Implementation Status Report

November 15, 2018

Submitted under the

Settlement Agreement

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

Hon. Thomas S. Zilly

U.S. District Court, Seattle

No. C09-1677-TSZ

Washington State Department of Social & Health Services

Transforming lives

Washington State Health Care Authority

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Wraparound with Intensive Services (WISe) Implementation Status Report

Introduction

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

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

On August 1, 2014, the State submitted a WISe Implementation Plan to the court, which was subsequently approved. The Implementation Plan was organized around seven objectives necessary to accomplish the commitments and exit criteria of the settlement agreement. This report follows these seven objectives so that progress and concerns can be tracked in a logical and consistent manner as the WISe program evolves over time.

This report is organized into three main sections. Section I is an Executive Summary that provides an overview on the State's progress in developing and implementing WISe over the past year. Section II has a description of the specific accomplishments made from November 2017 through September 2018, and then sets forth remaining tasks. Section III identifies overarching implementation challenges and proposals for addressing those areas of concern. Additionally, Section IV contains a glossary of key terms and Section V has relevant attachments.

I. Executive Summary

In September 2017, Pursuant to Paragraph 66 of the Settlement Agreement, the parties began discussions regarding "whether the Defendants are on track to meet the exit criteria" set forth in paragraphs 67-72 of the Settlement Agreement. The parties held discussions and enlisted mediator Kathleen Noonan to assist in reaching agreement about what remaining implementation tasks would be necessary to demonstrate substantial compliance with the exit criteria.

In March 2018, the parties attended two full days of in-person mediation with Ms. Noonan. Following those in-person meetings, the parties had several phone calls with Ms. Noonan and one another.

At this time, the State anticipates achieving substantial compliance by June 30, 2019. The parties' agreement defined a set of tasks that must be completed in order to demonstrate substantial compliance with the exit criteria. Items reviewed included:

- Access and Service Delivery;
- Due Process;
- Quality Management Plan;
- T.R. Implementation Advisory Group (TRIAGe)/Process; and
- WISe/Behavior Rehabilitation Services Integration.

On April 6, 2018, the parties executed an agreement[1] that clarified various exit criteria and related Settlement Agreement terms. The parties' agreement acknowledged that the State would not have completed all exit criteria by the original anticipated completion date of June 2018. In April 2018, parties submitted a Stipulation to the Court[2] regarding these clarifications to the T. R. Settlement Agreement and to further apprise the Court on the status of the implementation efforts.

Updates on the progress of these areas are included in this report. At the time of drafting of this report, the parties were still working towards finalizing the Exit Criteria for 69 (c) and the Quality Management Plan (QMP).

Report highlights indicate the strides that have been made in Washington since the last report to achieve the goal set forth under the Settlement Agreement, the key challenges that remain, and the priority tasks for the coming year as the State works diligently to meet exit criteria.

[1] Included in section V. Attachments, pp 88 – 91.
[2] Included in section V. Attachments, pp 84 – 87.

Washington Has Made Significant Advances over the Past Year

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

Implementation data indicates that the number of referrals and screenings continues to grow. From July 1, 2014 through June 30, 2018, 11,296 **WISe screens** were conducted for youth aged 5 and older. In that time frame, 169 screens were conducted on children younger than 5.

In SFY 2018, 4,496 WISe screens were conducted for an unduplicated total of 3,952 youth, representing a 42% growth in youth screened over the prior year. The largest referral sources for the WISe program are the Behavioral Health Organizations (BHOs) (28%), self and family (20%), and Children's Administration (CA), now known as the Department of Children, Youth, and Families (17%).

Of the 4,496 screens conducted in SFY 2018, **89% were conducted within 14 days of referral**, the standard for screening timeliness. This represents continued improvement, up from around 80% in SFY 2015 and 2016 and 87% in SFY 2017. For six of the regions, screening timeliness in SFY 2018 was above 90% for the fiscal year. The four remaining regions had screening timeliness rates at or above 80%. Health Care Authority (HCA) will work with these regions on improving screening timeliness in the upcoming year.

2. More children and youth are receiving WISe services

A total of **5,865 youth** are estimated to have received WISe services between July 1, 2014 and March 2018. This is an increase from the 3,515 reported in last year's annual report.

In the last four quarters of data available (April 2017 – March 2018), a total of 3,766 youth were served in the WISe program, up 43% from the 2,635 served in the prior year (April 2016 – March 2017).

The statewide average number of service encounters per youth per WISe service month was 12.2 in calendar year 2017. This average varied among regions, ranging from 7.4 encounters per service month in King County to 14.4 encounters per service month in the Spokane region. Across the state, services occurred in outpatient settings (41%), at home (29%), at school (8%), and in other community settings (20%). A small number of services were delivered in hospital emergency rooms, residential care settings, and correctional facilities (2%). There is no additional substantive detail in ProviderOne for mental health services in BHO outpatient settings to distinguish between types of outpatient settings.

The percentage of services modalities delivered in each region also varied. Statewide, the top five service modalities, by hours of WISe services are: individual treatment services (41%), peer support (15%), child and family team meetings (13%), care coordination services (11%), and family treatment (9%). The category of "individual treatment services"

is based on the service modality definitions outlined in the Division of Behavioral Health and Recovery's (DBHR) Service Encounter Reporting Instructions (SERI).[3]

3. Children and youth are benefitting from WISe services

Youth and families participating in WISe are receiving needed services and report substantial benefits from WISe. WISe uses quantitative and qualitative feedback from its youth and family survey as well as the Child and Adolescent Needs and Strengths (CANS) tool to measure progress and need for improvement.

CANS is administered at intake and every 3 months while the child participates in WISe. The tool measures the number of 'need' items that require immediate attention as well as the number of current strengths that the youth and family have. Both needs and strengths show improvement as WISe services are provided. The percentage of youth with clinically significant treatment needs declined across all five of the top behavioral and emotional domains including emotional control problems, attention/impulse problems, mood disturbance, oppositional behavior and anxiety.

Recent CANS data from youth who have received WISe shows improvement in the youths' level of functioning, including changes in needs, risk factors, and strengths. After receiving six months of WISe services, the percent of youth with actionable treatment needs related to emotional control problems decreased from 79% to 59%, the percent of youth with mood disturbance problems decreased from 69% to 47%, and the percent of youth with decision-making problems decreased from 56% to 42%. The percent of youth with educational system strengths increased from 65% to 78% after the first six months of receiving WISe.

Youth and families receiving WISe are asked to complete a voluntary survey to determine if services are helpful and if there needs to be changes in how WISe is administered. **1,063 youth and families provided feedback** for the second annual statewide youth and family survey. This survey was conducted by the Washington State University Social and Economic Sciences Research Center (SESRC) and consisted of an interview over the phone in English or Spanish based on the interviewee's preference. There is also a web based option to provide feedback if the youth or family prefers. The 2017 statewide survey interviews were completed in October 2017 and the interpretative summary of the survey disseminated the summer of 2018. The 2017 statewide survey received feedback from 279 youth 13 years and older and 784 caregivers of youth 13-21 years old and children under age 13. The majority of WISe participants reported having a positive experience throughout the WISe process. According to participants, WISe teams were able to help them identify strengths and needs, achieve treatment goals, and build confidence for the future. SESRC is currently preparing for the third annual statewide youth and family survey which will include participants in WISe during 2018.

[3] Current SERI protocol available at https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2018-1EffectiveJuly1_2018.pdf ; see page 28 of this report for additional information.

The next Annual WISe Dashboard, to be released in early 2019, will include additional outcome measures based on administrative data. This data will be analyzed alongside the CANS and survey data to assess the effectiveness of WISe services.

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

The current governance structure includes regional and state level FYSPRTs relaying challenges and successes related to the implementation of WISe. Currently there are ten regional FYSPRTs in addition to the statewide FYSPRT that act as a conduit to the Children's Behavioral Health Executive Leadership Team (ELT), bringing youth and family voice to the highest decision making levels in Washington State. This year, as a result of input from the statewide FYSPRT around the need for respite services, HCA submitted a budget decision package for Youth Behavioral Health Respite to the Office of Financial Management in September of 2018.[4]

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

Since the last court report, DBHR sought and received input from stakeholders including system partners and youth and families receiving WISe services to update the WISe information sheets. Those sheets are available for youth and families in eight languages. These info sheets are available online, under the heading "Is there more information or training?" at https://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/wraparound-intensive-services-wise.

Additionally, WISe "framework guides" are available to assist other child serving systems in developing WISe protocols. These documents were developed in partnership with representatives from other child serving systems such as K-12 educators and Juvenile Court Personnel with the purpose of creating an outline for a WISe protocol. Since DBHR cannot develop a protocol for other child serving systems, staff are available to provide technical assistance to customize the "framework guides" to further align with their system or program. The "framework guides" were emailed out to system representatives who assisted in the development of the document and they in turn disseminated throughout their network. Additionally, an in-person presentation and review of the "framework guides" was provided to Juvenile Court Administrators. To date no system representative has requested technical assistance to further develop a WISe protocol. Over the next six months, the DBHR WISe Communication Specialist will continue to provide outreach to the various systems to encourage development and implementation of a WISe protocols. The "framework guides" are available online, under the heading "Where can I find guidance for referring to WISe?" at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/wraparound-intensive-services-wise.

Information about WISe is available on the WISe implementation website https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/wraparound

[4] The decision package can be viewed, along with all other agency requests for funding, at https://abr.ofm.wa.gov/budget/agency/requests

-intensive-services-wise in addition to Managed Care Entities (MCEs) web sites. WISe has been promoted in a number of venues including behavioral health conferences, school based conferences, and juvenile justice and children's welfare trainings.

6. Washington has made a continued financial commitment

Washington continues to commit funding for implementation efforts. Appropriated amounts support direct services, a statewide governance structure, trainings and technical assistance, a statewide youth and family survey and the Behavioral Health Assessment Solution (the database for WISe). Additionally, this past year the State supported a WISe Symposium for practitioners and system partners focused on quality improvement within WISe. The appropriated state budget for State Fiscal Year 2019 is 89.9 million dollars. In addition, DBHR uses Mental Health Block Grant and System of Care funding to provide funding for training and governance structure activities as well as youth and family engagement strategies.

For WISe services, the Washington's actuarial contractor, Mercer, reviewed WISe encounter data to determine a Service Based Enhancement (SBE) that supports provision of WISe services. For SFY 2018, this SBE was increased from $2,115 to $2,721 and again to $2,833 per youth enrolled in WISe per month. For the first six months of FY19 (July 2018 – December 2018) the SBE is $2,907. Starting in January 2019, and for the remainder of the calendar year, the WISe SBE will be $3,012 per youth per month in WISe. This is in addition to the per member per month payment that managed care entities receive for covered lives under their responsibility.

In State Fiscal Year 2015, the first year of WISe, the budget was 15 million, and each following year the budget has increased. The current budget for the T.R. Settlement Agreement is 89.9 million dollars.

Washington Has More Work in the Coming Year

1. Washington is expanding the integration delivery of care model

Looking forward into 2019, HCA is preparing for an additional five regions to become integrated managed care (IMC) regions: four will transition on January 1, and one will transition on July 1. By July 1, 2019, there will be a total of seven IMC regions plus the statewide Apple Health Foster Care (AHFC) managed care entity delivering integrated physical and behavior health services. The AHFC contract serves children and youth in State foster care, those receiving adoption support medical coverage, and young adults who have aged out of the foster care system. The remaining three regions will transition to IMC on January 2020. This will move the WISe benefit from separate regional payers (BHOs) to a statewide five-payer system (5 MCOs contracted across multiple regions). Four of the MCOs already have experience operating a WISe program in the current IMC regions. To facilitate a smooth transition to the IMC model, HCA is holding regular webinars called Knowledge Transfers that educate the MCOs about the existing system and expectations, including presentation time from each BHO to focus on regional differences.

In order to continue directing MCOs towards positive WISe outcomes, HCA strengthened the contract language relating to the WISe program in the IMC and AHFC contracts, effective January 2019. Some of those changes include a requirement that MCOs must meet or exceed their monthly caseload target numbers of children and youth served for each of their regions. In addition, MCOs are required to build and sustain capacity to meet the potential demand for WISe services that exceeds the caseload targets for each of the MCO's contracted regions. If the MCO does not meet these requirements for the month in any of the MCO's contracted regions, the contract specifically requires the MCO to develop and implement a plan to build caseload capacity and achieve and maintain monthly caseload target numbers.

In preparation for this large IMC shift, Readiness Reviews were conducted with all five MCOs. These compliance reviews are performed prior to major changes in contracting to ensure MCOs will be able to meet all of the contract expectations to deliver Medicaid services. Readiness Reviews are conducted by HCA staff and consist of in-depth document reviews, onsite visits and interview questions with key MCO staff to assess the MCO's level of preparedness for fulfilling the scope of work in the contract. After a Readiness Review is completed, HCA can require corrective action for any critical elements that are deemed not ready for implementation. This year's Readiness Reviews assessed the level of preparation of five IMC MCOs in August and one focused Readiness Review in September of the one MCO responsible for the integrated AHFC contract. Both IMC and AHFC processes included an onsite review of their new behavioral health provider contracts, with a focused review of the MCO's contracted WISe providers to validate the existence of signed contracts with WISe providers in each contracted region as stated in their network submission. According to HCA's RFP rules, HCA did not award an MCO an IMC contract for a region if they did not have a signed contract for essential behavioral health providers. WISe providers were included as an "essential behavioral health provider" type. Additional information is required in mid-October from all five MCOs regarding the WISe program due to the complexity and importance of this program. The Readiness Review process is finalized in late October for IMC MCOs and mid-November for the integrated AHFC MCO and will determine whether an MCO is prepared to implement the scope of work in the new contract. North Sound did not pass review, and the transition in this region is postponed until July 1, 2019.

2. **Workforce issues continue to pose a challenge, and additional strategies have been implemented in 2018 that are expected to produce results in the coming year**

All of Washington's 39 counties have started implementing WISe; San Juan County, the last to start implementation, began providing WISe in June 2018. In July 2018, the statewide monthly caseload target increased from 2985 to 3150. **The State is meeting 72% of the new monthly caseload target of 3150** youth receiving WISe every month. Last year at this time, the State was meeting 58% of the lower monthly caseload target of 2985.

For purposes of exiting the Settlement Agreement, **the State is meeting 88% of the monthly substantial compliance caseload target of 2600.**

Starting in July 2018, the ten regions across the state are working to maintain a regional monthly average of 10.5 service hours with no region going below an average of 9 service hours a month. In calendar year 2017, the statewide average number of service encounters per youth per WISe service month was 12.2. This average varied among regions, ranging from 7.4 encounters per service month in King County to 14.4 encounters per service month in the Spokane region. King County BHO has worked with Research and Data Analysis (RDA) and DBHR on data validation and are working to remedy any encounter reporting errors. King County BHO is also working with individual WISe providers to review service delivery and ensure service provision and intensity is at the expected level.

As the last four annual status reports have indicated, there is on-going difficulty hiring and retaining qualified staff. BHOs, MCO's and WISe provider agencies continue to focus on recruitment to build additional WISe teams as well as retention of qualified staff.

As reported last year, even while utilizing a variety of recruitment strategies, including some provider agencies raising salaries, conducting national searches to identify qualified staff and offering finder fees for new staff hires across most of the state, workforce poses a considerable challenge. In January 2018, to further support navigating system implementation challenges, the State invested in a new full time position, the WISe System Coach dedicated to ongoing review of workforce impacts, monitoring progress, and assisting with identification of new solutions to assist reducing barriers. In July 2018, the State also invested in enhanced coaching and training for WISe practitioners to not only improve skill sets and ensure quality but to also support employment retention in WISe, a highly intensive service delivery model.

3. More work is being done across child serving systems to ensure that Washington's most vulnerable children and youth are linked to WISe

Prior to WISe implementation, Washington developed an algorithm to support decision making regarding whether a youth's mental health needs and associated functional impairments are at or above the severity level for WISe services. The algorithm uses information from CANS. The current algorithm does not specify if the needs of the youth are more acute than can be managed in an outpatient setting, such as WISe. In October 2017, the BHAS system implemented a field to capture rationale for referring a child to a more restrictive level of care than WISe. The Behavioral Health Assessment Solution (BHAS) requires this comment in any case where the referral outcome is different than the algorithm recommendation. These placement rationales are regularly scrutinized by DBHR and Department of Children, Youth, and Families (DCYF) staff to ensure that youth are placed appropriately.

Since July 2014, there was a policy in place not to offer WISe to youth in Behavioral Rehabilitation Services (BRS). BRS is a temporary intensive wraparound support and treatment program for youth with high-level intensive service needs. BRS is used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. These services are offered through contracts under DCYF. As a part of ongoing program development and as an outcome of discussions between the parties, there was an

agreement in March 2018 to begin to integrate BRS and WISe. In May 2018, DCYF and DBHR completed a work plan that includes four BRS/WISe integration sites. Three sites, started in October 2018; one site (King) has experienced a delay. The sites are located in King, Pierce, Spokane, and Yakima counties. DBHR and King County BHO are in the process of identifying another WISe provider to participate. The original identified provider had a recent staffing set back and does not believe it has the staff capacity to currently meet the needs of the BRS/WISe integration efforts. For King County, DBHR anticipates BRS/WISe integration will begin in mid-December 2018. A review of progress and process challenges is set for April 2019. At that time, DCFY and DBHR will develop steps to phase in more sites offering WISe services to BRS youth. Plaintiffs have asserted that, pursuant to the settlement agreement, youth in BRS are entitled to receive WISe or WISe-like services statewide. Additionally, between November 2018 and April 2019, BRS staff will receive training on the BRS/WISe integration and more in-depth information about WISe, including information on the CANS screening and assessment, the role of the Certified Peer Counselor, Child and Family Team meetings and the overarching Washington State Children's Behavioral Health Principles.

4. Continued work is being done to ensure access to meaningful data

Improvements were made to BHAS in the past year, and additional improvements will be made in the coming year. DBHR regularly surveys users, who have increasingly reported that the system adequately captures relevant data and allows for that data to be used to monitor progress and plan for individual and system level improvements. However, some aspects can be improved. Most of the planned reports are functional but some need refinement. For instance, capturing data from youth in transition from one agency to another remains problematic and the pending switch from BHO's to MCO's in five regions this coming year (four in January and one in July) presents data collection and analysis challenges. BHAS users continue to need additional technical assistance so that data is used to drive case level and systematic improvements. DBHR continues to contract with the Praed Foundation to produce and deliver aggregated CANS data reports.[5] Data from those quarterly reports are posted for public use online and are required in contract to be shared in regional FYSPRT meetings at least once per year.

Changes in administrative data systems following integrated managed care (IMC) implementation in early adopter regions (Southwest in April 2016; North Central in January 2018) have also created challenges to accessing and using encounter data. Substantial progress has been made on developing methods to summarize encounter data from IMC regions from HCA's ProviderOne data system that will be comparable to summary information from the BHO regions housed in DBHR's data system. These improvements are ongoing and remain a priority.

Despite data access challenges, the State has continued to make efforts to add educational data where available to WISe reporting. The WISe Screening Report, currently produced on

[5] Reports are available online at https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0

a quarterly basis, tracks the proportion of youth screened for WISe involved in special education and school-based behavioral health services, based on WISe screening data in the BHAS data system. Recent requests to obtain educational data have been denied by the Office of Superintendent of Public Instruction (OSPI) based on Family Educational Rights and Privacy Act (FERPA) privacy concerns. RDA is continuing to seek a solution to obtain a limited amount of deidentified educational data for WISe clients.

5. Washington continues its efforts to ensure due process protections

On July 1, 2018 DBHR became a part of HCA as the State continues working toward a fully integrated managed health care system by January 1, 2020. With the July 1st move in mind, DBHR and HCA began working together prior to the move to determine similarities and differences in due process policy and procedures within the Managed Care Entities (BHO's and MCO's). This team will continue to collaborate to determine changes and improvements to due process monitoring as we move forward into a fully integrated managed care system.

DBHR staff perform ongoing monitoring of BHOs and providers' compliance with due process requirements in the Prepaid Inpatient Health Plan (PIHP) contract. In order to do this work, quarterly reports received from BHOs are used to monitor compliance of grievance and denial policy. BHOs report the number of grievances, denials, types and resolutions, along with the number of Notice of Adverse Benefit Determination Notices (NOABD) issued. DBHR staff review these reports and randomly select one BHO for further review, selecting 3 grievances and 5 denials for a deeper look at compliance.

Based on concerns that some youth may have screened eligible for WISe but have not received WISe services and have not received a Notice of Adverse Benefit Determination, denials of WISe continue to be monitored. Each quarter 5 denials of a selected BHO are reviewed. The CANS screen is reviewed as part of this process and the BHO is contacted to follow up if DBHR staff have any concerns. Other than children/youth who are in the child welfare system and need higher level of services that require placement into BRS, there is no demonstration that the mental health system declines WISe services to those who screen eligible.

During a recent audit of WISe denials DBHR staff notified a BHO regarding concern that screens were too low and youth were not receiving WISe services. The BHO took this information to the providers and additional CANS training has been scheduled for all CANS screeners in that region. A contracted consultant, En Route, LLC, is doing additional training for CANS screening around the state so providers are aware of the due process requirements that attach to a screen that finds a youth does not meet WISe level of care standards.

DBHR uses its External Quality Review Organization (EQRO), Qualis Health, to review grievances, notices, and appeals. The EQRO follows CMS protocols, which are based on Code of Federal Regulations (CFR) requirements. This review was completed in 2018. If there are recommendations requiring corrective action, the Contract Monitoring team

issues an official corrective action request and follows up to ensure these findings are addressed. The EQRO follow up on any corrective actions issued during the following year's review.

Outside of the EQRO, if a BHO is not following a contract requirement or is not meeting a specific deliverable, the Contract Monitoring team provides coaching and technical assistance. If the BHO continues to not meet requirements, there are progressive remedial action steps utilized that are listed in section 17 of the PIHP contract.

DBHR and HCA staff worked on protocols for MCOs which are based on CFR requirements and have been reviewed with MCOs. MCOs will report 3rd quarter grievance and denials to be included in the next quarterly report which will be complete by the end of November, 2018.

6. Washington continues to ensure a robust, sustainable, and effective Quality Management, Improvement, and Accountability (QMIA) system going forward

An effective quality framework is essential to the WISe program. Reforming system practices requires well-designed monitoring, analysis, reporting, and real-time feedback capabilities in order to be successful. The QMP provides a basis for measuring the implementation and performance of the WISe program. The QMP was finalized in December 2014 and amended in May 2015, but has not been systematically updated since adoption. The QMP is being updated via a collaborative process with Plaintiffs' Counsel and is expected to be completed by the end of 2018. New quality improvement tools specific to the WISe program are also being developed and implemented, and integration of data from these tools into the Quality Infrastructure, including the online reporting platform for the Quality Improvement Review Tool, are part of the QMP revisions.

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

Objective 1: Communication regarding WISe

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

Progress and Accomplishments:

WISe information sheets go through an annual review. The sheets were sent out to the various affinity groups for comments and revisions with only minor updates suggested. In early 2018, the information sheets went through a review process to increase cultural relevance; various organizations and groups across the state were invited to provide feedback. This review was completed and the information sheets were sent to the HCA Communication Division for translation into eight different languages (English, Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese).

Publication of the English version of the affinity group WISe information sheets was completed, and the updated WISe information sheets are publically available on the HCA website.[6] Once the translations are complete, those versions will be posted to the HCA WISe web page (expected to be available in late 2018).

WISe Information sheet were updated for the following affinity groups:

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

WISe information sheets continue to be available at community mental health agencies, through Behavioral Health Organizations and Managed Care Organizations. Information sheets have also been shared at the statewide and regional FYSPRTs. Affinity groups and

[6] Available at: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/wraparound-intensive-services-wise

system partners, such as Office of Superintendent of Public Instruction and Developmental Disabilities Administration, have also sent information via their listservs. Volunteers from regional FYSPRTs will be asked to share WISe materials with their local school districts.

In 2018, to assist with tracking the use of the WISe information sheets, regional screening trend reports were developed. The reports are shared with the Managed Care Entities (MCEs) and are posted online,[7] and are used to monitor number of referrals and who referred to WISe. These reports assist with tracking and help MCEs identify which child serving systems are in need of outreach and education about the availability of WISe.

Objective 1 - Remaining Tasks[8]:

- Continue to disseminate WISe information and reports to youth and families, affinity groups, and to system partners.
- Continue to have FYSPRTs distribute WISe communication materials.
- Continue to share information drafted and incorporated into the WISe Manual with FYSPRTs, system partners, affinity groups, and Plaintiffs' Counsel.
- Continue to deliver information developed through a variety of online, print, and in-person methods, including targeted and in-person outreach to school personnel and medical providers.

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[7] Available at: https://www.hca.wa.gov/assets/program/WISe-screening-report-july-2018.pdf
[8] The "Remaining Tasks" reflect priorities for the upcoming year, but are not intended to expand or limit the parties' obligations under the Settlement Agreement.

Objective 2: Identification, Referral and Screening for WISe

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

Progress and Accomplishments:

WISe Access Protocol: Prior to implementation, a WISe Access Protocol was established to identify and refer class members for WISe services. The Access Protocol includes the identification, referral, screening, and intake/engagement process for WISe services. The WISe Access Protocol is included in the WISe Manual and provides uniform standards on the administrative practices and procedures for providing access to WISe and its services. WISe providers and MCEs use the protocols to identify youth who might qualify for WISe and conduct an appropriate screen. The annual review of the Access Protocol is incorporated in the WISe manual[9] review. Currently there are no updates to the protocol.

WISe screening algorithm: The Washington version of CANS and the BHAS computer application reflect an algorithm that was developed to determine which youth, among those screened for WISe, will likely benefit from the service. The screening algorithm was developed based on consultation with clinical experts, including Dr. John Lyons, prior to the availability of CANS screening and WISe service data. In January 2018, the State consulted with Dr. John Lyons to discuss the possibility of implementing a multi-tier model that directs youth above a certain level of need into more restrictive settings, and afterward analyzed data to determine what effect this modification would have on youth screened for WISe. The analysis ("WISe Screening Algorithm Analysis" released May 2018) determined that such a change would almost certainly produce the opposite of the intended effect – to unnecessarily send youth who have the potential to improve and succeed in the WISe program into inpatient or residential treatment. Accordingly, the algorithm was not modified.

Behavioral Health Assessment Solution (BHAS): Efforts to improve BHAS data and the use of that data continue. DBHR contracts with the Praed Foundation, who continues to subcontract with RCR Technologies to provide the online CANS service. Some important improvements were made in 2018 with other changes nearing completion. All agencies and BHO administrators using BHAS have access to a 'flat file' which is a spreadsheet showing all data entered into BHAS. The State has provided training on how to use those flat files and ways that this data can be used and organized to check accuracy as well as to run reports that are not automated in BHAS. With another five regions moving from BHO to MCO purchasing, it has become increasingly important to provide data to MCO's so that they can manage quality improvement. MCO representatives join our weekly call with Praed and RCR Technologies to ensure that data collection and reports are appropriate and usable as we move to a time when regions may have both and MCO and BHO in the region, which complicates permission structures in the system. Another important improvement

[9] The Wise Manual is available online at: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf

this year came as we implemented an 'administrative discharge' function for WISe clients who do not complete the expected course of treatment and never receive a formal 'discharge CANS'. This administrative discharge function allows the last CANS performed to act as the discharge, allowing those clients with unplanned exits to become part of the aggregated results, where previously missing a discharge summary excluded that data from our aggregated results. This function was implemented with extensive input from users at the BHO and MCO level.

Currently, the BHAS system is making final preparations to implement additional episode control features that will better allow us to track progress when a youth moves from one agency to another, as well as moves from WISe to CLIP and back into WISe.

Praed also creates quarterly reports for the State, region, and agency to help track aggregated progress, rather than the single time period comparisons that are available as on-demand reports from BHAS. These quarterly reports are required to be reviewed by the WISe Quality Infrastructure, including being shared at each regional FYSPRT at least one time per year, so that successes and challenges can be documented and used for system planning.[10]

Praed conducts regular follow-up surveys to the BHAS users survey conducted in October 2016. Results from surveys inform adaptations and features to BHAS to increase the accuracy, reliability, and usability of CANS data. The most recent survey demonstrated continued progress on customer satisfaction. The survey asked about the overall experience and usefulness of BHAS with 0 being 'very poor', 1 meaning 'poor', 2 indicating 'well' and 3 indicating 'very well'. The most recent reports shows an average of 2.2 when asked if the system allows them to enter data and get reports as well as the overall role of BHAS in working with their clients. These reports are posted on the BHAS site for users to view.

Additionally, after consultation with system partners and review with Plaintiffs' Counsel in September 2016 regarding updates to the WISe manual, DBHR agreed to change the timeliness guidelines for full CANS from 30 days from the CANS screen to 30 days from the first WISe service. DBHR is currently working to create a new timeliness report for BHAS that will reflect these revisions, which is being developed in consultation with the contracting agency, Praed Foundation; its subcontractor, RCR Technologies; other BHAS users, including BHO representatives; and RDA. Because there is a need for some structural changes to BHAS and other structural changes in the system are required immediately to have BHO's and MCO's operating in the same region, the anticipated timeline for changing the reports will be spring of 2019.

WISe screens: Anyone can make a referral for a WISe screen. Family, youth, and child-serving systems, such as DCYF, Rehabilitation Administration (RA), Developmental Disabilities Administration (DDA), HCA, BHOs, school personnel, county and community

[10] These reports are posted online at https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0.

providers, and medical providers can assist in the identification and referral of youth who might benefit from WISe. To be eligible for WISe, youth must be Medicaid eligible, under age 21, and have complex behavioral health needs.

From July 1, 2014 through June 30, 2018, 11,419 **WISe screens** were conducted for a total of 8,835 youth.

In SFY 2018 (July 2017 – June 2018), 4,496 WISe screens were conducted for an unduplicated total of 3,952 youth, representing a 42% growth in youth screened over the prior year. In SFY 2018, the four largest referral sources for the WISe program were mental health outpatient providers and BHOs (28%), self and family (20%), Children's Administration (now part of the Department of Children, Youth, and Families, or "DCYF") (17%).

In recent data, several referral sources grew in the rate of referrals made to WISe screening, including schools (7% of screens were referred by schools in SFY 2018, up from 3% in SFY 2015), mental health outpatient providers outside of the BHO system (5% of screens in SFY 2018, up from 2% in SFY 2015), and medical providers (3% of screens in SFY 2018, up from 1% in SFY 2015).

Below, *Table 1* provides the number and percentage of referral sources for both the full period and for the most recent state fiscal year.

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Table 1. WISe Screens, by Referral Source

	CUMULATIVE 7/2014 – 6/2018		SFY 2018 7/2017 – 6/2018	
	NUMBER	PERCENT	NUMBER	PERCENT
Referral Source				
MH-Outpatient/BHO	3,607	31.6%	1,274	28.3%
Self and Family	2,356	20.6%	903	20.1%
Children's Administration	1587	13.9%	772	17.2%
School	729	6.4%	323	7.2%
Other	529	4.6%	168	3.7%
MH-Crisis Services	516	4.5%	147	3.3%
MH-Outpatient/Non-BHO	367	3.2%	203	4.5%
MH-Inpatient/Non-CLIP	331	2.9%	146	3.2%
Medical Provider	322	2.8%	142	3.2%
MH-Other	301	2.6%	119	2.6%
Juvenile Justice/non-JRA	184	1.6%	85	1.9%
MH-Inpatient/CLIP	175	1.5%	76	1.7%
Community Organization	173	1.5%	40	0.9%
Juvenile Justice/JRA	146	1.3%	46	1.0%
Substance use Treatment Provider	37	0.3%	27	0.6%
Developmental Disabilities Administration	33	0.3%	19	0.4%
MH-Tribal	25	0.2%	6	0.1%
Missing	1	<0.1%	0	0.0%
TOTAL Duplicated Screens	**11,419**	**100%**	**4,496**	**100%**
TOTAL Unduplicated Youth Screened	**8,835**		**3,952**	

NOTES: This table presents data for all screens (duplicated) for WISe between 7/1/2014 and 6/30/2018. Youth screened more than once for WISe services over this period are displayed multiple times.

SOURCE: Washington Behavioral Health Assessment Solution (BHAS).

The WISe referral contacts list by county is available on the HCA website.[11] In addition, inquires about WISe referrals may be made directly to a managed care entity. Starting in January 2019, all WISe providers will be available to conduct a WISe screen and the referral list will be updated at that time.

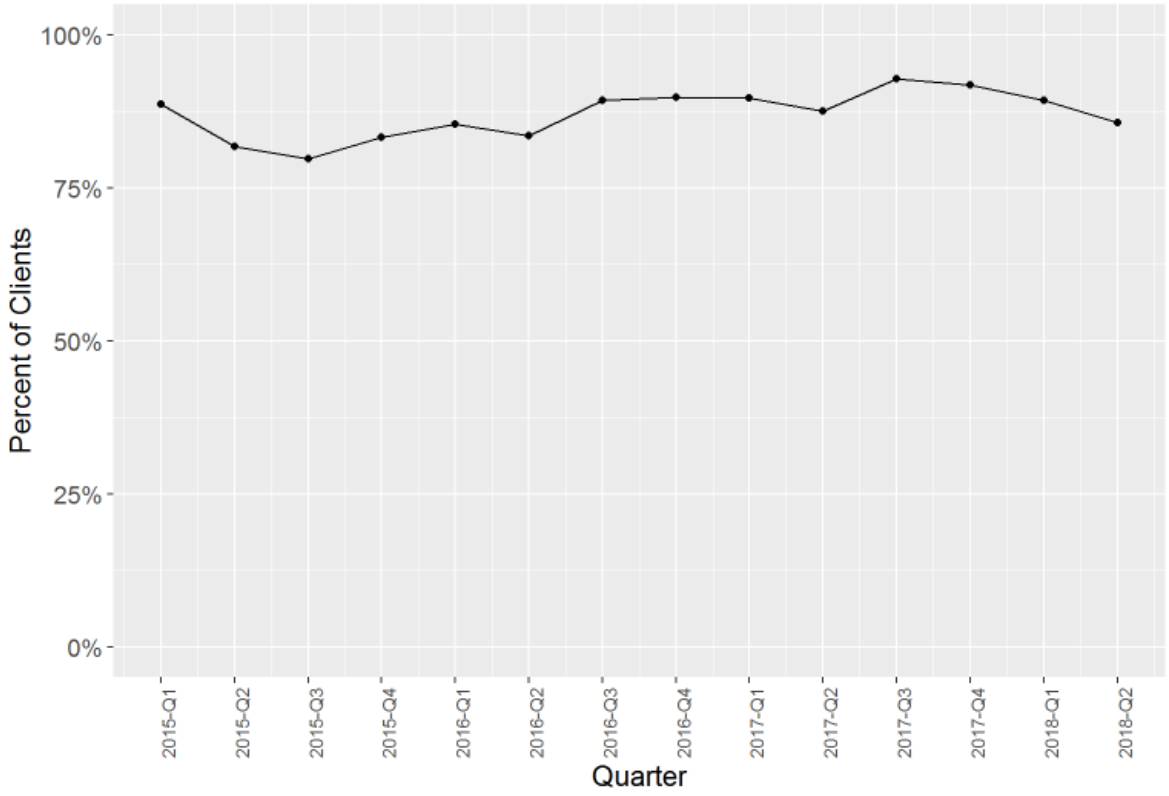
WISe screening data does not reflect a universal screening effort. Rather, WISe screening data come from select groups including: (1) children referred to the WISe program; (2) children entering/exiting CLIP services or re-screening while in CLIP services; and (3) children entering/exiting BRS services or re-screening while in BRS services. Because screenings are mandatory for CLIP and BRS involved children and youth, the numbers and proportions of CLIP and BRS youth in WISe screening data are substantially inflated relative to their proportions in the overall youth Medicaid population. These are very small

[11] Available at: https://www.hca.wa.gov/assets/free-or-low-cost/wise-referral-contact-list-by-county.pdf

programs, with only 194 youth in CLIP in SFY 2017 and only 1,060 youth in BRS in SFY 2017. In the same fiscal year, there were 959,439 total Medicaid youth age 0-20.

WISe screening timeliness: Of the 4,496 screens conducted between July 1, 2017, and June 30, 2018 (SFY 2018), **89% were conducted within 14 days of referral**, the standard for screening timeliness. This represents a consistently high level of 'on time screens' over time. Reviewing data since January 2015 shows that this percentage has consistently been higher than 80%, as depicted in *Figure 1* below.

Figure 1. WISe Screening Timeliness Trend, January 2015 through June 2018



NOTES: A screen is considered timely if it is completed within 10 business days of referral. For youth with multiple WISe screens in the date range, only data for the most recent screening is presented. Labels on the horizontal axis indicate calendar year quarters (e.g. Q1 starts January 1 and ends March 31).
SOURCE: Data from Washington Behavioral Health Assessment Solution (BHAS). Chart originally produced in *WISe Quality Management Plan, Quarterly Report for Quarter 2, 2018*.[10]

In SFY 2018, with the State at **89%** of the standard for screening timeliness, this represents continued improvement, up from around 80% in SFY 2015 and 2016 and 87% in SFY 2017. For six of the regions, screening timeliness in SFY 2018 was above 90% for the fiscal year; in Southwest and Pierce, the rates of screening timeliness were 100% and 99% respectively. The four remaining regions had screening timeliness rates at or above 80%. HCA will work with these regions on improving screening timeliness in the upcoming year.

Referrals Resulting From WISe Screening: In total, 8% of the 4,496 WISe screens conducted in SFY 2018 (July 1, 2017, to June 30, 2018) resulted in a referral outcome of BRS or CLIP. For most of these screens, the person making the referral for WISe screening had originally recommended BRS or CLIP as the most appropriate service placement for the youth in question. Many of those youth whose screening resulted in a service recommendation of BRS or CLIP likely were already engaged in BRS or CLIP at the time of screening, and thus the screening represents a recommendation to continue in the current setting. DBHR has begun collecting the reasons youth who meet the WISe algorithm are referred to BRS or CLIP. The most common reasons include:

- Lack of placement; and
- Current behavior problems prohibit the youth from being safely managed in a home setting.

The figures below describe WISe Screening results for SFY 2018 (July 1, 2017, to June 30, 2018): *Figure 2 (a)* describes results from all screens; *Figure 2 (b)* includes only screens from CA (now DCYF) referral; and *Figure 2 (c)* includes screens for all youth involved with CA, even if the referral source was not CA.

The chart below reflects an increase in the screening rate and children/youth being referred to BRS services. In the last year, both DCYF and HCA/DBHR have made a concerted effort to streamline and improve the screening process. Some activities have included revising BRS policy, changing the BRS referral form to document WISe screening results, and coaching calls to all BHO/WISe screening agencies on how to appropriately document decision making.

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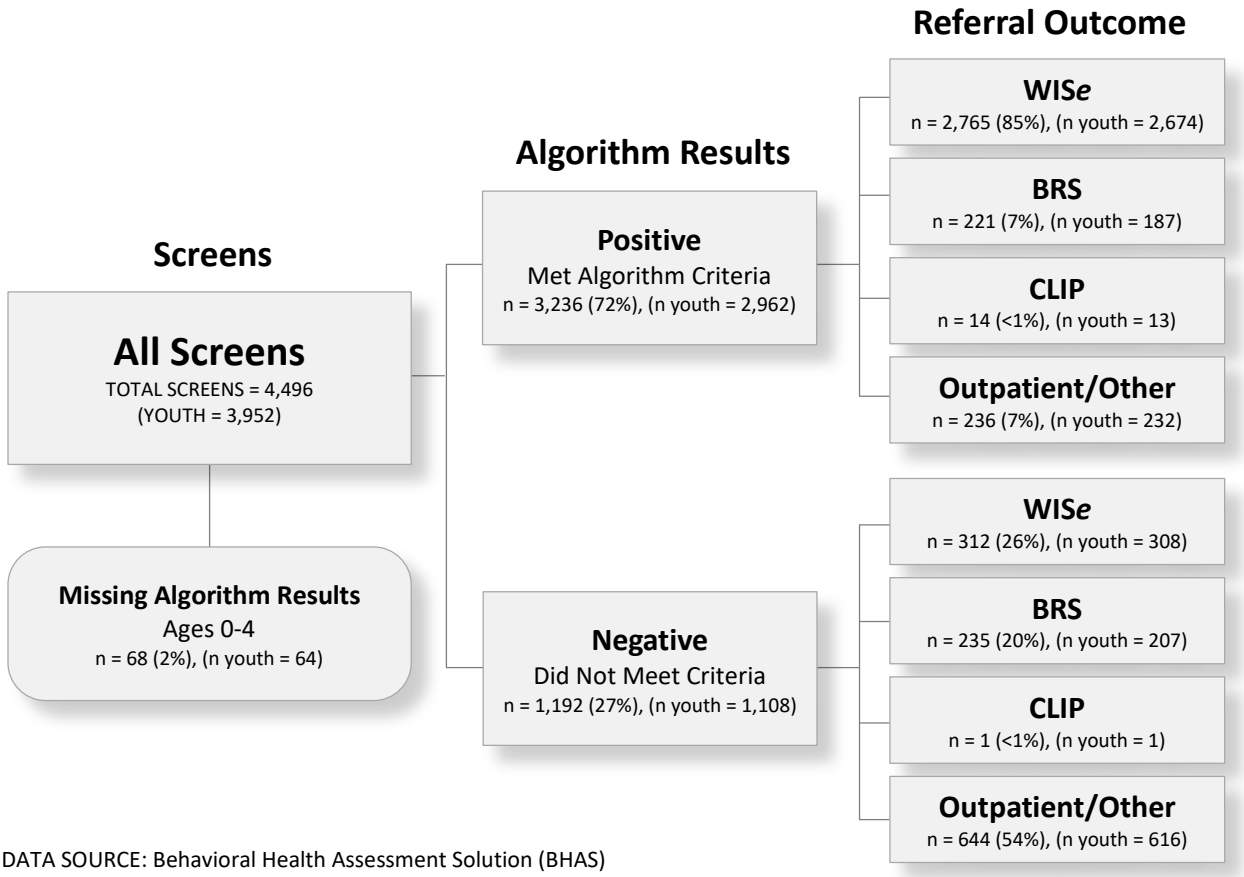
Figure 2 (a). WISe Screening Results, SFY 2018: All Screens
July 1, 2017, to June 30, 2018



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

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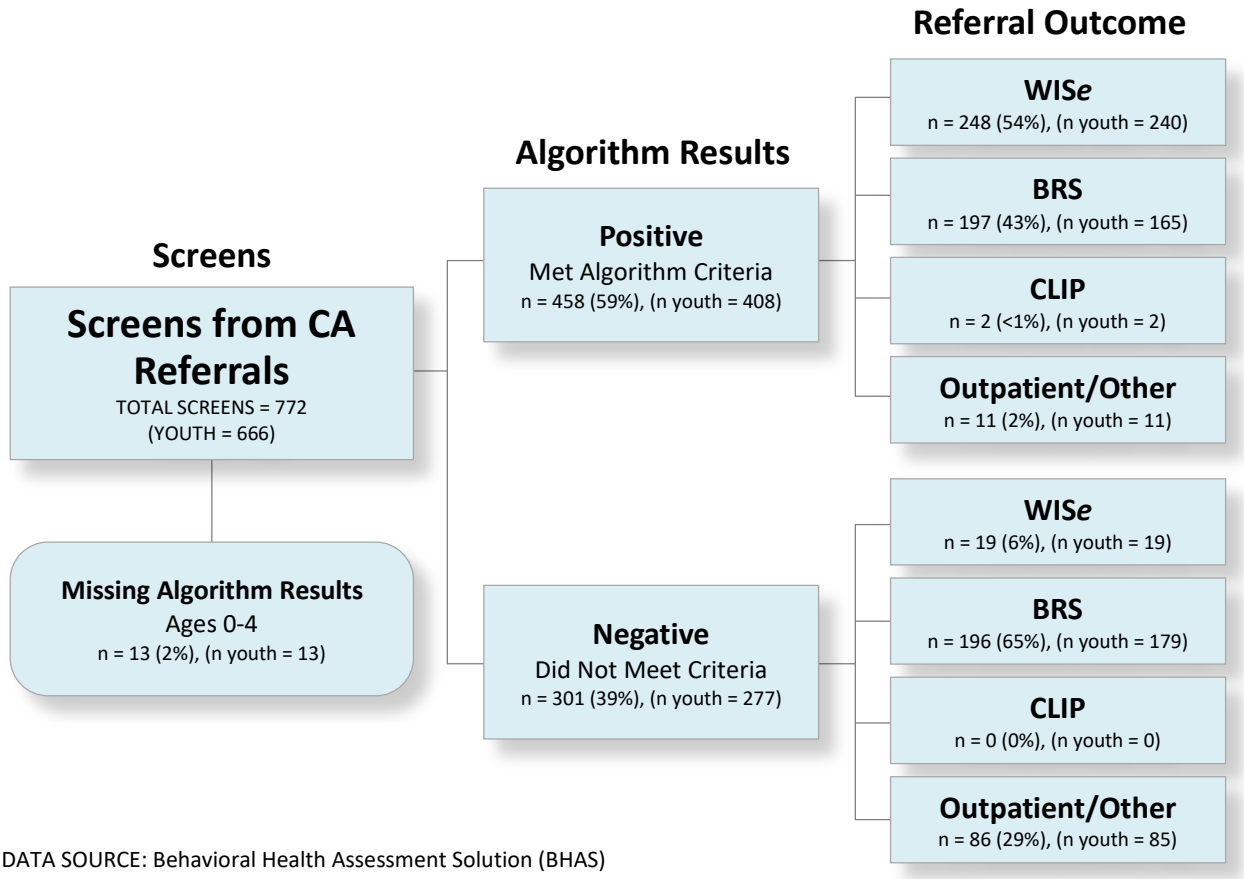
Figure 2 (b). WISe Screening Results, SFY 2018: CA referrals
July 1, 2017, to June 30, 2018



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

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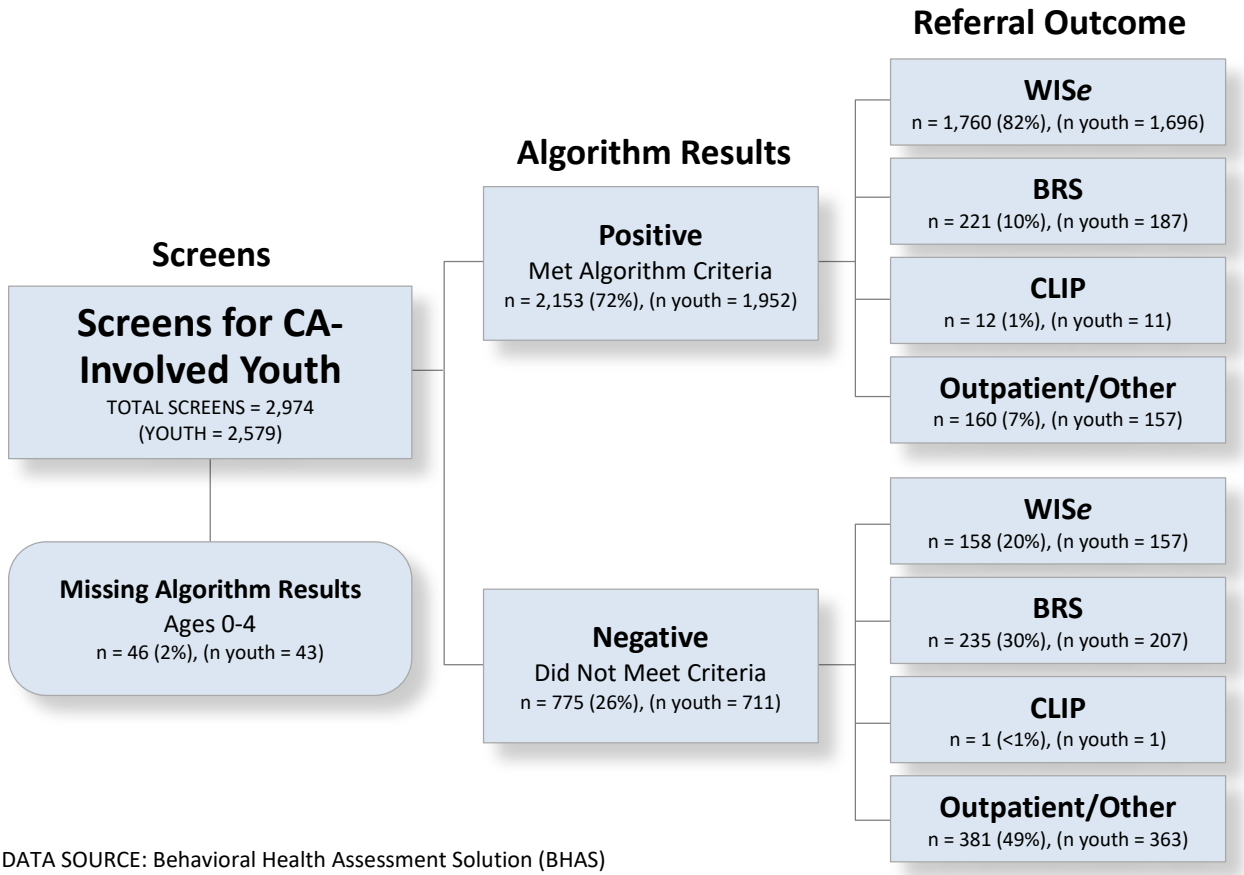
Figure 2 (c). WISe Screening Results, SFY 2018: CA-involved youth
July 1, 2017, to June 30, 2018



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

These data show that in SFY 2018, the majority of youth referred by CA meet algorithm criteria for entry into WISe, and 43%of these youth have a referral outcome of BRS (Figure 2 (b)). Of all screened youth with CA involvement, over 70% met algorithm criteria for WISe entry, and only 10% of these youth had a referral outcome of BRS (Figure 2 (c)). DBHR and DCYF analyzed the rationale for BRS placement and determined that in almost every case, BRS was recommended because of a lack of foster home placement.

Children's Long-Term Inpatient Program (CLIP): CLIP is the most intensive inpatient psychiatric treatment available to all Washington residents, ages 5-18 years of age. CLIP provides medically-based inpatient psychiatric treatment. Prior to admission to CLIP, youth receive a CANS screen or CANS full to determine if the youth is eligible to receive WISe. Children and youth also receive a full CANS assessment within the first 30 days following admission to CLIP, a CANS screen every six months while in CLIP, and another CANS screen within 30 days before being discharged from CLIP. In addition, community

WISe providers conduct a full CANS assessment for all Medicaid-eligible youth discharged from CLIP, within 30 days post-discharge.

CLIP programs convene multi-faceted discharge planning team meetings in coordination with the CLIP treatment team, the youth, youth's family, system partners, school, and community providers which include WISe Team members to develop successful discharge plans that best support the youth and their family. When youth have a WISe team involved before admitting to a CLIP facility, some WISe team members are remaining involved throughout the youth's CLIP treatment by participating in treatment plan reviews and/or discharge planning, resulting in improved continuity of care from the community to CLIP and back to the community. For youth engaging in WISe for the first time, CLIP coordinates with WISe teams to begin working with the youth, family, and CLIP treatment teams as early as possible prior to youth's planned discharge from CLIP. The receipt of WISe services after discharge from CLIP has continued to increase. In the most recent year of data available (discharges occurring 10/16 – 9/17), more than half of youth (53%) discharged from CLIP received WISe services within one month and approximately two-thirds (63%) received WISe within six months of discharge.

Over this past year, many of the CLIP facilities experienced significant turnover in clinical positions resulting in increased training needs regarding CANS and utilizing the BHAS system for new staff. Several strategies that had previously proved effective continued over the past year as an on-going effort to improve WISe screening rates across the CLIP system. A few of these strategies include the implementation of the CLIP Administration Office providing oversight to ensure all Voluntary Medicaid-eligible youth receive a CANS screen prior to their admission into CLIP. CLIP Programs have also implemented their own processes to ensure monitoring and completion of CANS assessments. In-person technical assistance for CLIP program staff continues to be helpful in resolving BHAS and data entry technical challenges. Finally, the DBHR CLIP Administrator continues to monitor the completion of CANS assessments and provides CANS screening data directly to the CLIP Directors to improve overall compliance rates. The CLIP Administrator continues to participate in any relevant discussions involving service transitions to and from CLIP and the community as well as the administration of the CANS tool within the CLIP Programs.

<u>Objective 2 - Remaining Tasks</u>:

- By July 2019, complete the annual review of the WISe Access Protocol and update as necessary.
- Annual updates to the Annual WISe Data Dashboard and Administrative Outcome Measures for WISe; quarterly updates for some measures.
- Continue to monitor WISe screens for BRS and CLIP and analyze cross-system barriers to WISe access.
- Continue to review implementation of CANS for care planning at CLIP facilities.
- Continue to resolve issues related to BHAS (see Section III, Implementation Challenges, BHAS).
- Continue to review and report timeliness standards.

- Continue to post regional and state level Quarterly Reports to DBHR website once all BHAS reports complete validation for accuracy.

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Objective 3: Provision of WISe

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

Progress and Accomplishments:

WISe Participants: A total of 5,128 youth received WISe services between SFY 2015 Q1 and SFY 2018 Q2 (July 1, 2014 to December 31, 2017). Below, *Table 2* identifies the demographic characteristics of WISe recipients.

Table 2. Demographics of all youth receiving WISe Services

	CUMULATIVE 7/2014 – 3/2018		SFY 2017 7/2016 – 6/2017		SFY 2018 - PARTIAL Q1-Q3 7/2017 – 3/2018	
	N	**%**	**N**	**%**	**N**	**%**
Gender						
Female	2,406	41.2%	1,195	40.3%	1,379	41.3%
Male	3,438	58.8%	1,769	59.7%	1,956	58.7%
Age Group						
0-4	74	1.3%	34	1.1%	34	1.0%
5-11	2,141	36.6%	1,073	36.2%	1,255	37.6%
12-17	3,447	59.0%	1,718	58.0%	1,907	57.2%
18-20	182	3.1%	139	4.7%	139	4.2%
Race/Ethnicity						
Non-Hispanic White	2,710	46.4%	1,378	46.5%	1,607	48.2%
Minority	3,134	53.6%	1,586	53.5%	1,728	51.8%
Minority Category[1]						
Hispanic	1,364	23.3%	693	23.4%	767	23.0%
Black	938	16.1%	505	17.0%	524	15.7%
American Indian/Alaska Native	776	13.3%	384	13.0%	395	11.8%
Asian/Pacific Islander	376	6.4%	178	6.0%	191	5.7%
TOTAL POPULATION with linked data available[2,3]	**5,844**		**2,964**		**3,335**	
TOTAL POPULATION SERVED[3]	**5,865**		**2,972**		**3,345**	

NOTE: (1) Minority Category is not mutually exclusive; categories do not sum to 100%. (2) Some youth served in the WISe program could not be linked with demographic characteristics in administrative data. (3) Youth who receive WISe in multiple fiscal years are counted once in each year they are served; the cumulative period column is unduplicated.
SOURCE: DSHS Integrated Client Database.

WISe Service Delivery: Based on currently available administrative data, a total of **5,865 youth** are estimated to have received WISe services between July 1, 2014, and March 31, 2018.

Of these 5,865 youth, service encounter data is currently available for 4,885 youth, with a total of 478,617 service encounters between July 1, 2014, and December 31, 2017. On average, a youth enrolled in WISe in a given month had 12.8 service encounters during that month.

The current service location data shows that WISe services were most frequently delivered in outpatient facilities (39%; includes "office", "independent clinic", "community mental health center") and in the youth's home (31%). Seven percent of services were delivered in schools, and 22% were delivered in other community settings. A small number of services were delivered in hospital emergency rooms, residential care settings, and correctional facilities (1%).

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

- The Southwest region is included, but represents DBHR-paid services only through March 31, 2016, as the region transitioned to fully integrated managed care (FIMC) on April 1, 2016.
- Greater Columbia BHO data prior to March 2016 is excluded from the service location data summary, as a data issue was causing all encounters to default to outpatient facility even when provided in another setting.

The top five service modalities, by hours of WISe services are: individual treatment services (41%), peer support (14%), child and family team meeting (13%), care coordination services (12%), and family treatment (9%). On the next page, *Table 3* presents statistics on the service locations and treatment modalities for WISe services.

Health Care Authority is planning an expansion of the Service Encounter Reporting Instruction (SERI) protocol to be used by MCOs as well as BHOs starting in calendar 2019.[12] This will result in the State being able to capture data on encounters regardless of the region being a BHO or MCO region.

[12] Current SERI protocol available at: https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2018-1EffectiveJuly1_2018.pdf

Table 3. Summary of WISe Service Characteristics

	FULL PERIOD 7/2014 – 12/17		SFY 2017 7/2016 – 6/2017		CALENDAR 2017 (Most recent 12 months with data available) 1/2017 – 12/2017	
Program Totals						
WISe Clients (unduplicated)	4,885		2,720		3,124	
Service Months	37,532		14,587		17,596	
Service Encounters	478,617		179,638		213,849	
Service Encounters per Month	12.8		12.3		12.2	
Service Location - *Average number of encounters per WISe service month*						
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Outpatient	5.1	39.2%	5.3	42.7%	4.9	40.6%
Home	4.0	30.6%	3.4	27.9%	3.6	29.4%
Other	2.8	21.8%	2.5	20.4%	2.5	20.2%
School	0.9	6.8%	0.9	7.5%	0.9	7.8%
Emergency Room - Hospital	0.1	0.6%	0.1	0.5%	0.1	0.7%
Residential Care Setting	0.1	0.5%	0.1	0.5%	0.1	0.5%
Correctional Facility	0.1	0.6%	0.1	0.5%	0.1	0.8%
Treatment Modality - *Average number of encounters per WISe service month*						
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Individual Tx/Other Intensive Services	**5.5**	**43.2%**	**5.6**	**45.1%**	**5.2**	**42.5%**
Individual Treatment Services	5.2	41.4%	5.3	43.4%	4.9	40.6%
Other Intensive Services	0.2	1.8%	0.2	1.6%	0.2	1.9%
Care Coord./Child & Family Team Mtg.	**3.2**	**24.7%**	**2.9**	**23.8%**	**3.0**	**24.4%**
Care Coordination Services	1.5	11.7%	1.4	11.0%	1.3	11.1%
Child and Family Team Meeting	1.7	13.1%	1.6	12.8%	1.6	13.3%
Peer Support	**1.8**	**14.3%**	**1.8**	**14.2%**	**1.8**	**15.2%**
Family Treatment	**1.1**	**8.9%**	**1.1**	**8.8%**	**1.1**	**9.0%**
Crisis Services	**0.4**	**2.8%**	**0.3**	**2.6%**	**0.3**	**2.9%**
Other Mental Health Services	**0.8**	**6.0%**	**0.7**	**5.5%**	**0.7**	**6.1%**
Medication Management	0.3	2.3%	0.3	2.2%	0.3	2.2%
Intake Evaluation	0.1	1.1%	0.1	0.9%	0.1	0.9%
Rehabilitation Case Management	0.1	1.1%	0.1	0.9%	0.1	1.1%
Group Treatment Services	0.1	0.7%	0.1	0.7%	0.1	1.0%
Therapeutic Psychoeducation	0.0	0.3%	0.1	0.4%	0.0	0.4%
Interpreter Services	0.0	0.2%	0.0	0.1%	0.0	0.1%
Medication Monitoring	0.0	0.2%	0.0	0.2%	0.0	0.2%
Involuntary Treatment Investigation	0.0	0.1%	0.0	0.1%	0.0	0.1%
Psychological Assessment	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%
Engagement and Outreach	0.0	<0.1%	0.0	<0.1%	0.0	<0.1%

DATA SOURCE: Administrative data (BHSS).

[13]***NOTES:*** *Due to table size and limits of page space, notes are presented in a footnote on the next page.*

Regional Variation: On the following pages, presents descriptive statistics on WISe services for the ten service regions in Washington State from July 2014 through March 2017. The data demonstrate variation in the average number of DBHR-paid managed care mental health service encounters being provided to youth in WISe, ranging from 10.0 service encounters per month in King County to 16.6 service encounters per month in the Southwest region.[14] To exit the settlement, the parties have stipulated that the average statewide WISe service intensity must be no lower than 10.5 hours per month, but no region will have an average service intensity lower than 9 hours per month. In addition to variation in the overall volume of services received by WISe youth, there is also variation in the package of WISe services being delivered, as indicated by the proportion of service encounters in key service modalities including care coordination (ranges from <0.1% to 29.6% of WISe service encounters), CFT meetings (ranges from 0.3% to 19.9% of WISe service encounters), and crisis services (ranges from 0.9% to 5.5% of WISe service encounters). The percentages of substantive modalities that include individual treatment services, peer support, family treatment, medication management, and other intensive services also varied significantly (the combination of these five modalities ranges from 45.1% to 86.9% of WISe service encounters).[15]

[13] **NOTES for Table 3**: WISe services include all WISe mental health outpatient service encounters recorded in the BHSS data system, including DBHR-paid managed care mental health outpatient services received in a month with at least one "U8" mental health service. Both the service location and service modality summary exclude data from Southwest after 3/31/2016, as it is unavailable in the BHSS data system.

[14] Note that encounter data from the Southwest region is not available after 3/31/2016 as it is unavailable in the BHSS data system. Additional details, including encounter data by region for each fiscal year, are available in the WISe Service Encounter Report (posted on the WISe Reports webpage, under "Cumulative Reports".)

[15] *Due to page size and formatting constraints, notes for Table 4 are presented here, instead of below the table.*

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

*Other Service Modality categories not shown (last row of tables) are: Involuntary Treatment Investigation, Psychological Assessment, and Engagement and Outreach. Together, these represent less than 1% of services in all regions, as well as statewide.

Table 4. WISe Service Characteristics by Region, January 1, 2017 – December 31, 2017 (last 4 quarters of data available) *(page 1 of 2)*

	STATEWIDE		Great Rivers		Greater Columbia		King County		North Central		North Sound	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Program Totals												
WISe Clients (unduplicated)	3,124		248		625		321		89		435	
Service Months	17,596		1,315		3,418		2,096		535		2,507	
Service Encounters	213,849		18,213		33,747		15,575		5,459		34,897	
Service Encounters per Month	12.2		13.9		9.9		7.4		10.2		13.9	
Service Location - *Average number of encounters per WISe service month*												
Outpatient	4.9	40.6%	7.5	53.8%	5.7	57.9%	5.1	68.2%	5.3	52.2%	4.8	34.2%
Home	3.6	29.4%	2.3	16.6%	1.8	17.8%	0.5	7.2%	1.8	17.6%	5.0	35.8%
Other	2.5	20.2%	2.8	19.9%	1.2	12.3%	1.0	13.0%	1.5	14.3%	3.3	23.9%
School	0.9	7.8%	0.9	6.4%	0.9	8.7%	0.8	10.8%	1.3	12.5%	0.8	5.5%
Emergency Room - Hospital	0.1	0.7%	0.1	0.7%	0.0	0.3%	0.0	0.4%	0.1	0.6%	0.1	0.4%
Residential Care Setting	0.1	0.5%	0.0	0.1%	0.0	0.4%	0.0	0.4%	0.0	0.3%	0.0	0.1%
Correctional Facility	0.1	0.8%	0.3	2.4%	0.2	2.4%	0.0	<0.1%	0.2	2.4%	0.0	<0.1%
Treatment Modality - *Average number of encounters per WISe service month*												
Individual Tx/Other Intensive S.	**5.2**	**42.5%**	**7.5**	**53.9%**	**4.9**	**50.0%**	**5.0**	**67.9%**	**4.2**	**40.7%**	**2.7**	**19.7%**
Individual Treatment Services	4.9	40.6%	7.5	53.9%	4.9	49.7%	5.0	67.9%	4.2	40.7%	2.7	19.7%
Other Intensive Services	0.2	1.9%	0.0	0.0%	0.0	0.3%	0.0	0.0%	0.0	0.0%	0.0	0.0%
Care Coord./CFT Meeting	**3.0**	**24.4%**	**2.4**	**17.5%**	**2.1**	**21.3%**	**0.3**	**3.4%**	**1.1**	**10.7%**	**7.2**	**51.5%**
Care Coordination Services	1.3	11.1%	0.6	4.3%	0.6	6.5%	0.2	2.6%	0.1	1.1%	3.9	28.2%
Child and Family Team Mtg.	1.6	13.3%	1.8	13.2%	1.5	14.9%	0.1	0.8%	1.0	9.6%	3.2	23.3%
Peer Support	**1.8**	**15.2%**	**1.4**	**10.1%**	**1.3**	**13.0%**	**0.9**	**12.4%**	**3.7**	**36.5%**	**1.8**	**12.8%**
Family Treatment	**1.1**	**9.0%**	**1.2**	**8.6%**	**0.6**	**5.7%**	**0.6**	**8.3%**	**0.2**	**1.8%**	**1.2**	**8.4%**
Crisis Services	**0.3**	**2.9%**	**0.4**	**3.2%**	**0.3**	**2.7%**	**0.2**	**2.2%**	**0.2**	**2.0%**	**0.2**	**1.7%**
Other Mental Health Services	**0.7**	**6.1%**	**0.9**	**6.7%**	**0.7**	**7.3%**	**0.4**	**5.7%**	**0.9**	**8.4%**	**0.8**	**6.0%**
Medication Management	0.3	2.2%	0.3	2.1%	0.3	3.3%	0.2	3.0%	0.1	1.3%	0.5	3.5%
Intake Evaluation	0.1	0.9%	0.3	1.8%	0.1	0.7%	0.1	0.8%	0.1	0.7%	0.1	0.6%
Rehabilitation Case Mgmt.	0.1	1.1%	0.2	1.6%	0.1	1.1%	0.0	<0.1%	0.5	5.3%	0.0	<0.1%
Group Treatment Services	0.1	1.0%	0.1	0.4%	0.2	1.6%	0.1	1.2%	0.0	0.0%	0.0	0.3%
Therapeutic Psychoeducation	0.0	0.4%	0.0	0.2%	0.0	<0.1%	0.0	0.4%	0.0	0.2%	0.2	1.2%
Interpreter Services	0.0	0.1%	0.0	0.1%	0.0	0.4%	0.0	0.2%	0.1	0.7%	0.0	0.2%
Medication Monitoring	0.0	0.2%	0.0	0.0%	0.0	0.1%	0.0	0.1%	0.0	0.0%	0.0	<0.1%
*Other categories not shown**		*<1%*		*<1%*		*<1%*		*<1%*		*<1%*		*<1%*

Continued on next page

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

	STATEWIDE		Optum Pierce		Salish		Southwest		Spokane Region		Thurston Mason	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Program Totals							*data not available*					
WISe Clients (unduplicated)	3,124		461		90				460		379	
Service Months	17,596		2,390		573				2,431		2,206	
Service Encounters	213,849		30,106		7,717				35,007		31,021	
Service Encounters per Month	12.2		12.6		13.5				14.4		14.1	
Service Location - *Average number of encounters per WISe service month*												
Outpatient	4.9	40.6%	2.6	20.7%	5.0	37.4%			6.1	42.3%	3.3	23.3%
Home	3.6	29.4%	6.0	47.9%	3.6	26.5%			4.1	28.5%	5.6	39.6%
Other	2.5	20.2%	3.1	24.9%	3.6	26.6%			1.9	13.2%	4.3	30.3%
School	0.9	7.8%	0.6	4.5%	1.1	8.0%			1.8	12.5%	0.8	5.9%
Emergency Room - Hospital	0.1	0.7%	0.1	0.9%	0.1	0.5%			0.3	2.0%	0.0	0.2%
Residential Care Setting	0.1	0.5%	0.1	0.8%	0.1	0.4%			0.2	1.3%	0.0	0.2%
Correctional Facility	0.1	0.8%	0.0	0.3%	0.1	0.5%			0.0	0.2%	0.1	0.5%
Treatment Modality - *Average number of encounters per WISe service month*												
Individual Tx/Other Intensive S.	**5.2**	**42.5%**	**4.7**	**37.3%**	**7.0**	**51.9%**			**7.8**	**53.8%**	**4.4**	**31.3%**
Individual Treatment Services	4.9	40.6%	4.6	36.7%	5.5	40.9%			7.2	49.7%	3.7	26.2%
Other Intensive Services	0.2	1.9%	0.1	0.6%	1.5	11.0%			0.6	4.2%	0.7	5.1%
Care Coord./CFT Meeting	**3.0**	**24.4%**	**2.1**	**16.6%**	**0.7**	**5.2%**			**2.0**	**13.6%**	**5.3**	**37.9%**
Care Coordination Services	1.3	11.1%	0.5	3.9%	0.0	0.0%			1.1	7.3%	2.8	19.9%
Child and Family Team Mtg.	1.6	13.3%	1.6	12.6%	0.7	5.2%			0.9	6.3%	2.5	18.0%
Peer Support	**1.8**	**15.2%**	**2.9**	**22.8%**	**2.6**	**19.1%**			**2.0**	**14.0%**	**1.9**	**13.6%**
Family Treatment	**1.1**	**9.0%**	**2.0**	**15.9%**	**1.9**	**13.9%**			**0.7**	**4.6%**	**1.7**	**12.2%**
Crisis Services	**0.3**	**2.9%**	**0.6**	**4.7%**	**0.1**	**1.1%**			**0.6**	**4.5%**	**0.2**	**1.6%**
Other Mental Health Services	**0.7**	**6.1%**	**0.3**	**2.7%**	**1.2**	**8.9%**			**1.4**	**9.5%**	**0.5**	**3.4%**
Medication Management	0.3	2.2%	0.1	1.0%	0.4	2.6%			0.2	1.6%	0.1	1.0%
Intake Evaluation	0.1	0.9%	0.2	1.2%	0.0	0.1%			0.2	1.2%	0.1	0.7%
Rehabilitation Case Mgmt.	0.1	1.1%	0.1	0.5%	0.6	4.6%			0.2	1.3%	0.2	1.3%
Group Treatment Services	0.1	1.0%	0.0	<0.1%	0.0	0.1%			0.5	3.3%	0.0	<0.1%
Therapeutic Psychoeducation	0.0	0.4%	0.0	0.0%	0.2	1.2%			0.1	0.4%	0.0	0.0%
Interpreter Services	0.0	0.1%	0.0	0.0%	0.0	0.0%			0.0	<0.1%	0.0	0.0%
Medication Monitoring	0.0	0.2%	0.0	0.0%	0.0	0.0%			0.1	1.0%	0.0	<0.1%
*Other categories not shown**		*<1%*		*<1%*		*<1%*				*<1%*		*<1%*

DATA SOURCE: Administrative data (BHSS). ***NOTES:*** *Due to table size and limits of page space, notes are presented in a footnote on page 30 (immediately before the table)*[15]

Service Coordination: DBHR, with system partners, reviews requirements/protocols related to: referral to WISe, participation in Child and Family Teams (CFTs) and transitions out of WISe. Over the past year, Children's Administration, now the Department of Children, Youth, and Families completed and implemented a policy for WISe. Juvenile Rehabilitation developed a protocol for the Medicaid enrollment and WISe suitability and referral process; details about this protocol are provided under Objective 4. DDA continues to disseminate and inform staff through webinars, email updates and this fall will mail out WISe materials on WISe. DDAs protocol was initially identified in Management Bulletin D17-027 and updated in June 2018. In June 2018, DDA Management Bulletin D17-021, *Referrals to WISe*, was updated and superseded by MB D18-015. The updated Management Bulletin more clearly outlines DDA's expectations of Case/Resource Managers with regard to making WISe referrals as well as being active participants of the Child-Family Treatment team.

This past year, DBHR finalized WISe "framework guides" for the education system, county probation, substance use disorder treatment agencies and for those working with youth experiencing homelessness and shared with system partners. Since DBHR does not have authority to implement protocols for these child servicing systems, these local systems and agencies may choose to adopt the protocols as a way to support better service coordination for WISe. To support this effort, the "framework guides" were emailed out to system representatives who assisted in the development of the document, and they in turn disseminated the guides throughout their networks. Additionally, an in-person presentation and review of the "framework guides" was provided to Juvenile Court Administrators. To date no system representative has requested technical assistance to further develop a protocol. Over the next six months, the DBHR WISe Communication Specialist will continue to provide outreach to the various systems to encourage development and implementation of WISe protocols. Details on WISe policies or protocols for DCYF, DSHS/DDA and DSHS/JR are located in Objective 4: Coordinating Delivery of WISe across Child-serving Agencies.

DBHR meets with BHO Care Coordinators on a quarterly basis, provides monthly WISe updates at the BHO Administrators meeting and as of August 2018 is a standing agenda item at the MCO Monthly meeting. These meetings provide the opportunity for on-going review of regional service encounter data including number of service encounters, modalities, and location. DBHR works directly with the BHO Care Coordinators to review the WISe screening reports and to ensure BHOs and their providers are utilizing regional proxy predictors to assist with outreach and referrals to WISe. The WISe Service Intensity report is also reviewed in these meeting as well as on WISe System Coaching calls with WISe providers. DBHR staff continue to monitor capacity/utilization through fiscal reports and the bi-monthly monitoring reports; progress shared in these meetings. Review for updates to system processes and protocols is also an ongoing topic. Additionally, DBHR and various system partner representatives meet regularly with RDA to review data related to service coordination and there is on-going review and feedback provided by the statewide FYSPRT and the Children's Behavioral Health Data and Quality Team.

Development and planning continue in effort to build sufficient provider capacity and address workforce challenges. These issues are a standing topic in all monthly meetings

with the MCEs. Over the past year, additional efforts to address this challenge have been: full time WISe System Coach; scheduled on-site visit with Suzanne Fields (national consultant); a request for information from MCO to identify strategies to increase WISe capacity starting in January 2019.

WISe Outcomes: Data shows improvement in WISe recipients' level of functioning. This suggests that WISe is beneficial to the youth's well-being. Data gathered from quarterly WISe dashboard reports provides information on outcomes for clinical improvements over time. The following three tables show change over time in needs and strengths for youth who entered WISe and completed an initial CANS assessment in between July 2014 and December 2017, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days).

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

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

Top 5 behavioral and emotional needs at intake shown

Behavioral/Emotional Needs, *N=2,477*	Intake	6 Mos.
Emotional control problems	78%	57%
Mood disturbance	68%	47%
Attention/impulse problems	66%	56%
Anxiety	61%	49%
Oppositional behavior	57%	41%

Definitions of top five needs:

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

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

Table 6, "Clinically Significant Improvements Over Time: Risk Factors," shows the top five risk factors for youth who entered WISe and completed an initial CANS assessment between July 2014 and December 2017, and subsequently completed a six-month CANS follow-up assessment. The following chart reflects the changes experienced over the first six months of WISe treatment for 2,477 children and youth ages 5-20. The top risk factors, by proportion at intake/initial assessment, are shown based on the proportion of youth with an "actionable treatment need" (rating of 2 or 3 on CANS item). A decline at the six-month reassessment represents clinical improvement.

Table 6. Clinically Significant Improvements Over Time: Risk Factors

Top 5 risk factors at intake shown

Risk Factors, *N=2,477*	Intake	6 Mos.
Decision-making problems	58%	43%
Danger to others	43%	23%
Intended misbehavior	31%	23%
Suicide risk	27%	12%
Non-suicidal self-injury	24%	10%

Definitions of top five risk factors:

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

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

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Table 7, "Strengths Development over Time: Child and Youth Strengths," shows growth in strengths for youth who entered WISe and completed an initial CANS assessment between July 2014 and December 2017, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days). The chart reflects the changes experienced over the first six months of WISe treatment for 2,477 children and youth ages 5-20. The five strengths that grew the most over the first six months in WISe services are shown, based on change in proportions of youth with "identified strength" (rating of 0 or 1 on CANS strength item). An increase at the time of the six-month reassessment represents improvement for these measures; i.e., an increase in the proportion of children and youth with noted strengths.

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

Top 5 child and youth strengths by growth over time shown

Strengths, *N=2,477*	Intake	6 Mos.
Educational system strengths	63%	78%
Relationship permanence	63%	72%
Optimism	57%	67%
Resilience	49%	61%
Community connections	45%	56%

Definitions of top five strengths shown:

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

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

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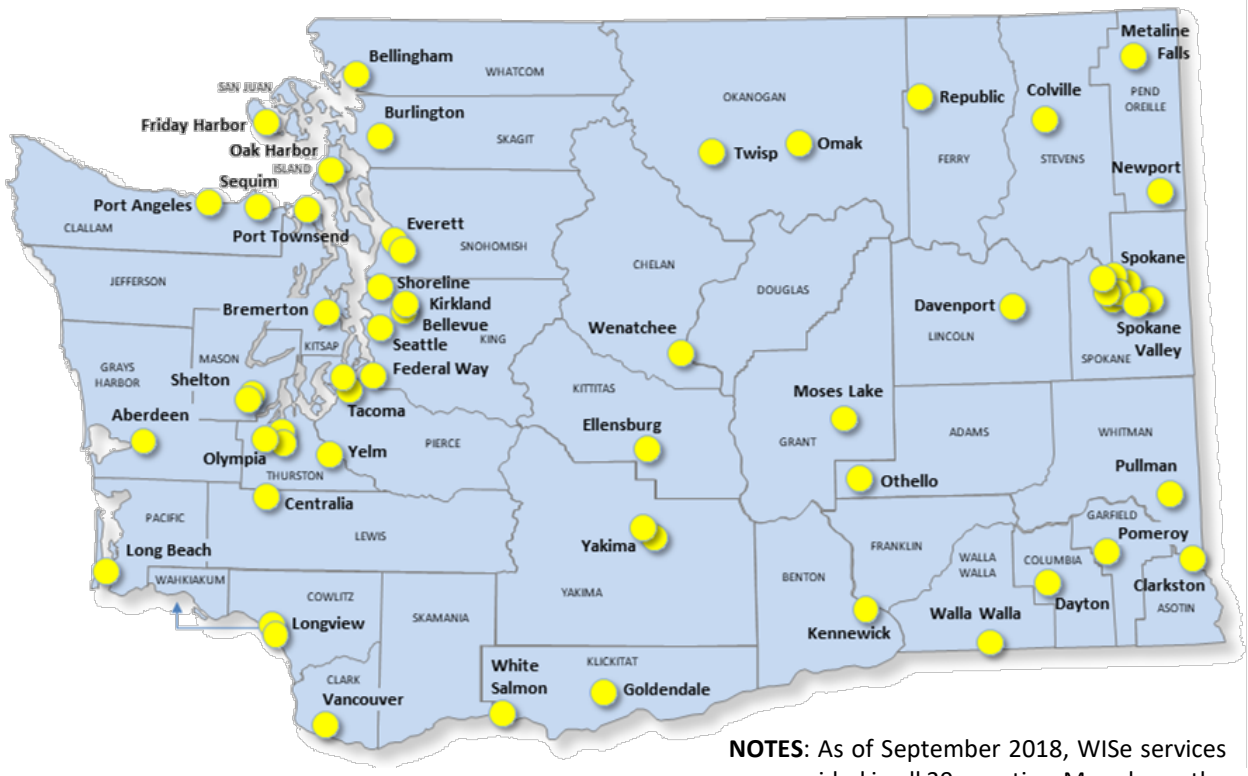
WISe Statewide Rollout and Capacity Development: As of September 2018, all of Washington's 39 counties have started implementing WISe. Below, *Figure 3* maps the locations of WISe sites statewide.

Figure 3. WISe Service Providers, as of September 2018



Counties with WISe services as of September 2018

WISe Sites as of September 2018

NOTES: As of September 2018, WISe services are provided in all 39 counties. Map shows the 58 WISe sites operating as of September 2018. Arrow indicates Longview agency providing WISe services to Wahkiakum County.

WISe agencies continue hiring and training new staff for WISe teams. BHOs and MCO's meet regularly with their WISe providers to review implementation challenges and successes. As reported in past annual reports, WISe capacity expansion continues to have challenges due to the behavioral health workforce shortage in Washington.

Table 8 below describes the progress of BHOs and the two Fully Integrated Managed Care (FIMC) regions have made towards the reaching the full capacity estimate targets.

Table 8. WISe progress to Full Implementation Capacity Targets by Region, as of September 2018 *Based on caseload counts reported directly by MCEs.*

Region	WISe Caseload September 2018 *	Monthly Caseload Target	Progress to Target
Washington State Total	**2277**	**3,150**	**72%**
Great Rivers BHO Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum	181	210	86%
Greater Columbia BHO Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	347	481	72%
King County BHO King	286	504	57%
North Central IMC Chelan, Douglas, Grant	85	93	91%
North Sound BHO Island, San Juan, Skagit, Snohomish, Whatcom	286	502	57%
Optum Health Pierce BHO Pierce	250	354	71%
Salish BHO Clallam, Jefferson, Kitsap	128	178	72%
Southwest IMC Clark, Skamania	133	217	61%
Spokane County Regional BHO Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens	385	450	86%
Thurston-Mason BHO Mason, Thurston	196	161	>100%

NOTES: *September 2018 caseload numbers shown here were reported directly to DBHR by MCEs.

In March 2018, the parties agreed to increase the number of youth served through WISe. This agreement adjusted the full implementation target for monthly caseload from 2,985 to 3,150. This means across the state, 3,150 youth and their families would receive WISE, every month. In July 2018, this commitment was included in contracts with MCEs.

The State is meeting 72% of the new monthly caseload target of 3150 youth receiving WISe every month. Last year at this time, the State was meeting 58% of the lower monthly caseload target of 2,985. **The State is at 88% of** the 2,600 monthly caseload the parties agreed, if provided with sufficient intensity, will demonstrate substantial compliance if reached by June 2019. In the past year, capacity has increased across the state, with the

greatest gain in Spokane County Regional BHO. To continue to meet the monthly caseload target and community need, increased capacity to serve youth and their families is required in every region of the state. Areas of that need to most significant increase in capacity are King County BHO, North Sound BHO and Southwest.

Every county in the state now has WISe available, including San Juan. In contract as of January 2018, all BHOs and MCOs, with the exception of Thurston Mason BHO, had another required increase in their WISe capacity targets. BHOs are in the planning process for the next scheduled expansion phase. DBHR will continue to monitor regional progress monthly.

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

For WISe services, the Washington's actuarial contractor, Mercer, reviewed WISe encounter data to determine a Service Based Enhancement (SBE) that supports provision of WISe services. For SFY 2018, this SBE was increased from $2,115 to $2,721 and again to $2,833. For the first six months of FY19 (July 2018 – December 2018) the SBE is $2,907. Starting in January 2019 and for the remainder of the calendar year, the WISe SBE will be $3,012 per youth enrolled in WISe per month. This is in addition to the per-member per-month payment that managed care entities receive for covered lives under their responsibility.

Appropriated funding for Fiscal Year 2019 is identified in *Table 9* (below).

Table 9. WISe Budget, State Fiscal Year 2019	
State	$44,965,000
Federal	$44,965,000
Total WISe Budget *(includes salaries & encounters)*	**$89,930,000**

The appropriated funding in *Table 9* is budgeted to provide services to youth and their families at the mid-level target range. "Total WISe Budget" means the amount when serving 3000 youth and their families across the state in WISe every month.

WISe Fee-for-service (FFS) is also available. In July 2017, FFS for mental health services was established specifically for American Indians and Alaska Natives (AI/AN). FFS is for clients who are not served in managed care receive services through the Medicaid fee-for-service program, where HCA pays providers directly for each service they provide. BHAS reports indicate that 28 youth were served in this FFS category as of November 1, 2018 Federal law makes American Indian/Alaska Natives voluntary, and they are exempt from managed care. They may choose to opt into BHO or MCO services.

HCA contracts with WISe agencies who are qualified and elect to participate in providing fee for service WISe AI/AN to youth and their families. FFS agencies providing WISe will receive an additional case rate plus FFS reimbursement for services provided. The WISe FFS case rate was established by Mercer and reviewed DBHR fiscal and budget staff. The case rate is set at $1,338.38 per youth per month enrolled in WISe.

WISe Screens are completed by staff at the FFS WISe agencies. DBHR continues to invite agencies to provide FFS WISe. A Referral list is posted on the HCA website. In addition, two staff at DBHR are available to provide WISe screens and referrals.

Objective 3 - Remaining Tasks:

- Review regional service encounter data variations regarding number of service encounters, modalities, and locations.
- Continue to build sufficient provider capacity and address workforce challenges to meet the statewide need for WISe services by June 30, 2019. (See Section III, Implementation Challenges, Access and Service Delivery)
- Continue to grow utilization of WISe to meet estimated need
- Continue to post on the DBHR website the list of qualified WISe providers by county.
- Continue to monitor capacity/utilization through fiscal reports and the monthly monitoring reports.
- Implement and monitor monthly provider network adequacy reports.
- Continue to collect and analyze outcome measures of performance for children and youth who have received WISe services.

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

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

Progress and Accomplishments:

WISe Cross System Coordination: System partners need concrete descriptions to identify youth and children for referrals, as well as system-specific indicators based on the proxy class. It is anticipated that the adoption of system partner protocols will assist with increasing the number of referrals from other child-serving systems.

In early 2018, DBHR, in partnership with members from education system, county probation, substance use disorder treatment agencies and for those working with homeless youth, completed the WISe "framework guides" to assist other child serving systems in the development of WISe protocols. These "framework guides" have been shared with system partners through distribution emailing lists and when requested reviewed with DBHR at in-person meetings (e.g. Juvenile Court Administrations Annual Meeting, September 2018). These local systems and agencies may choose to adopt the protocols as a way to support better service coordination for WISe.

DCYF has issued a WISe policy and updated its BRS guidance materials. Plaintiffs have reviewed these policies and recommended revisions to further strengthen alignment with WISe and coordination. DDA has continued to share their Management Bulletin that informs WISe protocol and in September 2018 provided two statewide webinars to staff on WISe which included information on the status of implementation, guidance for DDA staff on referrals and participation in CFTs, and provided the most up to date WISe referral list. DDA is also following up with a mailing, sending hard copy materials to staff. JR has completed the WISe protocol and continues to review with Plaintiffs' Counsel. More details about this cross system work is provided below

DBHR also worked with HCA staff and Coordinated Care of Washington (CCW) to support the transition of service benefits scheduled for January 2019. Over the past year DBHR staff have participated in meeting with CCW to prepare for the transition and recently participated in the CCW readiness review. Currently, CCW provides physical health (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees. In January 2019, CCW will begin to provide the full continuum of outpatient mental health benefits including WISe. CCW will contract directly with community providers for mental health services.

Information below provides highlights activities from system partners (DCYF, DSHS – JR and DDA) and also provides information specifically about the WISe in the Southwest and North Central regions.

WISe in Integrated Managed Care regions: The Medicaid Program Operation and Integrity (MPOI) division of the Health Care Authority (HCA) oversees the performance of the contracted Managed Care Organizations (MCOs) and their administration of Medicaid benefits. Monitoring of the services provided, such as WISe services, are done throughout the year and involve staff from both MPOI and DBHR. Monitoring efforts include technical assistance and coaching, deliverables monitoring, and compliance review. Focus is paid to ensure MCOs implement policies and procedures for the delivery of care consistent with the WISe Program, Policy and Procedure Manual. In concert with the monitoring of the WISe program, HCA monitors the behavioral health benefit for children and adults in the regions where physical and behavior health services are integrated under the managed care model.

In 2017 and 2018, HCA contracted with MCOs to administer behavior health services, including the WISe benefit, in the two integrated managed care (IMC) regions, Southwest Washington and North Central. MCOs and WISe service providers receive specialized technical assistance through monthly WISe Coaching calls. Coaching calls are well-received in both IMC regions. HCA also includes the delivery of WISe services in their monitoring activities conducted throughout the year.

Southwest Washington IMC Region - Clark & Skamania Counties (Klickitat will be added in January 2019): Community Health Plan of Washington (CHPW) and Molina Healthcare of Washington (Molina) represent the MCOs in the Southwest region. During the period of September 2017 to September 2018, both MCOs maintain a contract with the qualified agency providing WISe services in this region, Catholic Community Services (CCS). In January 2019, Amerigroup will be the third IMC MCO in this region.

From September 2017 to September 2018, both currently operating MCOs consistently reported that CCS experiences workforce recruitment and retention issues. CCS strategically confronted this issue with increased advertisements in the major MA and MSW university programs in Washington, Oregon, Idaho, Utah, and California, as well as listed in Craigslist. CCS places many of the job advertisements, timed with the MA and MSW program graduation, hoping to attract new graduate clinicians entering the field. During this reporting period, CCS received additional HR recruitment assistance from CCS of Western Washington to help with the hiring and recruitment processes.

In order to understand what may contribute to the problematic WISe staff retention, CCS undertook a massive survey effort of current and past WISe staff. CCS learned one of the reasons for the high turnover of MA clinicians is strain related to the demand of carrying up to 10 families with intensive complex needs. CCS reported before the implementation of WISe services, wraparound clinicians carried six to seven families, which is reported to be a more manageable caseload. The second highest concern reported by WISe staff contributing to the high turnover, is the stress of 24/7 on-call coverage. They strategized about ways to support staff while continuing the WISe model.

The MCOs continue to collaborate in supporting CCS, in expanding the number of children and youth served and in supporting the provider and staff. Both MCOs, along with CCS,

engage with other system partners such as DCYF, Juvenile Justice, and child mental health agencies, to support and share workforce recruiting efforts, and promote a child-focused System of Care.

North Central IMC Region (integrated as of January 1, 2018) – Chelan, Douglas, & Grant Counties (Okanogan will be added in January 2019): North Central is a rural community where HCA contracts with three MCOs: Amerigroup, Coordinated Care of Washington, and Molina. Molina brought experience from the early adopter region in Southwest WA and was open with sharing lessons learned specific to WISe with the two MCOs new to the integrated benefit structure. The three MCOs worked collaboratively to ensure the transition to the WISe program under their administration from the BHO went smoothly and clients did not suffer any negative impact from the change.

All three MCOs continue combined efforts throughout the year and collaborative meetings with the providers to discuss WISe services regionally. The WISe providers report experiencing delays with getting WISe staff and Peers signed up for hard to get trainings. DBHR responded by opening the youth peer trainings to allow greater availability. In addition, the WISe providers report similar staff retention concerns, as with CCS in the Southwest WA region.

Department of Children, Youth, and Families (DCYF), reports the following activities over the past year:

- Developed and implemented TR Implementation Team. Deputy Regional Administrators meet bi-monthly with Headquarters to implement and problem solve aspects of the settlement agreement in the field.
- The mental health trainings for new and ongoing staff include a section for the WISe access model and have been offered statewide. There were a total of 35 Regional Core Trainings reaching 181 new staff and 6 In-Service Trainings reaching 63 staff for a total of 249 DCYF staff trained to the WISe model. The In-Service trainings were offered in Moses Lake, Seattle, Spokane, Tacoma, Tumwater, and Yakima during this reporting period
- Updated CA/DCYF Social Service Specialists WISe information Sheet in May 2018.
- Created WISe information sheet for Foster Parents in June 2018.
- Created WISe information sheet for Kinship Caregivers in June 2018.
- Distributed ongoing communication with BRS contractors and Regional DCYF staff regarding the WISe informational sheet and WISe referral contact list. DCYF conducted gradual dissemination of DCYF WISe information sheet in conjunction with statewide WISe rollout when WISe is newly implemented in a county. Currently all DCYF offices and over 2,500 workers have received the DCYF WISe information sheet directly via e-mail attachment or as a hard copy handout.
- Facilitated in person consultation with regional BRS managers statewide to understand local WISe implementation strengths and challenges.

- WISe article was featured on the March, 2018 *Caregiver Connection*, a monthly resource for family caregivers, and foster and adoptive families in Washington State. The *Caregiver Connection newsletter has 9,000* subscribers.
- In partnership with DBHR, DCFY provided a WISe presentation at the Children's Justice Conference in March 2018.
- DCYF, in consultation with RDA, completed an internal small sample targeted case review (N=82) to deepen understanding of the characteristics of the youth who are placed in out-of-state treatment facilities. A brief summary was provided to TRIAGe in March, 2018.
- Provided ongoing implementation support to BRS Contractors and DCYF offices regarding WISe referral requirements, BHO contacts, and other general information when WISe is newly implemented in a county.
- Updated the BRS section of the Guide to Shared Planning Meetings to add WISe referral requirements.
- Developed and rolled out a DCYF WISe policy in October 2017, *4542.Wrapaorund with Intensive Services*.[16]
- DCYF TR Lead met with adoption support program supervisors to discuss WISe protocols and attended a statewide adoption support unit meeting to increase awareness of WISe.
- Ongoing participation in WISe program coordination, communication, implementation planning, and dissemination including but are not limited to, Statewide FYSPRT meeting, WISe Manual Advisory Group meeting, Children's Behavioral Health Data and Quality Team meeting, TRIAGe meeting, WISe Advisory Work Group meeting, WISe Communication meeting, System of Care Leadership meeting, WISe Community Training, and WISe conference.
- Expanded capability to identify children/youth who may be eligible for WISe through CHET. Trained 6 CHET Supervisors, who supervise 45 screeners statewide.
- Developed an overarching work plan and oversight workgroup that includes development of four BRS/WISe integration sites, working towards potential enhancement of BRS services to be more "WISe-like" and address policy regarding Washington State children placed in other states.
- Met with a range of BRS provider networks and BHO's to develop concept.
- Developed and identified four sites across the state to test proof of concept for integrating BRS and WISe services with implementation scheduled for October 2018. Developed MOU and work group to support the BRS/WISe integration..
- Approved and implemented new Placement – Intensive Resources, policy, policy number 4535, and revised BRS policy, policy number 4533, in July 2018.

[16] DCYF WISe Policy is available online at: https://www.dshs.wa.gov/ca/4500-specific-services/4542-wraparound-intensive-services-wise

Juvenile Rehabilitation (JR) continues to implement systems and engage stakeholders to increase WISe resource awareness among class members in the agency's care and JR personnel. JR also completed extensive work with HCA and Sea Mar to implement Medicaid enrollment changes and internal system changes to enhance access. Agency representatives, including the Clinical Director, engaged in multiple communications with BHO/MCO leaders and community providers to strengthen partnerships and increase WISe screening and engagement activities with youth prior to release from JR facilities.

JR and HCA completed initial implementation of the Medicaid suspension process in summer 2017. Sea Mar Community Health Services was enlisted as the enrollment agent through an MOU. Internal JR systems for coordinating enrollment activities were implemented and refined in the fall of 2017, with the partnership of Sea Mar. In March 2018, the system was enhanced to provide information to HCA upon a youth's intake at an institution, so that coverage is suspended for youth entering care on Medicaid and Sea Mar can enroll eligible youth who enter with no coverage.

JR implemented a new mental assessment process in April 2018. Qualified Mental Health Professionals (QMHP) administer mental health and trauma assessments within fourteen days of intake, and notify the Mental Health Coordinator, who works with JR counseling personnel and community providers, to coordinate CANS screening and service engagement for youth who are suitable for WISe and express sufficient interest in the service to sign a release of information.

JR has developed a protocol for the Medicaid enrollment and WISe suitability and referral process, with multiple meetings with plaintiff's counsel to provide opportunities for input. JR defines "WISe suitable" to mean youth with mental health needs who may screen as eligible when a CANS is administered. "Suitability" is defined broadly, based on information gathered in the agency's screens, mental health and substance use, and criminogenic risk/protective factor assessments. It is broadly defined so that the WISe option and CANS referral is offered to the maximum number of youth, thus allowing WISe provider engagement, CANS administration, and youth/family interest to be the primary determining factors in WISe participation. JR has invested substantial programmer resources to develop "Medicaid Enrollment and Tracking" and "WISe Eligibility & Referral" modules in its Automated Client Tracking (ACT) system. Initial development is complete and the modules are in the user testing stage. They are scheduled for release to production in November 2018.

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

- Included WISe Practitioners in Reentry Team Meetings (RTM) with youth who have been referred, and used Intake and Release RTMs to educate youth and families regarding WISe and other behavioral health services.
- Provided in-person training to 60 JR coordinators, reentry liaisons, program leaders and clinicians in November 2017.
- Provided in-person training to all case-carrying JR counselors between November 2017 and January 2018.

- Added content on WISe to the agency's New Employee Academy delivered to 160 counseling and security personnel in the spring and fall of 2018.
- In September 2017 WISe information sheets were incorporated in to orientation packets that are given and mailed to youth upon intake to a JR institution.
- Intake Specialists who administer the Integrated Treatment Assessment (ITA) inform youth and families of WISe resources during in-person interviews with youth and phone contact with families during a youth's first fourteen days in an institution.
- Qualified Mental Health Professionals (QMHPs) who administer mental health and trauma assessments during the first seven days after intake are trained to WISe and oriented to the suitability protocol. QMHPs share information regarding the WISe resource with youth. QMHPs contacts the Mental Health Coordinator regarding youth with mental health needs.
- Regional Mental Health Coordinators participate in local FYSPRTs, and are in frequent contact with BHOs and FYSPRTs within their region.
- The Clinical Director distributed a memo in March 2018 to WISe leadership representatives from BHOs, MCOs, and WISe team supervisors regarding Medicaid enrollment enhancements. The Clinical Director engaged in multiple follow-up contacts with BHO/MCO leadership, and attended a North Sound Behavioral Health Advisory Board meeting in October 2018
- In November 2017, the Clinical Director attended a Juvenile Court Administrator meeting to share information about WISe and brainstorm strategies for increasing WISE access for justice-involved youth.
- The Clinical Director and Clinical Training Consultant (and state-wide FYSPRT Tri-Lead) presented at the WISe Symposium in spring 2018, with the focus on engaging justice-involved youth in WISe. Twelve additional JR personnel attended the symposium as well.

Additional efforts JR will undertake in the coming months:

- JR will finalize the Medicaid/Wise Referral protocol and train staff in its use.
- JR's Mental Health Coordinator team and Behavioral Health Quality Improvement Committee will continue to meet regularly to oversee and strengthen internal processes for enrolling youth in Medicaid, identifying youth with mental health needs, referring suitable youth to WISe, and tracking WISe enrollment.
- JR leadership and regional Mental Health Coordinators will continue to meet regularly with MCO representatives and community providers to develop and strengthen processes for screening youth, and for engaging youth and families in pre-release activities that prepare them for WISe participation upon release.

Developmental Disabilities Administration (DDA) has continued to actively support activities related to the T.R. Settlement agreement throughout 2018.

DDA offers positive behavior support (PBS) as a service option for individuals enrolled on the five DDA waivers including: Basic Plus, Children's Intensive In-Home Behavioral Support (CIIBS), Individual and Family Services (IFS), Core, and Community Protection waivers. In September 2017, the Centers for Medicare and Medicaid Services (CMS) provided clarifying guidance that waiver funding may not be authorized for PBS unless the behavioral health need(s) cannot be addressed through benefits offered by private insurance and/or the Medicaid State Plan.

Applied Behavioral Analysis (ABA) and WISe are two such benefits that are available in the state plan to meet the behavioral health needs of young people with developmental disabilities. DDA has continued to work in partnership with the Health Care Authority (HCA), including DBHR, to coordinate efforts in supporting youth identified with behavioral health challenges.

Action items completed since the previous T.R. Implementation Status Report include:

- A two-day DDA Wraparound Training was provided to ten DDA employees who work with specialized caseloads and programs. The training was provided by Dan Embree, Executive Director and Principal of En Route, LLC.
- In March 2018, DDA Management Bulletin D17-027, *Authorization of Services under the DDA Home and Community Based Services (HCBS) Waiver Programs*, was updated to include detailed information pertaining to service access and authorization for several DDA waiver services. Changes relevant to the implementation of the T.R. Settlement agreement include:
  - Language about DDA Case/Resource Managers helping youth to pursue other state plan benefits, including WISe services, was added in relevant service sections.
  - The Management Bulletin (MB) also includes WISe-relevant attachments including the DDA WISe Brochure and reference to MB D17-021 *Referrals to WISe*.
- In June 2018, DDA Management Bulletin D17-021, *Referrals to WISe*, was updated and superseded by MB D18-015. The updated Management Bulletin more clearly outlines DDA's expectations of Case/Resource Managers with regard to making WISe referrals as well as being active participants of the Child-Family Treatment team.
- In September 2018, a series of two WISe webinars were offered to all DDA-staff. The presentation was a collaborative effort between the Developmental Disabilities Administration and the Health Care Authority's Division of Behavioral Health and Recovery. The webinar aimed to:
  - Reaffirm DDA staff's obligation to make WISe referrals as outlined in MB D18-015
  - Reaffirm DDA staff's obligation to be active cross-system partners in the WISe process

- Educate DDA staff about what they, and their clients, may expect once a WISe referral is made

Over the next year, DDA will continue to monitor the number of WISe Screens by Referral Source as documented in the Washington Behavioral Health Assessment Solution (BHAS).

Managed Care Entities (BHOs and MCOs) and their contracted WISe agency staff continue to be critical system partners. In particular, the BHOs contributions during implementation, and their sharing lessons learned has been essential to our building success. Each BHO is required to have one Performance Improvement Plan (PIP) specific to children's services; these PIPs must also reflect the Washington State Children's Behavioral Health Principles[17]. In 2014, to assist with infusing the Children's Behavioral Health Principles in the delivery of care, DBHR began to review and approve these PIPs to make them more meaningful.

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

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

- Salish BHO will increase the number of Child and Family Team meetings.
- Great Rivers will provide training and technical assistance to WISE providers to improve the CANS scores of youth receiving WISe for at least 90 days.
- Thurston/Mason BHO seeks to improve treatment planning and clinical outcomes across the children, youth, and family mental health treatment spectrum by using CANS, which is already being used in WISe. This will allow that BHO to track progress across levels of care.
- Optum Pierce County BHO seeks to improve outcomes by using parent peers to increase the reported identification of "Natural Supports" by families in WISe.
- Spokane County Regional BHO will provide additional training on crisis prevention to decrease the number of crisis services hours required by youth and families in WISe.

[17] Key components of the principles are included in WISe, CANS assessment, and the Child and Family Team meetings. For a list and description of the principles, see https://www.hca.wa.gov/assets/program/wa-state-childrens-behavioral-health-principles.pdf

Objective 4 - Remaining Tasks:

- Continue to promote Washington State Children's Behavioral Health Principles service delivery beyond WISe and in local and regional policy development through the Family, Youth and System Partner Roundtable (FYSPRT) governance structure.
- DBHR and DCYF will continue to review BRS and WISe materials annually to ensure clear guidance for identification and referral for WISe, participation on Child and Family Teams and coordination of care. Outcomes from the BRS WISe sites will provide guidance for updates.
- The WISe Workforce Collaborative will provide WISe training to BRS contracted staff starting in November 2018.
- Continue to review data regarding youth who screen positive for WISe but do not receive WISe services, to evaluate systemic barriers to access that should be addressed.
- Continue to participate in monthly meetings with DCYF and CCW to ensure provision of WISe services for foster youth.

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Objective 5: Workforce Development and Infrastructure

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

Progress and Accomplishments:

Between July 2014 and September 2018, **over 2,500 participants have attended WISe trainings** provided by either the Workforce Collaborative, the Praed Foundation, or DBHR staff.

WISe Workforce Collaborative: DBHR completed a competitive procurement process this year with the successful bidder, En Route Coaching and Training Services, LLC. This new vendor started under contract in July 2018 and will offered enhanced training and coaching for WISe practitioners across the state. This entity is now known as the WISe Workforce Collaborative. This collaborative continues to provide the same structure required to support workforce development for WISe. Prior to July 2018, the WSU Children's Behavioral Health Workforce Collaborative worked closely with DBHR to transition and close out their contract.

This past year, prior to the change in vendors, the Washington State Behavioral Workforce Collaborative was contracted to provide training, coaching, and technical assistance for WISe across Washington State. *Table 10* below provides an overview of the number of WISe staff trained during the 2017-18 contract year.

Table 10. Workforce Collaborative WISe trainings, July 2017 – September 2018

Training Type	Number of trainings	Number of staff trained
WISe 2-Day	25	555
Statewide YF CPC	2	66
Regional YF CPC	7	170
Train the Trainer	2	36

Between July 2017 and September 2018, a total of **827 participants attended WISe trainings** across the state. Those trained included Care Coordinators, Therapists, Family Partners, Youth Partners, or "other" (supervisors, program managers, etc.).

From June 2014 through September 2018, 2,233 participants received direct training on WISe through contracts with Portland State University, Washington State University, and, since July 2018, En Route LLC. Each region was provided with registration materials, training materials, tri-led trainers and an opportunity to participate in the training delivery.

Nine WISe Youth and Family Certified Peer Counselor trainings were provided since the last court report. A total of **236 people** participated in the Youth and Family Certified Peer Counselor trainings between July 2017 and September 2018, including one training provided at the request of the Lummi Nation.

Since July 2018, four regions have had on-site WISe Practitioner coaching sessions facilitated by the WISe Workforce Collaborative. These sessions focused on quality and fidelity indicators and planning and prioritizing coaching topics for WISe supervisors and practitioners for the next six months. One virtual coaching session was provided on the use of the CANS Screen for youth transitioning from residential placements.

Additionally, YouthSound hosted two Youth Professional Leadership trainings and launched a coaching pilot for participants with a total of 28 youth peers, including 18 WISe Youth Partners. The primary goal of youth professional leadership coaching is to foster the leadership capacity of youth professional leaders in Washington State. While professional development is the primary goal, participating coaches and organizations will benefit from the experience, knowledge, perspectives, and insights that youth professionals are uniquely able to contribute. Specific outcomes and objectives are determined collaboratively between the participating youth professional and the coach. The primary focus is for youth professionals to be able to apply with confidence the principles of adaptive leadership as a leader in youth-serving systems.

WISe Systems Coaching: In January 2018, DBHR hired a full time WISe System Coach. Prior to the system coach beginning her work, the DBHR WISe team and system coach meet with Kim Estep from the University of Maryland to discuss DBHRs vision for coaching, lessons learned in other states and strategies with system coaching of the WISe BHOs, MCOs and providers. After the work with Kim Estep in January 2018, the WISe system coach began work with the eight BHO regions and in March 2018 with the integrated regions. This process was introduced to celebrate successes and address known systems barriers to fidelity implementation of WISe. Monthly calls have featured such topics as utilization of WISe-required services, due process, provider crisis response capacity and review of data collected from the 2017 youth and family surveys. Providers in integrated and non-integrated regions have also used coaching calls to seek guidance on challenges including staff turnover, improving service delivery in rural and frontier communities and the inclusion of natural supports in team practice. Regional representatives described the calls as useful, and overall, provider attendance and participation was excellent.

In February, the Introduction to WISe training as offered by the WSU Workforce Collaborative was reviewed. Subsequently, the Collaborative received feedback that the training did not successfully capture essential components of the WISe process. The review also highlighted practice-related challenges with CANS/WISe integration, which inspired a review process that subsequently produced new guidelines.

In March, work began on an Onboarding Guidance Document which incorporated updated definitions of onboarding as well as workforce development strategies such as training, coaching and supervision. At that time, a companion document, which outlined best practice indicators for coaching implementation and documentation, was developed and shared.

In April, the WSU Workforce Collaborative offered an adapted Introduction to WISe training to representatives from seven Native American tribes in the northwestern part of

the state. Following the training, tribal leaders expressed interest in learning more and discussing the potential for serving Native American youth using WISe or WISe-like services.

Also in April, DBHR introduced an initiative to support BHOs and providers interested in developing regional capacity for offering the two-day Introduction to WISe training. The WSU Workforce Collaborative facilitated two Train the Trainer events – one on the east side, one on the west. The trainings were well attended and they resulted in the submission of two regional training plans from Lutheran Community Services and King County BHO. Subsequently, other providers and regions have expressed interest in designing their own plans. Next steps include developing a process that monitors curriculum adaptation and oversight.

In May, June, July and September, DBHR offered a Coaches training for providers, BHO leads and MCO representatives. The training presented coaching as a companion process to training and supervision and offered a framework to guide provider efforts to design and implement their own coaching practice. Approximately 180 managers, supervisors and coaches across the state attended the trainings, which were offered in six locations across the state. Evaluations were overwhelmingly positive. Several regions/providers requested follow up support and technical assistance on refining and adapting coaching-related forms, developing core competencies for WISe-affiliated roles and establishing best practice standards.

At around the same time, a systems coaching plan was developed for King County. The plan was developed with the full support of the BHO and regular reviews demonstrated its effectiveness as an accountability tool and change driver. The plan sparked initiatives to address hiring and recruitment practices, to shore up coaching practices across providers, to implement customized orientation and introductory trainings across the region and to address data anomalies.

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

Praed and Chapin Hall offered in-person CANS/BHAS data training for WISe practitioners providing CANS assessments and entering that data into BHAS. In order to administer CANS, WISe practitioners are required to be certified by completing an online CANS training and meeting the knowledge standards. DBHR found that additional face to face training was beneficial for staff to effectively administer CANS and, in-person trainings have been offered regularly since the spring of 2017. During 2017 and 2018, in addition to in-person trainings, CANS monthly coaching calls were provided. A total of 136 practitioners received face-to-face training by John Lyons or April Fernando and 30 trained as trainers to train staff in their agency or BHO in the past year. The training of trainers held in August 2018 will allow the state to develop regional capacity to onboard WISe staff as they join agencies rather than needing to wait for a state sponsored 'in-person' training.

DBHR funds the Evidence Based Practice Institute (EBPI) at the University of Washington to provide training and consultation to increase the use of evidence and research based practice in child and adolescent mental health. EBPI continues an increased focus on the use of Evidence and Research Based Practices (ERBPs) as part of the service array offered by WISe. EBPI's reporting guide that tracks the use of ERBPs among youth mental health providers including WISe settings. EBPI also received funding to provide trainings to WISe providers on cultural competence and appropriately treating young people with autism in a WISe setting. The first of those trainings took place in September, 2018 and will continue through December 2018.

*WISe Symposium***:** In July of 2018, DBHR sponsored the 2nd Annual WISe Symposium in Kennewick, Washington with **344 participants** in attendance.

The theme for this year's symposium was Building up Roles, Bridging the Gaps and Breaking down Barriers. DBHR welcomed youth, family, WISe team staff and managers, BHO Children's Care Coordinators and system partners to create an external planning committee for the 2018 symposium. The planning committee began meeting every 2 weeks starting in December 2017 and moved to monthly meeting in April 2018. This team brought great energy and ideas to the table, which contributed to a highly successful event. A participant evaluation conducted electronically after the Symposium asked participants to rate the conference using a 5 point scale, with higher ratings denoting more positive experiences. 147 evaluations were completed which is a response rate of 42.7%. The majority of participants (90%) gave high ratings for the workshop content, the symposium was a motivational experience, and they gained knowledge and skills related to their work.

Evaluation participants were asked which session they attended will help most in the future; the top five in order of selection were: Bridges out of Poverty, Teaching Parents How to Decrease Big Emotions, Engaging System Partners in the WISe Process, Trauma Informed Care, and the Affinity Group meetings on day one.

Additionally, DBHR hosted a 2nd annual System Partner meeting to continue the work begun last year with system partners to promote collaboration between local and state agencies that provide referrals and benefit from WISe; approximately 70 people attended this half day meeting.

A large number of participants in both the system partner meeting and symposium reported that they benefited from attendance and look forward to the Symposium being an annual event. DBHR is currently beginning to plan for next year's event. DBHR looks forward to partnering with BHOs/MCOs, regional youth/family representatives and system partners to plan the 2019 event. It is the intent of DBHR to continue to offer a limited number of 'scholarships' for travel reimbursement while offering the symposium to WISe team members free of charge.

Specialized Trainings for WISe Practitioners and System Partners: Between fall of 2018 and spring of 2019, the following trainings will be provided for WISe practitioners and system partners 1) Cultural Competency, 2) working with youth on the Autism spectrum, and

3) outreach and service provision of WISe for youth experiencing homelessness. BRS contracted staff throughout the state will receive WISe training and information about the BRS/WISe integration and updates on the progress.

Objective 5 - Remaining Tasks:

- Continue to implement the WISe coaching model. Developed in early 2017, this model now includes on-site coaching; details of the WISe Training and Coaching Framework are available in the WISe Manual in Appendix K.
- Continue to evaluate training curriculum; the WISe Workforce Collaborative will continue to oversee contracting for training evaluation.
- Workforce development will be an on-going agenda item at FYSPRT.
- DBHR will continue to consult with a national consultant to identify statewide and regional priorities and strategies to support increased workforce recruitment and enhanced service capacity; an on-site visit is scheduled for mid-October.
- Between fall of 2018 and spring 2019, the following trainings will be provided for WISe practitioners and system partners: 1) cultural competency, 2) working with youth on the Autism spectrum, and 3) outreach and service provision of WISe to youth experiencing homelessness.
- Between fall of 2018 and spring 2019, BRS staff will receive training on WISe and the BRS/WISe integration.
- Continue to identify and provide trainings for cross-system partners.
- Recruit and fill the vacant DBHR WISe Systems Coach position.
- Continue to promote and support trainers at the regional or agency to expand local capacity and timeliness of onboarding new WISe staff.

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Objective 6: Maintaining Collaborative Governance Structure

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

Progress and accomplishments:

FYSPRTs,[18] part of the Children's Behavioral Health Governance Structure (Governance Structure), are designed to influence the functioning of regional and state child-serving systems. FYSPRTs promote proactive changes that will improve access to, and the quality of, services for families and youth with complex behavioral health challenges, and the outcomes they experience. FYSPRTs are grounded in the Children's Behavioral Health Principles and provide a forum for regional information exchange and problem solving, as well as an opportunity for identifying and addressing barriers to providing comprehensive behavioral health services and supports to children and youth.

Ten Regional FYSPRTs continue to be maintained across Washington with state funds. In June 2018, DBHR worked with BHO Children's Care Coordinators and the Contract Manager for the Administrative Service Organization (ASO) in Southwest and North Central Washington regions, to send out consistent contract language to all the regional FYSPRT contractors. This effort was completed with the goal of ensuring continuity in contract language in consideration of all the transitions happening in the July 2018 – June 2019 contract year, which includes five regions transitioning to integrated regions in January 2019. The FYSPRT contract with these five regions: North Sound, King, Pierce, Spokane, and Greater Columbia, is for a 6 month period as the FYSPRT contract with these regions will transition to the ASO in January 2019. Salish, Thurston, Mason, and Great Rivers, who will not transition to integrated regions until January 2020, have signed FYSPRT contracts for one year, July 2018 – June 2019. Beacon continues to be the contracted ASO for the Regional FYSPRT in the North Central and Southwest regions.

Since the last court report, a Tri-lead team at DBHR including the SOC Lead, Family Liaison and Youth Liaison started working together to review Regional FYSPRT reports for progress and identify potential technical assistance needs. The goal of this is to model the Tri-lead approach and be able to provide feedback to the Regional FYSPRTs from multiple perspectives. This Tri-lead review team had check in meetings during the last year to identify how the report review process was working and what changes might need to be made to streamline the process.

In early 2018, feedback about the Regional FYSPRT Manual finalized in 2015 was requested to start the process of updating the manual. The Governance Structure team within DBHR's Child Youth and Family Unit also met to review, update and streamline the manual. In July 2018, the updated draft manual was emailed to Statewide FYSPRT members, Regional FYSPRT Coordinators and Children's Care Coordinators to review to ask questions or provide suggested edits. As a result of feedback received, information

[18] More information available at: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/family-youth-system-partner-round-table-fysprt

about the process around the Statewide FYSPRT moving a challenge with recommendations forward to the Children's Behavioral Health Executive Leadership Team was added. The updated Regional FYSPRT Manual was published in mid-September 2018.

Regional FYSPRT activities during this reporting cycle include:

- Continue to update Regional FYSPRT websites and share website link information with DBHR and the Workforce Collaborative.
- The How to Find Your Regional FYSPRT[19] document was developed to share at the 2018 WISe Symposium FYSPRT breakout session and to assist attendees at the Symposium to connect with their Regional FYSPRT. The information contained in this document includes the name of the Regional FYSPRT, Region covered, FYSPRT Coordinator contact information, and meeting day, time, and city. This information is also posted to the HCA FYSPRT website.
- Outreach to families, youth and system partners to build and/or maintain a Regional FYSPRT membership that includes at least 51% youth and families with other members representing the BHO or MCO, community system partners, and other relevant stakeholder groups from the community.
- Completion of an annual needs assessment to inform any needed updates to the five year strategic plan and develop an annual work plan to inform activities for the remainder of the contract year.
- Continue to meet on a monthly basis to discuss regional concerns, propose solutions, and improve coordination.
- Regional FYSPRT Coordinators continue to engage in monthly Regional FYSPRT Coordinator Calls to share information and support each other and the Regional FYSPRTs. Agendas for these calls are built by the FYSPRT Coordinators and DBHR.

A few challenges that Regional FYSPRTs continue to focus on include:

- Recruiting and sustaining family and youth Tri-Leads – as of August 2018, most Tri-lead roles in the regions were filled.
- Family and youth participation to meet the goal of 51% family and youth membership – as of summer 2018 percentages of youth and family engagement ranged from 35% - 80% in monthly meetings.
- Tribal engagement – in March 2018, DBHR's Tribal Liaison attended the Regional FYSPRT Coordinator Call to provide general technical assistance around engaging tribes in Washington and also offered that participants could call if they had more specific questions about engagement in their region.

In addition, technical assistance continues to be offered to the Regional FYSPRTs/BHOs. Washington State Community Connectors (WSCC), a family-run organization, is the contractor for the Washington State Children's Behavioral Health Statewide Family Network and continues to provide technical assistance for family engagement, voice and leadership as well as a Children's Behavioral Health Summit and trainings for parents to

[19] More information available online at: https://www.hca.wa.gov/assets/program/how-to-find-your-regional-fysprt.pdf

promote hope and resiliency as they move their family toward recovery. DBHR's Youth Liaison also has provided technical assistance to regions who have requested it and is working with youth and youth leaders across Washington to develop an infrastructure to enhance engagement and support sustainability of youth leadership and the youth peer workforce.

The Children's Behavioral Health Workforce Collaborative completed three Youth Professional Leadership trainings during this reporting period. The Youth Professional Leadership trainings are intended to support youth professionals, including Youth Partners working on WISe teams, Regional FYSPRT Youth Tri-Leads and other youth professionals, to support and further build their capacity as leaders. This is accomplished through interactive modules and is based on the curriculum of the Washington State Leadership Academy. Topics covered include: what is leadership, mental models, formal and informal authority, adaptive and technical challenges, and reset. Coaching on applying these skills in real life situations will be provided through the end of September 2018 to training attendees. In addition, the curriculum for the Youth Professional Leadership training is also being adapted to provide this training to incarcerated youth and youth in the community who are loosely affiliated with the peer movement and are considering entering the workforce.

The Statewide FYSPRT continues to meet on a quarterly basis to share resources, network, problem solve, and dialogue around challenges brought forward from the regions. Statewide FYSPRT meetings are facilitated by Statewide FYSPRT Tri-leads representative of the membership with a staffer from the DBHR Child Youth and Family Unit acting as the Statewide FYSPRT Coordinator. Statewide FYSPRT Tri-leads plan the agenda for every meeting based on feedback received through prior meeting evaluations and topics that are proposed to the Tri-leads and/or the Statewide FYSPRT Coordinator between meetings. The Tri-leads also track and develop next steps to address challenges that come forward from the regions.

Over the last year, Statewide FYSPRT agenda items have included updates on WISe implementation, integration, the State Youth Treatment Implementation Grant, and Children's Behavioral Health Executive Leadership Team[20] (CBH ELT), with dialogue around strategies to engage youth, system partners and families in FYSPRT and also youth and family presentations. The group also had a dialogue about the Data Quality Team (DQT) and how to increase youth and family involvement to build a better connection between the Statewide FYSPRT and the DQT. The Tri-leads facilitated multiple activities to generate questions for the Regional FYSPRTs to take back to their regions to gather information. Questions were generated for topics brought forward by the regions such as access to neuropsychologists and supporting youth experiencing homelessness. The Tri-leads also facilitated dialogue around WISe accessibility for those not eligible for Medicaid, access to neuropsychologists, and also information gathered from the regions around the topic of youth experiencing homelessness. The Statewide FYSPRT decided to move forward

[20] More information available online at: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/childrens-behavioral-health-executive-leadership-team-cbh-elt

to the CBH ELT the challenge around WISe accessibility for those not eligible for Medicaid. Since this challenge is not entirely under CBH ELT authority, DBHR has reached out to the Office of the Insurance Commissioner to take steps to research how this challenge might be addressed.

To address the youth experiencing homelessness challenge, the Executive Director of the Mason County HOST (Housing Options for Students in Transition) attended the Statewide FYSPRT meeting in May, per a suggestion of a Statewide FYSPRT member, to share information about the HOST program. The Office of Homeless Youth also had representation at the meeting to hear about information gathered in the regions and be a part of the dialogue and information sharing. Action items were created to share information about programs already in place to ensure youth have access to what is currently available. Action items were also created for Regional FYSPRTs.

In October 2017, the Statewide FYSPRT Tri-leads attended the CBH ELT meeting to present the respite challenge brought forward by the Statewide FYSPRT at the August 2017 meeting. The respite challenge was also a topic of dialogue at the December CBH ELT meeting. In February 2018, a CBH ELT member attended the Statewide FYSPRT meeting to share and dialogue about the response from the CBH ELT around this topic. Although it was decided not to open the state plan as recommended by the Statewide FYSPRT to add respite at this point, the response from the CBH ELT identified that DBHR will continue the conversation around respite. In June 2018, staff from the Child, Youth and Family team at DBHR started meeting to dialogue and plan for if a funding opportunity arose to fund respite services across Washington. In September 2018 after consulting with Children's Care Coordinators and family representatives from across the state, HCA submitted a decision package to the Office of Financial Management requesting state funds in the Governor's SFY 2020-2023 budget to fund youth behavioral health respite services.[21] The Decision Package requests $4.7 million per year for state fiscal years 2020, 2021, 2022, and 2023.

Due to multiple changes across the system, including role shifts with leadership, the CBH ELT did not meet in the first two quarters of 2018. In June 2018, the DBHR Child Youth and Family team submitted a proposal to DBHR leadership for the CBH ELT going forward. The proposal expanded on membership, to include adding the DBHR Family Liaison, DBHR Youth Liaison, and representation from the Office of Superintendent of Public Instruction, Department of Health, and DCYF, in addition to child serving systems such as JR and DDA. In August 2018, the DBHR Assistant Director attended the Statewide FYSPRT to provide an update on the CBH ELT membership and also shared that invitations being extended are requesting a formal appointment of delegates with decision making authority to participate in the meetings.

The intent of this objective, to maintain a collaborative governance structure, is to further establish meaningful partnerships between family, youth, and system partners throughout

[21] Details of the respite decision package and all other packages submitted by agencies can be viewed at https://abr.ofm.wa.gov/budget/agency/requests.

the state at every level of the child-serving system. Through the identified strategies, family, youth, system partners and providers will have the opportunity to work together cooperatively and collaboratively to build a delivery system with effective services and supports for youth and families across the state.

Objective 6 – Remaining Tasks**:**

- Continue to review and approve BHO/ASO reports and other deliverables summarizing Regional FYSPRT progress on contract requirements.
- Maintain similar Regional FYSPRT contract language in the BHO/ASO contracts to ensure consistent language and deliverables across the state.
- Continue to promote and refine the process for the Regional and Statewide FYSPRT to bring challenges forward to the Children's Behavioral Health Executive Leadership Team and develop responsiveness expectations.
- Continue to work with Office of Insurance Commissioner to address the challenge around WISe for youth and families who are not eligible for Medicaid and work with the CBH ELT to provide a response and/or next steps back to the Statewide FYSPRT.
- Continue to support activities through the contractor for the Washington State Children's Behavioral Health Statewide Family Network to promote family engagement and leadership.
- Continue to support activities of youth and youth partners across the state who are working together to develop an infrastructure to enhance engagement and support sustainability of youth leadership and the youth peer workforce.
- Continue Youth Professional Leadership trainings and coaching to support Youth Partners on WISe teams, Regional FYSPRT Youth Tri-Leads and other youth professionals in leadership development.

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Objective 7: Affording Due Process to Class Members

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

Progress and Accomplishments:

During 2018, BHOs submitted the required quarterly reports to DBHR which reflect data regarding the issuance of Notice of Adverse Benefit Determinations, which are sent to clients when a service has been denied. This report also reflects any grievance and denials that have been filed by a client during the quarter and the status of the grievance and appeal.

Additionally, the grievance and denial quarterly reports received from the BHOs are used to create a quarterly *Due Process Roll-up Report: Children and WISe*. When DBHR began creating this report, multiple report configurations were tried, resulting in the current format. The first version a more simple report, which lacked some important data from the BHOs. Refining this version resulted in a roll-up report with more in-depth reporting; however, in addition to lacking individual break downs of why grievances were filed, the revised version also had missing data for the 2 MCO regions. A team from DBHR and other HCA divisions, working together since before the July 2018 transition, has developed a plan for getting the same data from the MCOs. Upon discussion with multiple HCA units, the team determined the detailed information from MCOs was not in the data HCA collected. The team met over several months and determined what information was needed and how HCA would collect this information. Through collaboration with MCEs, the 2018 third quarter roll-up report will include BHO and MCO data on grievance and denials. This information will be broken down by region and by the reason for grievances and the type of denials that were issued (such as not meeting CANS algorithm, termination, reduction or suspension of service). The Due Process Roll-up Report continues to be shared quarterly with the BHO Quality Leads and MCOs during regular Quality Management meetings.

Over this past year, DBHR continued to offer technical assistance to staff with BHOs and MCOs involved with WISe and WISe provider agency staff. 42 CFR 438.400 (b) criteria regarding Notice of Adverse Benefit Determinations was the subject of the February Systems Coaching call in each region, including BHOs and MCOs. During these calls, all new due process policies and procedures were reviewed to ensure compliance with contract, state and federal regulation, and the WAC. In late spring during a System Coaching call there was a check-in regarding due process to ensure a uniform and consistent understanding of requirements.

In addition, the WISe Manual, Version 1.8, Section 5 on Client Rights was updated to reflect new policies and procedures for clients' due process including Notice of Adverse Benefit Determination.

Meetings with DBHR, BHO Quality Leads, and HCA representatives continue to be held bi-monthly. During this meeting the quarterly roll-up report reflecting data from the submitted quarterly reports is shared with the group. During this meeting the data is discussed, questions from BHOs and MCOs can be addressed, and any due process updates are reported out.

During this past year with continued quarterly monitoring and technical assistance offered BHOs and MCOs, no corrective action measures were taken.

In April 2018, in a Stipulation to the Court, HCA agreed to continue to following grievance and appeals monitoring process for WISe:

- Requiring quarterly quality reports from the MCEs that includes data regarding Notices (NOABDs) and Appeals.
- Identifying policies or practices by the MCEs or providers that violate the state and federal due process requirements.
- If informal efforts at remediation fail, take corrective action measures (including requiring a corrective action plan by the MCE) to address and remediate non-compliance by the BHO/MCO with notice and appeals requirements in the Settlement Agreement and state and federal law.

DBHR continues to recognize the need for ongoing technical assistance and quality improvement in the grievance and appeal system and will continuing to provide this over the next year.

Objective 7 - Remaining Tasks:

- Continue to provide BHOs and MCO's technical assistance on due process requirements outlined in the DBHR contract, Guidance Documents, and the updated WISe Manual for WISe-enrolled and WISe-referred BHO beneficiaries.
- Continue to monitor BHO and MCO reports on grievances, appeals and administrative hearings and to correct instances of non-compliance.
- Monitor BHOs for compliance with due process requirements in the Settlement Agreement, contract, Guidance Documents, and the WISe Manual, including the issuance of notices of adverse benefit determination in all instances where they are required for youth being referred to and screened/assessed for WISe, but do not meet WISe eligibility criteria.
- Starting in January 2019, implement and monitor monthly Grievance and Appeals reports from MCOs.
- Analyze and use the data as part of the WISe quality improvement program.
- Continue to provide BHOs and MCOs technical assistance on due process requirements outlined in the DBHR Guidance Document and the updated WISe Manual.

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

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

Objective A: Report on progress

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

Progress and Accomplishments:

WISe Quality Management Plan: The WISe Quality Management Plan (QMP) was adopted in December 2014 and amended in May 2015. The QMP provides tools, resources, and processes for measuring the implementation of WISe and the success of the goals and commitments of the T.R. Settlement Agreement. An overview of the reporting processes, measures, and operationalized criteria included in the QMP can be found in the Action Information Matrix (AIM), found in Appendix B of the QMP.[22]

Given recent development of new quality improvement tools and processes, including the WISe Quality Improvement Review Tool (QIRT), DBHR has consulted with WISe practitioners and Plaintiffs' Counsel to update and amend the QMP. This process continues and is expected to be complete by the end of 2018. This will include new guidance for using the Quality Improvement Review Tool (QIRT), which is expected to provide valuable data about WISe practices and will inform continuous quality improvement.

WISe Data Dashboard: This dashboard is designed to provide an overview of demographics and characteristics of the youth who are screened for and who receive WISe, the types of services provided in the WISe program, and outcomes. The WISe Dashboard is produced and distributed on a quarterly schedule, with the most recent annual update (expanded set of measures) occurring in February 2018 and the most recent quarterly update[23] occurring in July 2018. The next annual update, to be released in early 2019, will add administrative outcome measures such as mental health inpatient utilization and juvenile justice involvement.

[22] A copy of the QMP can be found online at: https://www.hca.wa.gov/assets/program/wise-quality-management-plan.pdf
[23] Available online at: https://www.hca.wa.gov/assets/program/WISe-dashboard-july-2018.pdf

The WISe Dashboards indicate:

- Over 5,000 youth received WISe services between July 1, 2014, and December 31, 2017.
- WISe continues to grow, and growth is accelerating – both in terms of the number of youth screened for WISe and the number of youth served in WISe.
- WISe services are now available to youth in all ten regions of Washington State, and one region caseload has met the full implementation target for number of youth served in a month.
- In general to date, youth served in the WISe program have more severe mental health needs and associated risk factors than youth in the WISe proxy. This indicates that the program is appropriately serving youth with among the most severe mental health needs in the state. The WISe proxy is best thought of as the target population to be screened for WISe services and represents a much broader population than the WISe service population; those youth served by the program are expected to be among the most severe youth included in the proxy.
- There are additional opportunities to link youth with WISe services in some areas (e.g., youth with co-occurring substance use disorders or juvenile justice involvement).
- Youth in WISe services are frequently served in home-and community-based settings in addition to office settings.
- Youth in WISe services experience measurable reductions in actionable treatment needs (e.g., emotional control problems, suicide risk) and measurable increases in identified strengths (e.g., resilience, optimism) over their first six months in services, based on CANS data. These positive changes are observed in every region operating the WISe program.

<u>Objective A – Remaining Tasks:</u>

- Complete the update of the Quality Management Plan, in collaboration with Plaintiff's Counsel.
- Continue to produce quarterly updates of the WISe Dashboard.
- Continue to produce annual update of the WISe Dashboard, incorporating newly agreed-on administrative outcome measures in the next release (early 2019).

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Objective B: Improve core system and cross-system competencies

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

Progress and Accomplishments:

As described in Objectives 4 and 5 above, DBHR and its system partners are implementing a range of strategies to address core and cross-system competencies, including workforce development. Additionally, DBHR and its agency partners have worked extensively with the Praed Foundation to develop and use a TCOM (formerly "Total Clinical Outcomes Management", now "Transformational Collaborative Outcomes Management") approach to developing and implementing the WISe program.

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

In mid-2018, DBHR contracted with the Praed Foundation to pilot a statewide TCOM implementation survey using a standardized instrument. Evaluation of the survey process and feedback from participants identified the need to develop a tailored instrument for future use, to ensure reliable data collection and system coverage.

Objective B – Remaining Tasks:

- Continue to provide needed training and technical assistance to support and sustain use of the TCOM approach.
- Pilot and implement a tailored, Washington/WISe-specific TCOM implementation survey to effectively evaluate system and infrastructure needs and strengths under the TCOM framework.

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

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

Progress and Accomplishments:

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

Fidelity monitoring and quality improvement: Over the past year, DBHR has developed and pilot-tested the Quality Improvement Review Tool (QIRT), in partnership with its contractors at the Praed Foundation. The QIRT builds off the methods and findings of the Quality Service Review (QSR, completed in 2016), and is designed to provide rapid and actionable feedback on the extent to which documented WISe practices are consistent with the WISe practice model.

The QIRT provides feedback on the extent to which documentation indicates that WISe practices are collaborative, timely, individualized, and effective in helping clients address needs and build strengths. The tool includes modules for each of the core roles on WISe teams, including care coordinators, therapists, and parent and youth peer partners. The QIRT summarizes information on the type, intensity, and usefulness of supports provided, regardless of the number and type(s) of roles examined, or the duration of care sampled. This flexible use and reporting is possible due to the tool's modular structure, and because of how QIRT items capture the WISe teams' practices.

In addition to use for statewide fidelity and quality review, the QIRT is suitable for integration into existing work practices at WISe-providing agencies, such as individual and group supervision. To facilitate this use, the QIRT was designed to quantify effective practices across the widest set of circumstances. This includes: differences in the duration of treatment reviewed, the role of the support provider, and the number of children and youth included. The QIRT can be completed online, in a secure web-based portal, or on paper and then entered online.

The QIRT online platform matches practice data from the QIRT with outcomes data from the Child and Adolescent Needs and Strengths (CANS). QIRT data are transmitted and stored in secure, HIPAA-compliant cloud environments. Each night, the QIRT data are matched with relevant CANS data from the Washington Behavioral Health Assessment Solution (BHAS). QIRT reports are available within 24 hours of data being entered.

Findings from QIRT pilot: In January and February 2018, the QIRT was pilot tested at three WISe provider agencies. Agency selection was intended to represent the geographic

diversity of WISe providers in Washington, with one agency selected from each of the Thurston-Mason, Greater Columbia, and King County regions.

A total of 38 files were reviewed in the pilot. Overall, the average time sampled period was 128 days. The pilot review focused on the initial engagement and treatment period, covering least the first three Child and Family Team (CFT) meetings. Client files were randomly selected, providing a 'real-world' test of the range of documentation practices users are likely to experience in everyday use of the tool. In nearly all cases, the time period sampled included care provided during 2017, reflecting recent WISe treatment, coordination, and documentation practices.

Below, *Table 11* compares CANS data at intake and 3 months for the pilot sample with statewide averages. The sample included in the pilot group had slightly lower levels of youth and caregiver needs compared to statewide averages. However, the changes in CANS at 3-month reassessment are of a similar magnitude to those observed statewide.

Table 11. Comparison of CANS: Statewide Averages vs QIRT 2018 Pilot Group Averages

Average number of actionable CANS items	Initial	3 Mos.	Change
Youth Actionable Needs			
QIRT Pilot Group	9.4	7.6	-1.8
Statewide	10.8	8.7	-2.1
Youth Identified Strengths			
QIRT Pilot Group	7.4	8.0	+0.6
Statewide	7.6	8.4	+0.8
Caregiver Needs and Resources			
QIRT Pilot Group	1.6	1.2	-0.4
Statewide	2.5	2.2	-0.3

SOURCE: Data from BHAS; comparison generated via QIRT online reporting platform.

The QIRT generates aggregate information about the amount of interaction that youth and families receiving WISe have with members of their core WISe team. Below, *Table 12* describes the averages for all files reviewed in the QIRT pilot: section (a) describes the average intensity of contact that the youth and family have with members of the core WISe team, and section (b) describes averages for key elements of the WISe practice model. For example, for files reviewed in the pilot, the average number of CFTs is 1.12, which is consistent with the WISe practice model expectation that CFTs happen at least one time per month.

Table 12. Cross-site practice pattern averages, QIRT 2018 pilot

(a) Face-to-Face contact with WISe team, outside of CFTs		
WISe Role	**Contact with**	**Average per month**
Care Coordinator	Youth	57 min
	Caregiver	52 min
	Other	54 min
Parent Peer Partner	Youth	40 min
	Caregiver	115 min
	Other	55 min
Youth Peer Partner	Youth	155 min
	Caregiver	40 min
	Other	52 min

(b) Teaming and treatment contact	Average
Engagement (contact before first CFT)	173 min
Child and Family Team (CFT) per month	1.12 sessions
CFTs attended by WISe team therapist	59 %
Therapy sessions per month	2.69 sessions

SOURCE: QIRT online reporting platform.

QIRT statewide implementation: To ensure reliable data is collected, DBHR requires QIRT reviewers to complete a 2-day training, feedback, and reliability assessment workshop prior to using the QIRT. To date, staff from one external quality review organization (EQRO) and staff of one provider agency have been trained in use of the QIRT. DBHR will continue to work with WISe provider agencies, MCEs, and HCA staff to expand the pool of trained QIRT users.

DBHR is also in the process of contracting with an EQRO for the first statewide use of the QIRT, which is expected to be completed in 2019.

Youth, Family and Caregiver WISe Survey: In 2017, DBHR again contracted with the Social and Economic Sciences Research Center (SESRC) to conduct a statewide survey of children and youth, and their caregivers, who are participating in WISe to gain direct feedback about their experience. A total of 1,063 interviews were conducted; below, *Table 13* presents response rates.

Table 13. Response Rates for 2017 Youth, Family, and Caregiver WISe Survey

Respondent group	Starting population	Completed interviews	Completed and partially completed interviews
Youth (age 13-21)	1164	260 (22%)	279 (at 24%)
Caregivers of youth age 13-21 and children under age 13	2007	739 (37%)	784 (at 39%)

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

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

- Youth strongly indicated (94%) that WISe teams helped them understand how WISe services would assist them in setting realistic goals, and eighty-nine percent of caregivers agreed.
- Youth and caregivers also agreed WISe teams assured them they are able to get help if and when they need it (92% and 89% respectively).
- Eighty-five percent of youth and seventy-four percent of youth and caregivers asserted WISe teams assisted them in developing confidence to manage future problems.
- A number of respondents indicated in comments that they were concerned about staff turnover and having WISe staff that were new to the behavioral health field and lacked some experience and training**.**

DBHR has also contracted with SESRC to conduct a 2018 the statewide youth and family survey. As of the time of writing this report, the 2018 survey is in progress; the 2018 survey report is expected to be available in mid-2019.

Based on the feedback from the most recent survey, DBHR will continue to emphasize ongoing training and coaching provided by the WISe Collaborative to provide both technical assistance and training to staff and supervisors. Training is also being provided by the University of Washington Evidence Based Practice Institute on working with youth experiencing autism and on using cultural humility in service provision. Trainings are planned for calendar 2019 on service provision to transition aged youth experiencing homelessness and on serving American Indian/Alaska Native youth. As well as training for BRS staff on BRS/WISe integration.

<u>Objective C – Remaining Tasks:</u>

- Implement and support roll-out of the first statewide QIRT review process.
- Continue to disseminate information about the QIRT, including reports on the completed pilot, protocol for use, and training process.
- Identify and train QIRT users to expand the pool of trained QIRT reviewers.
- Support completion of the 2018 WISe youth and family survey, and dissemination and use of findings from the 2017 survey (and 2018 survey, upon report release.)

Objective D: Improve clinical and program quality

Improve clinical and program quality.

Progress and Accomplishments:

DBHR continues to work closely with MCEs to implement and assess continuous quality improvement projects based on the Plan-Do-Study-Act (PDSA) framework.

The SFY 2018 round of PDSA projects built on findings from the Quality Service Review (QSR), which was completed in 2016 and produced a 'Lessons Learned' report that was released in early 2017. One of the key findings from the QSR emphasized the importance of using effective strategies to help build natural supports, which became the target area for the SFY 2018 PDSA projects. These PDSA projects use indicators from CANS data to identify and track targets for improvement, and to provide a consistent statewide measure of progress. Some BHOs and WISe provider agencies also identified and are using additional sources of information to help monitor the progress of their QI work.[24] Given the upcoming transition to integrated managed care in many of the regions, the SFY 2018 PDSA round was extended to the end of calendar year 2018. DBHR will continue to work with MCEs in all regions to support quality improvement projects once the current PDSA round is completed.

DBHR offers ongoing technical assistance to all MCEs and provider agencies, including a monthly WISe Quality Improvement Technical Assistance call. Additional support for quality improvement via training, coaching, and targeted technical assistance is described above in Objective 5. Future work in this area also includes training and support for statewide implementation of the QIRT. Findings from QIRT reports are expected to drive future PDSA projects at the agency and MCE levels.

Objective D – Remaining Tasks:

- Continue to support PDSA projects at the MCE and provider agency level, including supporting MCOs during the transition to integrated managed care in a majority of the regions.
- Once findings from the first statewide QIRT review process are available, identify targets for improvement and support implementation of new quality improvement projects.
- Support use of the QIRT statewide, including providing technical assistance for translating report findings into actionable quality improvement targets.

[24] Additional information about PDSA projects is provided in the External Quality Review Annual Technical Report; the 2017 annual report is available at https://www.hca.wa.gov/assets/billers-and-providers/eqr-technical-report-2017.pdf

Objective E: Multi-Level Communication

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

Progress and Accomplishments:

Communication and Quality Infrastructure: In addition to the communication activities described in several sections above, DBHR has established a data review process to address outcomes monitoring and continuous quality improvement. The proposed update to the QMP includes a revised and updated diagram depicting the infrastructure responsible for quality, included in *Figure 4* below, as well as in-depth descriptions of all of the groups included in the quality infrastructure diagram, and the communication pathways linking them.

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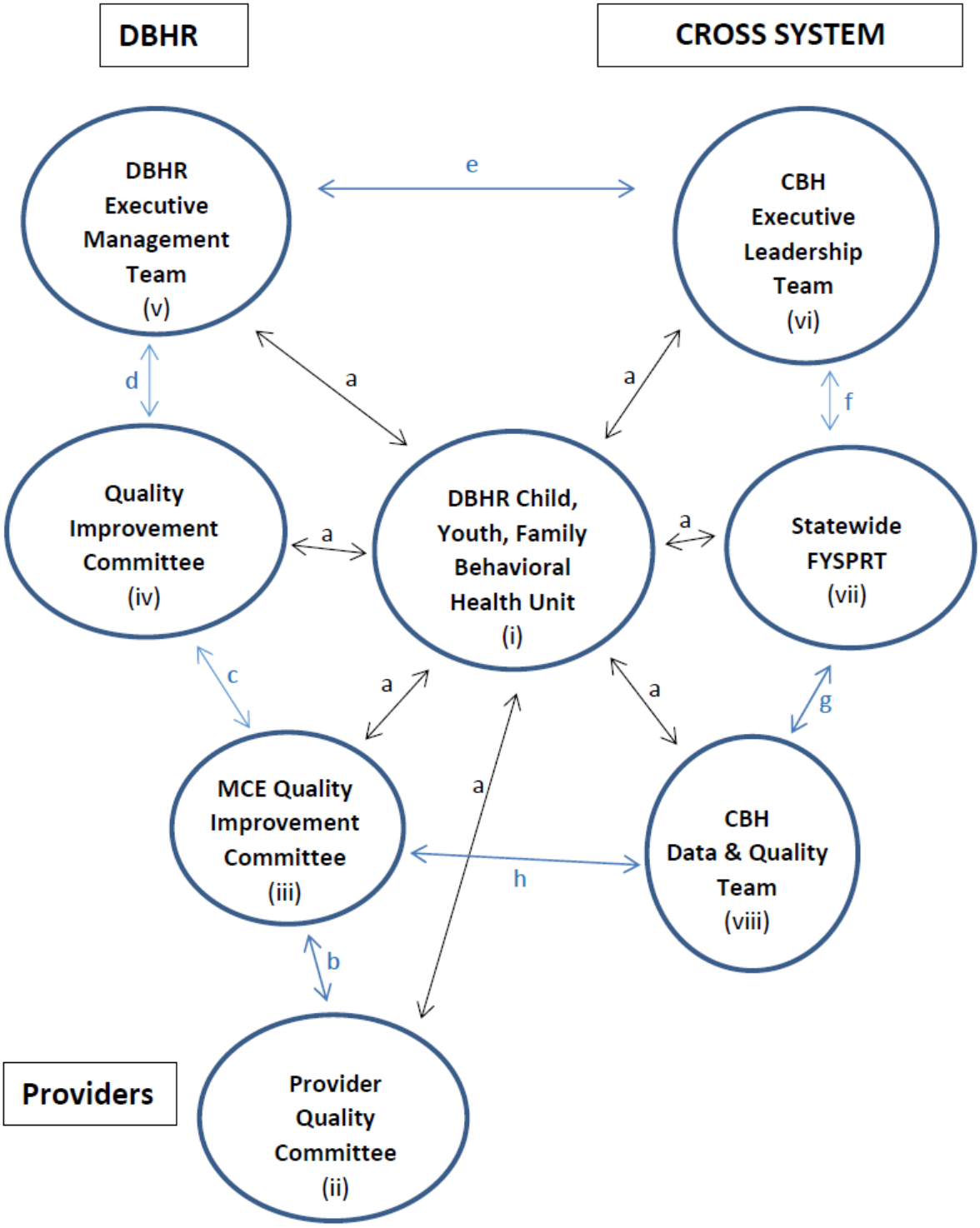
Figure 4. Quality Infrastructure for Children's Behavioral Health in Washington State



Children's Behavioral Health Data and Quality Team: In 2018, DBHR revised the structure of the Children's Behavioral Health Data and Quality Team (CBH DQT) to tighten the connection between the CBH DQT and the FYSPRT. Starting in February 2018, CBH DQT

meetings are now held immediately before the statewide FYSPRT, with FYSPRT attendees invited to join the CBH DQT meeting as well. Over the past three quarterly meetings, the CHB DQT has reviewed, provided feedback, and made recommendations about several data reports related to WISe, including: the BHAS quarterly trend reports, a statewide report on the behavioral health needs among children on Medicaid in Washington[25], and the draft of the 2017 WISe youth and family participant survey.

Finally, DBHR continues to work on improving communication of data and information, and is in the process of developing a new online reports archive, accessible to the public and to stakeholders on the HCA WISe website.

Objective E – Remaining Tasks:

- Continue to support the Children's Behavioral Health Data and Quality Team, ensuring review and dissemination of quality indicators is effective.
- Implement an online reports archive to improve ongoing access to current and recent reports.

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[25] https://www.dshs.wa.gov/ffa/rda/research-reports/behavioral-health-treatment-needs-and-outcomes-among-medicaid-children-washington-state

III. Implementation Challenges

In April 2018 parties submitted a Stipulation to the Court. At that time, the State notified Plaintiffs' Counsel that it anticipates reaching substantial compliance by June 30, 2019. The notification process agreed upon between the parties is the State will notify Plaintiffs' Counsel by the spring 2019 quarterly meeting if it believes it will not meet substantial compliance by June 30, 2019.

The parties also acknowledged that June 30, 2019, was the State's good faith estimate based on information known in March 2018 and the State reserves the right to initiate the exit procedure earlier than June 30, 2019, by setting a Paragraph 66 meeting in accord with the Settlement Agreement. It was also noted to the extent the parties reach new agreements about the Quality Management Plan and Paragraph 69(c) of the Settlement Agreement, the State's estimate of June 30, 2019, may require amendment. As of writing this draft, the parties are still negotiating the QMP and amended language for Paragraph 69(c).

The categories below are current areas of focus for WISe implementation, including QMP and strategies for meeting exit criteria for Paragraph 69(c):

Access and Service Delivery:

In the April 2018 Stipulation to the Court, the parties agreed "utilization for WISe is reached when the annual unduplicated caseload is 82.5% of the estimated number of class members to be served."

The agreement notes that number of children/youth to receive services is 7000 annually. For the purposes of translating between annual unduplicated and monthly caseload, HCA is using nine month as the average WISe service duration, with the monthly caseload target of 3150. To meet substantial compliance by June 2019, 2600 youth need to be receiving WISe monthly. In addition, each region must maintain an average of nine service hours a month or above. In September, the State was at 88% of the substantial compliance goal. If the State does not meet substantial compliance by June 30, 2019, the annual service target will be adjusted on an annual basis to reflect the most recently available annual caseload growth rate for the State's 0-20 Medicaid population.

In July 2018, through new contracts to MCEs, the statewide monthly caseload target increased from 2,985 to 3,150. As of September 2018, the State is at 72% of meeting the monthly caseload target of having 3,150 youth and their families enrolled in WISe, each month. Last year at this time the State was at 58% of the lower monthly caseload target (2,985). Again, this past year the State has experienced an increase in capacity, with the largest growth in Spokane County Regional BHO, yet the number of WISe staff hired across the state remains behind schedule.

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

As HCA prepares for another system transition in January 2019, when five additional regions become IMC regions, focused attention on WISe is underway. To facilitate a smooth transition to the IMC model, HCA is holding regular webinars, called Knowledge Transfers that educate the MCOs about the existing system and expectations, including presentation time from each BHO to focus on regional differences.

HCA strengthened the contract language relating to the WISe program in the IMC and AHFC contracts, effective January 2019. Some of those changes include a requirement that MCOs must meet their monthly caseload target numbers of children and youth served for each of their regions. In addition, MCOs are required to build and sustain capacity to meet the potential demand for WISe services that exceeds the caseload targets for each of the MCO's contracted regions. If the MCO does not meet these requirements for the month in any of the MCO's contracted regions, the contract specifically requires the MCO to develop and implement a plan to build caseload capacity and achieve and maintain monthly caseload target numbers.

In preparation for this large IMC shift, Readiness Reviews were conducted with all five MCOs. These compliance reviews are performed prior to major changes in contracting to ensure MCOs will be able to meet all of the contract expectations to deliver Medicaid services. Readiness Reviews are conducted by HCA staff and consist of in-depth document reviews, onsite visits, and, interview questions with key MCO staff to assess the MCO's level of preparedness for fulfilling the scope of work in the contract. After a Readiness Review is completed, HCA can require corrective action for any critical elements that are deemed not ready for implementation. The Readiness Review process is finalized in late October for IMC MCOs and mid-November for the integrated AHFC MCO, and will determine whether an MCO is prepared to implement the scope of work in the new contract.

As of July 2018, HCA contracts for BHOs and MCO include the performance measure of maintaining a regional average of 10.5 hours of encountered services per month. These services include any Medicaid behavioral health service. This measure is tracked through the WISe Service Characteristics Report produced by RDA. Based on SFY17 data, there are two regions below this performance measure – King County BHO and Greater Columbia BHO. DBHR with support from RDA is working with these two regions on data validation. King County BHO has identified data entry issues and authorization issues and is working to remedy. GCBHO was recently notified of this issue and is currently reviewing data. All other regions are above the performance measure.

In 2018, DBHR invested in a new position, the WISe System Coach. This full time position works directly with MCEs to isolate any system challenges, identify potential solutions and assist with planning and monitoring of strategy implementation. DBHR has experienced a recent turnover in this position and is currently recruiting for a new hire. DBHR will continue to consult with nationally prominent subject matter experts and has an onsite visit scheduled with one such expert, Suzanne Fields, in mid-October. She will be meeting with HCA staff and provide a webinar to MCOS. For capacity enrollment numbers, DBHR will continue to monitor regional progress monthly.

Behavioral Health Assessment Solution (BHAS):

The pending transition of five regions from BHO's to MCO's and Coordinated Care serving all youth in foster care presents challenges to data entry and report generation as previously a region was either managed by a BHO or MCO's. The new system of having both BHO's and MCO's in the same region presents challenges to the permission structure of BHAS. The system has a roll-out plan to address those challenges and anticipates that permission and other needed changes will be ready to implement by December of 2018, well in advance of the January 2019 date for BHO to MCO transition. There continue to be some remaining challenges with data entry. Specifically, the current BHAS system does not allow for a youth's case to be open in two agencies at the same time. This makes it difficult to record work being done as a youth transitions from one agency to another including those who are transitioning from CLIP to WISe. DBHR has prioritized the BHO to MCO transition and now expect this obstacle will be remedied by the end of state fiscal year 2019. Quarterly reports generated from BHAS data are distributed to each agency, while regional and state reports are posted online.[26] The BHAS system also has similar on-demand reporting functionality, allowing agency and MCE administrators to assess current strengths and challenges in real time.

BRS/WISe

In April 2018, DCYF and DBHR/HCA committed to developing four BRS/WISe integration sites. In preparation for this work DCYF and DBHR created an overarching work plan which was signed by leadership in May 2018. DCYF, in partnership with DBHR, convened a series of meetings to bring together BRS contractors, WISe agency leads, BHO Care Coordinators and RDA staff to create a workgroup, which has collaboratively developed the framework to launch the sites. This workgroup will continue to inform the State of the needs and strengths of BRS/WISe integration.

Four sites for initial BRS/WISe integration have been selected, with locations in King, Pierce, Spokane, and Yakima counties. The four sites include:

[26] Reports webpage: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0

- One Treatment Foster Care (TFC) and WISe with the same provider who offers both services;
- One TFC and a WISe provider – separate providers in the same area;
- One BRS Group or Staffed Residential Home and WISe – same provider who offers both services; and
- One BRS Group or Staffed Residential Home and one WISe provider – separate providers in the same area.

During the initial BRS/WISe integration, up to forty (40) youth are expected to be served. Youth receiving BRS services at the integration locations, who screen as eligible for WISe, will start the intake process during the month of October. A review of progress will be completed in April 2019 with a goal to identify how the model can be expanded statewide overtime. Currently, programmatic barriers or challenges experienced during the planning stages of the sites are being addressed by the workgroup. DCYF and DBHR anticipate other challenges will emerge as the integration efforts move forward. On-going meetings with the workgroup will continue to support process and implementation challenges moving forward. Additionally, each site will engage in at least one site visit from DBHR and DCYF between October 2018 and April 2019 to discuss implementation, including identifying implementation challenges and successes, case success stories and qualitative outcomes. Each site, both BRS and WISe, will also track demographic information and services received and report monthly. All information gathered (implementation monitoring/site visit, client lists/demographics, service data, CANS) will be reviewed and summarized to examine the strengths and successes of the model and changes that may be needed for successful statewide implementation.

At the time of drafting this report, parties are discussing measurable exit criteria related to Paragraph 69(c). Plaintiffs have stated their expectation, pursuant to the Settlement Agreement, that children in BRS receive WISe when a WISe screen indicates it is medically necessary.

Quality Management:

Quality management and improvement is a priority in the coming months. An update of the QMP will ensure sustainability of a robust and effective Quality Management, Improvement, and Accountability (QMIA) system going forward. Finalizing the QMP update efforts currently in progress is a top priority. The parties have continued to meet to address the necessary changes in the QMP, including providing edits and additions to the plan.

Additionally, the WISe Quality Improvement Reporting Tool (QIRT) protocol was finalized in late 2017 and pilot tested in early 2018. The online QIRT reporting platform was developed in mid-2018 and is now available for use. With these key elements in place, implementation of the QIRT is now in roll-out phase in all regions across the state, with an external QIRT review process anticipated to start in January 2019.

Other QMIA related tasks include improving data communication, piloting additional CANS reports using BHAS data, supporting the use of the PDSA framework to drive CQI, providing support for quality improvement work in regions transitioning to integrated managed care, and effectively disseminating quality, process, and practice improvements.

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IV. Glossary of Key Terms

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

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

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

3. **"Behavioral Health Administration" or "BHA"** is an administration of the Department of Social and Health services that operates three state psychiatric hospitals: Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center. BHA was the home of the Division of Behavioral Health and Recovery (DBHR) until DBHR moved to Health Care Authority in July 2018.

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

5. **"Children's Administration or CA"** was an administration under the Department of Social and Health Services and the public child welfare agency for the state of Washington. In July 2018, responsibilities of CA were transferred to DCYF.

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

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

8. **"Children's Long-term Inpatient Program" or "CLIP"** is the most intensive inpatient psychiatric treatment available to all Washington residents, ages 5-18 years of age; offers a medically based treatment approach providing 24-hour psychiatric care staffed by psychiatrists, Master-level social workers, RNs and other clinical experts.

9. **"Coordinated Care of Washington" or "CCW"** is a Managed Care Organization (MCO) that will provide behavioral health services for all youth in foster care statewide via the Apple Health Foster Care plan, starting January 1, 2019. CCW will also offer a behavioral health services plan available to Medicaid clients in the Greater Columbia, King, North Central, North Sound, and Pierce regions.

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

11. **"Developmental Disabilities Administration" or "DDA"** is an administration of the Department of Social and Health Services that provides services and programs for state residents with developmental disabilities and their families. https://www.dshs.wa.gov/dda/consumers-and-families/services-and-programs-non-residential

12. **"Division of Behavioral Health and Recovery" or "DBHR"** means the division within the Health Care Authority, the Medicaid authority for the State, whose staff are behavioral health subject matter experts. . DBHR was previously part of the Department of Social and Health Services (DSHS) Behavioral Health Administration (BHA) and transitioned to HCA on July 1, 2018.

13. **"Department of Children, Youth, and Families" or "DCYF"** means the cabinet-level agency focused on the well-being of children. DCYF, established in July 2018, holds a mission and vision to ensure that "Washington State's children and youth grow up safe and healthy—thriving physically, emotionally and academically, nurtured by family and community." DCYF currently includes the former Department of Early Learning and Children's Administration of DSHS; starting in July 2019, DCYF will include the Division of Juvenile Rehabilitation and the Office of Juvenile Justice, both currently part of the Department of Social and Health Services (DSHS).

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

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

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

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

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

19. "**Health Care Authority" or "HCA"** purchases health care for more than 2 million Washingtonians through two programs — Washington Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program. As of July 1, 2018, HCA includes the Division of Behavioral Health and Recovery (DBHR), which was previously part of the Department of Social and Health Services (DSHS)

20. **Managed Care Entity(s) or "MCEs"**- A term used to collectively refer to Behavioral Health Organizations (BHOs) and Fully Integrated Managed Care Organizations (MCOs).

21. **Managed Care Organizations or "MCO's**" is a health care provider or a group or organization of medical service providers who offers managed care health plans. It finances and delivers health care using a specific provider network and specific services and products.

22. **"Quality Improvement Review Tool" or "QIRT"** is a file review tool developed by DBHR for use with WISe documentation. The QIRT is designed to provide feedback on the extent to which documented practices are consistent with the WISe practice model.

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

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

25. **"System of Care" or "SOC** is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

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

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

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

29. **"Washington State Children's Behavioral Health Principles"** are a set of standards, grounded in the system of care values and principles, which guide how the children's behavioral health system delivers services to youth and families. The Washington State Children's Behavioral Health Principles are:
    - Family and Youth Voice and Choice
    - Team Based
    - Natural Supports
    - Collaboration
    - Home- and Community-based
    - Culturally Relevant
    - Individualized
    - Strengths Based
    - Outcome-based
    - Unconditional

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

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

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V. Attachments

The following documents, filed with the court earlier this year, are attached to this report to facilitate reference:

- Stipulation Regarding Clarifications to the Parties' Settlement Agreement, previously filed with the court on April 23, 2018 (*see pages 84 – 87).*
- Final Mediation Agreements as of March 27, 2018, previously filed with court as an exhibit attached to the above stipulation *(see pages 88 – 91)*.

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THE HON. THOMAS S. ZILLY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

T.R., by and through his guardian and next friend, R.R.; S.P., by and through her mother and next friend, D.H.; C.A., by and through her mother and next friend, A.A.; T.F., by and through her father and next friend, D.F.; P.S., by and through his mother and next friend, W.S.; T.V., by and through his guardian and next friend. C.D.; E.H. by and through his mother and next friend, C.H.; E.D., by and through his mother and next friend, A.D.; and L.F.S., by and through his mother and next friend, B.S., Plaintiffs, v. CHERYL STRANGE, not individually, but solely in her official capacity as Secretary of the Washington State Department of Social and Health Services; and SUSAN E. BIRCH, not individually, but solely in her official capacity as the Director of the Washington State Health Care Authority, Defendants.	No. C09-1677-TSZ **STIPULATION REGARDING CLARIFICATIONS TO THE PARTIES' SETTLEMENT AGREEMENT**

The parties respectfully submit this Stipulation Regarding Clarifications to the Parties' Settlement Agreement to apprise this Court of the status of the parties' settlement implementation efforts.

National Center for Youth Law
405 14th Street, 15th floor
Oakland, CA 94612
(510) 835-8099 – Fax: (510_835-8099

On December 19, 2013, the Court approved the parties' Settlement Agreement (Dkt. 119-1), calling it a "resounding success" and "nothing less than a landmark reform". Verbatim Report of Proceedings at 25, *T.R. v. Quigley*, No. C09-1677TSZ (W.D. Wash. Dec. 19, 2013). Under the terms of the Settlement Agreement, Defendants agreed to develop a program and deliver intensive mental health services, called Wraparound with Intensive Services ("WISe"), to Medicaid-eligible children in Washington statewide. Dkt. 119-1, ¶ 1. Defendants have submitted annual reports each year apprising the Court of the status of the settlement implementation efforts. Dkts. 149, 159, 166, and 170.

Pursuant to Paragraph 66 of the Settlement Agreement, in May 2017, the parties began discussions regarding "whether the Defendants are on track to meet the exit criteria" set forth in paragraphs 67-72 of the Settlement Agreement. After several calls and in-person meetings, the parties enlisted mediator Kathleen Noonan to assist with assist in resolving disagreements about the status of implementation efforts. See Dkt. 119-1, ¶ 75.

On March 8 and 9, 2018, the parties attended two full days of in-person mediation with Ms. Noonan. Following those in-person meetings, the parties had several phone calls with Ms. Noonan and one another. On April 6, 2018, the parties executed an agreement that clarified various exit criteria and related Settlement Agreement terms. The parties' agreement acknowledged that Defendants will not have completed all exit criteria by the original anticipated completion date of June 2018. Defendants now expect to achieve substantial compliance by June 30, 2019. The parties' agreement defined a set of tasks that must be completed in order to demonstrate substantial compliance with the exit criteria. The parties' agreement does not amend the Settlement Agreement.

The parties respectfully submit a copy of the parties' executed agreement as Exhibit A to this Stipulation.

Respectfully submitted this 23rd day of April, 2018.

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For Plaintiffs:	For Defendants:
/s/Susan Kas Susan Kas, WSBA No. 36592 David Carlson, WSBA No. 35767 susank@dr-wa.org davidc@dr-wa.org **DISABILITY RIGHTS WASHINGTON** 315 5th Avenue South, Suite 850 Seattle, WA 98104 Telephone: (206) 324-1521 Facsimile: (206) 957-0729 /s/Leecia Welch Leecia Welch, WSBA No. 26590 lwelch@youthlaw.org **NATIONAL CNTR FOR YOUTH LAW** 405 14th Street, 15th Floor Oakland, CA 94612 Telephone: (510) 835-8098 Facsimile: (510) 835-8099 /s/Patrick Gardner Patrick Gardner, CB No. 208199 Patrick@youngmindsadvocacy.org **YOUNG MINDS ADVOCACY PROJECT** 115 Haight Street Menlo Park, CA 92025 Telephone: (650) 494-4030 /s/ Kimberly Lewis Kimberly Lewis, CB No. 144879 lewis@healthlaw.org **NATIONAL HEALTH LAW PROGRAM** 3701 Wilshire Blvd, Suite 750 Los Angeles, CA 90010 Telephone: (310) 736-1653 Facsimile: (213) 368-0774	/s/ Eric Nelson ERIC NELSON, WSBA No. 27183 JENNIFER S. MEYER, WSBA No. 27057 EricN1@atg.wa.gov JenniS1@atg.wa.gov Assistant Attorneys General Attorneys for Defendants Office of the Attorney General 7141 Cleanwater Drive SW PO Box 40124 Olympia, WA 98504-0124 Telephone: (360) 586-6565

CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of April, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

Eric Nelson (EricN1@atg.wa.gov)
Jennifer Smith Meyer (jennies1@atg.wa.gov)

Dated this 23rd day of April, 2018 at Oakland, California.

s/ Kira Setren
Paralegal
National Center for Youth Law

National Center for Youth Law
405 14th Street, 15th floor
Oakland, CA 94612
(510) 835-8099 – Fax: (510_835-8099

Re: TR v. Birch & Strange – Final Mediation Agreements as of March 27, 2018

I. Access and Service Delivery.

1. For purposes of demonstrating Defendants have substantially complied with the exit criteria in Paragraphs 67(i) and (j) of the Settlement Agreement, the parties agree that:

   a. Utilization for WISe is reached when the annual unduplicated caseload[1] is 82.5% of the estimated number of class members to be served. The parties agree that until June 30, 2019, the estimated number of class members to be served will be 7,000 annually, and the Defendants will have reached utilization if by that time, the monthly caseload count is 2,600. Should substantial compliance not be achieved by June 30, 2019, the annual service target will be adjusted on an annual basis to reflect the most recently available annual caseload growth rate for Washington's age 0-20 Medicaid population.

   b. The average statewide WISe service intensity must be no lower than 10.5 hours per month, but no Region will have an average service intensity lower than 9 hours per month.

II. Due Process.

1. To meet the requirement in Paragraph 68(d) of the Settlement Agreement and Paragraph 3, Objective 7 of the Implementation Plan, and to address the non-compliance by the BHOs/MCOs with due process requirements, the State will routinely monitor the BHOs/MCOs compliance with due process requirements by taking all of the following steps:

   a. Requiring quarterly quality reports from the BHO/MCO that includes data regarding Notices (NOABDs) and Appeals.

   b. Identifying policies or practices by the BHOs/MCOs or providers that violate the state and federal due process requirements.

   c. If informal efforts at remediation fail, take corrective action measures (including requiring a corrective action plan by the BHO/MCO) to address and remediate non-compliance by the

[1]For the purposes of translating between annual unduplicated and monthly unduplicated WISe caseload, the state will use 9 months as its average WISe service duration.

BHO/MCO with notice and appeals requirements in the Settlement Agreement and state and federal law.

III. Quality Management Plan.

1. The parties agree that the Exit Criteria require Defendants to be operating a quality assurance (management) system consistent with the Quality Assurance Plan, now called the Quality Management Plan (QMP).

2. The parties will use the March 2018 QMP update proposal by the State as a starting point for amendments. Plaintiffs will have ten business days after the effective date of this agreement to propose additional items or elaborations for consideration in the process. Amendments cannot enlarge or increase the State's obligations under the Settlement Agreement.

3. The parties agree to amend the QMP such that:

   a. Items for which the State has not complied will be either updated for future compliance, or deleted as no longer relevant; and

   b. The amendments will be adopted only by consensus of Plaintiffs and Defendants, using Kathleen Noonan as mediator if necessary.

4. It is expected that the process will be completed by June 15, 2018 subject to mediator availability.

IV. TRIAGe/Process

1. Plaintiffs' counsel meetings with the State will be held in person on a quarterly basis. Plaintiffs' counsel monthly conference calls will no longer be held, unless agreed to between both parties. In person meetings will be facilitated by the mediator, subject to her availability, and will seek to focus on either outstanding exit issues including finalization of the QMP or barriers to implementation. Contact between the parties will continue on an as needed basis.

2. The November 2018 Court Report, and related exchanges, can suffice for the winter TRIAGE meeting; the parties expect to hold two in person quarterly meetings before the November 2018 Court Report is filed.

3. Data and reports to Plaintiffs counsel will continue to include those listed in Paragraph 85 (referencing Paragraphs 25, 27, 48, 50, 51, 54(b), 59 and 60) of the Settlement Agreement. For other data, the parties should adhere to Paragraph 86.

4. The parties agree to the following decision rule about requests for feedback and comments: the sending party will identify a timeline for feedback and comments, and the receiving party will make its best efforts to respond to the timeline. Extensions will be granted when reasonable.

5. Defendants agree that they will continue to make good faith efforts to negotiate the amount of attorneys' fees and costs pursuant to Paragraph 89 of the Settlement Agreement, including requests by Plaintiffs' counsel for attorneys' fees and costs post June 30, 2018.

6. The State has notified Plaintiffs' Counsel that it expects to reach substantial compliance by June 30, 2019. The State will notify Plaintiffs' Counsel by the Spring 2019 quarterly meeting if it believes it will not meet this good faith estimate of when substantial compliance will be reached. The parties acknowledge that June 30, 2019, is the state's good faith estimate based on information known in March 2018. Notwithstanding the foregoing, the State reserves the right to initiate the exit procedure earlier than June 30, 2019, by setting a Paragraph 66 meeting in accord with the Settlement Agreement. To the extent the Parties reach new agreements about the Quality Management Plan and Paragraph 69(c) of the Settlement Agreement, the State's estimate of June 30th, 2019 may require amendment.

V. **WISe/BRS Integration.**

1. CA has developed a work plan for a BRS/WISe pilot. The work plan is expected to have leadership approval within 45 days and the pilot is expected to launch by October 1st, 2018.

2. In an additional effort, CA, in conjunction with DBHR and HCA, is conducting work to consider how WISe components can be incorporated into the BRS program. This work includes considering 1) how BRS providers could conduct child and family team meetings every 30 days, 2) how peer support could be made available in BRS, 3) how training on CANs screens or other tools could be offered to BRS providers for use in CFTs and how such information could inform case and discharge planning. Program staff are looking at whether there are other ways in which WISe components can be incorporated into BRS, to the extent WISe is not available or cannot be utilized.

3. The State expects to propose measurable exit criteria related to Para. 69(c) by May 18, 2018, so that the parties can discuss and reach agreement at the June 2018 TRIAGe meeting.

4. CA is updating policies and procedures related to out of state services for youth to include 1) WISe screening prior to out-of-state placement, 2) routine reviews during out-of-state placement, and 3) planning to support timely transition to WISe or in state services consistent with the WISe access protocol.

TR MEDIATION DOCUMENT
SUBJECT TO CONFIDENTIALITY TERMS
AS AGREED TO BY MEDIATOR AND PARTIES

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