Implementation Status Report

November 16, 2015

Submitted under the

Settlement Agreement

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

Hon. Thomas S. Zilly

U.S. District Court, Seattle

No. C09-1677-TSZ

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Wraparound with Intensive Services (WISe)
Implementation Status Report

Introduction

The State of Washington settled *T.R. v. Quigley and Teeter* in December 2013. The case had been filed four years earlier, asking the State to provide children and youth on Medicaid with intensive mental health services in their 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 will be available in every county across the state by June 2018.

Until the exit of the Settlement Agreement, the State will provide the Court, the Plaintiffs, and the public an annual Implementation Status Report to describe progress in meeting the obligations under the agreement. The report is to include accomplishments, remaining tasks and identification of potential or actual problems, as well as remedial efforts to address them. This Implementation Status Report represents the second annual report, detailing the State's accomplishments in developing and implementing the WISe program.

The State submitted a WISe Implementation Plan to the Court on August 1, 2014, which was subsequently approved. The Implementation Plan was organized around seven objectives necessary to accomplish the commitments and exit criteria of the Settlement Agreement. The layout of this report follows these same 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 further organized into two sections. Section 1 has a description of accomplishments made in year two of the Implementation Plan, and then sets forth remaining tasks. Section 2 identifies overarching implementation challenges and proposals for addressing those areas of concern.

This report briefly addresses the requirement for an annual quality management plan (QMP) report. The annual QMP report is in process and on time to meet the December 19, 2015 deadline for completion.

1. 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:

An overarching goal of this objective is to deliver information through a variety of online, print, and in-person methods and deliver information in a way that conveys consistent messaging and content to audiences across the state.

A key strategy for communicating with families, youth, and child-serving partners and stakeholders about the nature and purpose of WISe was to develop and disseminate informational materials in a manner that recognizes cultural and linguist differences of class members. The U.S. Department of Health and Human Services set national standards for Cultural and Linguistically Appropriate Services (CLAS standards) that guided efforts for appropriate outreach and engagement.

Between July 2014 and July 2015, the communications developed were tailored to meet the needs of these groups, herein referred to as "affinity groups." Fourteen affinity groups were identified (see list below). The Division of Behavioral Health and Recovery (DBHR) engaged representatives from identified affinity groups, such as Children's Administration, Rehabilitation Administration (RA), Developmental Disabilities Administration (DDA), Family/Youth Organizations, and Regional Support Networks (RSNs), in the development of draft materials to inform youth, families, and child-serving system partners about WISe.

The draft materials went through multiple rounds of vetting through the statewide Family, Youth and System Partner Roundtable (FYSPRT), a DSHS Diversity Affairs Workgroup representative, and Plaintiffs' Counsel. In compliance with current DSHS policies, the family and youth information sheets were translated into eight different languages (English, Cambodian, Chinese, Korean, Laotian, Russian, Spanish, and Vietnamese).

All information sheets, including translations, were published in late July 2015. The DBHR website link for accessing the WISe Information Sheets is: http://www.dshs.wa.gov/dbhr/cbh-wise.shtml.

Materials were developed for each of the following affinity groups:

- Child Psychiatrists and ARNPs
- Children's Administration Social Service Specialists

- Children's Long Term Inpatient Program Staff
- Developmental Disabilities Administration
- DMHPs 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 Personnel
- K-12 Educators and Professionals
- Pediatricians, Family Practitioners, Physicians Assistants and ARNPs
- Substance Use Disorders (SUD) Providers
- Youth/Youth Organizations

On September 15, 2015, WISe communication sheets were disseminated to the following distribution lists:

- Statewide Family, Youth and System Partner Roundtable
- Children's Mental Health Committee
- Children's Long Term Inpatient – Improvement Committee
- Diversity Affairs/Cultural Competency Workgroup
- Office of Consumer Partnership
- Behavioral Health Advisory Committee
- Community Connectors
- WISe Advisory Manual Group
- TR Implementation Advisory Group
- Children's Behavioral Health ListServ

From these lists, approximately 900 youth, family, and system partner stakeholders from across the state received copies of the WISe Information Sheets. Furthermore, each affinity group representative assisted DBHR in identifying and implementing strategies for sharing the WISe information specific to their network (e.g., Educational Service Districts, Substance Use Disorder Residential Providers, Informing Families Organization and ListServ). This initial dissemination through affinity group representatives also occurred in September 2015. Affinity group stakeholders were also encouraged to include these materials in their own system and community trainings.

On November 10, 2015, a link to a 10 minute YouTube video describing WISe was also sent out to the distribution lists above. This video can be accessed through the following link: https://youtu.be/NScjTSwT6U4 .

Another key strategy for communicating with interested stakeholders is to maintain a WISe implementation website (www.dshs.wa.gov/dbhr/cbh-wise.shtml). This site has a variety of information including a WISe referral contact list by county, a map of where WISe is currently being implemented, the current version of the WISe Manual,

as well as the information sheets discussed above. The website also offers an email address for feedback and questions. The address is WISeSupport@dshs.wa.gov. Additionally, the website provides an opportunity to sign up for the Children's Behavioral Health ListServ, for those interested in receiving announcements and updates.
The expected results of this work are that youth and families in need of WISe services will receive sufficient information to be informed about and access WISe services, and system partners will understand how to best support them in understanding and accessing these services.

Objective 1 -Remaining Tasks:

- Continue to disseminate the developed information to the affinity groups, system partners, and to youth and families about WISe, as described above.
- 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. (Also, see Objective 5 for general WISe training information and specifically, conference presentations provided to school personnel in FY 2015).
- Continue to deliver information in a way that conveys consistent messages and content to audiences across the state.
- Continue to have FYSPRTs distribute WISe communication materials.
- Annually review and update the informational materials using the same groups involved in development. The first review needs to start in December 2015 and be completed by July 2016.
- Include in the Quality Management Plan (QMP), a process for improvement of effectiveness of communications.

Objective 2: Identification, Referral, and Screening for WISe

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

Progress and Accomplishments:

Prior to implementation, a WISe Access Protocol was established to identify and refer class members for WISe services. The WISe 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 Regional Support Networks (RSNs) use the protocols to meet requirements related to:

- Identification of youth who might qualify/benefit from WISe.

- Elements of the WISe screening.
- Conducting a WISe screen.

Starting in July 2015, the WISe Access Protocol is to be reviewed annually. The next review is in April 2016, after RSNs transition to Behavioral Health Organizations. The timing of this review assists with updating the protocol with any regional operational changes.

In July 2014, system partners started using system-specific indicators, informed by the data used to identify class members in the Proxy, to identify potential referrals. This work included coordination of WISe screens for youth referred to, participating in, or discharging from Children's Administration's Behavior Rehabilitation Services (BRS), as well as Children's Long Term Inpatient Programs (CLIP). Rehabilitation Administration, Juvenile Rehabilitation, is working to include an identifier-checklist in their Automated Client Tracking (ACT) to assist with coordination of WISe referrals. System partner representatives from the identified affinity groups worked with DBHR to develop identifiers to be included on the WISe information sheets. Identification of system identifiers to improve access and referrals is on-going work. DBHR and our system partners will continue to monitor for additional improvements over time.

Child and Adolescent Needs and Strengths: Per the Settlement Agreement, a Washington version of the Child and Adolescent Needs and Strengths (CANS) screen and assessment tool was developed and an initial CANS screening algorithm was put in place in July 2014. 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 service outcomes through the mental health system. CANS trainings have been offered in-person and on-line.

DBHR and its contractor, RCR Technologies, have developed an online data system to store and report on CANS related data. The Behavioral Health Assessment System (BHAS) data system was launched in July 2014. BHAS captures and communicates youth and family needs and strengths for treatment planning purposes. CANS data reports are available in real time at local (clinician, supervisor, agency), regional (RSN, county), and state levels for quality improvement purposes.

In May 2015, one-day trainings on how to use the BHAS data as part of Transformational Collaborative Outcomes Management (TCOM) were offered in various locales for RSNs currently implementing WISe. BHAS Quarterly Reports are being generated and reviewed through the quality infrastructure as outlined in the WISe Quality Management Plan. An e-learning module is also in production to assist with understanding data protocol reviews. The first complete review cycle was completed with 2nd quarter data and a "best practice" report identified and disseminated to all RSNs.

WISe Screens: Anyone can make a referral for a WISe screen. Family, youth, and child-serving systems, such as Children's Administration, Rehabilitation Administration, Development Disabilities Administration, Health Care Authority Regional Support Networks (RSNs), school personnel, county and community providers, and medical providers can assist in the identification and referral of youth who might benefit from WISe. Consideration for referral begins with youth who are Medicaid eligible, under age 21, and have complex behavioral health needs.

The WISe referral contacts list by county can be found in the following link: http://www.dshs.wa.gov/dbhr/cbh-wise.shtml. In addition, referrals for a WISe screen may be made directly to an RSN or any RSN provider.

From July 1, 2014, through June 30, 2015, (FY 2015) **1,417 WISe screens** were conducted for youth age 5 up to 21 years old. (Note that this number may be slightly higher than previous estimates for the same time period due to additional data maturity.)

The table below provides referral sources. The largest referral sources for the WISe program are the RSNs (36%), self and family (19%), and Children's Administration (18%). A smaller number of referrals are coming from other mental health services and programs (e.g., crisis services, Health Care Authority-paid mental health) and other settings (e.g., Rehabilitation Administration, community organizations, schools, and medical providers).

In FY 2015, only a small number of WISe referrals came from school personnel (3%). Nevertheless, additional analyses show that a significant number of youth screened into WISe in FY 2015 had received school-based behavioral health services in the 30 days prior to screening (20%) and that nearly half of youth screened into WISe (47%) had received special education services in the 30 days prior to screening. On the one hand, there exists an opportunity to continue to expand outreach efforts to school personnel, including better informing school administrators as well as school social workers and counselors, about the WISe program. At the same time, a good number of youth with identified functional impairments and behavioral health issues in the school setting are already making their way into the WISe program through other channels.

In FY 2015 WISe presentations were provided to the Student Support Conference in Wenatchee and the Washington Association of School Social Workers in Federal Way as well as the distribution of WISe information sheets, as described in Objective 1 and this outreach will continue. Opportunities for additional outreach also exist with medical providers and the Rehabilitation Administration.

	Referral Source Types	
Mental Health Referral Source Types	**N**	**% of Screens**
MH-Outpatient/RSN	508	36%
MH-Crisis Services	75	5%
MH-Other	24	2%
MH-Outpatient/Non-RSN	24	2%
MH-Inpatient/Non-CLIP	21	1%
MH-Inpatient/CLIP	*	*
MH-Tribal	*	*
Other Referral Source Types	**N**	**%**
Self & Family	272	19%
Children's Administration	255	18%
Other	84	6%
Community Organization	51	4%
School	38	3%
Juvenile Justice/non-JJRA	24	2%
Juvenile Justice/JJRA	13	1%
Medical Provider	12	1%
Developmental Disabilities Administration	*	*
Chemical Dependency Provider	*	*
TOTAL DUPLICATED SCREENS	**1,417**	**100%**

NOTES: A total of 1,417 WISe screens (CANS screens) were conducted for youth age 5 or older in FY 2015. Screens for youth below age 5 are excluded due to low numbers (11 total conducted in FY 2015). Some youth have multiple WISe screens (CANS screens) in the fiscal year, and are represented multiple times in the above counts. Continued work on refining the BHAS data system may yield changes to these numbers. *Cells representing fewer than 10 individuals have been suppressed to protect confidentiality.
SOURCE: Washington Behavioral Health Assessment System (BHAS).

WISe Manual: DBHR, in collaboration with Portland State University (PSU), University of Washington (UW) and the WISe Manual Advisory Workgroup, developed the initial WISe Manual that was completed in June 2014. The purpose of the WISe Manual is to direct the development of a sustainable service delivery system for providing intensive mental health in home and community settings to Medicaid eligible children and youth. The manual is to assist the community mental health system and allied agencies, as well as other formal, informal, and natural supports with the identification of eligible youth and the implementation and provision of WISe. The manual is a living document that will continue to be informed by those working on implementation and monitoring the progress. The WISe Manual Advisory Workgroup, a diligent and essential work group, reviewed the manual quarterly between September 2014 and June 2015. As of July 2015, the manual will be updated annually. The manual is disseminated to WISe provider sites, the statewide FYSPRT, Plaintiffs' Counsel, and is available on line at: www.dshs.wa.gov/dbhr/cbh-wise.shtml.

Quality Improvement: The initial Quality Management Plan (QMP) was completed in December 2014. This document will continue to be adapted and updated to best support continuous quality improvement. The QMP provides the foundation for measuring the implementation and success of the goals and commitments of the TR Settlement Agreement. An overview of the work included in the QMP can be found in Appendix B, the Action Information Matrix.

A copy of the Quality Management Plan can be found online at: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/QMP%20FINAL-updated5.2015.pdf

The QMP (pages 4-7) identifies the process for improving outcomes related to the effectiveness of identification, referral, and screening. Quarterly reports are a vital component to reviewing system and service outcomes and will become increasingly useful as the data from Behavioral Health Assessment System (BHAS) becomes more accurate. Work with RCR Technology Corporation toward this goal is progressing. In the meantime, we are using the quarterly reports to have the RSNs become familiar with the expectations for the quarterly review set forth in the Quarterly Data Review Protocol (Appendix D of the QMP) for assessing performance on access, engagement, service appropriateness, service effectiveness, and linkages. Each RSN submitted their review on time. Two RSNs were not meeting screening timeliness expectations; one identified a plan to address the gap. Changes based on data will not be expected in the quarter immediately following the planned improvement because the changes will not be in effect. There will always be at least a one quarter lag. Additional information on timeliness is included on the following page.

Quarterly Reports include information relevant to stakeholders at each level of the system. These reports are designed to help decision-makers review areas of variation in performance which, among other things, is intended to identify exceptionally effective performance, or performance needing improvement. These reports are part of the BHAS online information system. Statewide and RSN level reports will posted on the DBHR website once BHAS data and reporting challenges have been addressed. See Section 2 for additional information on BHAS updates.

Examples of multi-level BHAS outcomes reports, some of which are still being tested by the contracted BHAS developer (RCR Technology Corporation) and the State's DBHR and Research and Data Analysis staff, include:

- Screening Timeliness
- Clinician Screening Results
- Initial Full Assessment Screening Results
- Key Intervention Needs Over Time
- Strengths Development Over Time

The reports produced via the BHAS system reflect up-to-the-moment assessments of clinical performance at each level of the system, and may be configured to provide

assessments of previous performance. In the next six to nine months, once report validation is completed, quarterly reports by RSN and statewide will be posted on the DBHR website to inform stakeholders and ensure transparency. Quarterly reports will be aggregated so that they contain no personally identifiable protected health information and to comply with the Health Insurance Portability and Accountability Act (HIPAA).

For RSNs and agencies providing WISe, quarterly reports were available on the BHAS site April 1, 2015 for the WISe first quarter data. These reports included: first Quarter Reports (January 1, 2015 – March 31, 2015); Implementation Reports (July 1, 2014 – December 31, 2014); and Longevity Reports (July 1, 2014 – March 31, 2015). Quarterly Reports were disseminated to all groups identified in the Quality Structure of the QMP. Individual RSN BHAS reports were emailed to each RSN currently implementing WISe. Second quarter reports were sent out in August 2015.

An example of one of the BHAS reports included in the quarterly report is the Screening Timeliness Report. Outcomes for FY 2015 indicate that of the 1,417 WISe screens conducted, **76% were conducted within 10 business days of referral**, the standard for screening timeliness. The timeliness of screens improved over the course of the fiscal year. For four regions, the screening timeliness was near or above 90% across the fiscal year. For one region, the screening timeliness was at 49% at the start of implementation and in the last quarter of SFY 2015 increased to 62%. For the remaining region, there is an expectation, as identified in the Quarterly Data Review Protocol (Appendix D of the QMP), to review timeliness reports and identified to how to better ensure that referred youth are being screened for WISe in a more timely manner. The Quarterly Data Review process began for RSNs in August 2015. Additional information and data will be provided in the annual QMP report due in late December 2015.

FY 2015 Quarter	Screens	% Timely
JUL-SEP 2014	305	63%
OCT-DEC 2014	379	74%
JAN-MAR 2015	339	86%
APR-JUN 2015	394	78%
FY 2015 Total	**1,417**	**76%**

NOTES: A screen is considered timely if it is conducted within 10 business days of referral. A total of 1,417 WISe screens (CANS screens) were conducted for youth age 5 or older in FY 2015. Screens for youth below age 5 are excluded due to low numbers (11 total conducted in FY 2015). Some youth have multiple WISe screens (CANS screens) in the fiscal year, and are represented multiple times in the above numbers. Continued work on refining the BHAS data system may yield changes to these numbers.
SOURCE: Washington Behavioral Health Assessment System (BHAS).

Statewide Measures of Performance: Work on the WISe Statewide Measures of Performance "dashboard" is underway and expected to be completed in January

2016. A significant amount of work in the past several months has gone into refining data systems to ensure adequate data quality, and accuracy. As this work continues, additional work has begun mapping out preliminary plans for what will be included in the first year version of the WISe dashboard. The analytical datasets to execute these plans are being built, at the same time as plans are being refined and better specified. At the current time, the following elements are planned to be in the first annual WISe dashboard:

- An updated Functional Proxy Profile identifying children and youth to be screened for need for intensive home and community-based mental health services.
- The number and characteristics of youth screened for WISe and youth receiving WISe services in FY 2015. Characteristics will include demographics, behavioral health history, cross-system involvement, and functional proxy indicators.
- WISe service characteristics for youth served in WISe in FY 2015, including caseload counts and service hours, service locations, provider types, and treatment modalities. WISe caseload counts by county and region, and a map showing progress to full implementation service targets.
- Change in outcomes for WISe participants over the first six months in the WISe program, as measured by changes in BHAS scores, such as Behavioral and Emotional Needs and Risk Factors (examples of such outcomes included under Objective 3). (Note that the program has not been running a sufficient amount of time to examine long-term outcomes or to examine outcomes measured in administrative data for youth screened into and/or out of the WISe program.)

Objective 2 - Remaining Tasks:

- Annually review the WISe Access Protocol. Next review to be completed by June 30, 2016.
- Completion of the Statewide Measures of Performance for WISe by January 2016.
- Annually refine the identification over time to account for learning from actual use and performance and include education system information as it becomes available. Next review to be completed by December 31, 2016.
- Continue to incorporate the WISe Manual in the RSN/BHO contracts.
- Continue to provide training and technical assistance on compliance with the WISe Manual.
- Continue to address issues related to BHAS (see Section 2, Implementation Challenges, BHAS).
- Continue to review and report timeliness standards.
- Continue to review and report on BHAS data as identified in the QMP.
- Continue to require that youth referred to, participating in, or discharging from BRS or CLIP receive a WISe screen.
- Post RSN and state level Quarterly Reports to DBHR website once all BHAS reports complete validation for accuracy. (See Section 2, Implementation Challenges, BHAS).

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:

Youth Strengths and Needs: The following story is about "Mary", the pseudonym for a youth participating in WISe and developing her own personal strengths.

Mary started WISe in January 2015 at 17 years old. Mary self-referred to the program with prompting from her social worker. She was living in a crisis residential center. Mary was battling addiction, severe anxiety, PTSD, and depression. Before arriving at the crisis residential center, she had moved alone from the East Coast at age 14 to escape abuse and neglect from her biological family and moved in with her biological aunt. She lost placement with her aunt after an altercation that landed her in detention. After detention Mary was placed in local foster care at the crisis residential center and placed in a psychiatric hospital. After being released from the hospital, Mary ran away from the crisis residential center a few times. Amidst all her crisis, Mary was able to maintain a job, get herself to and from work, continue school, and was involved in a local church group. A few days after starting WISe, Mary enrolled in a local stabilization bed, returned back to the crisis residential center, and then was placed with a foster family.

Mary's WISe team met with her school and supports to create a safety plan for her to remain safe in her community. WISe advocated for Mary to get treatment in her community when other services wanted impatient treatment outside of the community. Mary enrolled in intensive outpatient drug and alcohol treatment and began meeting her WISe therapist twice a week. Mary used WISe on-call services several times when first enrolled in the program. WISe staff would respond to Mary at her school when she was having panic attacks. The WISe team connected Mary to a local psychiatrist, and assisted her in obtaining medical and dental appointments to address health concerns. The team worked together to create the WISe Cross System Care Plan that addressed Mary's need to know that she is stable in our community. As Mary and her WISe team continued to meet the intensity of her needs, the interventions decreased. Mary's team went from meeting daily, to every two weeks, to monthly, and now every six weeks.

Today, Mary is 237 days clean and sober. Mary is working, caught up on her school credits, and looking forward to graduating this upcoming school year. Mary turned 18 and signed herself into extended foster care. The judge and everyone in the court room cheered and applauded Mary for her hard work and continued dedication. Mary

has reconnected with her aunt and other natural supports. Mary is in the transition phase of WISe and will graduate the program within three to six months. Mary plans to reach out to apply for a youth partner position in the WISe program after high school graduation.

Named Plaintiffs' are: As of November 2015, three of the ten named plaintiffs in services, either receiving WISe, "WISe-like" services, or in other outpatient mental health services, including intensive services, to meet their current level of care need. The other seven named plaintiffs have aged-out, opted-out, or moved out of state. Plaintiff Workgroups were identified in August 2014, with the first meetings held in September 2014, and on-going meetings are held to monitor progress. These workgroups will continue to meet on a quarterly basis and with more frequent communication, when indicated.

WISe Participants: From July 1, 2014, through June 30, 2015, (FY2015) **a total of 925 youth** received WISe services. (Note that this number may be slightly higher than previous estimates for the same time period due to additional data maturity.)

In terms of demographics, WISe clients were approximately 37% female, 61% male, and 3% had unknown gender (sums to greater than 100% due to rounding error). Unknown demographic data is due to data lag in linkage processes. Only four WISe clients were younger than age 5 (<1%). One-third of WISe clients were between ages 5 and 11 (33%), three-fifths (60%) were between ages 12 and 17, and the remainder were either between 18 and 20 (3%) or of unknown age (3%). Slightly more than half of WISe clients were non-Hispanic white (52%). The most common minority races/ethnicities (not mutually exclusive) were Hispanic (20%), American Indian/Alaska Native (15%), black (12%) and Asian/Pacific Islander (7%).

	ALL YOUTH RECEIVING WISe SERVICES (FY 2015)	
	N	**%**
Gender		
Female	339	36.7%
Male	561	60.7%
Unknown	25	2.7%
Age Group		
0-4	4	0.4%
5-11	306	33.1%
12-17	558	60.3%
18-20	29	3.1%
Unknown	28	3.1%

Race/Ethnicity		
Non-Hispanic White	482	52.1%
Minority	416	45.0%
Unknown	27	2.9%
Minority Category (not mutually exclusive / do not sum to 100%)		
Hispanic	180	19.5%
Black	115	12.4%
American Indian / Alaska Native	141	15.2%
Asian / Pacific Islander	60	6.5%
TOTAL POPULATION	**925**	

NOTE: Unknown demographic data due to data lag in linkage processes.
SOURCE: RDA Integrated Client Database.

WISe Program Model: The 925 youth in WISe in FY 2015 received a total of **68,811 hours of outpatient care** under the WISe program. On average, a youth enrolled in WISe in a given month received 14 hours of services during that month.

The table below presents statistics on the types of providers, service locations, and treatment modalities for WISe services. The most frequent provider types, by hours of service, were below master's level (43%) and MA/PhD (38%). Approximately one-sixth of all service hours (17%) were delivered by peer counselors. Service hours were most frequently delivered in the youth's home (40%) and mental health outpatient facilities (27%). Five percent of service hours were also delivered in schools, and a large number in service hours (27%) were delivered in settings other than those listed in the table below. This may reflect providers delivering services in natural community settings like parks, community centers, or other places that youth may spend time. The top five service modalities, by hours of WISe services are: individual treatment services (36%), peer support (17%), child and family team meeting (15%), family treatment (10%), and care coordination services (10%). An average of 14 WISe service hours per month were provided, which include a variety of treatment modalities as identified below.

	ALL WISe SERVICES (FY 2015)	
	N	%
Program Totals		
Number of WISe Clients (unduplicated within FY)	925	---
Number of Service Encounters	70,133	---
Number of Service Hours	68,811	---
Number of Service Months	4,940	---
Number of Service Encounters per Month in Program	14.2	---
Number of Service Hours per Month in Program	13.9	---
Service Provider Type		
WISe service hours provided by these provider types		
Below Masters Level	29,656	43.1%
MA/PhD	26,069	37.9%
Peer Counselor	11,602	16.9%
Psychiatrist/MD	998	1.5%
Other	453	0.7%
Designated Mental Health Professional	33	0.0%
Service Location		
WISe service hours provided in these settings		
Home	27,215	39.6%
Other	18,707	27.2%
Mental Health Outpatient Facility	18,485	26.9%
School	3,297	4.8%
Emergency Room - Hospital	663	1.0%
Prison - Correctional Facility	224	0.3%
Residential Care Setting	220	0.3%
Treatment Modality		
WISe service hours provided under these service modalities		
Individual Treatment Services	24,447	35.5%
Peer Support	11,706	17.0%
Child and Family Team Meeting	10,197	14.8%
Family Treatment	7,164	10.4%
Care Coordination Services	7,133	10.4%
Crisis Services	2,126	3.1%
Group Treatment Services	1,303	1.9%
High Intensity Treatment	1,253	1.8%
Intake Evaluation	1,143	1.7%
Medication Management	895	1.3%
Rehabilitation Case Management	642	0.9%
Involuntary Treatment Investigation	487	0.7%
Interpreter Services	175	0.3%

Therapeutic Psychoeducation	104	0.2%
Medication Monitoring	13	0.0%
Integrated Substance Abuse MH Screening	10	0.0%
Psychological Assessment	9	0.0%
Integrated Substance Abuse MH Assessment	4	0.0%

NOTE: WISe services include all mental health outpatient service encounters submitted to CIS with WISe "U8" modifier and other WISe-approved outpatient services received in a month with at least one "U8" service.
SOURCE: RDA Integrated Client Database.

Transitions: In total, 12% of the 1,417 WISe screens conducted in FY 2015 resulted in a service recommendation of Behavior Rehabilitation Services (BRS) or Children's Long Term Inpatient Program (CLIP). For nearly all 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. Many of those youth whose screening resulted in a service recommendation of BRS or CLIP were likely already engaged in BRS or CLIP at the time of screening, and thus the screening represents a recommendation to continue in the current setting. The BHAS data system is currently undergoing modifications to more clearly track this.

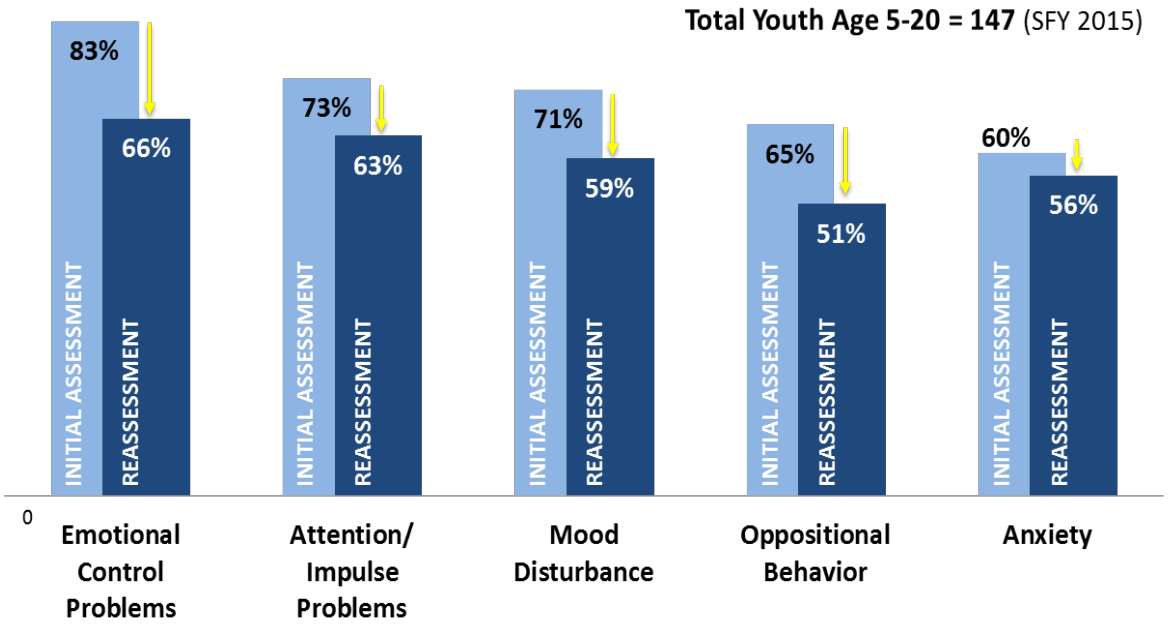
The BHAS data does show, however, that some youth are successfully transitioning from BRS and CLIP into WISe services. Out of 32 screens conducted for youth who had been in CLIP within the 30 days prior to screening, 88% were screened into the WISe program. Out of 173 screens conducted for youth who had been in BRS within the 30 days prior to screening, 22% were screened into the WISe program.

WISe Initial Outcomes: From quarterly reports, data were gathered to provide initial outcomes for clinical improvements over time. The following chart shows change over time in **behavioral and emotional needs** for children who entered WISe and completed an initial CANS assessment in FY 2015, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days).

The chart below reflects the changes experienced over the first six months of WISe treatment for the 147 children and youth ages 5-20 who had received an initial and follow-up CANS assessment. The top five behavioral and emotional needs, by proportion at intake/initial assessment, are shown. 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.

CLINICALLY SIGNIFICANT IMPROVEMENTS OVER TIME

Behavioral and Emotional Needs

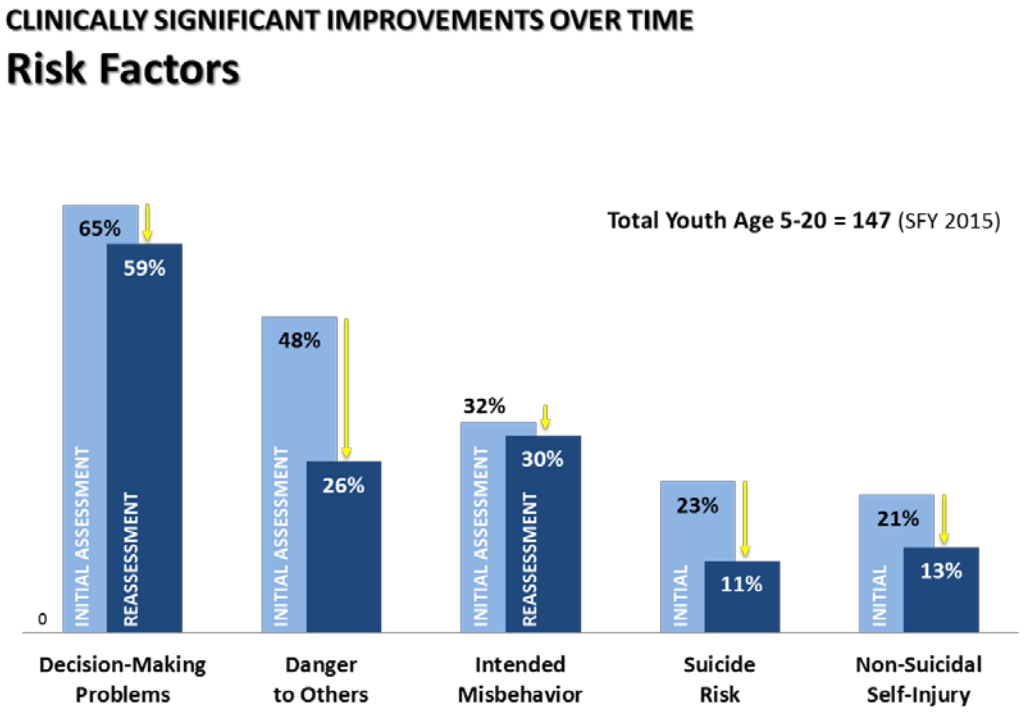


Definitions of top five needs:

- Emotional Control Problems: Youth's inability to manage his/her emotions, lack of frustration tolerance.
- 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.
- Mood Disturbance: Includes symptoms of depressed mood, hypermania, or mania.
- Oppositional Behavior: Non-compliance with authority. (Different than conduct disorder, where emphasis is seriously breaking social rules, norms, and laws).
- Anxiety: Symptoms of worry, dread, or panic attacks.
- Other youth behavioral needs on CANS assessment that are not in the top five at intake (and not shown here): Psychosis; Conduct; Substance Abuse; Adjustment to Trauma.

The other youth behavioral needs on the full CANS assessment that are not in the top five at intake show either positive change or remain relatively steady between intake and six-month follow up. Specifically, we observed a decrease in problems over the first six months in WISe related to: Conduct, Adjustment to Trauma, and Psychosis. For Substance Abuse, numbers are relatively low at intake (fewer than 20% have actionable treatment needs), and remain relatively steady at six-month follow-up (small and likely statistically insignificant increase observed). These analyses are only for youth with a first full CANS assessment in FY 2015. DBHR will continue to monitor as the program grows and matures.

Risk Factors, Clinical Improvement Over Time, is a chart that show the top five **risk factors** for children who entered WISe and completed an initial CANS assessment in FY 2015, 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 147 children and youth ages 5-20.

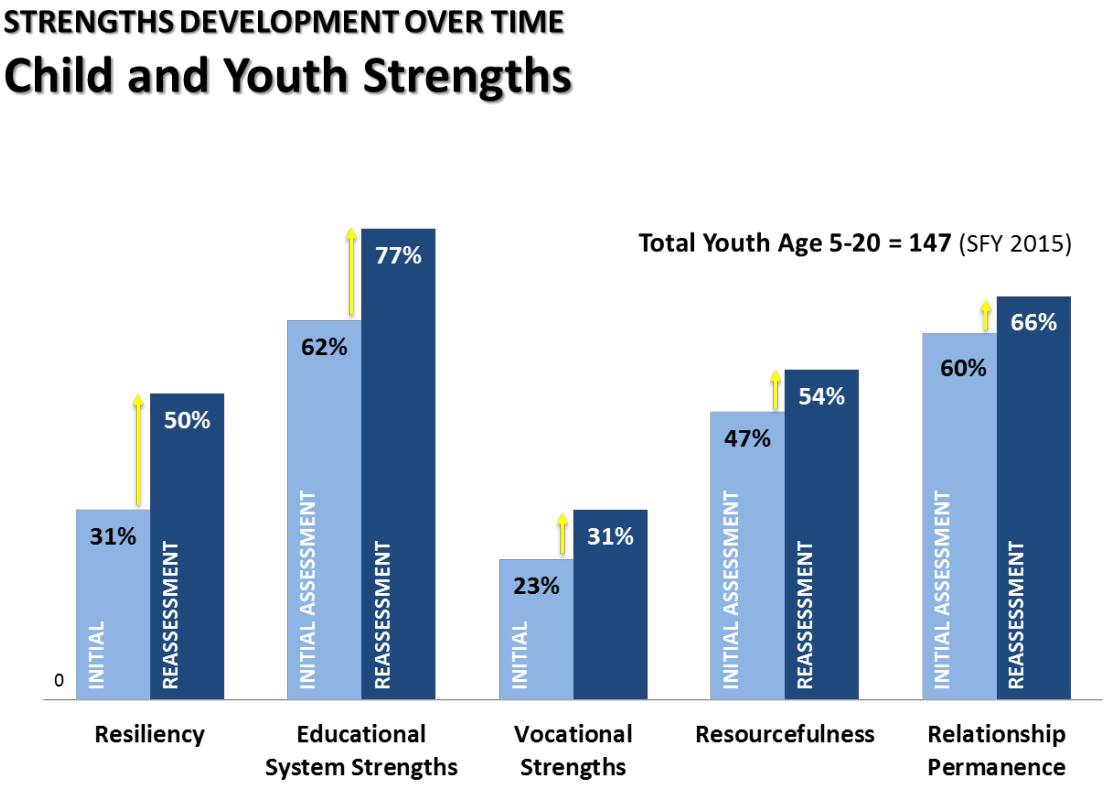


Definitions of top five risk factors:

- 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).

The following chart shows growth in **child and youth strengths** for children who entered WISe and completed an initial CANS assessment in FY 2015, 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 147 children and youth ages 5-20. The five strengths that grew the most over the first six months in WISe services are shown.

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.



Definitions of top five strengths shown:

- Resiliency: 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.
- 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.
- Vocational Strengths: Youth has vocational or pre-vocational skills; may or may not be currently working.
- Resourcefulness: Youth's ability to identify and use external/environmental strengths in managing their lives and achieving a healthy lifestyle.
- Relationship Permanence: Youth has some or significant stability in relationships with family members and/or other individuals. Other strengths on CANS assessment that are not in the top five in terms of growth over time (and not shown here): Family; Optimism, Spiritual/religious, Talents/interests, Recreation, Natural supports, Community connections, and Primary care physician relationship.

WISe Statewide Rollout: For the planned statewide phase-in of WISe services, DSHS developed an initial WISe rollout model. The model is currently being updated and is expected to be posted to the DBHR website in January 2016. The model needs to adjust for growth, needed capacity, and provider readiness with the end point being full statewide capacity by June 30, 2018. In addition, WISe implementation plans are

being addressed in the detailed plan submission required for the new Behavioral Health Organization (BHOs). A list of current qualified WISe providers is available on the DBHR website and will be updated throughout the implementation process.

Nineteen of Washington's 39 counties, representing four million of the state's seven million residents, are currently implementing WISe with a statewide monthly caseload capacity of 760 youth and their families receiving services each month.

As of November 2015, the counties currently offering WISe are shaded in the map below.

The following information identifies which regions have implemented WISe and their progress towards the initial full capacity estimates for June 2018.

WISe Progress to Full Implementation Target by Region as of September 2015

Regions September 2015		HIGHEST MONTHLY CASELOAD	MID LEVEL MONTHLY SERVICE TARGET	PROGRESS TO TARGET
ALL REGIONS (by June 2018)		**542**	**2,985**	**18%**
Chelan-Douglas	Chelan Douglas	0	50	0%
Grays Harbor-Cowlitz	Cowlitz Grays Harbor	18	133	14%
Greater Columbia	Asotin Benton Columbia Franklin Garfield Kittitas Klickitat Walla Walla Whitman Yakima	132	418	32%
King	King	0	527	0%
North Sound	Island San Juan Skagit Snohomish Whatcom	91	460	20%
Peninsula	Clallam Jefferson Kitsap	0	189	0%
Pierce	Pierce	114	345	33%
Southwest	Clark Skamania	76	201	38%
Spokane	Adams Ferry Grant Lincoln Okanogan Pend Oreille Spokane Stevens	11	450	2%
Thurston-Mason	Mason Thurston	139	142	98%
Timberlands	Lewis Pacific Wahkiakum	0	70	0%

NOTES: Table displays the highest monthly WISe caseload recorded as of September 2015, based on the number of children residing in each region receiving WISe services. Due to data lag, progress shown reflects highest WISe caseload as of May 2015. Note that the agency providing WISe services may not be located in the same region as the child's residence. RDA's Client Services Database (CSDB) obtains client addresses from multiple data systems across DSHS, and performs processes to standardize and geocode these addresses each quarter using industry standard software to maintain consistency and accuracy. Mid-level monthly service targets reflect mid-level estimates of WISe youth projected to be served each month at full implementation (please refer to the RDA document, "Addendum to 'Initial Estimates of WISe Utilization at Full Implementation,'" dated February 26, 2015).

Based on the table above, RSNs who started implementation in July 2014 range from 20% to 38% with one RSN at 98% of meeting its June 2018 WISe capacity goals. DBHR believes the first year was foundational for ongoing WISe implementation and views these efforts as a success.

During a TRIAGe meeting in December 2014, there was a discussion and an agreement among the parties not to bring on new RSNs during the first year of implementation. This consideration came directly from RSNs implementing WISe with the rationale to allow for more time to identify successes and address barriers related to implementation efforts.

By April 2016, all RSNs will begin WISe implementation in at least one county in their region. To stay on target to meet June 2018 goals, by June 2016, capacity needs to double statewide. DBHR recognizes this as a challenge during a year when RSNs will be transitioning to BHOs. DBHR will review submitted BHO Detailed Plans during November 2015. These plans require BHOs to address WISe capacity building and the plans also present an opportunity to identify technical assistance for new or on-going implementation efforts.

RSNs are concerned that the mid-level monthly capacity targets identified in the "Initial Estimates of WISe Utilization at Full Implementation" document produced by RDA are greater than the actual need for intensive mental health services for children and youth in their local areas. This concern is reportedly based on their local service data. As identified in the Implementation Plan, review of WISe capacity should happen annually and should direct adjustments as needed. DBHR has asked that RDA review capacity targets for any needed adjustments. This review is anticipated to be completed in late December 2015.

WISe Budget

For the 2015-2017 biennium, the following chart describes the Department of Social and Health Services budget for intensive mental health services for high needs youth to continue implementing the commitments set forth in the T.R. Settlement Agreement.

WISe Budget	FY2016	FY2017
State	16,094,161	24,069,838
Federal	15,558,861	23,456,889
Total WISe Budget (includes Salaries & Encounters)	**31,653,022**	**47,526,727**

WISe Case Rate Payment: In accord with the Settlement Agreement, WISe will be implemented incrementally with the intention that the delivery model be statewide in 2018. At implementation, DBHR established a reimbursement method for WISe providers. DBHR worked with Mercer, its actuary, to develop and implement actuarially sound rates, including a case rate for WISe. The case rate payment is in addition to capitation revenues paid through existing eligibility in one of the RSN

rating groups. The rate was initially established through June 30, 2015. For FY 2015, the WISe case rate was established at $2,070.12 per WISe eligible person per month.

For FY 2016, Mercer evaluated the impact of trend inflation to project the WISe case rate. As the WISe program was effective July 1, 2014, actual encounter data was not available for use in updating the case rate. The WISe case rate for FY 2016 was calculated by applying an additional year of the 2.2% trend to the previously certified FY 2015 WISe case rate. The resulting FY 2016 WISe case rate is $2,115.67 per WISe eligible person per month.

Encounter data is monitored on a monthly basis by DBHR's budget unit and reviewed by subject matter experts for quality and completeness. In 2016, Mercer will review more recent financial Revenue and Expenditure reports to determine whether a financial experience adjustment is warranted. However, with WISe still in the early stages of implementation, DBHR does not anticipate having adequate statewide encounter data to support WISe case rate development until 2017.

Objective 3 - Remaining Tasks:

- Continue Quarterly Named Plaintiff Workgroups with Plaintiffs' Counsel, DBHR staff, and the named plaintiffs' home RSN staff.
- Annually, review WISe Manual for updates. Next review to be completed by June 30, 2016.
- Annually review with system partners, protocols related to: referral to WISe; participation in Child and Family Teams; and transitions out of WISe. Next review to be completed by December 31, 2016.
- Continue to review implementation of CANS for care planning at Children's Long Term Inpatient Placement (CLIP) facilities.
- Continue to build sufficient provider capacity to meet the statewide need for WISe services by June 30, 2018. (See Section 2, Implementation Challenges, WISe Roll Out)
- Review WISe capacity needs annually and make adjustments as needed.
- Continue to monitor utilization of WISe services to assist with state rollout strategies.
- Continue to work with RSNs to establish local training schedules and post training dates.
- Continue to post on the DBHR website, a list of qualified WISe providers by county.
- Continue to work with the actuary to establish a reimbursement method.
- Continue to develop Decision Packages bi-annually.
- Continue to modify ProviderOne, the Medicaid payment system. (See Section 2, Challenges, ProviderOne).
- Continue to monitor capacity/utilization through fiscal reports and the new RSN bi-monthly monitoring reports (to start in January 2016).
- Continue to update the QMP, when indicated, for the provision of improvement of WISe services and supports.

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

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

Progress and Accomplishments:

In April 2013, an initial financing plan that coordinates resources to strengthen inter- and intra-agency collaboration, sustain WISe, and improve long-term outcomes was adopted. Per the WISe Implementation Plan, this finance plan was to be reviewed for updates beginning in July 2015 and completed by December 2015. DBHR anticipates an updated finance plan produced by Mercer for Behavioral Health Organizations and service integration by the mentioned deadline. The on-going actuarial rate study for WISe will continue through 2018.

Cross-System Partner Activities: DBHR has worked closely with representatives from other administrations within the department and with representatives from Health Care Authority. Below are highlighted WISe related activities as reported from our state system partners.

Juvenile Rehabilitation (JR) reports the following:

- JR Mental Health Program Administrator and Executive Leadership designees have been working with HCA and have developed a Memorandum of Understanding (MOU) to allow Health Care Authority (HCA) staff, in collaboration with JR youth and JR residential counselors, to apply for Medicaid benefits for the eligible youth 30 days prior to release from JR incarceration. When the obstacles of funding, administrative precedence, and authorization are surmounted, the approved MOU will grant permission to the youth and staff and/or HCA designee to obtain Medicaid coverage for the youth while still incarcerated. This would allow WISe Child Family Team (CFT) Coordinators and Reentry Team Meeting (RTM) Coordinators to work together to begin WISe service planning.
- JR Mental Health Program Administrator, Institution, and Regional Mental Health Coordinators are developing a statewide WISe (JR) youth eligible (identifier) checklist and WISe serving agency/RSN/BHO referral document.
- The WISe criteria identifier-checklist automation in JR's Automated Client Tracking (ACT) system is in development. The module will allow essential JR staff to generate *WISe eligible youth* roster report lists that can be distributed to residential program staff to begin the RTM and CFT coordination to operationalize WISe service implementation in JR.
- As a System Partner, JR has worked closely with Behavioral Health and System Integration Administration (BHSIA)/ DBHR, Children's Administration (CA), Developmental Disabilities Administration (DDA), the Department of Health (DOH), and the Office of the Superintendent for Public Instruction (OSPI), the

HCA, as well as RSNs, family and youth, and community providers to build System of Care (SOC) Expansion focused state and regional governance structure called Family Youth System Partner Round Tables (FYSPRTs). The regional and statewide FYSPRTs were developed as a key component for ensuring behavioral health and other public child, youth, and family serving systems in Washington State are coordinated and informed by input from multiple stakeholders, especially youth and families.

Children's Administration reports the following WISe highlights:

- Mental Health: In-Depth Applications for Child Welfare training was enhanced to include a WISe module. From December 2014 through September 2015, trainings were offered at Centralia, Lynnwood, Spokane, and Seattle. An average around 15 people (new and ongoing social workers, foster parents, Court Appointed Special Advocates, and local service providers) attended each training; more than 60 total attended the trainings.
- CA also enhanced the training required for all new social workers, Regional Core Training (RCT), to include information regarding the WISe. During the same period, December 2014 through September 2015, RCT was offered at Centralia, Everett, Lynnwood, Seattle, West Seattle, Smokey Point, Spokane, Tacoma, Toppenish, Tumwater, and Centralia, with a minimum of 180 new social workers participating.
- In May 2015, Passion to Action, a statewide, youth-led advisory board to CA, was consulted and helped develop a WISe information sheet for youth and youth organizations that was published on DSHS WISe Implementation website in August 2015.
- Children's Administration, in conjunction with DBHR, finalized a WISe information sheet specifically for CA Social Service Specialists in August 2015. The information sheet has been published on DSHS WISe implementation web site. This information sheet will be distributed to all CA offices progressively, targeting the offices in the counties where WISe has already implemented or is being implemented.
- In July 2015, the BRS contract handbook was updated to include the detailed information for managing WISe screens, which is required every six months and upon discharge.
- In September 2015, CA provided communication via email to BRS contractors and Regional CA staff regarding the WISe informational sheet and WISe referral contact list.
- CA continues to support and actively participate in activities related to WISe program coordination, communication, implementation planning, and dissemination. These meetings and trainings 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, TCOM/CANS training, and WISe Community Training.

Developmental Disabilities Administration (DDA) representatives participate on the statewide FYSPRT. DDA has also expressed an interest in collaborating on an advanced training on wraparound with DBHR.

Health Care Authority (HCA) reports the following WISe highlights:

- HCA continues to be involved in supporting WISe implementation.
- HCA participates actively in the FYSPRTs.
- HCA is working closely with DHBR regarding contract language for its Managed Care Organizations (MCOs).
- HCA is working to align WISe and the MCOs – and has been instrumental in collaborating with our plans.
- HCA continues to participate in system of care and encourages contracted providers to use EBPs when appropriate.
- HCA continues to communicate with our providers to educate about WISe services.

RSN staff and their contracted WISe agency staff have been essential system partners during the first year of implementation. The RSN contributions in early implementation, and sharing lessons learned has been essential to our early successes.

Children's Behavioral Health Principles: From June 2014 through November 2014, an External Quality Review Organization (EQRO) was contracted to review RSNs for the implementation of the Children's Behavioral Health Principles.

Key components of the principles are included in Wraparound with Intensive Services (WISe), the Child and Adolescent Needs and Strengths (CANS) assessment, and the Child and Family Team (CFT) meeting. A copy of the principles can be found on the DBHR website at: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WA%20State%20Children%27s%20BH%20Principles.pdf

For RSNs who were early implementers of WISe, a review of clinical records for Cross System Care Plans and required elements of CFT meetings was conducted. The review covered cases for which the RSN submitted service codes for CFT services, High Intensity Treatment services, and Wraparound services. The report was completed and submitted to DBHR in December 2014.

Challenges identified in the 2014 EQRO Report focused on three areas: Implementation of WISe and Grievance systems, specifically:

- Many RSNs said they found it difficult to retool their mental health delivery systems in an environment of constant change with regard to the WISe Manual and turnover of State staff in the children's program.
- RSNs found it difficult to maintain and recruit adequate numbers of qualified staff to meet the contractual timelines for both intakes and follow-up appointments.

- Most RSNs expressed concern that youth in Behavior Rehabilitative Services must receive a CANS screening by the RSN, even though those children are not eligible to receive WISe services.
- All RSNs expressed concern that the direct service staff of community partners (e.g., DSHS, juvenile justice, schools) knew little about the Children's Behavioral Health Principles and WISe. Most RSNs said it will take time to change the local culture of using out-of-home placement for youth with serious emotional disturbances.
- Clinical chart reviews showed that many of the cross-system care plans did not specify objective and measurable treatment service goals and the supports designed to achieve these service goals. The cross-system care plans consistently lacked an evaluation of progress and a statement of the family/youth needs and goals in the youth's and family's own voice. Crisis plans were present in only 54% of the CFT cross-system care plans.
- The EQRO found that tracking and monitoring of grievances vary among RSNs.

In response to the issues identified in the 2014 EQRO Report, the following steps were taken:

- Quarterly updates to the WISe Manual were required under the Implementation Plan during first year of implementation with annual updates starting in July 2015. During the first year of WISe implementation, DBHR incorporated RSN feedback in the WISe Manual. Through review by the WISe Manual Advisory Workgroup, the WISe Manual was further clarified to meet practice realities without altering the requirement to provide services based on Children's Behavioral Health principles.
- Development of a Workforce Collaborative to provide ongoing training and assist with developing a five-year strategic plan to include strategies to address workforce development.
- DBHR shared with RSNs that the Settlement Agreement requires that youth referred to BRS receive a WISe screen.
- RSNs are to develop and implement policies and procedures specific to the WISe program and articulated in the detailed plans required for conversion to Behavioral Health Organizations (BHOs), due October 31, 2015.
- WISe information sheets are being distributed to system partners, and family, youth organizations. Communication dissemination and training is on-going.
- DBHR engaged RSNs directly to identify strategies to strengthen participation by system partners (as well as family and youth) in implementing the WISe program.
- DBHR reiterated to RSNs the need for on-going training with provider agencies to create and document cross-system care plans that address all required elements, as well as all required elements of CFT meetings, including all team members.

- DBHR has added language to RSN contracts requiring them to incorporate the results of Grievances, Appeals, and Fair Hearings into their Quality Management Plans and to address any trends in a QI Plan.
- Reporting requirements have been clarified and will be monitored on a quarterly basis. Reporting of client-level information for Notices of Action has been implemented for those in the WISe program. This is a pilot and lessons learned will be incorporated into specific reporting requirements for BHOs

In addition, DBHR began approving the children's Performance Improvement Plans (PIPs) in 2014 and has made many changes to the process to make these more meaningful including requiring that:

- All PIPs are justified on the basis of clearly identified needs and are relevant to the Medicaid population, includes enrollee input into prioritization and selection of the topic, and focuses on a high-volume or high-risk population.
- RSNs develop PIPs with the intention of completing the second re-measurement within three to four years and then choosing a different topic; DBHR approves all PIP topics prior to RSN implementation.
- RSNs to demonstrate that their PIP interventions address barriers identified by means of a thorough root cause analysis or other recognized quality improvement process.

In 2016, the EQRO Children's Focus will be on Quality Service Reviews (QSRs). A Chapin Hall consultant and DBHR staff reviewed existing QSR protocols for effectiveness and utility, incorporating elements which meet the needs of children and youth, state and federal audit and quality requirements, and the Settlement Agreement. A draft QSR Protocol was developed in August, reviewed with the DBHR Children's Behavioral Health Unit, RSN Quality Leads and Children's Care Coordinators, statewide FYSPRT, Children's Behavioral Health Data, and Quality Team. Suggested modifications were made and pilot tested at one agency in October. The QSR is currently being modified based on the results of the pilot testing. Training on its use and use at three providers will occur in 2016. The QSR will help us identify the essential requirements to implement WISe successfully and lead to improved outcomes for children and youth.

The QSR will also assist with reviewing cross-system coordination in several ways. First, with a review of CANS items, a rating is made of functional and treatment needs. This indicates formal and informal linkages and supports, and whether a net gain in supports has occurred. Improvements or gaps in certain areas, such as educational systems, religious participation, and community connection, are identified. Second, an assessment of goal-related stakeholder participation across Child Family Team meetings is made to determine whether system partners are participating in meetings. Third, updates in the crisis plan will be reviewed to see if input from cross-system providers and natural supports are included. Fourth,

completed transition plans will be assessed to identify how input from cross-system partners and natural supports was incorporated.

Objective 4 - Remaining Tasks:

- Review the initial finance plan and work towards completion by December 2015.
- By July 2016, review and reestablish of the Memorandum of Understanding between DSHS and HCA regarding collaboration and coordination, cross system participation on Child and Family Teams, and the use of a single plan of care to direct services.
- In partnership with the Washington State University Workforce Collaborative, DBHR will continue to refine training curricula for RSNs, providers, systems partners, and community organizations that participate on Child and Family Teams. These materials will be reviewed annually beginning in December 2015.
- Continue to promote Washington State Children's Behavioral Health Principles in service delivery and policy development through the governance structure.
- DBHR and CA to continue to review BRS and WISe materials annually.
- Conduct the QSR for low, middle, and high performing providers.
- Continue to review the QMP process for improvement, including the effectiveness of transitions from out-of-home placements. The next QMP annual report is due on December 19, 2015, and is on target to meet the deadline.

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:

WISe trainings: From March 1, 2014, through September 30, 2015, a total of **27 WISe training sessions** were offered statewide by the DBHR contracted WISe training team. These training opportunities included four-day, in-person trainings, webinars, and community meetings, with a total of **768 participants**. Participants included prospective direct WISe service providers such as care coordinators; family partners; youth partners; therapists; and RSN Administrators, Clinical Directors, and Supervisors, as well as, child serving system partners and community partners. In June 2015, DBHR provided a four-day WISe training to Tribal Behavioral Health agencies hosted by Yakama Nation Behavioral Health in Toppenish, Washington.

DBHR worked closely with Rehabilitation Administration (RA), Juvenile Rehabilitation (JR) to inform JR staff on the WISe program model. The following trainings were offered to JR staff:

- June 23, 2015: two-hour WISe Webinar for all JR staff; 53 attendees. The WISe webinar was made available to all JR staff via a link on the JR home (web) page; 950 potential JR staff viewers.

- June 24, 2015: five-hour WISe In-Person Regional Training for Western Washington JR staff; 49 attendees.
- June 26, 2015: five-hour WISe In-Person Regional Training for Eastern Washington JR staff; 40 attendees.

The WISe webinar and in-person training participants included Mental Health Coordinators, Community Mental Health Coordinators, Mental Health Unit Supervisors and Program Managers, Residential Counselors/Case Managers, Psychiatrists, Psychologists, Juvenile Parole Program Managers, Residential Treatment Coordinators, and Community Counselors.

Childrens' Administration (CA) enhanced an existing mental health training to include a module on the WISe access model. The training is provided through the Alliance for Child Welfare Excellence and is offered six times during a fiscal year in an in-service format. Participants in these trainings are new and ongoing social workers, foster parents, Court Appointed Special Advocates (CASAs), attorneys, and local service providers. From December 2014 through September 2015, trainings were offered at Centralia, Lynnwood, Spokane, and Seattle. CA also enhanced the training required for all new social workers, Regional Core Training (RCT), to include information regarding the WISe. During the same period, December 2014 through September 2015, RCT was offered at Centralia, Everett, Lynnwood, Seattle, West Seattle, Smokey Point, Spokane, Tacoma, Toppenish, Tumwater, and Centralia, with a minimum of 180 new social workers participating.

In addition to WISe trainings, during this last year WISe presentations were offered at the Behavioral Health Conference in Vancouver, the System of Care Institute in Everett, the Student Support Conference in Wenatchee, the National Alliance of Mentally Ill Conference, in Vancouver, and the Washington Association of School Social Workers in Federal Way.

WISe Training Evaluation: In order to evaluate the quality and impact of trainings for the WISe initiative, the University of Washington Wraparound Evaluation and Research Team administered the Impact of Training and Technical Assistance (IOTTA) survey to all training attendees since the first trainings were held in early 2014.

The IOTTA is collected twice. First, a baseline administration is completed in person at the end of a training event. The baseline survey focuses on trainee perceptions of quality, organization, trainer competence, and the importance of the training subject matter. The survey also asks the trainee to rate his or her perceived mastery over the material before the training as well as after.

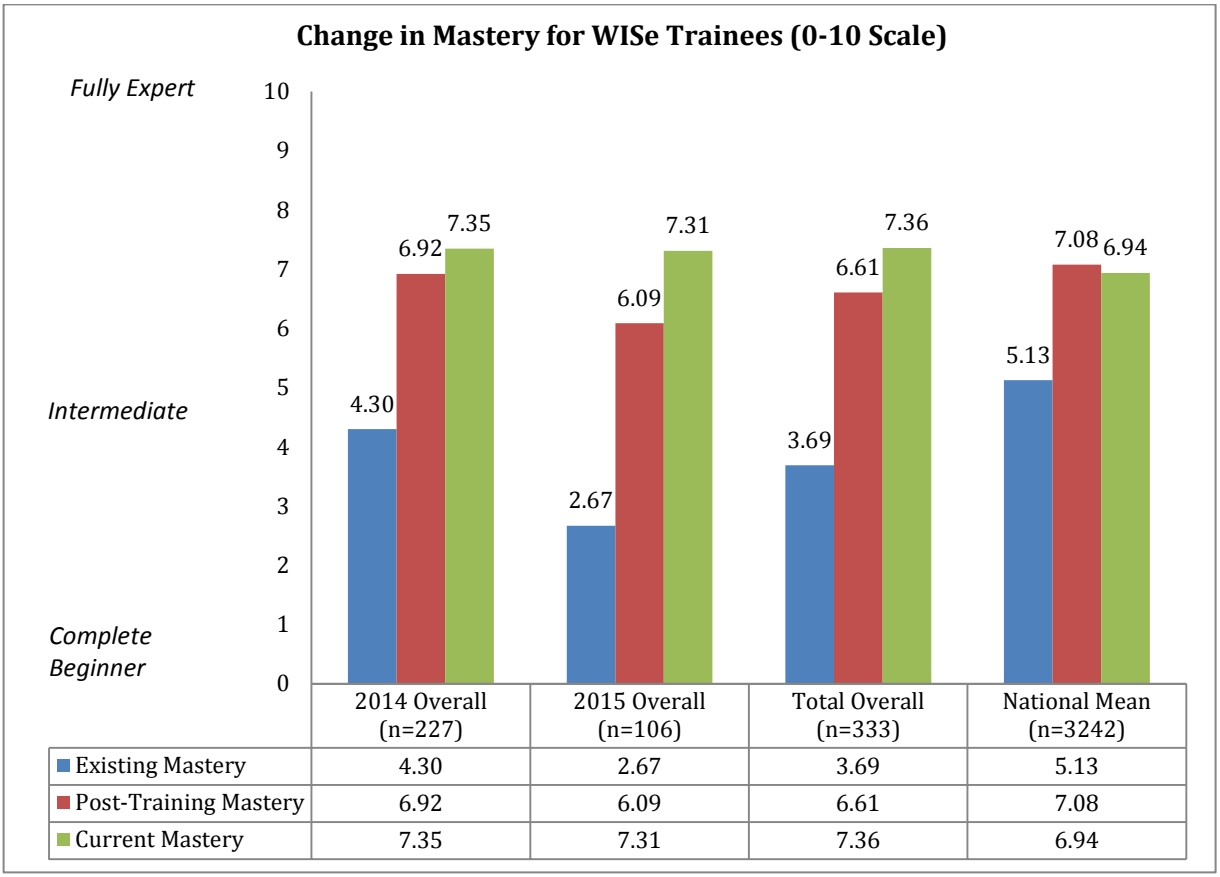
Then, two months later, a follow-up version of the survey is emailed to participants to complete online. The online survey asks respondents similar questions to the baseline survey: about their perceived mastery over the material presented in the training, their

perception of the quality of the training, and the impact of the training on their work in the two months since the training occurred.

To date, IOTTA data have been collected from trainees who attended 16 WISe trainings in Washington State from the period of March 2014 to July 2015. In 2014, ten four-day, in-person trainings were held and 227 trainees completed baseline surveys at the end of the trainings. In 2015, six four-day, in-person trainings were held, with 106 trainees completing baseline IOTTA surveys. The follow-up response rates in 2014 was 69% (156/227 across ten trainings) and in 2015, to date has been 47% (43/92 respondents across five trainings). The 6th training of 2015 was conducted in late July, too recently for follow-up surveys to have been completed and analyzed for this report.

Outcome highlights from the IOTTA results included:

- On average, throughout the 2014 trainings, existing mastery (prior to the training) was rated at a mean score of 4.30 and post-training mastery was rated at a mean of 6.92 (national mean = 7.08); the average mastery change within trainings was 2.62 (national mean = 1.95).
- For the six trainings in 2015, the mean score for existing mastery was 2.67 with the post-training mastery mean of 6.09. The mastery change within trainings was 3.42 (national mean = 1.95); an increase from the 2014 scores.



	2014 Overall (n=227)	2015 Overall (n=106)	Total Overall (n=333)	National Mean (n=3242)
Existing Mastery	4.30	2.67	3.69	5.13
Post-Training Mastery	6.92	6.09	6.61	7.08
Current Mastery	7.35	7.31	7.36	6.94

The above results suggest that, despite lower baseline mastery, the Washington WISe trainings are promoting greater improvement in self-reported mastery of the subject matter than national trainings, to the extent that post-training ratings are similar to post-training ratings for the national comparison sample.

From the IOTTA, direct feedback from trainees about the WISe trainings strengths, needs for improvement, and recommendations included**:**

- Strengths (n=762 comments)
    - Learned new information that was taught in different training styles and was detailed, helpful, and applicable. *(n=173)*
    - Presenters were enthusiastic, passionate, knowledgeable, and maintained interest with humor and self-disclosure. *(n=170)*
    - The group components helped clarify and solidify concepts, while allowing for further discussion of ideas. *(n=128)*
    - Information was thorough and presented in an organized, interesting way with a variety of visual aids and handouts. *(n=124)*
    - The training was engaging with a variety of videos, hands-on activities, and role plays that promoted audience participation. *(n=107)*
    - There was a good background and review of main topics (e.g., Wraparound, Systems of Care, the overall WISe process, etc.). *(n=36)*
    - Appreciated the application of techniques and input from family and youth (e.g., understanding the CANS and how to rate it, etc.). *(n=24)*

- Need for Improvement (n=256 comments)
    - More specific information and techniques (e.g., more on Intensive Services, a better distinction of roles, and WISe practice models). *(n=55)*
    - More practical examples, activities, and scenarios of case examples that would be applicable for trainees. *(n=52)*
    - Better attention to time-keeping and atmosphere, suggest allowing for fewer audience questions, activities, off-topic discussions, inappropriate comments, biases, and personal side stories. *(n=43)*
    - The training was too long, too fast, and too much information all at once – try to add more breaks in between sections or have shorter but more training days. *(n=42)*
    - Better organization, as well as structure of the presentation (e.g., need clearer or written instructions for group activity, less slide reading, and more clarity on handouts). *(n=35)*
    - Trainees have different backgrounds, so some information tended to be repetitive, confusing, or hard to understand. *(n=21)*

  - The role of the therapist seemed to be minimized and was not really represented or explained. *(n=8)*

- Recommendations (n=182 comments)
  - Shorten the training, have less group work and activities, have more notice of the schedule ahead of time, follow-up with teams, and offer more breaks and snacks between sections. *(n=44)*
  - Provide more specific information and case examples to learn from concepts (e.g., completing a plan of care, crisis plan, etc.) and provide completed examples for trainee reference. *(n=40)*
  - More applicable and interactive activities and movement to keep it engaging (such as a role plays) as well as post-discussion to supplement learning. *(n=32)*
  - Provide a more thorough definition of roles (e.g., therapist, peer support partner, etc.) as well as more information on Intensive Services. *(n=26)*
  - Limit the overview of CANS and phases/principles, but perhaps provide a sample CANS to better demonstrate application of use. *(n=18)*
  - Try to assess the background knowledge of audience and tailor training in that respect, as well as fully listen to trainees' questions before responding. *(n=8)*
  - More diversity of youth voice, maybe have a youth co-presentor or add information to the training. *(n=5)*

Overall, in terms of training-specific issues, data suggest that certain improvements could be made in the trainings' ability to:

- Facilitate understanding of expectations and skills of <u>all</u> WISe roles (not just facilitators).
- Include more specific information on WISe.
- Provide more WISe examples and less generic information around wraparound and system of care.
- Provide better understanding of what is meant by "Intensive Services" and how these integrate with wraparound facilitation.
- Promote greater understanding of how to use CANS in a WISe context, and less general information on the CANS.

On-going training improvements will be addressed through the Tri-Lead Workforce Collaborative, the WISe training team, and additional workgroups as needed.

Workforce Collaborative: DBHR staff and members of the statewide FYSPRT worked with Washington State University (WSU) to design an organizationally independent

WISe Workforce Collaborative. A contract between DBHR and WSU establishes the staffing infrastructure for the Workforce Collaborative. The collaborative operates independently and is tri-led by youth and family, state systems, and partner universities. This tri-led model was originally supported by Washington's System of Care Grant in 2013. Building a strong workforce is an essential component of an effective system of care.

The immediate purpose of the Workforce Collaborative is to develop sustainable local and statewide education, training, coaching, mentoring and technical assistance to support agencies in providing WISe with consistency across the state. The long-term goal is that the collaborative, in partnership, will provide comprehensive professional development services and supports to behavioral health providers and other stakeholders to build a highly-skilled workforce and support system-wide implementation of evidence and research-based practices to meet the behavioral health needs of youth, families, and adults in Washington.

As of October 1, 2015, the collaborative is responsible for coordination of WISe training efforts and will work directly with RSNs to establish training plans that meet the needs of their unique regions. The training plan will be updated every six months by and through the Workforce Collaborative.

The Workforce Collaborative will also be responsible for assessing ongoing training needs, completing a framework for statewide WISe trainings, and for completing a strategic plan. A group of stakeholders including RSNs, system partners, youth, and families met on September 21, 2015, and began the strategic planning process. The strategic plan will be adaptable to meet the needs of local implementation as more RSNs roll out WISe and current sites increase capacity. The plan will also address increasing training capacity for youth peers, family peers, and system partners. It will offer the following trainings: WISe half-day community orientation, WISe trainings, WISe clinical supervisor trainings. DBHR will also coordinate the state-certified Family and Youth Peer Counseling Training through the Workforce Collaborative as well as other training initiatives for youth, families, and system partners.

Objective 5 - Remaining Tasks:

- Continue to support a WISe Workforce Collaborative.
- Continue to refine training curriculum with WISe training partners. As of October 2015, the Workforce Collaborative will oversee and convene workgroups to address this on-going work.
- Continue to work with RSNs and system partners to develop training plans. As of October 2015, the Workforce Collaborative will coordinate trainings.
- Continue to evaluate training curriculum. As of October 2015, Workforce Collaborative will oversee contracting for training evaluation.
- WISe e-learning modules are being developed for ongoing training; six training modules are scheduled to be completed by December 2015.

- Continue to work collaboratively with system partners to develop a "Train the Trainer" model with the goal that all trainings are provided by WISe providers by 2018. The development of the training model is behind schedule based on the Implementation Plan deadline of June 2015. Anticipated completion date is March 2016.
- On-going collaboration with system partners to include WISe modules in their trainings, manuals, and other workforce development efforts.
- Workforce Collaborative to develop a five-year strategic plan with youth, family, and system partners.
- Workforce development will be an on-going agenda item at FYSPRT meetings.

Objective 6: Maintaining Collaborative Governance Structure

Maintain a collaborative governance structure to achieve the goals of the Settlement Agreement.

Progress and accomplishments:

The Governance Structure consists of inter-agency members on an Executive Leadership Team of state administrators, the statewide, regional, and local Family, Youth, System Partner Round Tables (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. Quigley and Teeter Settlement Agreement.

FYSPRTs were developed under the Department of Social and Health Services' (DSHS) Washington State System of Care (SOC) Expansion Project as a key component for ensuring behavioral health and other public child, youth, and family-serving systems in Washington are coordinated and informed by input from multiple stakeholders.

FYSPRTs are designed to influence the functioning of local and state child-serving systems, and to 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 local 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.

Plaintiffs' Counsel stress that the following activities are essential for FYSPRTs to play their intended role within the Governance Structure: 1) Robust stakeholder engagement, recruitment, and community-building efforts; 2) Family and youth-driven leadership development; 3) The ability to identify – and act on - issues of local and regional concern; 4) Transparent and action-oriented communications; 5) Continuous quality improvement and accountability, and 6) Sufficient resources.

To assist with ensuring that all members of the statewide FYSPRT are engaged as full partners within the work of the FYSPRT and are included in all aspects of the development, implementation, and evaluation of WISe, DBHR developed an evaluation tool. FYSPRT evaluation tools are available on the DBHR website at:

https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/family-youth-and-system-partner-round-tables-fysprts

In addition to evaluation tool, DBHR collects quarterly reports from regional FYSPRTs, as required under the SOC grant. In the most recent SOC quarterly report, the following comment was noted from a regional FYSPRT Tri-Lead: "As noted by the clinical staff working with the WISe families, the WISe process is quickly changing families' perception of their inherent skills and resources such that they are avoiding crisis and should crisis occur, it is being resolved much more quickly and without accessing extreme resources such as in-patient care."

DBHR is aligning the regional FYSPRTs with the soon to be operational Behavioral Health Organizations (BHOs)/Regional Service Areas (RSA). Laws of 2014, ch. 225, (2SSB 6312) directs DSHS to integrate chemical dependency and mental health purchasing primarily with managed care contracts by April 1, 2016. To match the developing BHO/RSA regions, the number of regional FYSPRTs needs to increase from six to ten.

In late 2014 through early 2015, multiple stakeholder meetings and focus groups with youth and family leaders in the state were conducted by the University of Washington (UW) to gather information to inform the alignment and transition to ten regional FYSPRTs.

Listed below are a few examples of the stakeholder meetings:

- November 20, 2014 – Children's Mental Health Committee meeting with RSN Children's Care Coordinators, family leaders, and DBHR representatives. The UW team led an activity around the alignment of the FYSPRTs and the BHOs.
- November 25, 2014 – Statewide FYSPRT meeting with system partners and FYSPRT Tri Leads. The UW team led an activity around the alignment of the FYSPRTs and the BHOs.
- January 2015 – University of Washington staff sent out a survey titled the "Washington Governance Structure Survey" to 201 stakeholders and received 111 responses.
- January 27, 2015 - University of Washington staff presented to the atatewide FYSPRT members information gathered from the 1) statewide FYSPRT meeting evaluations, 2) Tri Lead focus groups, 3) group decision processes with the Children's Mental Health Committee and statewide FYSPRT, 4) Youth N Action

BHO Alignment meetings, and 5) the 111 responses received from the Washington Governance Structure Survey.
- February 24, 2015 and March 12, 2015 - DBHR provided updates to the T.R. Implementation Advisory Group (TRIAGe) regarding the FYSPRT review process.

In late May/early June, DBHR shared with statewide FYSPRT members, RSN Administrators, and TRIAGe that to assist with the BHO alignment, future regional FYSPRT contracts would be held with RSNs/BHOs starting October 2015. Additionally, on June 4, 2015, Ellen Kagen, Senior Policy Associate of the Georgetown University Center for Child and Human Development, facilitated a daylong meeting with family leaders, youth leaders, system partners and RSN Children's Care Coordinators titled "*Planning for Meaningful Youth and Family Participation in Policy, Management, and Services in the Context of WISe*". During this meeting, Ms. Kagen also provided a Participant Resource Guide with activities and exercises to facilitate family, youth, and system partner leaders to come together in their region and continue building a plan for collaboration.

DBHR, through the System of Care grant funding, contracted with UW Evidence-Based Practice Institute to include coordination and collaboration with youth, families, and system partners to gather feedback and compile a FYSPRT manual. The manual will assist with structure of the regional FYSPRTs.

FY 2015 contract requirements for regional FYPSRTs include, but are not limited to:

- Development and execution of a written outreach strategy to engage youth, family, and system partners in the planning process, including current/former members.
- Planning meetings with existing regional FYSPRT contractors, current FYSPRT participants, and other interested stakeholders.
- Develop a process for application to provide travel, and other meeting support (e.g., mileage/public transit reimbursement, onsite child care), to FYSPRT members wanting to attend FYSPRT related meetings and activities.
- Conduct a needs assessment, using the region's tool/method of choice to assist in the planning and development of regional and local FYSPRTs.
- Convene regular regional FYSPRT meetings at a minimum of once per month, starting on or before January 2016.
    - Meeting materials must be made publicly available prior to the meetings.
    - Meetings must follow the regional FYSPRT meeting protocol, set forth in the FYSPRT Manual.
- Submit a written report on the results of the needs assessment, including but not limited to:
    - Local/regional strengths and barriers with regard to the development and sustainability of the regional FYSPRT.

- Recommendations regarding the development and operation of the regional FYSPRT.

Objective 6 - Remaining Tasks:

- In January 2016, DBHR to review and approve RSN reports summarizing the regional FYPSRT progress on contract requirements through December 2015, including the identification of barriers on FYSPRT Implementation, and plans regarding next steps.
- In April 2016, DBHR to review and approve RSN reports summarizing the regional FYPSRT progress on contract requirements through March 2016, including an updated membership roster and the results of the needs assessment and the strategic plan framework.
- In April 2016, DBHR to review RSN submitted sign-in sheets (with role/organization represented) and meeting minutes from each FYSPRT regional meeting.
- Maintain similar regional FYSPRT contract language in BHO contracts starting in April 2016.
- By July 2016, review and reestablish the Memorandum of Understanding between DSHS and HCA to address coordination, training, and quality assurance.
- Continue to bring issues identified through the regional and statewide FYSPRT to the Executive Leadership Team.
- Continue to review the protocols and procedures in the WISe Manual for Community Collaborative/s to oversee implementation of local WISe programs.

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

Objective 7: Affording Due Process to Class Members

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

Objective 7 Strategies - Progress and Accomplishments:

In the November 2014 annual report, DSHS reported that it had previously adopted contractual provisions related to the grievance system, informed class members of their due process rights through the Medicaid Mental Health Benefits Booklet, developed a model "Notice of Action" for use by RSNs, and published a section in the

WISe Manual that includes a Client Rights section on the right to appeal denials, reductions, or terminations of services.

In regard to due process protections, the major milestone accomplished this year was adoption of new grievance and appeals rules. These rules, which apply to all individuals who apply for, are eligible for, or receive RSN-authorized mental health services, are found at WAC 388-877A-400 to 460. The rules became effective on July 26, 2015. This is a key element of Objective 7 that satisfies the requirements of the Settlement Agreement, Sections 35 and 68(b). The rules generally describe how individuals can express concerns through the various levels of the grievance system, provide definitions, describe the grievance process, the right to receive a notice of action from the RSN, how to appeal that notice of action, the right to continued benefits, and the right to an administrative hearing. Finally, the rules describe rights that are specific to Medicaid recipients, which include all WISe enrollees.

The rules at WAC 388-877A-400 to 460 were drafted to be compliant with federal Centers for Medicare and Medicaid Services (CMS) rules governing Medicaid managed care, grievances and appeals. 42 CFR 438, Subpart F (Sections 438.400 to .424), which took effect in 2002.

Two changes will affect the substance of the new due process rules in Ch. 388-877A and require that the rules be amended in the coming year. First, on June 1, 2015, CMS published a notice of rulemaking proposing extensive amendments to 42 CFR Part 438. 80 FR 31098 (June 1, 2015). These proposed amendments include some significant changes to Part 438, Subpart F, which will in turn drive changes to the new DSHS regulations. The comment period closed on July 27, 2015. It is unknown when CMS will adopt its final rules. CMS has proposed that the term "action" be replaced with "adverse benefit determination." The proposed rule also aligns the Medicaid and CHIP managed care appeals process with Medicare Advantage and private plans, proposes some changes to definitions and timeframes for the resolution of appeals, streamlines levels of internal appeals, and requires that enrollees rely first on the managed care plan's internal process before proceeding to a state fair hearing.

Second, under Laws of 2014, ch. 225 (2SSB 6312), Regional Support Networks become "Behavioral Health Organizations" (BH0s) effective April 1, 2016. This state law change furthers efforts to integrate mental health services and chemical dependency services, and is primarily codified in ch. 71.24 RCW. Implementing this legislative mandate to integrate behavioral health into one system of care will require DSHS to amend many of its regulations, including the new due process provisions in WAC 388-877A-400 to 460 to reflect adoption of BHOs as the new managed care entity and reflect a service array that encompasses both mental health and chemical dependency.

In addition to the rule-making, DSHS has worked with WISe stakeholders to further develop the Client Rights (Section 5) of the WISe Manual.

DSHS continues to monitor compliance with due process requirements and address noncompliance by requiring RSN/BHO policies to be consistent with due process regulations and policies. It also requires, in contract, that RSNs collect and report data on actions, grievances, and appeals. Reports are analyzed and used by the RSN contract compliance staff members and provide input to audit activity by DBHR staff and EQRO external auditors.

DSHS is analyzing and using grievance and appeal data as part of the WISe quality improvement program. Data being collected by DBHR contract compliance staff is currently being analyzed on a regular basis for adherence to contract requirements. Use of WISe specific data regarding due process rights is in the beginning phases of inclusion into the WISe quality improvement program.

DSHS will work in the coming year to develop a comprehensive oversight plan for compliance with WISe enrollee right requirements. This plan will link with DBHR contract compliance staff, EQRO review staff, Children and Youth Behavioral Health team staff, and DBHR WAC rule development and monitoring staff.

The expected results of this objective are to ensure Medicaid beneficiaries (including class members) are aware of their due process rights; that RSNs and providers are complying with the Medicaid due process rights; and beneficiaries have access to and can exercise their notice, grievance and appeal rights.

Objective 7 - Remaining Tasks:

- Amend the new due process provisions in WAC 388-877A-400 to 460 to reflect adoption of BHOs.
- If necessary, once federal regulations are adopted, amend due process provisions to be compliant with federal Centers for Medicare and Medicaid Services (CMS) rules governing Medicaid managed care, grievances and appeals.
- Develop a model notice of action for RSNs. Require RSNs to use the model notice, or complete a checklist and attestation that their notice has all the same elements as the model notice.
- Continue to monitor RSN reports on grievances and appeals related to WISe.
- Continue to monitor RSN compliance with due process requirements related to WISe through EQRO and compliance reviews and data analysis.
- Analyze and use the data as part of the WISe quality improvement program. Use of WISe specific data regarding due process rights is in the beginning phases of inclusion into the WISe quality improvement program.

The expected results of this objective are to ensure Medicaid beneficiaries (including class members) are aware of their due process rights; that RSNs and providers are complying with the Medicaid due process rights; beneficiaries have access to and can exercise their notice, grievance and appeal rights.

2. Implementation Challenges

DBHR has access to the statewide FYSPRT and the related workgroups (the Children's Behavioral Health Executive Leadership team, the Children's Behavioral Health Data and Quality Team, and T.R. Implementation Advisory Group (TRIAGe)) to assist with identifying and reviewing implementation issues (and successes). These groups are active and meet either on a quarterly or monthly basis. Their participation will be vital in the on-going monitoring and refinement of the service implementation.

Our anticipated challenges for the next year are outlined below according the T.R. Implementation Plan Objectives. The below categories are current areas of focus for WISe implementation:

Rollout of WISe Services **(Objective 3)**

DBHR is in the process of updating the WISe rollout schedule with RSNs and the upcoming BHOs. The staged rollout of WISe services poses challenges both in terms of geographic availability and capacity until June 2018. During the implementation period, the WISe program will not be available for all youth for whom the services may be appropriate. The new schedule will be posted on the DBHR website as soon as it is completed. The biggest change to the initial rollout plan is that King County RSN has volunteered to implement WISe prior to original date of November 2017; the anticipated start date is early 2016. All RSNs will begin WISe implementation in at least one county in their region by April 2016. RSNs currently implementing WISe, with the exception of Thurston Mason RSN, will need to continue to build capacity in their region. The September 2015 State Mental Health Contract amendment, received by all RSNs, included the projected WISe capacity estimates needed at full implementation. These capacity projections were also included in the BHO's Detailed Plans.

To assist with finalizing the WISe capacity numbers linked to the rollout plan, DBHR has requested an updated review of estimated capacity needs for each county to identify any changes since the initial report generated by the department's Research and Data Analysis Division (RDA) in July 2014. Completion of this work is anticipated in late December 2015.

As noted under Objective 3, DBHR finds success in the WISe capacity development during the first year of implementation. DBHR also recognizes the capacity target for FY2016 is aggressive, particularly when RSNs are transitioning to BHOs. DBHR will continue to monitor utilization through fiscal reports. Per contract requirements starting in December 2015, DBHR will monitor bi-monthly progress reports submitted by the RSNs. The progress reports will identify current WISe capacity in the RSN region, indicate any decreases in capacity, and present an action plan to regain compliance. In this report, RSNs are also required to identify challenges in meeting their service capacity targets and identify strategies to address those challenges. From these reports, DBHR can further support and assist RSNs with their identified strategies to meet implementation challenges.

As identified in the first annual Implementation Status Report, capacity building for WISe is a big challenge. In addition to funding for capacity, there is also a ramp-up to meet the staffing requirements for WISe teams. RSNs have had to manage capacity and ramp-up for WISe services and will continue to meet unique challenges (e.g. workforce recruitment, workforce shortages, staff turnover, Requests for Proposals). RSNs continue to report difficulty in workforce recruitment and staff turnover on the WISe teams.

There is an overarching interest in identifying technical assistance and supports to bolster the children's behavioral health workforce. In support of this, the WSU Workforce Collaborative will coordinate and collaborate with current initiatives and identify more long-term strategies in a five-year Workforce Development Strategic Plan that is under development. Once completed, DBHR will work to support the strategies identified in the Workforce Development Plan.

The Workforce Collaborative will also align with the efforts under contract with the University of Washington Evidence-Based Practice Institute (EBPI). DBHR has also contracted with the University of Washington EBPI to develop a state implementation plan for Evidence-Based Practices based on the regional needs of RSNs, providers, and stakeholders for children's mental health services.

Workforce shortages, competition for existing skilled staff, and difficulty with recruitment in children's behavioral health services will continue to cause challenges for WISe implementation. There is a need to identify creative and collaborative ways to support RSNs and WISe providers. DBHR believes the noted workforce contracts with WSU and U of W will assist with this work.

DBHR will to review workforce issues in TRIAGe, in the statewide FYSPRTs, and with the Workforce Collaborative Steering Committee.

Payment Mechanisms and Reporting (Objective 3)

ProviderOne (P1)

P1 is the online electronic system that manages Medicaid claims. During the first year of WISe implementation, a number of ongoing issues were encountered for the WISe Service Based Enhancement (SBE) payments due to established coding within P1. At the end of the fiscal year, withheld payments were monitored and processed directly by fiscal staff. To mitigate this ongoing problem, DBHR will dedicate fiscal staff to review and generate WISe SBE payments for RSNs/BHOs. DBHR reviewed the proposed new SBE process with RSNs in late September 2015. The new process will be tested, phased in, and fully implemented by January 2016.

Behavioral Health Assessment System (BHAS)

The BHAS system launched in July 2014 with five Regional Support Networks and their contract WISe agencies inputting CANS screening and assessment data. To bring on a system and users in such a quick turnaround time was an accomplishment. However, these accomplishments also came with some challenges; some expected and some unexpected.

When implementing such a system, in users will experience problems that need to be addressed. Additional staff were needed to address technical fixes and continue building the Washington State report structure. The process of fixing system issues and creating BHAS reports began September 2014 and is ongoing. At first, the technical ability to create the reports did not exist and no project management staff were available to create, modify, adjust, and validate these reports. Since such time, a project manager has been hired by the vendor and more developers and programmers have been brought on board.

The system challenges have been prioritized and are being addressed by the vendor, DSHS, and DSHS' contractor, Dr. Nate Israel, in systematically working through each report. This work entails looking at requirements, logic patterns, outputs, and validation against extract data run through the same logic parameters. This process will ensure that the reports produced by BHAS come with only the highest form of accuracy.

Upcoming work on the BHAS system consists of the following:

- Functionality to bring greater detail to the screening referral outcome.
- Algorithmic functionality to allow Washington to create, test, and employ new algorithms to the CANS screen.
- Transfer capability added to the RSN and agency levels that will allow clients to change locations.
- Functionality that will allow users according to permission to discharge, delete, and suppress CANS to allow for more accurate records and data.
- Adding additional reports, e.g. a CANS 90-day timeliness report.

WISe Training (Objective 5)

Training needs for WISe exists on a variety of levels, with our system partners, with youth and family members, and with RSNs and their WISe affiliated agencies. DBHR is meeting with a workgroup of representatives from RSNs, WISe agencies, WSU, UW EBPI, and PSU to develop a WISe Train the Trainer Model (TtT). This model will assist with increasing local training expertise and provide trainings in a timely manner that best meets the needs of the local RSN/BHO. The goal was to have the WISe TtT completed this past summer but has fallen behind schedule. Part of the delay for the TtT, was an interest in hiring an executive director for the WSU Workforce

Collaborative that took longer than expected. And, DBHR is currently in the process of changing its training platform from a required four-day, in-person training to having online training modules available and an experiential two-day, in-person training. The training curricula needs continued refinement and re-design to match the experience of the individual RSNs workforce. This project is moving forward in partnership but needs to be completed so that additional trainers can be available in local communities as WISe services continue to increase statewide.

Also, there is an ongoing interest to work with Cross System partners for a better understanding on how and why a Cross Care Plan benefits youth and families. To that effect, DBHR continues to work with key system partners to identify methods to increase trainings and information to their critical staff. The 2016 EQRO review and Quality Services Reviews (QSRs) will assist with ongoing quality improvement and training needs. Later in 2016, a written report on the lessons learned from the QSRs will also be available to guide quality improvement.

DBHR will continue to work with the Workforce Collaborative under Washington State University, UW EBI, and system partners to identify a plan to establish and sustain WISe provider trainings with sufficient frequency, depth, and scope to address capacity expansion, as well as staff turnover.

Family, Youth, and System Partner Roundtables (Objective 6)

Establishment and support of the Family, Youth, System Partner Roundtables (FYSPRTs) is derived from the goals, commitments, and exit criteria of the T. R. Settlement Agreement. The agreement stipulates that the Washington State Children's Behavioral Health Delivery System will "maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders."

As noted in Objective 6, the statewide, regional, and local FYSPRTs are designed to influence the functioning of local and state child-serving systems, and to 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 Washington State Children's Behavioral Health Principles and provide a forum for local 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.

FYSPRTs are to engage family, youth, and local community representatives as "full partners" with the same access to data and equal rights in the decision-making processes as other committee members.

Towards the end of FY 2015, DBHR began the work to align the regional FYSPRTs with the soon to be operational Behavioral Health Organizations (BHOs)/Regional Service Areas (RSA). 2SSB 6312 directs DSHS to integrate chemical dependency and mental health purchasing primarily with managed care contracts by April 1, 2016. To better

match the regional FYSPRT with the developing BHO/RSA regions, the number of regional FYSPRTs needed to increase from six to ten. The start date to increase the number of regional FYSPRT and the transition of RSNs receiving the contracts was October 1, 2015.

The governance structure is intended to:

- Increase family and youth participation in governance activities at all levels of the system.
- Include authentic and substantial family and youth involvement in all aspects of policy making and decision-making for the WISe program.

To assist with meeting this intent, contracts require the national best practice that each regional FYSPRT include a minimum of 51% youth and family stakeholders. As the regional and local FYSPRTs continue to develop in the new BHO/RSA, they may or may not be able to recruit a sufficient number of youth, family and system partner members. RSN reports submitted to DBHR on membership rosters and recruitment strategies will reveal if there are shortages. DBHR is preparing to address this issue, should it prove to be a challenge, by providing sufficient technical assistance for meeting any shortages.

Opportunities for technical assistance and leadership development activities are available through contracts with the Workforce Collaborative, Youth 'N Action, as well as by DBHR staff. DBHR is also in the process of developing an RFP for a Family-led organization that can also provide expertise in leadership development and offer consultation and technical assistance.

DBHR will require regional and local FYSPRTs to use the evaluation tool noted in Objective 6. Also, within the current Regional FYSPRT contract, concrete deliverables are required. Again, some of these contractual requirements are noted under Objective Six and Remaining Tasks.

Throughout the process of transitioning from six to ten FYSPRTs, Plaintiffs' Counsel and stakeholders have expressed ongoing concerns about the transition of the regional FYSPRTs to the RSNs/BHOs. Areas of concern with the RSNs/BHOs receiving the contract include:

- Authentic youth and family representation as full partners.
- The inclusion of historical FYSPRT work, contractors, and members.
- The timelines around the development of local FYSPRTs.

Through stakeholder meetings, discussions, and input into the contract language and FYSPRT Manual, DBHR has attempted to address these concerns. DBHR and Plaintiffs' Counsel have made a mutual commitment to continue to address any ongoing FYSPRT concerns.

Regional FYSPRTs will locally identify barriers on FYSPRT implementation and develop plans regarding next steps. DBHR will review these plans in January 2016. In addition, barriers and best practices will continue to be discussed at the statewide FYSPRT meetings.

The work of developing regional and local FYSPRTs started prior to the Settlement Agreement under the System of Care grant and is an evolving process. The commitment to the intent has been voiced in numerous meetings and collectively from youth, family, and system partners. This work is critical and on-going.

3. Glossary of Key Terms

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

a. **"Behavioral Health Assessment System" or "BHAS"** is an online data system to store and report on Child and Adolescent Needs and Strengths (CANS) data for Wraparound with Intensive Services (WISe).
b. **"Behavioral Health Organizations" or "BHOs"** are created by state law to ch. 225, Laws of 2014, 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).
c. **"Behavioral Health and Service Integration Administration" or "BHSIA" is** an administration of the Department of Social and Health services and provides prevention, intervention, in-patient treatment, outpatient treatment, and recovery support to people with addiction and mental health needs. In addition, BHSIA operates three state psychiatric hospitals: Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center.
d. **"Behavior Rehabilitation Services" or 'BRS"** is a temporary intensive wraparound support and treatment program for youth with high-level service needs. BRS is used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. These services are offered through contracts under the Children's Administration.
e. **"Children's Administration" or "CA"** is an administration of the Department of Social and Health Services and the public child welfare agency for the state of Washington.
f. **"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.
g. **"Child and Family Team" or "CFT"** includes the youth, parents/caregivers, relevant family members, and natural and community supports.
h. **"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.
i. "**Culturally and Linguistically Appropriate Services" or "CLAS"** – the national standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care. https://www.thinkculturalhealth.hhs.gov/content/clas.asp

j. **"Developmental Disabilities Administration" or "DDA"** is an administration of the Department of Social and Health Services that provides programs for state residents with developmental disabilities and their families.
k. **"Division of Behavioral Health and Recovery" or "DBHR"** means the DSHS-designated state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.
l. **"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.
m. **"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.
n. **"Fiscal Year 2015" or "FY2015'** is the state fiscal year running from July 1, 2014, through June 30, 2015.
o. **"Full partners"** are persons or entities who play an active role in the development and implementation of activities under the "T.R. v. Quigley and Teeter" (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.
p. 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. Quigley and Teeter Settlement Agreement.
q. "**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.
r. **"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. Quigley and Teeter* Settlement Agreement.
s. **"Regional Service Areas" or "RSAs,"** as directed by E2SSB 6312, the Health Care Authority (HCA) and Department of Social and Health Services (DSHS), have jointly decided on common Regional Service Areas (RSAs) for Medicaid purchasing of physical and behavioral health care, beginning in 2016. Map as of June 2015: http://www.hca.wa.gov/hw/Documents/2016rsa_boundaries.pdf
t. **"Regional Support Network"** or "**RSN**" means a county authority or group of county authorities or other entity recognized by the DSHS Secretary through a DSHS contract for a DSHS-designated region which provides management of behavioral health services.

u. **"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.

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

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

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

y. **"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.

z. **"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

aa. **"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 Quigley and Teeter (formerly Dreyfus and Porter) Settlement Agreement.

bb. **"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.