Wraparound with Intensive Services (WISe)

Implementation Plan

August 1, 2014

Submitted under the

Settlement Agreement

in *T.R. v. Quigley and Teeter*

Hon. Thomas S. Zilly

U.S. District Court, Seattle

No. C09-1677-TSZ

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Introduction

This Implementation Plan is intended to carry out the obligations of the Settlement Agreement (Agreement), dated December 19, 2013 in *T.R. v. Quigley and Teeter*, a class action lawsuit filed on November 24, 2009. It should be read as entirely consistent with the Agreement and is not intended to supersede or replace any of the Agreement's goals, commitments, or exit criteria. Consistent with the Agreement, the purpose is to direct the development of a sustainable service delivery system for intensive mental health services provided in homes and community settings to Medicaid-eligible children and youth in Washington State. The purpose reflects the State Defendants' (State) understanding and policy that these children are best served in their homes and communities rather than in out of home care or in institutional placements. To achieve the purpose requires the development of a sustainable system of care to serve children in the home and community.

The Implementation Plan sets forth a blueprint for further developing the service delivery system and the quality and accountability structures necessary to fulfill the terms of the Agreement and deliver effective intensive mental health services provided in home and community settings statewide. The specific package of services being developed is called Wraparound with Intensive Services (WISe), which will be rolled out across the state over the next four years. WISe is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to their families.

The goal of the program is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements. To that end, WISe will encompass an array of Medicaid-funded services that are individualized, intensive, coordinated, comprehensive, culturally competent, and home and community based. Major components of the service array include: Intensive Care Coordination, Intensive Services provided in Home and Community Settings, and Mobile Crisis Intervention and Stabilization Services. These services are defined in Appendix A of the Agreement. Care planning will take place within the context of a strength-based child and family teaming process, and services will be integrated such that youth are served in the most natural, least restrictive environment.

As required by the Agreement, the Implementation Plan is intended to describe how the State will accomplish the requirements of the Agreement and must be approved by the Court.

Paragraph 57 of the Agreement provides:

> Defendants will develop the Implementation Plan using the Governance Structure, with input from the Implementation Advisory Team, and will:
>
> 1. Identify and sequence tasks necessary to fulfill the Commitments and achieve the Exit Criteria;

2. Estimate expected WISe utilization among PIHPs (Prepaid Inpatient Health Plans) and a roll-out schedule to achieve it;
3. Set clear and accountable timelines through June 30, 2018;
4. Assign responsibility for achieving tasks;
5. Establish processes to monitor and provide feedback on progress:
   a. in meeting their obligations under the Agreement, and
   b. of implementation, including any need to adjust or amend the Implementation Plan;
6. Establish a collaborative method to problem-solve challenges encountered; and
7. Describe the communication and outreach activities to inform the community, stakeholders, and families about WISe.

The Implementation Plan is not intended to be a detailed work plan for each implementation activity through June of 2018. It presents activities in sufficient detail to describe how the State will accomplish the requirements of the Agreement. The assignment of the responsibility of achieving implementation tasks, as set forth in paragraph 57(d) of the Settlement Agreement, will be addressed in the internal work plans developed by the State during implementation.

Paragraph 58 of the Agreement states that the implementation plan must be reasonably capable of resulting in the fulfillment of the Commitments and achieving the Agreement's Exit Criteria.

Overview of the Implementation Plan

Successful implementation will require both a series of activities to improve and expand service delivery and the development and deployment of a quality management and improvement system. The Implementation Plan is presented in two Sections:

Section I is comprised of Objectives that are derived from the Settlement Agreement's Goals. Section I describes the activities intended to increase service capacity and system performance sufficient to provide WISe to all eligible class members pursuant to the Agreement, the timing for those activities and the expected results from the activities.

Section II describes activities that are intended to develop a quality assurance program, including a Quality Management Plan (QMP), due to the Court by December 19, 2014 (one year after executing the Settlement Agreement).

The State will present annually a report on progress in executing the Implementation Plan to the Court, Plaintiffs, and public that describes: (1) strategies completed and in-process for each Objective; (2) planning for strategies to be completed or begun in the next year; (3) identification of potential or actual problems as well as remedial efforts to address them; and (4) quality assurance program information and results. The State will disseminate the report in accord with the Communication Plan described herein.

Information regarding implementation will be found at: http://dshs.wa.gov/dbhr/cbh-wise.shtml.

SECTION I: Development of a System to Deliver Services that Effectively Meet the Individualized Needs of T.R. Class Members

This section of the Implementation Plan identifies and sequences activities needed to achieve the Goals, Commitments, and Exit Criteria of the Settlement Agreement.

Objective 1: Communicate with families, youth, and stakeholders about the nature and purpose of WISe, who is eligible, and how to gain access.

Strategies to accomplish the Objective:

1. Develop accessible information for youth, families and child serving system partners, as identified in the Point of Identification section of the Access Model (hereafter system partners) about WISe, to include:
    - Who WISe is intended to serve
    - What WISe services are
    - How to make a referral or self-referral for a WISe screening
    - How medical necessity for WISe is determined
    - How youth and family can be involved in WISe governance
    - Due process

    a. In collaboration with Portland State University, the Division of Behavioral Health and Recovery (DBHR) will develop information materials that include the information described above for youth, families and system partners. DBHR will engage affinity groups in the development of materials. Affinity groups include youth, families, system partners and other community organizations that serve youth's behavioral health and support needs.
        i. To begin July 2014.
        ii. To be completed by December 2014.

    b. Review and update the information materials using the same groups involved in development, Plaintiffs' counsel, and Family Youth and System Partner Round-Tables (FYSPRTs).
        i. Annually, beginning in December 2015, to be completed by July 2016.
2. Disseminate the developed information to the affinity groups, system partners system and to youth and families about WISe.

a. Share information with FYSPRTs, system partners, affinity groups, and Plaintiffs' counsel as they are drafted and incorporated into the WISe Manual.
b. Deliver information developed through a variety of online, print, and in-person methods. Communication activities will prioritize providing information in regions where WISe is scheduled to roll out.
c. Deliver information in a way that conveys consistent messages and content to audiences across the state.
    i. Within sixty days of the completion of information materials.

3. All materials will be developed and disseminated in a manner that recognizes the cultural and communication and linguistic differences of class members. The Department of Social and Health Services (DSHS) will implement this strategy in compliance with its current policies and procedures regarding cultural competency and language, but also through the inclusion of culturally appropriate organizations in the development and review of materials.
    a. Translation to be completed prior to dissemination.
4. Include in the QMP a process for improvement of effectiveness of communications.
    a. Quality Plan due December 19, 2014.
    b. Timing to be established in the Quality Plan.

Expected results of Objective 1 are:

- Youth, families, system partners and affinity groups will be fully informed about WISe.
- Youth and families needing WISe services will receive sufficient information to access WISe services.

Objective 2: Effectively identify, refer and screen class members for WISe services.

Strategies to accomplish the Objective:

1. Identify and refer class members to WISe.
    a. Establish, periodically review and update as necessary the WISe Access Protocol, which includes a consistent identification, referral, screening, and intake/engagement process.
        i. Included in the WISe Manual, first published June 2014.
        ii. Reviewed annually beginning July 2015.
    b. Informed by the information used to identify class members in the Proxy, develop and use a description of likely class members for systematic

identification and referral to screening. Identifiers, including the system-specific identifiers developed as described below, will consider:

- Requests for out-of-home placement to meet mental health needs.
- Step down from out of home placement requests
- Youth accessing crisis services
- Existing information
- Identification without resort to mental health training.

i. Proxy identifiers were developed prior to the settlement agreement.
ii. The youth likely to benefit from WISe services are described in the WISe Manual dated June 2014.

c. In partnership with DBHR, each system partners will develop and use system-specific indicators, informed by the information used to identify class members in the Proxy, to identify likely class members for referral to WISe.

- Create and sign a Memorandum of Understanding with all system partners.

i. To be completed July 2013.

- Identify affinity groups for each child-serving system.

i. To be completed and included in June 2014 version of the WISe Manual.

- Work with each system partner to develop and use specific indicators and training materials.

i. Beginning July 1, 2014, and ending December 2015.
ii. Prioritize Children's Long-term Inpatient Programs (CLIP) for completion by September 2014.
iii. Prioritize Children's Administration for completion by October 2014.

d. Refine the identification over time to account for learning from actual use and performance and include education system information as it becomes available.

i. On an annual basis, beginning January 2015.

e. Require WISe active Regional Support Networks (RSNs) to accept referral from the child serving systems and to accept parent or youth to self-referral for a WISe screening.

i. To be included in the June 2014 version of the WISe Manual.
ii. Compliance with the WISe Manual is required in RSN contracts effective July 1, 2014.

2. Screen class members for medical necessity for WISe.

a. Develop and use the Washington version of the Child and Adolescent Needs and Strengths (CANS) tools to use for screening, assessment, care planning, quality planning and improvement.
    i. Initial CANS screening algorithm will be in-place by July 2014.
    ii. The Behavior Health Assessment System to be completed and online by July 2014.
b. Develop, disseminate and use a WISe Manual, consistent with the core practice model, that includes:
    - How identified class members are referred to trained screeners, in accord with the Access Protocol.
    - A WISe screening process, explaining how the CANS algorithm will be used, along with the RSN intake process, to consistently determine medical necessity for WISe statewide.
    - Screening of youth already served by the RSN, using information known by the RSN and providers to avoid duplication and burden to the youth and family.
    - Youth for whom WISe is determined to be medically necessary, will receive WISe services from a WISe qualified provider to address their needs and strengths as determined by a full CANS assessment.
    - How qualified WISe providers will take steps to engage and firmly and timely link youth for whom WISe is determined to be medically necessary to WISe.
    - How DBHR will assess and promote compliance with the WISe screening process.
    - Referral to and coordination of appropriate services for youth for whom WISe is not indicated.
    i. To be completed and included in the June 2014 version of the WISe Manual.
    ii. To be reviewed and updated as part of WISe Manual revisions, currently quarterly.
c. Incorporate the WISe Manual into RSN contract requirements.
    i. In contracts effective July 1, 2014.
d. Provide training and technical support on compliance with the WISe Manual.
    i. Beginning March 2014.
    ii. The first training for WISe providers will be provided prior to implementation of WISe with any provider.
    iii. Technical support at all levels of the system has been continuous, and will be available on an ongoing basis and as needed to any

group, organization or individual with priority given to those with WISe implementation in-progress.

e. Develop an online data system to store and report out on CANS related data.
    i. The Behavior Health Assessment System to be completed and online by July 2014.
f. Review data to determine whether those youth that screen into WISe receive WISe services and that those services are provided in accord with RSN contractual timeliness standards.
    i. Timeliness standards are included in RSN contracts.
    ii. For services provided after July 2014, but data not available for analysis until November 2014.
    iii. Review and report on first quarter of services in January 2015, thereafter within ninety days of the end of each quarter.

3. Describe how youth eligible for and needing WISe services will be transitioned from existing non-WISe services or providers.
    a. Transition current "WISe-like" services to WISe to serve at least 250 youth by July 2014.
        i. To be completed by July 2014.
    b. Establish protocols to refer and screen youth to WISe prior to admission and discharge from Behavioral Rehabilitation Services (BRS)/CLIP.
        i. Initial work to be completed for July 2014 operations, finalized by September 2014.
    c. Require WISe screen as part of referral to BRS or CLIP when there are active WISe programs in the youth's home community.
        i. Initial work to be completed for July 2014 operations, finalized by September 2014.
    d. Require that youth receiving BRS services receive a WISe screen at least every six month and upon discharge.
        i. To be included in July 1, 2014 version of the BRS Manual, but will be implemented as WISe capacity developed with the goal of being fully implemented in the final year of implementation.
    e. Require RSNs to coordinate with providers serving youth in residential and inpatient mental health treatment settings to screen for WISe prior to discharge for continuity of care.
        i. To be added to WISe manual no later than January 1, 2015.
4. Include in the QMP a process for improvement of effectiveness of identification, referral and screening. Provide feedback to all levels of the system in order to make adjustments and improve performance, including provision of reports at all levels via CANS Behavioral Health Assessment System, DBHR/Consumer

Information System, and Statewide Measures of Performance Dashboard. Post all aggregate reports on the Children's Behavioral Health website.

a. Quality Plan due December 19, 2014.
b. Timing to be established in the Quality Plan.

Expected results of Objective 2 are:

- Class members are identified and referred for WISe screening.
- Improve identification, referral and screening of class members over time.
- All child-serving systems and providers use consistent, established protocols statewide to identify and refer class members to WISe in a timely and efficient fashion.
- Clients' identification, referral and screening experiences are consistent across the state, are not burdensome to clients and are in compliance with the WISe Manual and core practice model.
- Have a systematic feedback methodology that uses results to improve outcomes over time.

Objective 3: Provide timely and effective mental health services and supports that are sufficient in intensity and scope, are individualized to youth and family strengths and needs, and delivered consistently with the WISe Program Model as well as Medicaid law and regulations.

Strategies to accomplish the Objective:

1. Provide WISe to the named plaintiffs immediately, as needed.
    a. Assess and serve as appropriate each named plaintiff:
        - Determine whether named plaintiffs are residing in the state, are Medicaid eligible and under twenty-one years of age.
        - Offer WISe screening, including CANS, to named plaintiffs who are Medicaid eligible in Washington State and are under twenty-one.
        - For named plaintiffs where WISe is medically necessary, offer to each plaintiff WISe or, where WISe services are not presently available, offer WISe equivalent services. Actively engage the youth and family consistent with the WISe Practice Model.
        - If WISe is not indicated or the named plaintiff refuses WISe services, provide services that address the strengths and needs of the named plaintiff and respect their choice.

b. Develop a workgroup for the named plaintiffs to include plaintiffs' counsel, DBHR program staff, and named plaintiffs' home RSN staff, to assist DSHS in monitoring delivery of services to named plaintiffs.
    i. Group(s) formation to be completed by August 29, 2014, with priority given to youth with current needs.
    ii. Review progress and outcomes quarterly beginning with the quarter ending September 30, 2014.
c. DSHS will provide oversight and technical assistance and support to RSNs serving named plaintiffs.
    i. Continuous; beginning with interim agreement.
d. DSHS and plaintiffs' attorneys to bring lessons learned to the ongoing T.R. Implementation Advisory Group and consider inclusion of any lessons learned into ongoing quality improvement.

2. Describe the intensive services included in the WISe service array and their purposes.
    a. Develop and utilize a WISe Manual statewide to support delivery and documentation of WISe services in a manner consistent with the WISe program model. The WISe Manual will include sufficient detail to guide the delivery of WISe services consistent with the core practice model.
        i. To be included in the June 2014 version of the Manual.
        ii. Quarterly revision and updates as described herein.
    b. Transition existing WISe-like services to WISe to include:
        - WISe training
        - Technical assistance
        - Transition planning
        - RSN attestation regarding readiness

        i. To be completed by June 2014 for RSNs that opted-in to July implementation.
    c. Update and refine WISe Program Manual over time based on feedback from cross-system stakeholders, outcomes data, and Children's Behavioral Health Governance Structure.
        i. Reviewed quarterly through 2014 and as determined necessary by WISe advisory groups thereafter.
3. Describe how WISe Medicaid services and providers will be coordinated with other services and supports. Coordination is more thoroughly described in the specific objective related to coordination.
    a. Develop and utilize protocols with system partners related to referral to WISe, participation in Child and Family Teams, Community Collaboratives and transitions out of WISe.
        i. To be completed and in use by December 2014.

ii. To be reviewed and updated at least annually starting in December of 2015.

4. Consistent with the WISe Practice Model, the WISe Manual will address transition of youth from WISe services, including:
    - Transition planning via the Child and Family Team process for all WISe participants, including those transitioning to adulthood, with the goal of having appropriate adult services in-place when WISe services end.
    - Transition of youth who no longer require WISe-level services to less intensive services and supports to avoid a gap in services when WISe services end.

    i. First version of WISe Manual published June 2014.
    ii. WISe Manual will be revised and updated as described herein.
5. Require CLIP programs to use CANS for care planning.
    a. Beginning July 2014 and fully implemented by October 2014.
6. Build sufficient provider capacity to meet the statewide need for WISe services within 5 years.
    a. Review quality assurance and utilization information to develop and maintain estimates of WISe capacity needs by each RSN and address those needs in the WISe roll out schedule.
        i. Initial Estimates of WISe Utilization at Full Implementation developed, see Appendix A.
        ii. Review capacity needs annually and make adjustments as needed.
    b. Identify RSNs and providers ready, willing and able to meet the identified capacity need. Develop specific plans for those providers, utilizing successful agency experience.
        i. Initial planning to be completed by July 2014.
        ii. DSHS will develop and update its public rollout plan that adjusts for growth, needed capacity and provider readiness with the end point being full statewide capacity to provide WISe services to address client need.
    c. Provide training and technical support to providers implementing WISe on a publically posted schedule.
        i. Beginning March 2014.
        ii. WISe training will be provided prior to implementation of WISe with any provider.
        iii. Technical support will be on an ongoing basis and as needed.
    d. Develop a list of qualified WISe providers by county.
        i. To be completed by for July 1, 2014
        ii. Updated the list as capacity changes with ongoing implementation.

7. Require RSNs to attest to provider readiness prior to implementing WISe with any provider. The payment of the WISe Case Rate is dependent on attestation.
    a. To be completed July 1, 2014.
8. Establish a reimbursement method for WISe providers and make payments accordingly. The initial incremental cost of WISe services is based on experience in other similar program implementations and historical Washington information on similar services. At the end of implementation, payments for WISe services will be based on Washington experience.
    a. Develop and implement actuarially sound rates, including a case rate, for WISe.
        i. Rate established through June 30, 2015.
        ii. Updated annually.
    b. Develop and implement funding for WISe infrastructure development.
        i. Funding established through June 30, 2015.
        ii. Updated annually.
    c. Develop Decision Packages for the legislature to include service and infrastructure costs.
        i. Bi-annually.
    d. Modify the Medicaid payment system, ProviderOne, to allow for payment of the case rate for WISe.
        i. In process and anticipated to be completed by October 2014, will be retroactive to July 1, 2014.
9. Include in the QMP a process for improvement of effectiveness of the provision of WISe services and supports.
    a. Quality Plan due December 19, 2014.
    b. Timing to be established in the Quality Plan.

Expected results of Objective 3 are:

- Medicaid eligible youth for whom WISe is medically necessary will receive WISe timely, including services in the WISe service array, to meet individual and family needs and strengths.
- Services will be provided consistent with the WISe Practice Model, as described in the WISe manual.
- RSNs will be paid to provide WISe.
- There will be sufficient qualified provider capacity to provide WISe statewide.

Objective 4: Coordinate delivery of WISe services across child-serving agencies and providers.

Strategies to accomplish the objective:

1. Establish expectations for child-serving agencies and providers to address the needs of all class members.
    a. Create and adopt a financing plan that coordinates resources to strengthen inter- and intra-agency collaboration, sustain WISe and improve long-term outcomes.
        i. Initial plan adopted in April 2013.
        ii. Plan to be reviewed for updates, beginning July 2015 for December 2015 completion.
    b. Develop, use and refine over-time guidance and training curricula for RSNs, providers, system partners and community organizations who might participate on Child and Family Teams, regarding roles and responsibilities for appropriate identification and referral for WISe, to participate on Child and Family Teams and to coordinate care, maximize shared goals and minimized fragmentation.
        i. To be included in July 2014 version of the Behavioral Rehabilitation Services (BRS) Manual.
        ii. BRS Manual to be reviewed for updates by October 2014.
        iii. Other materials to be completed by December 2014.
        iv. All materials to be reviewed annually beginning December 2015.
    c. Establish a Memorandum of Understanding between DSHS administrations and Health Care Authority that includes expectations for collaboration and coordination, cross-system staff participation on Child and Family Teams, and use of a single plan of care to direct services from all systems serving each youth and family.
        i. To be completed July 2013.
2. Promote the shared values and goals outlined in the Washington State Children's Mental Health Principles among child-serving agencies and institutionalize the values where possible.
    a. Utilize the governance structure to promote the Washington State Children's Mental Health Principles in service delivery and policy development.
        i. Governance development is a key activity under the Systems of Care Substance Abuse and Mental Health Services Administration (SAMHSA) grant that began in 2011 and the grant continues to support the further development of the FYSPRTs.
        ii. To be included in the June 2014 version of the WISe manual.
    b. Assess implementation of Principles in RSNs.
        i. Begun January 2014 and EQRO report due December 2014.

3. Include in the QMP a process for improvement, including the effectiveness of transitions-from out of home placements.
    a. Quality Plan due December 19, 2014.
    b. Timing to be established in the Quality Plan.

Expected results of Objective 4 are:

Child-serving systems will coordinate care to support youth and family progress on individualized treatment goals. Services will be consistent with the WISe Program Model and the Access Protocol.

Objective 5: Support workforce development and infrastructure necessary for education, training, coaching, supervision, and mentoring of providers, youth, and families.

Strategies to accomplish the objective:

1. Identify and address present and future workforce needs.
    a. Develop and maintain an organizationally independent WISe Workforce Collaborative, including WISe providers, RSNs, system partners and national experts and co-led by youth and families to:
        - Create a model for workforce development.
        - Sustain local and statewide training, curriculum, technical assistance, coaching and mentoring.
        - Assess current and future training and technical assistance needs.
        - Support agencies in providing WISe to fidelity standards.

        i. Contract with Portland State University for training, coaching, technical assistance and consultation is in effect through June 2015
        ii. To be in contract with Washington State University by August 2014
        iii. Collaborative to be establish by January 2015
        iv. Initial training curriculum to be completed by March 2014 and will be refined over time by the WISe Workforce Collaborative to maintain quality and consistency across the state.
    b. Develop Training Plan to ensure each WISe provider, RSN, and system partner has received training based on the WISe Manual.
        i. Initial training to be provided to RSNs and providers implementing WISe in July 2014.
        ii. Training Plan to be completed by October 2014.
        iii. Will be updated at least every six months.

2. Train and provide necessary technical assistance, coaching and mentoring to providers, RSNs, and system partners on the WISe model and service array in accordance with WISe rollout.
    a. Develop, provide and evaluate a consistent training curriculum for all roles in the provision of WISe services and supports (WISe program staff roles, system partner roles as well as participating youth, families, natural supports).
        i. In process – contract with Portland State University
        ii. Contract with Washington State University to be in place by July 2014.
        iii. Initial training a curriculum has been completed and is anticipated to be refined over time by the WISe Workforce.
        iv. Training will be provided to prepare providers, RSNs and system partners to provide WISe prior to implementation in an RSN.
    b. Develop a long-term training and technical assistance plan that includes support for individual roles with the WISe model as well as therapists responsible for overseeing the therapeutic interventions as an appendix to WISe manual.
        i. First draft of the Manual to be completed by June 2014.
        ii. To be updated with WISe manual.
    c. Develop and provide training that addresses identification, referral, participation in cross system care planning, and ongoing support and transition of WISe youth and families after WISe is determined no longer medically necessary.
        i. To be completed by December 2014.
    d. Develop e-learning modules to address the need for refinement of skills and on-going training.
        i. In process; to be completed by December 2014.
    e. Develop sustainable training and technical assistance capacity through a "Train the Trainer" model established in partnership with our current trainers from Portland State University.
        i. Curriculum to be completed by June 2015.
        ii. All trainings to be provided by WISe providers by 2018.
    f. Collaborate with system partners to include WISe modules in their trainings, manuals, and other workforce development efforts.
        i. In process; to be completed by December 2014.

Expected results of Objective 5 are:

The statewide WISe workforce will include a sufficient number of clinicians, staff, and supervisors who have received adequate training to identify class members needing WISe, to use the CANS assessment for screening and clinical practice, and to deliver WISe services in accordance with the WISe manual.

Objective 6: Maintain a collaborative governance structure to achieve the goals of the Agreement.

Strategies to accomplish the objective:

1. Adopt and use a Governance structure to make decisions and policies necessary to implement the Settlement Agreement. The Statewide and Regional Family Youth and System Partner Round-Tables (FYSPRTs) will maintain available agendas and minutes. Meeting of FYSPRTs and Collaboratives will be open public meetings.
    a. Establish Agreement(s) with system partners across DSHS and Health Care Authority. Complete agreements among system partners to address funding coordination, training and quality assurance.
        i. Memorandum of Understanding signed July 2013.
    b. Establish charters for the various components of the governance structure that describes their role in providing for adherence to Settlement Agreement and implementation progress.
        i. Executive Team, February 2014.
        ii. Statewide FYSPRT, 2013.
        iii. Regional FYSPRT, February 2014.
        iv. Local as WISe becomes active in an RSN, must be in-place to provide services.
        v. Workgroups listed in WISe Manual.
    c. Provide financial information and data from the cross-administration Finance Team and Data Quality Team to FYSPRTs and executive management and elected officials to guide recommendations and decision making.
        i. Decision package completed; funding included in state budget for Fiscal Year 2014-2015
        ii. Decision package to be prepared for each biennium
        iii. DSHS will comply with the schedule for submission of decision packages as set forth by the Office of Financial Management and the Governor's Office.

d. Develop clear protocols and procedures in the WISe Manual for Community Collaboratives of youth and families to oversee implementation of local WISe programs.
    i. To be completed in June 2014 version of the WISe Manual.
    ii. Will be updated as needed with WISe Manual.

2. Increase family and youth participation in all aspects of policy development and decision-making.
    a. Develop and implement a plan to increase family and youth participation in policy development and decision-making.
        i. Participation included in governance structure charters.
        ii. Described in the System of Care Grant work plan beginning January 2012 with activities continuing through September 2016.
    b. Develop FYSPRT leadership trainings.
        i. Initial training completed October 2013.
        ii. Additional training October 2014.
    c. Develop a protocol for regional and Statewide FYSPRTs to bring local and statewide issues to the Executive Team.
        i. Included in charters and June 2014 version of the WISe Manual.

Expected results of Objective 6:

Meaningful partnerships between family, youth and system partners throughout the state are developed at every level of the child serving system. Providers will work together cooperatively and collaboratively to build a delivery system with effective services and supports for youth and their families.

Objective 7: Afford due process to Class members.

Strategies to accomplish the Objective:

1. Adopt legally appropriate, federally compliant due process rules and policies.
    a. Change contractual provisions related to the grievance system.
        i. Amendments to the Prepaid Inpatient Health Plan/RSN contract were made effective September 2012. These provisions apply the general grievance system requirements under 42 CFR 438 Subpart F, including the grievance process, notices of action, appeals procedures, fair hearings, and RSN recordkeeping and reporting requirements. "Action," as defined in Section 1 of the contract, includes "Enrollee disagreement with the treatment plan." Section 8.8.2.10 of the contract addresses delegation to subcontractors (providers) of notice requirements when actions are taken and

requires the RSN to monitor the content of providers' Notices of Action.

b. Develop and modify Washington Administrative Code that addresses Medicaid due process requirements for Medicaid enrollees.
    i. In August 2014, DBHR will publish a notice in the State Register stating the intent to engage in rulemaking regarding Medicaid grievance and administrative hearings.
    ii. During the fall of 2014, DBHR will develop a proposed rule with input from Plaintiffs and interested parties, with an anticipated public hearing date of December 2014 or January 2015.
    iii. Promulgate the rule.
        1. Effective date anticipated to be March 2015.

2. Inform Class members of their rights to due process.
    a. Develop/update Medicaid due process informing materials for distribution and posting to class members and families.
        i. DSHS currently publishes information on Grievances and Appeals in its Medicaid Mental Health Benefits Booklet, available on the internet or by mail. The Benefits booklet sets forth accessible information about complaint, grievance and appeals, as well as contact information for RSN Ombuds and the DBHR Office of Consumer Partnership, so that Medicaid mental health consumers may understand their rights. http://www.dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml
    b. Require RSNs to provide notice of actions for all denials, terminations or reductions in services.
        i. RSN contract updated; effective September 2012.
    c. Require RSNs to provide information to clients regarding due process rights (grievance and appeals).
        i. RSN contract updated; effective September 2012.
    d. Develop a model notice of action for RSNs. Require RSNs to use the model notice, or complete a checklist and attestation that their notice has all the same elements as the model notice.
3. Monitor compliance with due process requirements and address noncompliance.
    a. Require all RSN policies to be consistent with due process regulations and policies.
    b. Require the RSNs to collect and report data on actions, grievances and appeals.
    c. Monitor RSN compliance with due process requirements through audits, compliance reviews and data analysis.
    d. Analyze and use the data as part of the WISe quality improvement program.

Expected results of Objective 7 are:

- To ensure Medicaid beneficiaries (including class members) are aware of their due process rights
- To ensure RSNs and providers are complying with Medicaid due process requirements
- To ensure beneficiaries have access to and can exercise their notice, grievance and appeal rights.

SECTION II: An Accountability Structure that Ensures Ongoing Quality Assurance and System Improvement on Behalf of the T.R. Class Members, Monitors Achievement of Settlement Goals, and Facilitates Development of the Washington State System of Care

System performance, and reforming system practices, requires well designed monitoring, analysis, reporting, and real-time feedback capabilities in order to be successful. Moreover, an effective and feasible quality assurance process is essential to reviewing progress, removing barriers, improving practice, ensuring accountability, allocating resources wisely, and making midstream corrections. In short, an effective Quality Management, Improvement, and Accountability (QMIA) system is essential for communicating goals and objectives, directing efforts to achieve them, and determining whether they have been met.

This Section presents the competencies and activities needed to develop a comprehensive T.R. Accountability Structure or system, driven in large part by the development of a Quality Management Plan (QMP), due to the Court by December 19, 2014. This section is intentionally more schematic because the QMP is intended to provide the detailed roadmap for the design and implementation of the full QMIA system.

The competencies described herein provide the overarching framework of goals for the QMIA system and guidance for developing the more specific and integrated QMP. Some of the activities described herein are ongoing or completed, will be taken immediately, or will be initiated while the QMP is being developed. Those activities are governed by this Plan. Longer-term and ongoing activities will be further detailed and governed directly by the QMP.

The competencies needed to fully develop the QMIA system called for by the Settlement Agreement are divided into six sections, although in order to distinguish them from the foregoing objectives, they are labeled a-h. Immediate tasks need to be addressed at the earliest opportunity in order to provide a necessary foundation or benchmark for future activities. Short-term tasks may be ongoing or will be started during the QMP planning process. Finally, long-term activities and tasks are expected to happen or be completed after the QMP is adopted and will be guided directly by the QMP.

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

Immediate:

1. Estimate class size and distribution for benchmarking. Initial estimate of utilization by each RSN March 19, 2014. Initial estimates will be used to inform rollout of WISe over time.
2. The WISe Quality Assurance subcommittee will identify priority information needs for WISe in developing the QMP, review presently available data (e.g., CANS data, evaluation of initial WISe trainings), and develop a draft QMP to the Children's Behavioral Health Data and Quality Team for final approval.

Short-term:

3. Develop and use a Quality Assurance Plan to be completed by December 19, 2014.
4. Develop publicly accessible children's behavioral health measures of statewide performance specific to putative and actual Class members.

Long-term:

5. DBHR will oversee a process of communication and outreach that fully informs all stakeholders of the progress toward meeting goals, and the status of service delivery, system improvement, and outcomes of the T.R. Class Members, as described in the final QMP.
6. Reports on progress in implementing this Plan will be presented annually to the Judge, Plaintiffs, and Public in a format that describes (1) strategies completed, under way, and yet to be started within each Objective in Section I above, and (2) information and data relevant to QMP. Final Reports will be provided on the dates below, with presentations to stakeholders and the public provided consistent with the Communication Objective [Object 1 herein] and the QMP.
7. Assess and refine service use [DBHR, Research & Data Analysis] monthly beginning in July 2015. DBHR, working with Research & Data Analysis, will assess and refine estimates of service need and actual use. Details on this process will be included in the QMP. Utilization data, analysis, and reports will include:
    a. All youth screened for WISe, to ensure that there is no systematic screening out of children who met medical necessity but were not served,
    b. Out-of-home placements of youth with mental health needs who are not provided WISe after screening, and,
    c. Youth who may meet medical necessity for WISe are not being screened, and make data-informed adjustments to algorithm or identification and referral processes as needed.

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

Short-term:

1. DBHR and its agency partners will develop a Total Clinical Outcomes Management plan, in close collaboration with the T.R. Implementation Advisory Group or its representatives, for describing, rating, and guiding development of essential competencies for system reform, focusing on administrative and management systems. The plan will be used to evaluate system and infrastructure strengths and needs in order to be able to identify and prioritize actions necessary to ensure the success of the Implementation Plan and the overall reforms called for in the Settlement Agreement.
2. Identify the resources necessary to support successful implementation and the steps needed to secure them. Decision Package(s) developed pursuant to the Implementation Plan will include allocations specific to the quality assurance activities described herein and undertaken pursuant to the final QMP.

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

Immediate:

1. Complete the children's behavioral health Measures of Statewide Performance and continually populate and update with relevant data. Post the measures online along with notes from the Children's Behavioral Health Data and Quality Team.
2. RSNs statewide will complete Performance Improvement Projects on improving WISe services.
3. The steps for monitoring WISe implementation and related outcomes will be incorporated into the larger T.R. QMP to be developed by the Children's Behavioral Health Data and Quality Team.

Short-term:

4. Gather and review immediately available data. Data are available for several data elements (e.g., initial collected CANS, WISe Training evaluations) and are being reviewed and discussed by the WISe Quality Assurance Subcommittee for use in quality improvement.
5. Have publicly accessible Children's Behavioral Health Measures of Statewide Performance specific to putative and actual Class members. (To be completed with the second annual Implementation Report November 2015.) Similar to the measures of overall statewide children's behavioral health system performance, a dashboard populated with specific indicators and data from the QMP and Total Clinical Outcomes Management processes will be developed and included in the QMP.

6. Collect utilization and CANS data at the clinical, provider agency, RSN and state levels for use in a coordinated, comprehensive quality and outcomes monitoring and improvement program.
    a. The WISe screening algorithm, to identify putative class members for WISe services, has been incorporated into the Behavioral Health Assessment System.
    b. The Quality Improvement process monitors implementation to ensure the algorithm is working as specified and that appropriate class members are being identified.
    c. Review multi-level reports available in the Washington's Behavioral Health Assessment System. To be fully implemented by December 2014.
    d. Integrate multi-level reports available in the Behavioral Health Assessment System into a comprehensive quality outcomes monitoring and improvement program. Due December 19, 2014.

Long-term and Ongoing:

7. Implement QMP statewide for WISe programs and services.
8. With support from RSNs and consultants, DBHR and Research & Data Analysis will produce data that meet the information needs identified in the QMP, and report annually to the Judge, the Plaintiffs, and the public as part of the annual reporting requirements.
9. DBHR will oversee a process of communication and outreach that fully informs all stakeholders of the progress toward meeting goals, and the status of service delivery, system improvement, and outcomes of the T.R. Class Members, as described in the final QMP.
10. Provide annual Implementation Status Reports [DBHR, Research & Data Analysis]. The QMP will provide specific details on the data to be presented in status reports, a proposed timeline of reports, target audiences, and intended data use. These details will be summarized in terms of Domains (to correspond with the Information Needs describe above, e.g., Access, Timeliness, Appropriateness, Fidelity of Implementation, Satisfaction of Youth/Families, Satisfaction of Providers, Child and Family Outcomes, and System Outcomes); Outcomes (e.g., children served, service denials, child functioning); Indicators, and Data Sources. Examples of high-priority information to be reported within this framework are provided below:
    a. Number and characteristics of WISe program children/youth as they enter, progress through and transfer from the WISe program.
    b. Implementation report to monitor CANS assessments conducted at required intervals, including discharge from WISe services.
    c. Extent to which provided services are consistent with WISe program requirements.
    d. Demographics, clinical differences and outcomes (short-term, e.g., CANS scores and long-term, e.g., Measures of Statewide

Performance) for those youth who received WISe and those who were screened out.

e. Whether the cross-system identification and referral process is being implemented as intended.
f. Transitions services for out of home youth, in particular youth exiting BRS and CLIP.

11. Develop and implement a WISe fidelity model and fidelity monitoring approach. [DBHR, January 1, 2015]. A key component of the WISe QMP will be a comprehensive approach to monitoring adherence to the WISe service model as well as necessary organizational supports. This approach will be based on best practices in fidelity monitoring standards for relevant programs (e.g., Wraparound, Assertive Community Treatment). Fidelity monitoring will be pilot tested as part of the Quality Service Review implementation (to be completed before July 2017).

Objective D: Improve clinical and program quality.

Short-term:

1. The QMP will include provisions that:
    a. Provide for multi-level feedback of CANS data on youth strengths, needs, and progress in real time on a web-based platform which, combined with information on strategies and treatment received will inform decision-making action on multiple levels (youth, team, supervisor, provider, RSN, state);
    b. Identify effective treatment practices and disseminate those practices across the system through review of data and information by a statewide learning community; and
    c. Support persons at multiple levels of the system to work together effectively and appropriately allocate resources to the most important needs.

Long-term and Ongoing:

2. Develop and Use Quality Service Reviews within 3 years [DBHR]. As described in the Settlement Agreement, DBHR will use initial results of ongoing Quality Assurance to:
    a. Identify one low, one medium and one high performing program or provider by July 2015.
    b. Assess child and system outcomes as identified in the QMP and test identified process for Continuous Quality Improvement – August-November 2015.
    c. Write report on Lessons Learned with improvement recommendations and submit to DBHR Quality Improvement Committee – January 1, 2016.
3. Conduct Problem-Solving Decision-Making as needed after review of process and outcome data with the:
    a. Statewide FYSPRT

b. RSN Quality Leads (as well as administrators, Performance Indicator Work Group, Children's Mental Health Committee)
c. DBHR QIC
d. Children's Behavioral Health Data and Quality Team.

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

Short-term:

1. Reporting and feedback processes will be identified and included within the QMP in partnership with the FYSPRTs, DBHR Quality Improvement Committee, Children's Behavioral Health Data and Quality Team, Cross Systems Initiative Teams, CBH Executive Leadership Team, RSNs, T.R. Implementation Advisory Group. Due by December 19, 2014.

Conclusion

The State of Washington anticipates that it will successfully implement this Plan, and, through the successful implementation, will demonstrate they have substantially complied with the Commitments during the pendency of the plan, and with the Exit Criteria by June 30, 2018. At that time, Exit Criteria will be the sole objective measures used to demonstrate that State of Washington is in substantial compliance with the terms of the Agreement. If, at that time, the State has successfully met the exit criteria, the Parties' obligations under the Settlement will terminate.

The parties will meet to determine whether there is any dispute as to whether the Defendants are on track to meet the exit criteria by September 30, 2017, or nine months prior to the date implementation is anticipated to be completed.

July 28, 2014
Olympia, Washington

Initial Estimates of WISe Utilization at Full Implementation

Number of children served in at least one month of the year

The Department of Social and Health Services is engaged in the five-year rollout of a program that enhances mental health care services for the highest-need Medicaid children and youth in Washington State. The Wraparound with Intensive Services (WISe) program provides intensive home- and community-based services to help these children receive mental health treatment and connect with natural supports in their homes, schools, and communities.

The program will be phased in over time as capacity is built throughout the state. Planning for capacity-building requires anticipating the caseload in each county and RSN once the program is fully implemented in SFY 2019. Assuming a 12-month average duration of participation in WISe, the forecast average monthly capacity at full implementation will be approximately 50 percent of the unduplicated annual utilization reported in this document.

The table to the right displays low-, mid-, and high-range forecasts of WISe utilization at each level of geography at full implementation. The forecasts take into consideration the number of Medicaid children in each locality with mental health needs, the estimated severity of mental health needs and associated functional indicators, and the resulting number of children at greatest risk for out-of-home placement. The mid-range forecasts can be considered the "best estimate" of a locality's WISe caseload at full implementation. The low and high bounds aim to demonstrate the magnitude of uncertainty around that "best estimate" due to the margin of error in predicting which children and youth will need WISe services.

DRAFT WISe Roll Out Plan

2014	2015	2016	2017
Benton	*Adams*	*Asotin*	*Clallam*
Clark	*Chelan*	*Columbia*	*Island*
Cowlitz	*Douglas*	*Ferry*	*King*
Franklin	*Grant*	*Garfield*	*San Juan*
Kittitas	*Grays Harbor*	*Jefferson*	
Klickitat	*Kitsap*	*Lewis*	
Mason	*Lincoln*	*Okanogan*	
Pierce	*Skamania*	*Pacific*	
Skagit	*Spokane*	*Pend Oreille*	
Snohomish		*Stevens*	
Thurston		*Wahkiakum*	
Walla Walla			
Whatcom			
Whitman			
Yakima			

NOTE: *Roll out schedule is tentative beyond Sept 2014.*

	LOW	MID	HIGH
WA State	**4,760**	**5,722**	**6,701**
RSN			
Chelan-Douglas	61	97	138
Grays Harbor	71	95	121
Greater Columbia	619	797	989
King	937	1,011	1,085
North Sound	737	882	1,026
Peninsula	281	363	437
Pierce	600	661	724
Southwest	458	545	640
Spokane	686	864	1,030
Thurston-Mason	217	273	332
Timberlands	93	134	179
County			
Adams	6	16	26
Asotin	11	23	37
Benton	160	195	230
Chelan	41	62	86
Clallam	73	104	129
Clark	326	373	422
Columbia	0	3	9
Cowlitz	128	160	196
Douglas	20	35	52
Ferry	2	9	17
Franklin	59	82	107
Garfield	0	1	4
Grant	54	76	109
Grays Harbor	71	95	121
Island	32	48	65
Jefferson	13	25	37
King	937	1,011	1,085
Kitsap	195	234	271
Kittitas	21	36	51
Klickitat	13	26	40
Lewis	85	111	138
Lincoln	2	9	17
Mason	44	64	85
Okanogan	27	43	61
Pacific	6	16	28
Pend Oreille	4	14	24
Pierce	600	661	724
San Juan	0	5	11
Skagit	106	133	162
Skamania	4	12	22
Snohomish	443	507	562
Spokane	554	643	702
Stevens	37	54	74
Thurston	173	209	247
Wahkiakum	2	7	13
Walla Walla	56	77	98
Whatcom	156	189	226
Whitman	9	19	31
Yakima	290	335	382

TECHNICAL DETAIL

This document presents estimates of utilization for the Wraparound with Intensive Services (WISe) program at full implementation service levels in SFY 2019. The forecast unduplicated annual count of clients receiving WISe services in at least one month of SFY 2019 is 5,722. Based on the number of Medicaid children in each county with mental health needs, and the severity of these needs, this statewide caseload is apportioned to counties and RSNs. Ranges of utilization are constructed to account for the uncertainty in predicting which children and youth will need WISe services.

Mid-Range Forecast. The mid-range estimates apportion the forecast full-implementation caseload of 5,722 statewide to counties according to the number of Medicaid children in each county with mental health needs, weighted by their mental health "risk scores." This population includes Medicaid clients under age 21 in the first month enrolled in Medicaid in SFY 2011, with at least one indication of mental health service need based on diagnoses, psychotropic medication receipt, and service utilization in SFY 2011. For each child, a mental health "risk score" was calculated representing the child's severity of mental health needs in the current year and his or her probability of an out-of-home placement in the subsequent year. The risk score calculation is based on prior predictive modeling work which maps a child's indications of mental health service need (including out-of-home placements and proxy functional indicators) onto his or her probability of mental health inpatient admissions, chemical dependency inpatient admissions, JRA institutions admissions, or behavioral rehabilitation services.

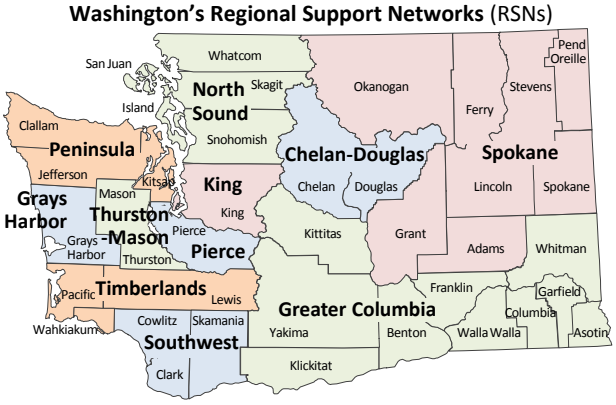
Low and High Forecast. Because outcomes that individuals experience are never perfectly predicted by any risk model, there is uncertainty associated with apportioning WISe caseload strictly based on the forecasted magnitude of mental health risk among the children and youth in a given locality. First, even if the model produces mental health risk scores that perfectly reflect each child's true probability of out-of-home placement, there remains some variation between predicted outcomes and realized outcomes. For example, a child with a 20 percent probability of out-of-home placement in the follow-up year will perhaps experience a placement and perhaps not. If the same follow-up year could be repeated ten times, on average this child would experience a placement in two of these years, and not experience a placement in eight of these years. Second, no risk model perfectly estimates these underlying probabilities. For this reason, other methods of apportioning WISe caseload were considered.

To account for the first source of uncertainty, we ran 10,000 simulations of out-of-home placement outcomes based on the mental health "risk scores" for Medicaid children in each county. Each simulation implies a slightly different apportioning of WISe caseload across counties. We used the 95 percent confidence interval of the implied caseloads for each county (discarding the most extreme 2.5 percent of results at both ends of the empirical distribution) to establish low and high utilization forecasts.

To account for the second source of uncertainty, we also considered two other approaches to apportioning WISe caseload: 1) proportional to the number of Medicaid children in each county with an indication of mental health need; and 2) proportional to the number of Medicaid children in each county with an indication of mental health need and a functional proxy indicating that the child should be screened for WISe services. The final high and low utilization forecasts for each county reflect the maxima and minima across all three approaches to apportioning.

Additional Uncertainty. Other forms of uncertainty that will affect WISe utilization in SFY 2019 could not be incorporated into these initial forecasts. Utilization may be impacted by future demographic trends, economic conditions, and other factors. As a result, these initial forecasts are estimates and subject to change.

Washington's Regional Support Networks (RSNs)



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Appendix A