resolve the dispute. This initial meeting will be a direct negotiation between the parties without the assistance of a mediator or other non-party. Any Agreement reached in this forum will be formalized as an addendum to the parties' Agreement and submitted to the Court for approval.

94. In the event the parties are unable to resolve the dispute through direct negotiation, they will engage the mediation services of Kathleen Noonan for the purpose of mediating a resolution to the dispute. That meeting will be at a mutually agreeable time and place, and, with the assistance of the mediator, the parties will use their good-faith, best efforts to discuss and resolve the dispute. Any Agreement reached in this forum will be formalized as an addendum to the parties' Agreement and submitted to the Court for approval.

95. The parties agree to use their best efforts to secure third-party funding to support the mediation and consultation role of Kathleen Noonan, described above. If such funds are not secured at the time of Ms. Noonan's invoice for payment, Defendants agree to pay the reasonable costs of her services**.**

96. If, after participating in good faith at the mediation, no resolution is reached Plaintiffs may file an appropriate motion with the United States District Court in this matter. Plaintiffs shall provide the appropriate notice to Defendants' counsel of such action.

97. Disability Rights Washington (DRW), as the Protection and Advocacy agency for the State of Washington does not waive its federal authority in the event that DRW has reasonable cause to believe that there is a risk of imminent harm to class members. Should that circumstance arise, Plaintiffs will make a good faith effort to consult with Defendants' counsel to discuss the issue or issues. If the issue or issues are not resolved within a reasonable amount of time, parties will engage in an expedited mediation process, using Kathleen Noonan as detailed in the dispute resolution provisions set forth herein. If the systemic matter is not resolved through the mediator, Plaintiffs may proceed directly to the Court or may take any other necessary legal action. Plaintiffs will provide at least one business day's written notice to Defendants' counsel via facsimile or email and first class mail prior to initiating court action. "Imminent", as defined in RCW 71.05.020(20), is "the state or condition of being likely to occur at any moment; near at hand, rather than distant or remote." A "systemic obligation" is one that may affect all, or a substantial portion of, the class and is not represented or proven by a circumstance or condition affecting an individual class member.

IX. SCOPE OF RELEASES AND WAIVERS

98. Nothing in this Agreement shall be deemed to limit the Court's powers of contempt or any other power possessed by the Court.

99. Nothing in this Agreement shall be deemed to limit the ability of any individual class member to obtain individual relief of any kind to which they would otherwise be entitled under state or federal law other than for the claims for systemic injunctive relief adjudicated by this action.

100. The parties agree that nothing in this Agreement is intended to address or preclude any claims or defenses that may be available to the parties in the pending matter of *J.E. v. Porter.* (C.A. 2:11-cv-01669-JCC. W.D. Wash). Similarly, the parties to these proceedings (*T.R. v. Dreyfus*) do not intend that *J.E. v. Porter* addresses or precludes any claims or defenses they may have in this case.

101. Nothing in this Agreement shall be deemed to limit the ability of DRW to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, *et seq*., and the regulations promulgated thereto, 42 C.F.R. § 51 *et seq*., and the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, *et seq*., and the regulations promulgated thereto, 45 C.F.R. § 1386 *et seq.*

X. PLAINTIFF COUNSEL ACCESS TO INFORMATION

102. The Plaintiffs agree to minimize the number and scope of requests for data and information not already provided to the Settlement Design Team pursuant to this Agreement.

A. Non-Confidential Implementation Data and Information

103. Should Plaintiffs seek any data and information concerning Defendants' progress in implementing this Agreement not otherwise available in this Agreement:

a) Plaintiffs will make their request for that additional data and information to Defendants through the Settlement Design Team. Plaintiffs' request will establish a reasonable purpose and scope which shall include:

(1) Specific data and information sought,

(2) Specific provision(s) of the Agreement to which the data and information are relevant, and

(3) Specific concerns the data and information are sought to address.

b) Where Defendants agree the data and information requested are relevant to the Agreement, Defendants will provide access to relevant data and information within their control within a reasonable time period. Within ten (10) days of receipt of a request for additional data or information under this paragraph, Defendants will provide a letter that acknowledges such receipt, and gives an estimate of the time and costs needed to comply with the request. Plaintiffs will pay reasonable copy costs for records not otherwise provided in other provisions of this Agreement.

c) Any disputes within that process regarding the necessity or availability of requested data and information will be resolved through dispute resolution (Section VIII herein).

B. Confidential Information Contained In Class Member Individual Records

104. In the event Plaintiffs seek the review of confidential information contained in the individual records of a class member not named as a party in this proceeding, DRW may obtain those records pursuant to its federal authority under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, et seq. (also known as Probable Cause Authority). Where records are sought outside of DRW's federal authority, the following procedures will apply:

a) Plaintiffs will obtain a Release from the individual class member or his/her parent or guardian. Plaintiffs may use the release to directly obtain the information sought. The parties agree that, so long as individual names and contact information are known, the Release process is the primary means to obtain confidential information.

b) If the name/contact information is not known to Plaintiffs but is known to Defendants, Defendants will provide that information through the Settlement Design Team so that Plaintiffs may obtain a Release.

c) If there is no way to obtain a Release or Plaintiffs believe that effort will be futile, and there is reasonable cause to believe an individual class member is not being appropriately served under this Agreement, Plaintiffs may seek a court order requiring the release of confidential information from the State, the PIHP, and/or the provider of services. Under most circumstances Defendants will take no position on the request or will stipulate to the order for the release of information so long as notice is provided to the class member (if possible) and he/she is give an opportunity to be heard. Defendants reserve the right to oppose the request if it amounts to a blanket order for the confidential information of class members.

d) Plaintiffs will pay reasonable duplication costs pursuant to 42 CFR 51.41(e).

XI. ATTORNEYS' FEES AND COSTS

105. The parties will make good faith efforts to negotiate the amount of attorneys' fees, costs, and litigation expenses to be awarded to plaintiffs' counsel. In the event that the parties cannot reach Agreement with respect to attorneys' fees, costs, and expenses, they will submit the matter for mediation to a mutually agreeable mediator. If attempts to mediate are not successful, Plaintiffs may file the appropriate motion with the district court.

XII. OTHER PROVISIONS

106. The Parties agree those materials contained in the several appendices to this Agreement, as they are referenced in the main body of the Agreement, are included and fully

incorporated into this Agreement as if fully set forth herein. Appendix F provides a consolidated list of the Commitments made by the State of Washington in this Agreement, and Appendix G provides a consolidated list of the Expected Achievements of this Agreement. Notwithstanding their full incorporation herein, these two appendices are provided for convenience. The Commitments Appendix and the Expected Achievements Appendix must be read and interpreted within the context of this Agreement and not in isolation. When interpreting the Commitments and Expected Achievements, the language contained in the main body of the Agreement is controlling.

107. This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

108. The Parties have participated and had an equal opportunity to participate in the drafting and/or approval of this Agreement. No ambiguity shall be construed against any party based upon a claim that the party drafted the ambiguous language.

109. Signors of this Agreement represent and warrant they have full power and authority to enter into this Agreement and to carry out all actions required of them to the extent allowed by law. Each of the signors warrants that he/she has fully read and agrees to all the terms and conditions contained herein.

110. This Agreement may be amended by mutual agreement of the parties and approval of the Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the parties, and approved by the Court. The parties further agree to work in good faith to obtain Court approval of necessary amendments or modifications.

111. The parties agree that this Agreement is intended to be interpreted to provide flexibility and economic efficiencies in the implementation of the Patient Protection and Affordable Care Act of 2010, P.L. 111-148.

112. This Agreement shall inure to the benefit of and be binding upon the legal representatives and any successor(s) of Plaintiffs and Defendants.

113. If, for any reason, the Court does not issue an order regarding enforcement of this Interim Agreement, the Agreement shall be null and void.

114. This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail which shall be deemed the same as an original signature.

FOR PLAINTIFFS:

By: _____ Dated: _____
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Disability Rights Washington

_____ Dated: _____
SUSAN E. FOSTER
Perkins Coie LLP

_____ Dated: _____
PATRICK GARDNER
National Center for Youth Law

_____ Dated: _____
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FOR THE STATE OF WASHINGTON

By: Robin Arnold-Williams Dated: 2/10/12
DEFENDANT
ROBIN ARNOLD-WILLIAMS
Secretary
Washington State Department of Social
and Health Services

By: Doug Porter Dated: 2-16-12
DEFENDANT DOUG PORTER
Director
Washington State Health Care Authority

COUNSEL FOR DEFENDANTS:

By: Dated: 2-20-12
JOHN K. MCILHENNY, JR.
Assistant Attorney General
WSBA NO: 32195

Dated: 2-21-12
ERIC NELSON
Assistant Attorney General
WSBA NO: 27183

Washington Individualized Youth Services (WIYS)

1. Intensive Care Coordination

Intensive Care Coordination (ICC) includes facilitating assessment, care planning, coordination of services, and monitoring of services and supports to address children's mental heath conditions by a single consistent care coordinator.

Intensive Care Coordination provides:

- A single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and culturally, and linguistically relevant manner;
- Services and supports that are guided by the needs of the youth;
- Facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems;
- Support the parent/caregiver in meeting their youth's needs;
- A care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to allow the youth to be served in their home and community; and
- Facilitated development of an individual's care planning team.. Teaming is a process that brings together individuals agreed upon by the child and family who are committed to them through informal, formal and community support and service relationships. ICC will facilitate cross system involvement and/or a formal Child and Family Team where medically necessary.

ICC service components consist of:

Assessment: The care planning team completes a strength-based, needs driven, comprehensive assessment to organize and guide the development of an Individual Service Plan (ISP) and a risk management/safety plan. The assessment process determines the needs of the youth for any medical, educational, social, mental health, or other services. ICC may also include the planning and coordination of urgent needs before the comprehensive assessment is completed. Further assessments will be provided as medically necessary and in accordance with best practice protocols.

Planning – Development of an Individual Care Plan: Using the information collected through an assessment, the care coordinator convenes and facilitates the team meetings and the care planning team develops a child- and family-centered Individual Service Plan (ISP) that specifies the goals and actions to address the medical, educational, social, mental health, or other services needed by the youth and family. The care coordinator works directly with the youth, the family and others significant to the child to identify strengths and needs of the youth and family, and to develop a plan for meeting those needs and goals.

Referral, monitoring and related activities: The care coordinator

- works directly with the youth and family to implement elements of the ISP;

- prepares, monitors, and modifies the ISP in concert with the care planning team; to determine whether services are being provided in accordance with the ICP; whether services in the ISP are adequate; and whether these are changes in the needs or status of the youth and if so, adjusting the plan of care as necessary, in concert with the care planning team;
- will identify, actively assist the youth and family to obtain and monitor the delivery of available services including medical, educational, mental health, social, therapeutic, or other services.

Transition: The care coordinator:

- develops a transition plan with the care planning team, and implements it when the youth has achieved goals of the ISP; and
- collaborates with the other service providers and agencies on the behalf of the youth and family.

Settings: ICC may be provided to children living and receiving services in the community, including foster care placements, as well as to children who are currently in a hospital, group home, or other congregate or institutional placement as part of discharge planning.

2. In Home and Community-Based Direct Services (Direct Services)

Intensive Home and Community-Based Services (Direct Services) are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child's functioning. Interventions are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the youth successfully function in the home and community.

Direct Services are delivered according to an individualized treatment plan developed by a care planning team. The care planning team develops goals and objectives for all life domains in which the child's mental health condition produces impaired functioning, including family life, community life, education, vocation, and independent living, and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the child's ability to live and participate in the community and to function independently, including through building social, communication, behavioral, and basic living skills. Providers of intensive home-based services should engage the child in home and community activities where the child has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

Direct Services includes, but is not limited to:

- Educating the child's family about, and training the family in managing, the child's disorder;
- In-home functional behavioral assessment;

- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the child's family and others how to implement behavioral strategies, and in-home behavioral aids who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan's effectiveness to clinical professionals;
- Therapeutic services delivered in the child's home including, (but not limited to) therapeutic interventions such as (a) individual and/or family therapy; and (b) evidence based practices (e.g., Family Functional Therapy, Multi-Systemic Therapy, Trauma-Focused Cognitive Behavioral Therapy, etc.). These services are designed to :
    - Improve self-care, including by addressing behaviors and social skills deficits that interfere with daily living tasks and with avoiding exploitation by others;
    - Improve self-management of symptoms, including assisting with self-administration of medications;
    - Improve social functioning, including by addressing social skills deficits and anger management;
    - Support the development and maintenance of social support networks and the use of community resources;
    - Support employment objectives, by identifying and addressing behaviors that interfere with seeking and maintaining a job;
    - Support educational objectives, through identifying and addressing behaviors that interfere with succeeding in an academic program in the community; and
    - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

Settings: Direct Services may be provided in any setting where the child is naturally located, including the home (biological, foster, relative, or adoptive), schools, recreational settings, child care centers, and other community settings.

Availability: Direct Services are available wherever and whenever needed, including in evenings and on weekends.

Providers: Non-clinical Direct Services are typically provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide Direct Services. Clinical services are provided by a clinician rather than a paraprofessional.

3. Mobile Crisis Intervention and Stabilization Services (MCIS)

Mobile crisis services include crisis planning and prevention services as well as face-to-face interventions that support the child in the community.

Services include:

- Crisis Planning that, based on child's history and needs, (a) anticipates the types of crises that may occur, (b) identifies potential precipitants and creates plan to reduce or eliminate, and (c) establishes responsive strategies by caregivers and members of child's team to minimize crisis and ensure safety;

- Assessment of (a) precipitants of crisis, (b) behaviors that are occurring, (c) child and family safety, (d) what kinds of resources are available to address immediate problems, and (e) what strengths of the child and family can be used to address crisis;

- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions; and

- Referral and coordination with (a) other additional services and supports necessary to continue stabilization or prevent future crises from reoccurring, and (b) any current providers and team members, including care coordinator, therapists, family members, primary care practitioners, or school personnel; and

- Post-crisis follow-up services (stabilization services) provided periodically up to 14 days after initial crisis occurs to (a) ensure continued safety, delivery of additional services identified as necessary to prevent future crises, and, (b) if placed out of home, coordinate services from out-of-home provider and child's treatment team to facilitate plan for rapid return home.

Settings: MCIS are typically provided at the location where the crisis occurs, including the home (biological, foster, relative, or adoptive) or any other setting where the child is naturally located, including schools, recreational settings, child care centers, and other community settings.

Availability: MCIS are available 24 hours a day, 7 days a week, 365 days a year.

Providers: MCIS are provided by a trained and experienced mobile crisis professional or team, preferably drawn from members of the child's treatment team.

Administrative Data Proxies for Identifying Children and Youth To Be Screened for Need for Intensive Home- and Community-based Mental Health Services

Context. This document contains a detailed description of the methods used by DSHS Research and Data Analysis Division staff to estimate the number of children and youth enrolled in Medicaid who are at increased risk of needing intensive home- and community-based mental health services. These estimates were used to inform the Department's approach to children's mental health system redesign efforts, and to respond to data needs related to the TR Lawsuit. These methods use mental health service need indicators and "functional proxy flags" derived from administrative data to identify the size of the target population to be screened for need for intensive home- and community-based mental health services.

Overview. There are three basic components to the estimation process:

1. Identify the appropriate population of Medicaid children and youth under the age of 21;
2. Identify the subset of Medicaid children and youth under 21 with indications of a mental health service need; and
3. Among Medicaid children and youth under 21 with indications of a mental health service need, identify the subset who have a "functional proxy flag" indicating that they should be screened for need for intensive home- and community-based services.

To allow consideration of the broadest potential set of functional proxy indicators, our estimates focused on data for State Fiscal Year (SFY) 2008.

Medicaid population identification. The list below summarizes the medical coverage categories that were used to define the Medicaid population. We then determined the population of Medicaid children and youth under the age of 21 based on the persons age in their first month enrolled in Medicaid in SFY 2008. Eligibility data was derived from the "Client by Month" data table in the ProviderOne Operational Data Store (ODS).

- Categorically Needy and Medically Needy Disabled
- Pregnancy-related coverage
- TANF and related Family Medical coverage
- Children's medical coverage
- Foster care and adoption-related coverage
- Disability Lifeline Unemployable and ADATSA ("Medicaidized" under a waiver effective January 1, 2011)
- Refugee coverage
- Healthcare for workers with Disabilities
- Other medically needy Medicaid coverage groups

Based on these medical coverage categories, we identified 685,674 children and youth who were enrolled in Medicaid for at least one month in SFY 2008 and were under age 21 in their first month of Medicaid enrollment in that year.

Mental health need definition. Mental health needs were flagged based on the occurrence of any one (or more) of a set of criteria based on diagnoses, psychotropic medication receipt, and service utilization.

With regard to diagnosis, clients were flagged if any of the diagnoses listed in the table below were found in their medical and behavioral health service encounters in SFY 2008.

Diagnosis Category	ICD-9-CM Code Values
Psychotic disorder	'295' to '295.99', '297' -'297.99', '298'-'298.99', '293.81'-'293.82'
Mania and bipolar disorders	'301.13', '296'-'296.19', '296.4'-'296.99'
Depression	'293.83', '296.2'-'296.29', '296.3'-'296.39', '300.4'-'300.49', '300.5'-'300.59', '311'-'311.99'
Anxiety	'300.0'-'300.09', '300.2'-'300.39', '308'-'308.99', '309.22'-'309.23', '309.81'-'309.89', '309.9'
Adjustment disorders	'309.24'-'309.8', '309'-'309.20'
Childhood psychiatric disorders including ADHD	'313.81', '312'-'312.99', '314.1'-'314.99'

With regard to receipt of psychotropic medications, children were flagged if they had a filled prescription in SFY 2008 for medication in any one or more of the following therapeutic classes:

- Antipsychotic
- Antimania
- Antidepressant
- Antianxiety
- ADHD

In addition to the diagnosis and medication based indicators of mental health need, we treated use of the following mental health related services in SFY 2008 as a definitional indication of a mental health service need:

- Receipt of any mental health service from the DSHS Division of Behavioral Health and Recovery (DBHR)
- Receipt of tribal mental health services
- Receipt of mental health services paid for through the Medicaid "medical" benefit
- Receipt of Behavioral Rehabilitation Services through the DSHS Children's Administration

Based on these criteria, we flagged with a mental health need 69,417 of the 685,674 children and youth under the age of 21 who were enrolled in Medicaid for at least one month in SFY 2008.

Functional proxy flag definitions. For the population of Medicaid children and youth under age 21 with indications of a mental health service need, we used a set of "functional proxy flags" to indicate that the child should be screened for need for intensive home- and community-based services. A child with any one (or more) of the selected functional proxy flags is counted as appropriate to be screened for need for intensive home- and community-based services. Functional proxy measures are based on the child's experiences in SFY 2008. The set of functional proxy flags are described in greater detail below:

1. Child Long-Term Inpatient (CLIP) stay in SFY 2008.
2. State mental hospital (including Child Study Treatment Center) stay in SFY 2008.
3. Community inpatient mental health admission in SFY 2008.
4. Children's Administration (CA) Behavioral Rehabilitation Services in SFY 2008

5. CA Other Intensive Services in SFY 2008 (primarily consists of services related to treatment foster care, CHAP and SAY)
6. Involved in CA services in SFY 2008 and experienced 3 or more lifetime out of home placements
7. Received JRA services in SFY 2008, including institution stays, community placement, parole or dispositional alternatives
8. Adjudicated in SFY 2008 with one of the following dispositions (from the AOC data via the WSIPP criminal recidivism database):
    a. Convicted, including sentencing to JRA or county juvenile detention facilities
    b. Diverted or deferred
9. Received RSN crisis services in SFY 2008
10. Homeless: identified based on ACES living arrangement codes and includes status of "homeless without housing" or a shelter stay at any time in SFY 2008
11. Four or more psychotropic medications received in at least one month in SFY 2008. Count of 4 or more includes antipsychotics, antimania medications, antidepressants, antianxiety medications, ADHD medications, sedatives and anticonvulsants
12. Two or more medical inpatient admissions with a primary mental illness diagnosis on the claim
13. Two or more medical outpatient Emergency Department visits with a primary mental illness diagnosis on the claim
14. DBHR-MH service utilization at or above the 90th percentile, based on the RDA Client Services Database mental health service cost imputation models
15. Drug overdose diagnosis in a medical claims or encounters. Identified by the following ICD-9-CM criteria: 909.0, 965.00, 965.01, 965.02, 965.09, 965.1, 965.7, 965.8, 965.9, 967.6, , 967.8, 967.9, 969.0, 969.1, 969.2, 969.3, 969.4, 969.5, 969.6, 969.7, 969.8, 969.9, 970.0, 970.1, 970.8, 970.9, E850.0, E850.1, E850.2, E850.3, E850.4, E851, E852.5, E852.8, E852.9, E853.0, E853.1, E853.2, E853.8, E853.9, E854.0, E854.1, E854.2, E854.3, E854.8, E980.0, E980.1, E980.2, E980.
16. Anorexia/Bulimia diagnosis in medical claim or encounter: 307.1, 783.0, 307.51
17. Suicide attempt or self-injury in medical claim or encounter: E950 to E959
18. *Possible* suicide attempt or self-injury in medical claim or encounter: E980 to E989
19. Alcohol or other drug use treatment need, identified by the occurrence of any of the following:
    a. A medical claim or encounter with diagnosis of a substance use disorder
    b. Substance abuse treatment or detox service use
    c. An arrest for a substance-related offense in the Washington State Patrol database (includes DUI/DWI, drug possession, and related offenses)

Based on these criteria, we identified 19,652 Medicaid children and youth under the age of 21 in SFY 2008 with a mental health service need who met one or more of the 19 functional proxy criteria listed above. This is the size of the population estimated to need screening for intensive home- and community-based mental health services.

Functional Proxy Profile for Persons Under 21 on Medicaid in FY 2008 Meeting Mental Health Need Criteria

October 2011 • DEPARTMENT OF SOCIAL AND HEALTH SERVICES RESEARCH AND DATA ANALYSIS DIVISION

Medicaid + Broad MI Flag

	NUMBER	PERCENT OF TOTAL*
MENTAL HEALTH INPATIENT STAY (FY 2008)		
MHD Child Long Term Inpatient (CLIP)	165	0.8%
MHD State Mental Hospitals	120	0.6%
MHD Community Inpatient	1,295	6.6%
CHILDREN'S ADMINISTRATION ENCOUNTERS (FY 2008)		
Behavioral Rehabilitation Services	1,467	7.5%
Other Intensive Services	662	3.4%
CA-involved in FY 2008 with 3+ lifetime CA out-of-home placements	3,851	19.7%
OTHER RISK INDICATORS (FY 2008)		
JRA Services	818	4.2%
Convicted, deferred or diverted	5,764	29.4%
RSN Crisis Encounter	2,364	12.1%
Homelessness	1,604	8.2%
Four or more Psychotropic Medications prescribed in at least 1 month	4,604	23.2%
Two or More Medical Inpatient Admissions with primary MI Dx on claim	305	1.6%
Two or More Emergency Room Visits with primary MI Dx on claim	584	3.0%
MHD Costs in FY 2008 at or above the 90th percentile ($4,600)	3,852	19.7%
Drug overdose diagnosed in medical claim/encounter	480	2.5%
Anorexia/bulimia diagnosed in medical claim/encounter	250	1.3%
Suicide/self-injury diagnosed in medical claim/encounter	299	1.5%
Possible suicide/self-injury diagnosed in medical claim/encounter	134	0.7%
Alcohol drug treatment need flag	5,979	30.5%
ANY FUNCTIONAL PROXY, MEDICAID POPULATION AGE 0-20, WITH MH NEED FLAG, FY 2008	**19,652**	**100%**
MEDICAID POPULATION AGE 0-20 WITH MENTAL HEALTH NEED FLAG, FY 2008	**69,417**	
TOTAL UNDUPLICATED POPULATION OF MEDICAID CLIENTS AGED 0-20, FY 2008	**685,674**	

TR Governance Structure

The interagency governance structure is intended to improve the coordination of and access to intensive mental health services for TR class members and thereby improve both effectiveness of services and outcomes for youths and their families. Governance informs decision-making at a policy level that has legitimacy, authority, and accountability. The Secretary of DSHS in partnership with the Director of the Health Care Authority will commission and lead a Joint Governance / Core Leadership entity to oversee and guide the implementation of the TR Interim Agreement.

Governance will be managed by an Executive Team led by Assistant Secretaries of the Children's Administration, Aging and Disabilities Services Administration (DBHR and DDD), Economic Services Administration, Health Care Authority (Medicaid); and Juvenile Rehabilitation Administration.

The overarching responsibility of this entity is to ensure:

- adherence to the Interim Agreement among constituencies,
- steady progress in implementing agreed-upon benchmarks, practice improvements and quality oversight,
- meaningful partnership with families and youth,
- effective communication and problem solving including judicious use of mediation,
- effective use of data to inform progress in achieving cross-system outcomes,
- appropriate Interface with the State Legislature and key advocates; and
- sustainability of a shared investment and liability, i.e. vision, fiscal support, empowered leadership and system improvements.

The Executive Team will discuss all policy implications and make recommendations to the DSHS Secretary and HCA Director.

The structure of TR Governance will consist of chief operating bodies with clear roles and reporting guidelines (see Governance Structure chart for membership):

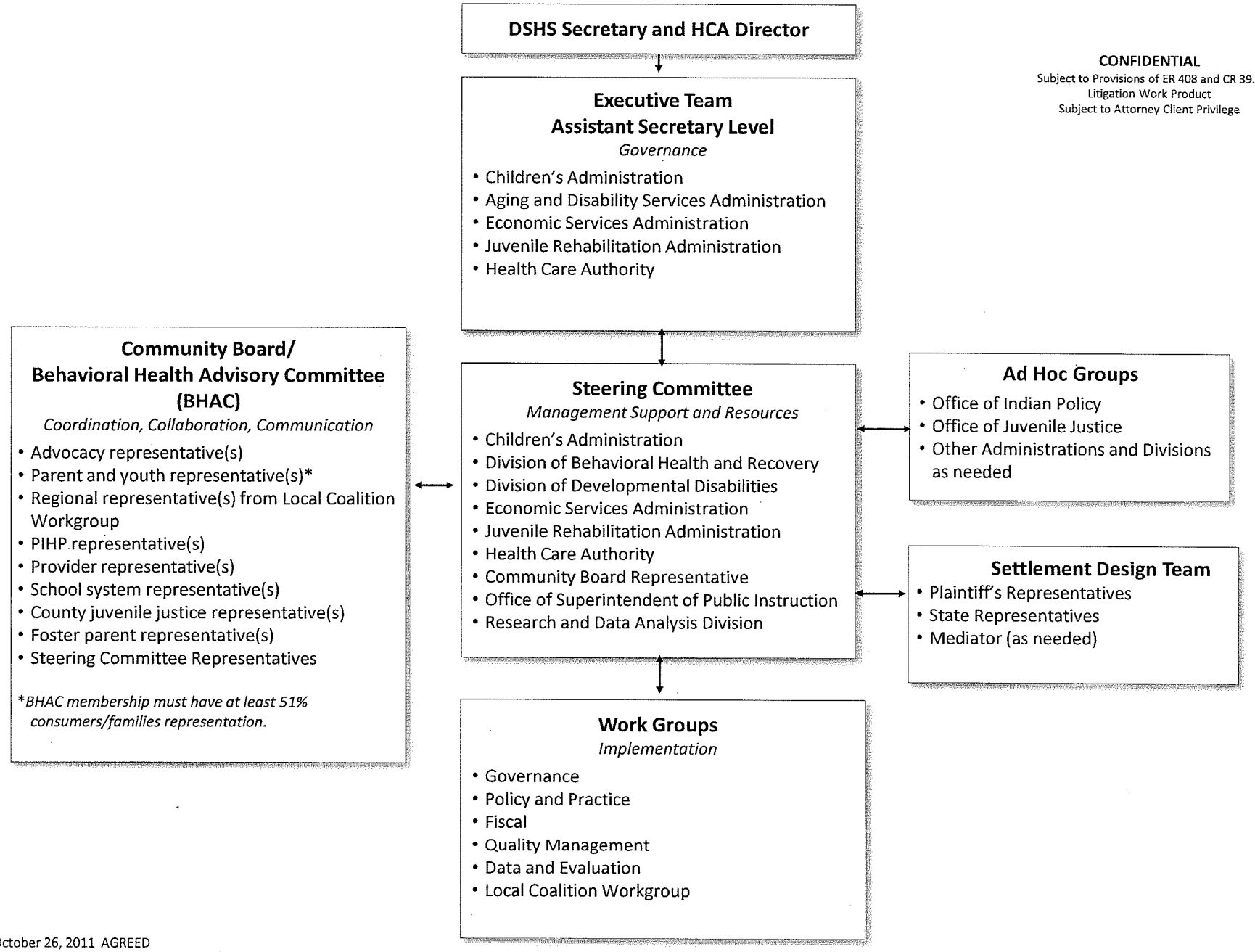
- Executive Team
- Steering Committee
- Settlement Design Team
- Ad Hoc Groups
- Community Board/Behavioral Health Advisory Committee
- Work Groups

Governance will develop a **Charter** guided by principles consistent with the TR Interim Agreement, Core Practice Model, and shared goals and outcomes, including:

- Family inclusion as full partners in governance boards, committees and groups;
- Interagency governance that provides for high-level, cross-system policy development, program planning , decision making, oversight and implementation;
- Leadership through effective communication and problem solving that maintains focus on clear goals, shared objectives, capacity building and sustainability.

- Strengthen inter-agency collaboration to align funding sources and support improved long-term outcomes among children and youth served by DSHS systems.
- Data-driven decision-making and resource allocation
- Collaborative and coordinated care consistent with the TR principles, core practice model, and purposes and intents of the TR Interim Agreement
- Regular publication and review of data and reports consistent with the Quality Management Plan
- Develop strategies to implement TR values and core practice model at the local level through existing local coalitions and work groups consistent with the purposes and intents of the TR Interim Agreement.

Governance Structure



Core Practice Model

A. PURPOSE OF T.R. PRACTICE MODEL

The Washington State Division of Behavioral Health and Recovery T.R. practice model is an overarching framework for providing comprehensive behavioral health services and supports for class members. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that care providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

B. T.R. PRACTICE MODEL COMPONENTS

Practice components embrace wraparound principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the child and family all of components 1-6 (below) over the course of treatment and transition.

1. *Engagement*: Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
2. *Assessing*: Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.
3. *Service Planning and Implementation*: Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.
4. *Teaming:* Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
5. *Monitoring and Adapting*: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
6. *Transition*: The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

THE CHILD AND FAMILY TEAM

Child and Family Team: TR class members, especially those who are served by multiple child-serving agencies, whose individualized strengths and needs (as identified by a standardized assessment process) indicate that they would benefit by having a Child and Family Team should be provided a formally organized *Child and Family Team*. In such cases, the Child and Family Team drives the treatment planning process to ensure that services and supports are provided in accordance with TR Principles and the Core Practice Model. The role of the Child and Family team includes:

- Assemble as a group of caring individuals to work with and support the child and family that, in addition to the child and family, community members and various agency and provider staff involved in service delivery, includes at a minimum a facilitator and a family support partner or family specialist for youth. Team facilitation can be done by a qualified and committed CFT facilitator, mental health provider, social worker, or probation officer. The facilitator maintains a committed team and is qualified with the necessary skills and persuasiveness to bring people and resources to the table in support of the child and family.
- Continue the process of engagement with the family and or caregivers about their strengths and needs, ensure that services are well coordinated, and provide a process for transparent communication.
- Identify the strengths and needs of the child and develop an individualized, strengths-based, child and family-focused plan to address them.
- Implement the plan and refer the child and family to resources in the community.
- Monitor and modify the individualized plan to address the child's changing strengths and needs and/or improve the effectiveness of the plan and services/supports provided.
- Develop and implement a transition plan as soon as the team determines it is appropriate.

The CFT, with the participation of the duly authorized provider representative (DAPR), has the ability to access services and supports included in the plan.

- In the case of any disagreement between the DAPR and other CFT members regarding service recommendations, the DAPR works with the CFT to resolve any differences of opinion, with particular attention to the input and preferences of the parent(s)/guardian(s) of the enrolled child.
- When agreement cannot be reached regarding service planning at the CFT level, the DAPR helps unite the team in agreeing to try a particular service approach on an interim basis for a specified period of time during which the behavioral outcomes of the child are carefully monitored by the CFT. The team later reconvenes to consider the outcomes in relation to the services that have been provided and works together to make needed adjustments as time progresses. When deciding upon a service approach in the case of disagreement between CFT members, the DAPR gives as much or more weight to the opinions and

preferences of the parent/guardian as to any other member of the CFT.

Interim Agreement No. 1 Commitments Appendix F

This Appendix provides a consolidated list of the Commitments made by the State of Washington in Section VI. of this Agreement. It is provided for convenience. The Commitments listed herein must be read and interpreted in the context of the Agreement and not in isolation. When interpreting these Commitments the language contained in the main body of the Agreement is controlling.

A. System Principles

1. Defendants agree to operate a Medicaid-funded mental health system that delivers services to children and youth guided by the Principles [set forth in the Agreement].

B. Population and Service Definition

2. Defendants will develop a written "crosswalk" that matches the following Medicaid covered mental health services for eligible children and youths to Washington Medicaid State Plan Modalities: (1) Mobile Crisis Intervention and Stabilization Services, (2) Intensive Care Coordination, and (3) Intensive Home and Community Based Direct Services. WIYS are more fully described in Appendix A. The crosswalk will describe the services and their components, who is authorized to provide them, and how an agency or provider may authorize and bill for them. In accordance with the Principles, Core Practice Model, Access Model, Governance Model, and existing Washington State Medicaid State Plan, Defendants will develop:

a) a funding strategy to expand capacity statewide for use in any subsequent agreement

b) a plan to train and coach providers and Prepaid Inpatient Health Plans (PIHP) to prepare for delivery of these intensive services.

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c) a plan to transition existing intensive services capacity to the WIYS array to the extent feasible using existing resources.

3. Defendants will define initial expected service utilization among PIHPs of WIYS.

4. Upon Court entering an order regarding enforcement of this Agreement:

a) Defendants will offer a reassessment to each of the eight named plaintiffs currently enrolled in the WA Medicaid program within 20 days.

b) This reassessment will be scheduled within 60 days or at the Plaintiff's convenience. The reassessment will determine the client's current need for intensive home and community based mental health services.

c) Defendants will provide medically necessary services to address these needs as soon as possible but no later than 90 days after reassessment.

d) Any variance to these timeframes will be documented in the client file.

5. Defendants will develop a flexible statewide communications plan for outreach and education of the community, stakeholders, and families about eligible children and youths and the WIYS array to be developed within six months of a signed agreement in concert with the implementation plan. Information will be provided with appropriate translations and other necessary accommodations to promote recipient understanding.

6. Defendants will develop a plan to screen children and youth who have a mental illness or condition and functional impairment as listed in the Proxy.

7. Defendants will develop instructions, guidance, and/or technical assistance so that PIHPs, providers, allied agencies and partners are prepared to screen children and youth for the presence of the functional indicators contained in the Proxy.

C. Screening, Assessment and Access To Care

8. Defendants will develop an access model to be fully implemented in any subsequent Agreement that describes access pathways to WIYS consistent with this Agreement within six months of the Court entering an order regarding enforcement of this Agreement.

9. Defendants will begin transitioning existing intensive services capacity to the WIYS array in accordance with the completed transition plan, subject to existing resources and PIHP capacity.

10. Defendants will begin to implement the Child and Adolescent Needs and Strengths (CANS) tool.

11. Defendants will train providers to recognize functional impairments commonly associated with the functional indicators identified in the T.R. class proxy criteria and evaluate if they amount to a high risk behavior, as defined under 1915(b) Waiver Access to Care Standards, and exist due to the presence of a mental health condition (Diagnosis B "Additional Criteria").

12. Defendants will train providers that screening for intensive services or WIYS, if applicable, is essential when there is a:

a. request for out of home treatment or placement due to mental health needs;

b. step-down request from institutional or group care; or

c. PIHP crisis intervention and the individual presents with past or current functional indicators in the T.R. proxy.

13. Defendants will allow families or their representative referral sources to directly contact the PIHP or PIHP contracted Community Mental Health Agency (CMHA) to request and receive screening.

14. Defendants will provide medically necessary services or up to 14 days of medically necessary stabilization during the screening/assessment process through the contracted CMHA.

D. Service Delivery

15. Defendants will institute contract language requiring PIHPs to develop Child and Family Teams (CFT) consistent with the T.R. Principles and the Core Practice Model.

16. Defendants will establish a process for CFTs to obtain authorization by PIHPs. The process will be defined whereby a formally organized CFT, with the participation of the Duly Authorized Provider Representative (DAPR), has the ability to access services and supports included in the class member's treatment plan.

17. Defendants will establish Agreements across DSHS with child serving agencies requiring that local and regional representatives participate in CFTs (or care planning teams) for children served by multiple agencies.

18. Defendants will develop plans to provide guidance, training, supervision, and/or support to Child and Family Teams and informal care planning teams consistent with T.R. Principles and the Core Practice Model.

E. System Collaboration / Governance Model

19. Defendants will establish a sustainable interagency governance structure designed to achieve the responsibilities as outlined in the Governance Structure Appendix C. The governance structure will establish a process for (a) high-level policy-making, program planning, decision-making, oversight, and implementation of the intents set forth in the Agreement and

(b) local engagement, including participation by families/youth and local community representatives.

20. Defendants will establish Agreements with other child-serving systems to promote collaborative and coordinated care for high needs youth consistent with the T.R. Principles, Core Practice Model, and purposes and the intents of the Agreement.

21. Defendants will include families as full partners in the governance committees and groups as depicted in the Governance Structure in Appendix C.

22. Defendants will begin the process of aligning funding sources to strengthen interagency collaboration, support improved long-term outcomes, and establish systems to develop funding mechanisms for WIYS.

23. Defendants, with input from the Settlement Design Team, will undertake analyses and make recommendations to improve the integration of Children's Administration's and Division of Behavioral Health & Recovery's Title XIX services to class members. Defendants will implement their recommendations to the extent that it can be done within the term of this Agreement.

F. Quality Management And Quality Improvement Strategy

24. Defendants will begin development of a Quality Management Plan (QMP). The QMP is a comprehensive integration of the quality management goals, objectives, tools, and resources needed to implement the commitments set forth in this Agreement.

25. Defendants will develop the mechanisms for measuring these [QMP] system and clinical performance indicators.

26. Defendants will develop methods and procedures for PIHPs to monitor and periodically report on the degree to which services are aligned with T.R. Principles and the Core Practice Model.

27. Defendants will use data to manage and allocate resources through the governance structure, including initiating system improvements when indicated by data.

28. Defendants will share information developed under this section with the Settlement Design Team in order to facilitate reaching any subsequent Agreement.

29. Defendants will refine the annual satisfaction survey for youth and families to include questions regarding intensive services.

G. Due Process

30. Defendants will require that PIHPs provide a Notice of Action to Class members when any of the following apply:

a) The regional support network or the PIHP denies, terminates or reduces services.

b) The class member indicates to the PIHP their disagreement with specific treatment recommendations made during the development of his or her treatment plan.

31. Defendants will inform class members in the benefits booklet of the circumstances in which they have a right to receive a notice of action and request a fair hearing, including the circumstances listed in [number 30] above.

32. Defendants will provide directives to PIHPs and Community Mental Health Agencies (CMHA) reflecting the limits of CMHA's authority to deny, terminate, or reduce services for reasons that are solely clinical. Defendants will train CMHAs and PIHPs as to the limited role of CMHAs.

33. Defendants will require the PIHP to monitor for CMHA reductions, terminations and denials of services, to take such actions as are necessary to correct unauthorized actions by CMHAs. Defendants will require all PIHPs to collect data that tracks Notices of Action issued and Grievances and Appeals filed and to analyze the information on grievances and appeals as part of the PIHPs quality improvement program. Compliance will be monitored through an EQRO review. Defendants will address compliance concerns when they are identified.

H. Implementation

34. Defendants will implement the Agreement consistent with the T.R. Principles and Core Practice Model, and include them as appropriate in:

a. A governance plan

b. Contracts with PIHPs

c. Training materials

d. Communication materials

e. Quality review planning

f. Transition plan for existing intensive services.

35. Defendants will begin to develop an Implementation Plan for this Agreement once the Court enters an order regarding enforcement of the Agreement and will complete the Implementation Plan within three months thereafter. The Implementation Plan shall be developed under the direction of the Division of Behavioral Health and Recovery with input as outlined in the governance structure by the Settlement Design Team and shall:

a) identify and sequence necessary tasks;

b) set clear and accountable timelines for completing tasks;

c) assign responsibility for achieving tasks;

d) establish processes to provide feedback on implementation progress, including the need to adjust or amend the plan;

e) establish a collaborative method, to the greatest extent possible, to resolve disputes among the parties; and

f) be reasonably capable of achieving the terms of this Agreement.

36. Defendants will provide the Court, the plaintiffs, and the public with a Report that describes Defendants' progress in meeting their obligations under this Agreement. The Report will include accomplishments and identify potential or actual problem issues that need attention as well as remedial efforts to address them. The Report shall also set forth a funding plan for implementing WIYS and discuss the status of negotiations towards a subsequent Agreement.

T.R. Expected Achievements **Appendix G** **2/01/12**

This Appendix provides a consolidated list of the Expected Achievements set forth in Section VII of this Agreement. It is provided for convenience. The Expected Achievements listed herein must be read and interpreted in the context of the Agreement and not in isolation. When interpreting these Expected Achievements the language contained in the main body of the Agreement is controlling.

A. Population and Service Definition Achievements

1. Defendants have defined the WIYS array, as described in Appendix A, and produced a written "crosswalk" that matches WIYS to the Washington Medicaid State Plan Modalities.

2. Defendants have described the population of youth that will be eligible for WIYS.

3. Defendants have described the population of youth that will be served by CFTs.

4. Defendants have developed a flexible Communication Plan for outreach and education of the community, stakeholders, and families about eligible children and youths and the WIYS array. The plan includes language that it will be updated per department policy.

B. System Collaboration Achievements

5. Defendants have established an interagency governance structure, substantially similar to the structure described in Appendix C, that provides for high-level policy-making, program planning and implementation, and local engagement and decision-making. Families are full partners in governance and policy development. The Settlement Design Team is operational during the term of this Agreement.

6. Defendants have developed and adopted cross-system protocols consistent with this Agreement and have embedded those protocols in established Agreements/MOUs with child-serving agencies.

C. Access and Assessment Achievements

7. Defendants have adopted an access model as described in paragraphs 30-32.

8. Defendants have developed and adopted CANS as an assessment strategy and communications consistent with paragraph 33.

9. Defendants have established the threshold CANS criteria for access to WIYS in consultation with clinical experts agreed upon by the state and Plaintiffs.

D. Service Delivery Achievements

10. Defendants have adopted the Core Practice Model for the purpose of guiding service delivery consistent with the T.R. Principles and the Agreement.

11. Defendants have required PIHPs to develop CFTs pursuant to PIHPs' amended contracts.

12. Defendants have established a protocol that identifies the process by which a CFT may present treatment recommendations for authorization by the PIHP.

13. Defendants have developed a CFT quality tool to measure CFT voice, choice, and efficacy.

14. Defendants have defined the initial expected service utilization of WIYS among PIHPs.

15. Defendants have a written implementation plan developed for this Agreement, as described in paragraphs 66-67. This plan is created with input from the Settlement Design Team and approved through the Governance process.

16. Defendants have developed a plan, subject to existing resources and PIHP capacity, to transition existing intensive services capacity to the WIYS array consistent with the T.R. Principles and Core Practice Model.

E. Quality Management Achievements

17. Defendants have identified quality management tools and measures to be used for reporting, providing, and improving the quality care, and for providing transparency and accountability.

18. Defendants have begun to develop the Quality Management Plan, as described in paragraphs 50 - 60.

19. Defendants have clarified Notice of Action and grievance protocols and incorporated them into the Communication Plan and Benefits Booklet. DBHR has in place a process to monitor and periodically report on PIHP's compliance with this provision.

20. Defendants require that at least one PIHP annual Performance Improvement Project (PIP) is focused on improving mental health services to Medicaid funded children and youth.