Implementation Status Report

November 15, 2016

Submitted under the

Settlement Agreement

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

Hon. Thomas S. Zilly

U.S. District Court, Seattle

No. C09-1677-TSZ

Washington State Department of Social & Health Services

Transforming lives

Washington State Health Care Authority

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Wraparound with Intensive Services (WISe)
Implementation Status Report

Introduction

In December 2013, the State of Washington settled *T.R. v. Lashway and Teeter,* filed four years earlier, which asked the State to provide children and youth on Medicaid with intensive mental health services in homes and community settings. In the settlement, Washington State committed to developing intensive mental health services, based on a "wraparound" model, so that eligible youth can live and thrive in their homes and communities and avoid or reduce costly and disruptive out-of-home placements. As part of the settlement, Washington State developed Wraparound with Intensive Services (WISe). WISe is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to assist their families on the road to recovery. WISe 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 with an annual Implementation Status Report that describes progress in meeting obligations under the agreement. The report is to include accomplishments, remaining tasks, and potential or actual problems, as well as remedial efforts to address any identified problems. This Implementation Status Report represents the third annual report, detailing the State's accomplishments in developing and implementing the WISe program.

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

This report is organized into three sections. Section I is an Executive Summary that provides an overview on the State's progress in developing and implementing WISe over the past year. Section II has a description of the specific accomplishments made December 2015 through September 2016, and then sets forth remaining tasks. Section III identifies some overarching implementation challenges and proposals for addressing those areas of concern.

I. Executive Summary

Reforming the children's mental health system of care requires dedicated resources and infrastructure to support high quality providers of home based services capable of meeting the needs of thousands of vulnerable children and youth. This report highlights the strides that have been made in Washington to achieve this goal, the key challenges that remain,

and the priority tasks for the coming year. These advancements and challenges are summarized below.

Washington Has Made Significant Advances Over the Past Year.

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

New data has confirmed that thousands of Washington youth may need to be referred for a WISe screen to assess whether they need WISe services. This past year, the Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) reviewed the "WISe Proxy" which was first generated with State Fiscal Year (SFY) 2011 data. The WISe proxy is best thought of as the target population to be screened for WISe services. Overall, the size of the proxy is slightly larger in SFY 2015, but with somewhat lower average severity. The number of children and youth has grown slightly to about 25,000 youth in the SFY 2015 proxy compared to about 23,000 youth in the SFY 2011 proxy. Those children and youth who met criteria for the T.R. proxy in SFY 2015 have slightly fewer and less severe functional indicators, on average, compared to those who met criteria in SFY 2011.

Implementation data indicates that the number of referrals and screenings continues to grow. From July 1, 2014, through June 30, 2016, SFY 2015 and SFY 2016, **3,707 WISe screens** were conducted. The largest referral sources for the WISe program are the Behavioral Health Organizations (36 percent), self and family (21 percent), and Children's Administration (CA) (13 percent). A smaller number of referrals are coming from other mental health services and programs.

Of the 2,145 screens conducted in SFY 2016**, 83 percent were conducted within 14 days of referral**, the standard for screening timeliness. The timeliness of screens improved slightly over the course of the fiscal year.

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

A total of 1,705 youth received WISe services between July 1, 2014 and March 31, 2016. This is an increase from the 925 reported in last year's annual report.

The 1,705 youth in WISe services between July 1, 2014 and March 31, 2016 received a total of 148,379 hours of WISe services in their homes (39 percent), outpatient facilities (29 percent), schools (5 percent), and other community settings (25 percent). On average, a youth enrolled in WISe in a given month received 14 hours of services during that month.

The most frequent provider types, by hours of service, were MA/PhD (37 percent) and below master's level (43percent). Approximately one-sixth of all service hours (17 percent) were delivered by peer counselors.

The top five service modalities, by hours of WISe services are: individual treatment services (34 percent), peer support (17 percent), child and family team meeting (16 percent), family treatment (10 percent), and care coordination services (10 percent).

3. **Children and youth are benefitting from WISe services**.

Young people who receive WISe services are functioning better in their lives. Child and Adolescent Needs and Strengths (CANS) data reflects positive changes experienced over the first six months of WISe treatment for the 514 children and youth ages 5-20 who received an initial and follow-up CANS assessment. Between the initial intake assessment and six-month reassessment, the percentage of youth with clinically significant treatment needs declined across all five of the top behavioral and emotional domains including emotional control problems, attention/impulse problems, mood disturbance, oppositional behavior and anxiety.

Data also shows a significant decrease in the percentage of participating youth exhibiting the top five **risk factors** between their initial CANS assessments and six-month CANS follow-up assessments. Risk factors include suicide risk, decision-making problems, danger to others, intended misbehavior and non-suicidal injury. And data shows that children receiving WISe services are developing strengths in important life areas such as education, resiliency, optimism, family and recreation over six months.

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

Youth and family voice continues to grow stronger in the children and youth mental health governance system. By providing support to the Statewide and Regional FYSPRTs, the Division of Behavioral Health and Recovery (DBHR) offers forums to youth, families, and system partners 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.

Since the number of Regional FYSPRTs increased from six to ten to be in alignment with Behavioral Health Organization (BHO) and Fully Integrated Managed Care regions in October 2015, each Regional FYSPRT engaged in a needs assessment to develop a strategic plan specific to each geographic area. Washington State is committed to maintaining the Regional FYSPRT structure and continuing to promote and refine the process for Regional and Statewide FYSPRT to bring issues to the Executive Leadership Team and receive timely responses.

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

DSHS solicited input from stakeholders and from FYSPRTs and updated the information sheets developed and tailored for key affinity groups. These information sheets are publicly available in eight languages. http://www.dshs.wa.gov/dbhr/cbh-wise.shtml. DSHS also

maintains a WISe Implementation website (www.dshs.wa.gov/dbhr/cbh-wise.shtml) that provides information such as a WISe referral contact list by county, a map of where WISe is being implemented, the current version of the WISe Manual, as well as the information sheets discussed above.

Washington Has Significant Work Ahead.

1. **Workforce issues pose a significant challenge.**

As of October 2016, 28 of Washington's 39 counties have started implementing WISe. The additional 11 counties are scheduled to have WISe available by June 2018. In 2017, the additional counties' BHOs will identify qualified agencies to provide services and initiate the WISe training process. **The State has achieved 45 percent of the full implementation target for the mid-level range**; last year at this time progress towards completion was 18 percent.

As the last two annual status reports have indicated, there is on-going difficulty hiring and retaining qualified staff. BHOs and WISe provider agencies continue to focus on recruitment to build additional WISe teams, some conducting national searches to identify qualified staff. Across most of the state, workforce poses a significant challenge.

Further investigation and work will be undertaken in the next year to understand with more specificity why these workforce issues exist. For example, which recruitment strategies have been tried and found effective or not effective? Which supervision structures best support retaining qualified staff? As the services continue to roll out statewide it is important to better understand administrative constraints that impact providers' ability to scale up WISe services, such as regulatory, subcontracting, and licensing issues that impact services.

2. **The system needs to be adequately funded.**

As of this report, Washington's actuarial contractor, Mercer, has reviewed WISe encounter data to determine whether a financial experience adjustment is warranted; this review will continue through December 2016 to set rates for SFY 2018, which starts July 1, 2017.

Establishing a case rate that fully supports the provision of WISe services is crucially important for ensuring that high quality WISe services will be available. In order to build capacity within the system, the case rate must reimburse providers such that they can build up this service model and deliver WISe effectively.

Plaintiffs' counsel have expressed significant concerns with any decrease in funding, as service capacity is scaling up. Plaintiffs' counsel hope and expect that they will be provided with information about the rate setting process that is sufficient to allow them to assess whether the process is taking into consideration factors important to support WISe services.

Plaintiffs' counsel highlight that the coming year will be pivotal in developing capacity in the system to support the program, and close attention must be paid to ensuring an adequate case rate, supporting an appropriate capacity increase, and developing an adequate skilled workforce.

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

Linking the youth who are assessed to need WISe with WISe services continues to pose challenges. Washington has developed an algorithm to support decision-making regarding whether a youth's mental health needs and associated functional impairments are at or above the severity level for WISe services. The algorithm uses information from CANS. The algorithm criterion was selected because research demonstrates that child outcomes improve when clinical judgment is informed by CANS information.

Current data indicates that some foster youth are being referred to higher levels of facility-based care rather than WISe, even after they are screened eligible for WISe. There are many factors that may be impacting this data point. For example, it may be that more foster youth are referred for screening, or that they are mandated to be screened when they are already receiving facility-based services. To better understand why youth who meet medical necessity for WISe may be getting referred to more restrictive services, the Behavior Health Assessment System (BHAS) is being modified to track the source of these referrals, and the referral outcome, including why a youth may have screened positive for WISe but did not transition into WISe (e.g., need for placement, family opted out, WISe not yet available in the community, currently in Children's Long-term Inpatient Program (CLIP) or Behavior Rehabilitation Screening (BRS) and rescreening.) DBHR, RDA, CA, and T.R. Plaintiffs' counsel will continue to analyze this data and evaluate the trainings and protocols developed relating to referral to WISe.

Washington is changing how it is managing the provision of Medicaid services to foster children. Thus, ensuring access to WISe services for children and youth in state custody will require additional planning. Work in the coming year will include planning meetings with Health Care Authority (HCA), CA, Coordinated Care of Washington (CCW) and DBHR regarding the transition of service benefits scheduled for October 2018. Currently, CCW provides physical health (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees. In October 2018, CCW will begin to provide the full continuum of outpatient mental health benefits including WISe.

4. **Continued work is needed to ensure access to meaningful data.**

The State continues to experience challenges with its Behavioral Health Assessment System (BHAS) for capturing CANS assessment data. Increased demands on BHAS due to an increase in users and changes in functionality needs have created strains on the system that are resulting in "glitchy" user experiences when entering and saving data. As a result, many BHAS users have expressed skepticism about the BHAS data. This is a challenge to

using this data to inform quality improvements and promote necessary system changes. DBHR and RDA staff have been working diligently with the BHAS contractors to address the system problems and to ensure future data reports are accurate and reliable.

5. Efforts must be made to ensure due process protections.

DBHR adopted a new set of grievance and appeals rules to be compliant with federal Medicaid rules in 2015. Subsequently, the Regional Support Networks (RSNs) converted into BHOs and expanded from providing mental health services to also cover chemical dependency services as mandated by Laws of 2014, ch. 225 (2SSB 6312). This change necessitated further state rule amendments to reflect the adoption of BHOs. In the meantime, the Centers for Medicaid and Medicare Services (CMS) has made amendments to 42 C.F.R. Part 438, Subpart F, as noted in the Objective 7 "Remaining Tasks." Those changes will be effective July 1, 2017.

There is a need for ongoing monitoring of BHO's compliance with due process requirements and to address due process obligations in the settlement agreement and state and federal regulations and policies. In particular, analysis of BHO policies, procedures and data concerning notices, and grievances and appeals regarding WISe services is needed to ensure BHOs and providers are complying with their responsibilities to issue notices of actions when access to WISe is denied, terminated or reduced, and to appropriately inform families of their due process rights.

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

Objective 1: Communication Regarding WISe

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

Progress and Accomplishments:

Previously, WISe Information Sheets were developed and tailored for 14 various groups, known as "affinity groups." In April 2016, DBHR staff began the process of soliciting updates and recommended changes from identified representatives of the various affinity groups, a DSHS Diversity Affairs Workgroup representative, Plaintiffs' counsel, and through the Statewide and Regional Family, Youth and System Partner Round Tables (FYSPRTs). The process for revising the documents was completed in August 2016. The key update during this revision was the inclusion of information about FYSPRTs and information on how to get involved, including the website address that provides meeting dates and location.

All updated information sheets were published in early September 2016. 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). The information sheets for youth and for families were also translated into Trukese (an Austronesian language of the Truk Islands in Micronesia) based on a community request. The DBHR website link for accessing the WISe Information Sheets is: http://www.dshs.wa.gov/dbhr/cbh-wise.shtml. Materials were updated for each of the following affinity groups:

- Child Psychiatrists and Advanced Registered Nurse Practitioners (ARNPs)
- CA Social Service Specialists
- CLIP Staff
- Developmental Disabilities Administration (DDA)
- Designated Mental Health Professions and Crisis Teams
- Families/Family Organizations
- Heath Care Authority and Contracted Providers
- Individuals providing Mental Health Services
- Juvenile Court, Detention, and Probation Personnel
- Juvenile Rehabilitation (JR) Personnel
- K-12 Educators and Professionals
- Pediatricians, Family Practitioners, Physicians Assistants, and ARNPs
- Substance Use Disorder (SUD) Providers
- Youth/Youth Organizations

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. Web analytics show from January to August 2016, this website was viewed over 4,500 times. 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. Currently, the ListServ reaches 627 individuals.

As a process to improve the effectiveness of WISe communications, DBHR engaged the statewide FYSPRT, and in turn asked Tri-Leads (Family, Youth and System Partner Representatives) to engage with the Regional FYSPRTs, to review the WISe information sheets. Regional FYSPRTs were invited to critique the materials created for all of the affinity groups. Tri-leads were also invited to bring any WISe materials created at a regional level and share with the statewide FYSPRT. This process, seeking feedback from the statewide FYSPRT, has been utilized in prior years to review the WISe video, and the first developed WISe info sheets. DBHR will continue to work to identify additional processes to improvement the effectiveness of communications to include in the Quality Management Plan.

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[1]:

- Continue to disseminate WISe information to youth and families, affinity groups, and to system partners.
- Continue to have FYSPRTs distribute WISe communication materials.
- Continue to share information drafted and incorporated into the WISe Manual with FYSPRTs, system partners, affinity groups, and Plaintiffs' counsel.
- Continue to deliver information developed through a variety of online, print, and in-person methods, including targeted and in-person outreach to school personnel and medical providers.
- Annually review and update the informational materials by engaging affinity groups, system partners, and FYSPRTs to guide improvement and identify proxy indicators that should trigger referral.

Objective 2: Identification, Referral and Screening for WISe

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

Progress and Accomplishments:

This past year, DSHS Research and Data Analysis (RDA) reviewed the "WISe Proxy" which was first generated with SFY 2011 data**.** The "WISe proxy" is a data-driven profile of children and youth enrolled in Medicaid in Washington State who are at increased risk of needing intensive home- and community-based mental health services. The WISe Proxy uses DSHS's administrative data from across the administrations within the agency, and represents actual Medicaid clients with both mental health treatment needs (as indicated by diagnoses, psychotropic medications, and service utilization) and one or more proxy functional indicators.

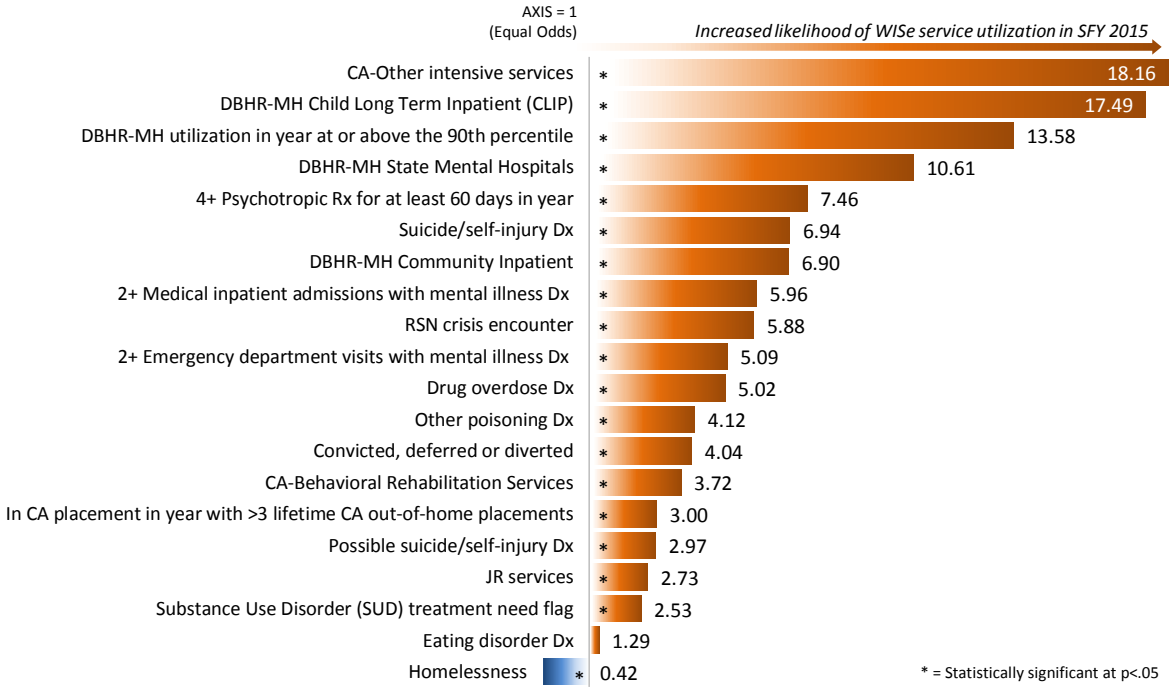
The WISe proxy is best thought of as the target population to be screened for WISe services. The youth served in the WISe program are expected to be a subset of those in the proxy, encompassing Medicaid youth in Washington State who need WISe services.

The number of children and youth has grown slightly over time with about 25,000 youth in the SFY 2015 proxy compared to about 23,000 youth in the SFY 2011 proxy. Those children and youth who met criteria for the T.R. proxy in SFY 2015 have slightly fewer and less severe functional indicators, on average, compared to those who met criteria in SFY 2011. Overall, the size of the proxy is slightly larger in SFY 2015, but with somewhat lower average severity.

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

Based on the review of the proxy functional indicators, the below graph represents the increased likelihood of when WISe services would be indicated:

Proxy Functional Indicators (SFY 2014), Ordered by Predictive Strength for WISe Utilization (SFY 2015)



Definitions

CA-Other intensive services. Received other intensive services from Children's Administration in SFY 2014. Primarily consists of services related to treatment foster care, crisis care services, Children's Hospitalization Alternatives Program (CHAP), and Sexually Aggressive Youth (SAY) Treatment.

2. **DBHR-MH Child Long Term Inpatient (CLIP).** Children's Long-Term Inpatient stay in SFY 2014.

3. **DBHR-MH utilization in year at or above the 90th percentile.** DBHR-MH service use at/above 90th percentile based on count of outpatient encounters.

4. **DBHR-MH State Mental Hospitals.** State mental hospital (including Child Study Treatment Center) stay in SFY 2014.

5. **4+ Psychotropic Rx for at least 60 days in year.** Had at least 60 days in SFY 2014 where the child was holding (based on date of fill and days supplied) at least 4 psychotropic medications. Count of 4 or more includes antipsychotics, antimania medications, antidepressants, antianxiety medications, ADHD medications, sedatives and anticonvulsants.

6. **Suicide/self-injury Dx.** Suicide attempt or self-injury diagnosis in medical claim or encounter.

7. **DBHR-MH Community Inpatient.** Community inpatient mental health stay in SFY 2014.

8. **2+ Medical inpatient admissions with mental illness Dx.** Two or more medical inpatient admissions with a mental illness diagnosis on the claim.

9. **RSN crisis encounter.** Received RSN crisis services in SFY 2014.

10. **2+ Emergency department visits with mental illness Dx.** Two or more medical outpatient Emergency Department visits with a mental health diagnosis on the claim.

11. **Drug overdose Dx.** Drug overdose diagnosis in medical claim or encounter.

12. **Other poisoning Dx.** Diagnosis of poisoning by a substance other than drugs of abuse or alcohol in medical claim or encounter.

13. **Convicted, deferred or diverted.** Adjudicated in SFY 2014 with one of the following dispositions, from Administrative Office of the Courts (AOC) data via the Washington State Institute for Public Policy (WSIPP) criminal recidivism database: a. Convicted, including sentencing to JR or county juvenile detention facilities.
b. Diverted or deferred.

14. **CA-Behavioral Rehabilitation Services.** Children's Administration (CA) Behavioral Rehabilitation Services in SFY 2014.

15. **In CA placement in year with >3 lifetime CA out-of-home placements.** In a CA out-of-home placement in SFY 2014, and experienced more than 3 lifetime out of home placements.

16. **Possible suicide/self-injury Dx.** Possible suicide attempt or self-injury diagnosis in medical claim or encounter.

17. **JR services.** Received Juvenile Rehabilitation (JR) services in SFY 2014, including institution stays, community placement, parole, or dispositional alternatives.

18. **Substance Use Disorder (SUD) treatment need flag.** Identified by the occurrence of any of the following:
a. A medical claim or encounter with diagnosis of a substance use disorder.

b. Substance use disorder treatment or detox service use.
c. An arrest for a substance-related offense in the Washington State Patrol database (includes DUI/DWI, drug possession, and related offenses).
19. **Eating disorder Dx.** Diagnosis of anorexia, bulimia, or other eating disorder in a medical claim or encounter.
20. **Homelessness.** Identified based on ACES living arrangement codes and includes status of "homeless without housing" or a shelter stay any time in SFY 2014.

WISe Access Protocol: Prior to implementation, a WISe Access Protocol was established to identify and refer class members for WISe services. The Access Protocol includes the identification, referral, screening, and intake/engagement process for WISe services. The WISe Access Protocol is included in the WISe Manual and provides uniform standards on the administrative practices and procedures for providing access to WISe and its services. The Access Protocol was reviewed and updated in April and July of 2016. WISe providers and BHOs use the protocols to identify youth who might qualify for WISe and conduct an appropriate screen.

At the start of implementation, system partners identified system specific indicators, informed by the data used to identify class members in the Proxy, to identify potential referrals. Monitoring for systemic improvements will continue over time.

The Behavioral Health Assessment System (BHAS), the computer application used to administer and report on the WISe screening tool called the Child and Adolescent Needs and Strengths (CANS), remains in use. Issues with user experience and data entry continue.

An October 2016 survey of BHAS users showed that a number of users have ongoing problems with entering CANS data into BHAS. For example, some report that when they get to the bottom of a page of data entry and hit 'save', the system appears to not save this data and the user has to re-enter that page of data. Another system-wide problem with data entry involved a comment box not working correctly when information was entered into the comment field. Others describe problems on the client level with BHAS reports not showing all fields of data that are expected; the clinician is unable to confirm that all data elements entered were saved. Specifically, there have been instances when the diagnosis field was empty despite the clinician entering that data into the system. Some front-end users have a lack of confidence in that all data elements are being saved in BHAS. All data that is captured in BHAS and administrative data that is reflected in state and regional reports are reviewed and validated by DSHS RDA before dissemination. DBHR is confident that the data provided is accurate, yet recognizes that user functionality needs immediate attention to further the reliability of data and user experience. Efforts to address this problem are detailed in Section III. In the meantime, DSHS RDA staff and DBHR staff continue to review CANS data entered into BHAS and reports prior to dissemination to ensure accuracy of what is reported, including all BHAS data included in this report.

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

The WISe 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 a BHO or any BHO provider.

WISe screening data does not reflect a universal screening effort. Rather, WISe screening data come from select groups including: (1) children referred to the WISe program; (2) children entering/exiting CLIP services or re-screening while in CLIP services; and (3) children entering/exiting BRS services or re-screening while in BRS services. For this reason, the numbers and proportions of CLIP and BRS youth in WISe screening data are substantially inflated relative to their proportions in the overall youth Medicaid population. These are very small programs, with only 189 youth in CLIP in SFY 2015 and only 992 youth in BRS in SFY 2015. In the same fiscal year, there were 904,944 total Medicaid youth age 0-20. It is important for the parties to critically assess whether these or other factors are improperly restricting access to WISe services

From July 1, 2014 through June 30, 2016 (SFY 2015 and SFY 2016), **3,707 WISe screens** were conducted. The table below provides referral sources. The largest referral sources for the WISe program are the BHOs (36 percent), self and family (21 percent), and CA (13 percent). A smaller number of referrals are coming from other mental health services and programs (e.g., crisis services).

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Just over three-quarters (79 percent) of youth referred to WISe by schools have a referral outcome of WISe services. This is slightly higher than the overall average; of all screens conducted in the two-year period, 73 percent had a referral outcome of WISe services.

	SCREENS	
	NUMBER	PERCENT
Referral Source		
MH-Outpatient/BHO	1,342	36.2%
Self & Family	767	20.7%
Children's Administration	487	13.1%
MH-Crisis Services	238	6.4%
Other	224	6.0%
School	173	4.7%
MH-Other	89	2.4%
Community Organization	83	2.2%
Medical Provider	73	2.0%
Juvenile Justice/non-JJRA	53	1.4%
Juvenile Justice/JJRA	51	1.4%
MH-Inpatient/Non-CLIP	45	1.2%
MH-Outpatient/Non-BHO	37	1.0%
MH-Inpatient/CLIP	26	0.7%
MH-Tribal	9	0.2%
Developmental Disabilities Administration	8	0.2%
Chemical Dependency Provider	1	0.0%
Missing	1	0.0%
TOTAL Duplicated Screens	**3,707**	**100.0%**

NOTES: This table presents data for all screens (duplicated) for WISe between 7/1/2014, and 6/30/2016. Youth screened more than once for WISe services over this period are displayed multiple times.
SOURCE: Washington Behavioral Health Assessment System (BHAS).

WISe screening algorithm: The Washington version of CANS and the BHAS computer application reflect an algorithm that was developed to determine which youth, among those screened for WISe, will likely benefit from the service. The initial version of the screening algorithm was developed based on consultation with clinical experts, including Dr. John Lyons, prior to the availability of CANS screening and WISe service data. These data are now available to empirically test the functioning of the algorithm in Washington, and work on analyzing the functioning of the WISe screening algorithm is underway. Although the analysis is not responding to any specific concerns, it may still identify opportunities for refining the algorithm to better and more systematically identify youth across the state who would benefit from WISe services.

This analytical work examines youth characteristics in WISe screening data relative to proxy functional indicators and other risk factors in administrative data and tests algorithm performance against screening results and youth outcomes. WISe screening data items that most strongly predict need for WISe services, including information on out-of-

home placement outcomes, will be identified. The algorithm analysis is complex, involving the cleaning, recoding and restructuring of multiple large datasets; linking data from multiple data sources together with a unique person-level identifier; running and interpreting advanced multivariate statistical models; defining appropriate algorithm results metrics; and considering algorithm combinatorics. Due to the complexity of this work and competing demands from other analytical tasks that support the WISe program, this work is expected to take several months. Results from this work may include a recommendation for a revised WISe screening algorithm and will be available by June 2017.

WISe Manual: Since July 2015, the on-line WISe Manual was updated twice. The first time in April 2016 was to incorporate technical changes of our delivery system changing from RSNs to BHOs, and the second in August 2016 to incorporate policy-related revisions. During the second revision, Section 6, Governance and Coordination of System Partners was revised. A revision this past year removed the requirement for a regional Community Collaborative from the Governance Structure. Based on feedback from stakeholders and review with the WISe Manual Advisory Group, this requirement was viewed as duplicative. The intention of the Community Collaborative was to create a cross-system group (including youth and family representation) to review challenges related to individual youth and their families in the community receiving behavioral health services particularly for WISe yet inclusive of the broader array of mental health services offered. This work is already happening in communities and there are linkages between these workgroups and FYSPRTs. Additional technical changes were made to replace reference to RSNs to Managed Care Entities to incorporate the nine BHOs and the two MCOs in Clark County and Skamania County.

The manual is disseminated to BHOs, WISe provider representatives, the statewide FYSPRT, and Plaintiffs' counsel and is available online at: www.dshs.wa.gov/dbhr/cbh-wise.shtml. On-going training and technical support on compliance with the WISe Manual has been provided this past year. More information is available in Objective 5: Workforce Development and Infrastructure.

Quality Improvement: The Quality Management Plan (QMP) 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 T.R. 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 QMP 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 BHAS becomes more accurate. This is not to say that current reports are

inaccurate; rather, the gap is that the system is not capturing the richest data possible because the contractor has been unable to make requested enhancements to the BHAS system, (e.g., removing clients who do not require a reassessment from the reassessment report as well as increased specificity regarding CLIP/BRS assessments). DBHR continues to work with its contractor, the Praed Foundation, toward this goal. Options on how best to move forward with BHAS and increase user functionality are currently being reviewed (See Section III, Implementation Challenges for additional information).

DBHR continues to use the quarterly reports to familiarize the BHOs with the expectations for the quarterly review set forth in the Quarterly Data Review Protocol (Appendix D of the QMP). The reviews include assessing performance on access, engagement, service appropriateness, service effectiveness, and linkages. The BHOs are submitting their reviews on time and are implementing improvement projects based on the data in the reports. Examples include providing more services in the community rather than the mental health facility (reducing frequency of services provided in the mental health agency from 44 percent to 34 percent) (Spokane County BHO). Progress on this goal is reported to the Regional FYSPRT. One BHO is clarifying and developing WISe practices with the goal of reducing the proportion of clients who leave WISe prior to the end of the 180-day authorization. They have achieved a 16 percent reduction. All BHOs are working on improving both screening and full assessment timeliness. Additional information on timeliness is included on the following page.

As shared in last year's annual report, examples of multi-level BHAS outcomes reports, some of which are still being tested, 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 are designed to reflect assessments of clinical performance at each level of the system, and may be configured to provide assessments of previous performance. (For report outcomes see Objective 3, WISe Outcomes.) Once BHAS report validation is completed, quarterly reports by BHO and statewide will be posted on the DBHR website to inform stakeholders and ensure transparency (See Section III, Implementation Challenges for more information). Quarterly reports will be aggregated to protect health information and to comply with state and federal confidentiality laws.

One of the BHAS reports included in the quarterly report is the Screening Timeliness Report. Of the 2,145 screens conducted in SFY 2016**, 83 percent were conducted within 14 days of referral**, the standard for screening timeliness. The timeliness of screens improved slightly over the course of the fiscal year. For six regions, the screening timeliness was near or above 90 percent across the fiscal year. For two regions that continued providing services from SFY 2015, the screening timeliness increased over the

course of the fiscal year (from 64 percent to 79 percent). For two regions that began providing WISe services in SFY 2016, screening timeliness was lower, and expected to improve as services become more established.

Quarter	Screens	% Timely
Q1: JUL-SEP 2015	364	81%
Q2: OCT-DEC 2015	483	82%
Q3: JAN-MAR 2016	645	82%
Q4: APR-JUN 2016	653	85%
SFY 2016 Total	**2,145**	**83%**

NOTES: A screen is considered timely if it is completed within 14 days of referral. A total of 2,145 WISe screens (CANS screens) for all ages were conducted in FY 2016. Some youth have multiple WISe screens (CANS screens) in the date range, and are represented multiple times in the above numbers.
SOURCE: Washington Behavioral Health Assessment System (BHAS).

Statewide Measures of Performance: The first annual WISe Statewide Measures of Performance "dashboard" was completed in January 2016. It is designed to provide an overview of demographics and characteristics of the youth who receive WISe, the types of services provided, and outcomes. Quarterly updates on specific measures were completed in April 2016 and October 2016.

The 2016 third quarter update includes:

- The number and characteristics of youth screened for WISe and youth receiving WISe services July 1, 2014 through March 2016. Characteristics include demographics, behavioral health history, cross-system involvement, and functional proxy indicators.
- WISe service characteristics for youth served in WISe July 1, 2014 through March 2016, 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 CANS scores.
- Wise Progress to Initial Full Implementation Target by RSN and County, Data available as of April 2016.

The second annual update will be completed in January 2017 and posted to the DBHR website.

The WISe "dashboards" indicate:

- The 1,705 youth in WISe services between July 1, 2014 and March 31, 2016 received a total of 148,379 hours of outpatient care under the WISe program. They were frequently served in home-and community-based settings in addition to office settings.

- In general, youth served in the WISe program have more severe mental health needs and associated risk factors than youth in the WISe proxy. There are additional opportunities to link youth with WISe services in some areas (e.g., youth with co-occurring substance use disorders or juvenile justice involvement).
- Youth in WISe services experience measurable reductions in treatment needs and measurable increases in strengths over their first six months in services, based on CANS data. These positive changes are observed in every region operating the WISe program.
- WISe services are becoming available to youth in more regions of the state over time as the rollout continues. As of April 2016, youth in eight of ten Washington regions were receiving WISe services, and one region's monthly caseload had met the full implementation target.

Objective 2 - Remaining Tasks:

- By June 2017, results from the review of WISe screening algorithm and any potential recommendations will be available.
- By August 2017, complete the annual review of the WISe Access Protocol and update as necessary.
- By August 2017, complete another review of the WISe Manual for any needed updates.
- Annual updates to of the Statewide Measures of Performance for WISe; quarterly updates for some measures.
- Continue to monitor WISe screens for BRS and CLIP and analyze cross-system barriers to WISe access that should be addressed.
- Resolve issues related to BHAS (see Section III, Implementation Challenges, BHAS).
- Continue to review and report timeliness standards.
- Post BHO and state-level Quarterly Reports to DBHR website once all BHAS reports complete validation for accuracy. (See Section III. Implementation Challenges, BHAS).

Objective 3: Provision of WISe

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

Progress and Accomplishments:

Named Plaintiffs' Workgroup: As of September 2016, one of the original ten named plaintiffs is receiving behavioral health services; this youth transitioned out of WISe and is receiving outpatient mental health services to meet his current level of care needed. The

other nine named plaintiffs have aged out, opted out, or moved out of the class. Named Plaintiff Workgroups were identified in August 2014 and regular meetings were held to monitor progress of the one remaining class member.

WISe Participants: **A total of 1,705 youth** received WISe services between SFY 2015 Q1 and SFY 2016 Q3 (July 1, 2014 to March 31, 2016).

A table below identifying the demographic characteristics of WISe recipients is set forth below.

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	ALL YOUTH RECEIVING WISe SERVICES (SFY 2015 Q1 - SFY 2016 Q3)	
		%
Gender		
Female	655	38.4%
Male	1,049	61.5%
Unknown	1	0.1%
Age Group		
0-4	15	0.9%
5-11	574	33.7%
12-17	1,069	62.7%
18-20	46	2.7%
Unknown	1	0.1%
Race/Ethnicity		
Non-Hispanic White	797	46.7%
Minority	907	53.2%
Unknown	1	0.1%
Minority Category (not mutually exclusive / do not sum to 100%)		
Hispanic	367	21.5%
Black	248	14.5%
American Indian / Alaska Native	240	14.1%
Asian / Pacific Islander	112	6.6%
TOTAL POPULATION	**1,705**	

NOTE: One youth served in the WISe program could not be linked with demographic characteristics in administrative data.
SOURCE: RDA Integrated Client Database.

WISe Program Model: The **1,705 youth in WISe services** between SFY 2015 Q1 and SFY 2016 Q3 (July 1, 2014, to March 31, 2016) received a total of **148,379 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. This is more than four times as many hours as received on average by other youth age 0-20 with any DBHR outpatient services (including WISe); the average for this group is three hours of services per 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 percent) and MA/PhD (37 percent). Approximately one-sixth of all service hours (17 percent) were delivered by peer counselors.

The current service location data shows that service hours were most frequently delivered in the youth's home (39 percent) and mental health outpatient facilities (29 percent;

includes “office”, “independent clinic”, “community mental health center”). Five percent of service hours were also delivered in schools, and a large number of service hours (25 percent) were delivered in settings other than those listed in the table below. The above statistics are impacted by a known data issue for Greater Columbia BHO, for which all encounters are currently defaulting to outpatient facility even when provided in another setting. Removing Greater Columbia from the analysis, the proportion of WISe services delivered in outpatient settings drops to 20 percent. In contrast, two-thirds of all DBHR youth outpatient encounters are delivered in outpatient settings.

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The top five service modalities, by hours of WISe services are: individual treatment services (34 percent), peer support (17 percent), child and family team meeting (16 percent), family treatment (10 percent), and care coordination services (10 percent).

	ALL WISe SERVICES (SFY 2015 Q1 - SFY 2016 Q3)	
	NUMBER	PERCENT
WISe Clients (unduplicated)	1,705	
Service Encounters	152,651	
Service Hours	148,379	
Service Months	10,638	

	HOURS	
Below Masters Level	63,809	43.0%
MA/PhD	55,071	37.1%
Peer Counselor	24,451	16.5%
Other	3,019	2.0%
Psychiatrist/MD	1,912	1.3%
Designated MH Professional	118	0.1%

	HOURS	
Home	58,375	39.3%
Mental Health Outpatient Facility	42,375	28.6%
Other	37,517	25.3%
School	7,603	5.1%
Emergency Room – Hospital	1,676	1.1%
Residential Care Setting	419	0.3%
Correctional Facility	415	0.3%

	HOURS	
Individual Treatment Services	50,608	34.1%
Peer Support	25,504	17.2%
Child and Family Team Meeting	23,501	15.8%
Family Treatment	15,161	10.2%
Care Coordination Services	15,013	10.1%
Crisis Services	5,420	3.7%
Other intensive services	3,984	2.7%
Intake Evaluation	2,310	1.6%
Group Treatment Services	2,192	1.5%
Medication Management	1,714	1.2%
Rehabilitation Case Management	1,402	0.9%
Involuntary Treatment Investigation	976	0.7%
Interpreter Services	339	0.2%
Therapeutic Psychoeducation	149	0.1%
Psychological Assessment	55	0.0%
Integrated SUD/MH screening	27	0.0%
Medication Monitoring	16	0.0%
Integrated SUD/MH assessment	11	0.0%

NOTE: WISe services include all mental health outpatient service encounters submitted to CIS with the WISe "U8" modifier and other WISe-approved outpatient services received in a month with at least one "U8" service. Service
provider type, location, and treatment modality are based on the distribution of WISe service hours.
SOURCE: RDA Integrated Client Database.

Service Coordination: DBHR, with system partners, reviewed requirements/protocols related to: referral to WISe, participation in Child and Family Teams (CFTs) and transitions out of WISe. No changes have been made to date. However, one change has been requested related to assessment timeliness and the 30 day time frame for the completion of the Full CANS assessment. BHOs and WISe agencies have requested that the tracking of this timeliness standard start at intake into services versus the completion of the WISe screen. This request is currently under review, Data was presented to Plaintiffs' counsel in September 2016, and a determination should be made during the next TRIAGe meeting at the end of November 2016.

System partners reviewed the access protocols in June and July 2016. They also reviewed the information provided on the information sheet, specific to their affinity group, and made changes as necessary regarding referral and CFT information. DBHR meets with BHO Care Coordinators on a quarterly basis. Review for updates to the protocols will continue over the next year. Additionally, DBHR and various system partner representatives meet regularly with RDA to review data related to service coordination. Work in the coming year will include planning meetings with HCA, CA, Coordinated Care of Washington (CCW) and DBHR to guide the transition of service benefits scheduled for October 2018. Currently, CCW provides physical health (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees. In October 2018, CCW will begin to provide the full continuum of outpatient mental health benefits including WISe. CWW will contract directly with community providers for mental health services that are currently provided through contracts with BHOs and other MCOs.

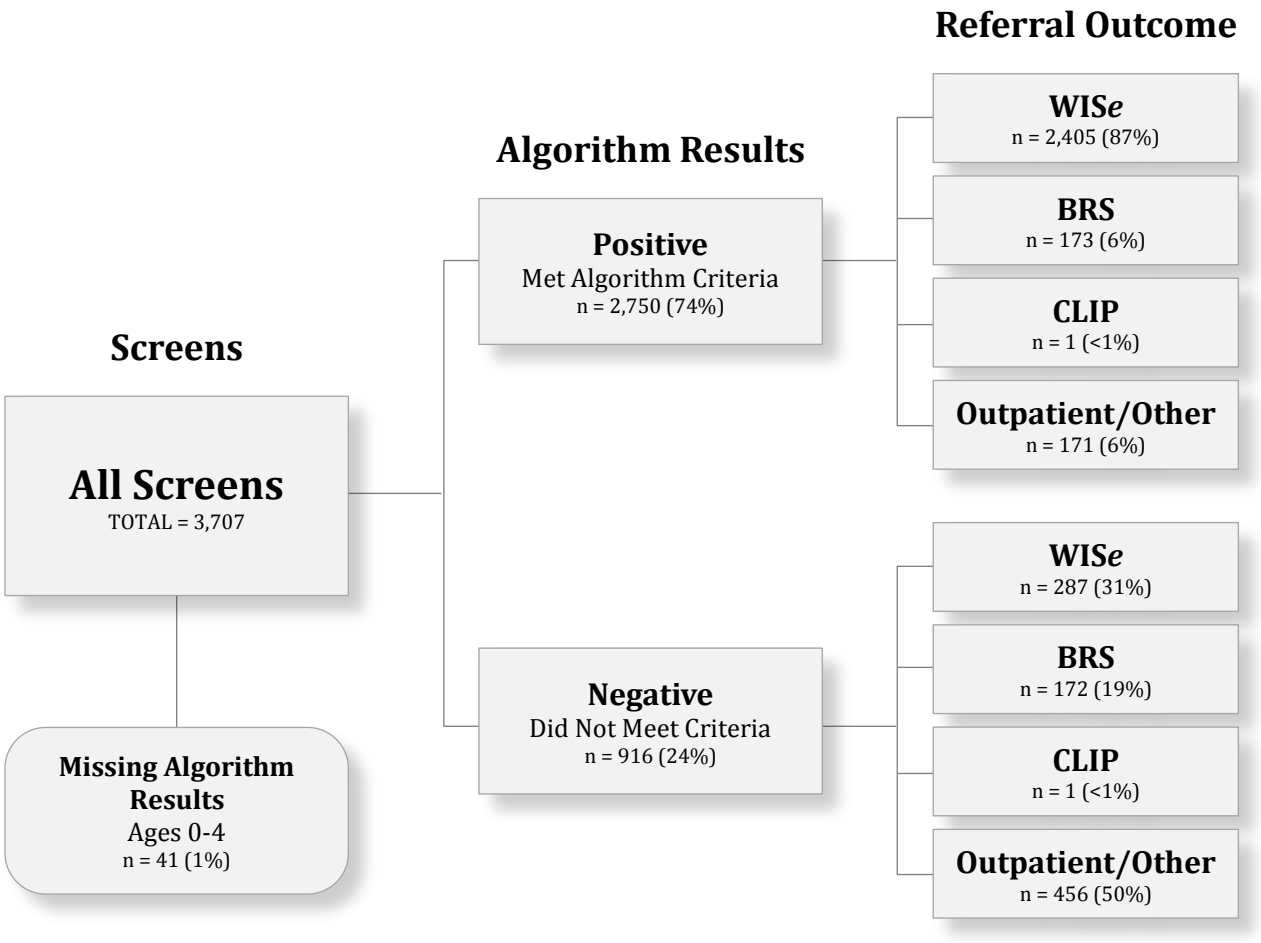
Transitions: In total, nine percent of the 3,707 WISe screens conducted in SFY 2015 and SFY 2016 (July 1, 2014 to June 30, 2016) resulted in a service recommendation of BRS or CLIP. For most of these screens, the person making the referral for WISe screening had originally recommended BRS or CLIP as the most appropriate service placement for the youth in question. Many of those youth whose screening resulted in a service recommendation of BRS or CLIP likely were already engaged in BRS or CLIP at the time of screening, and thus the screening represents a recommendation to continue in the current setting.

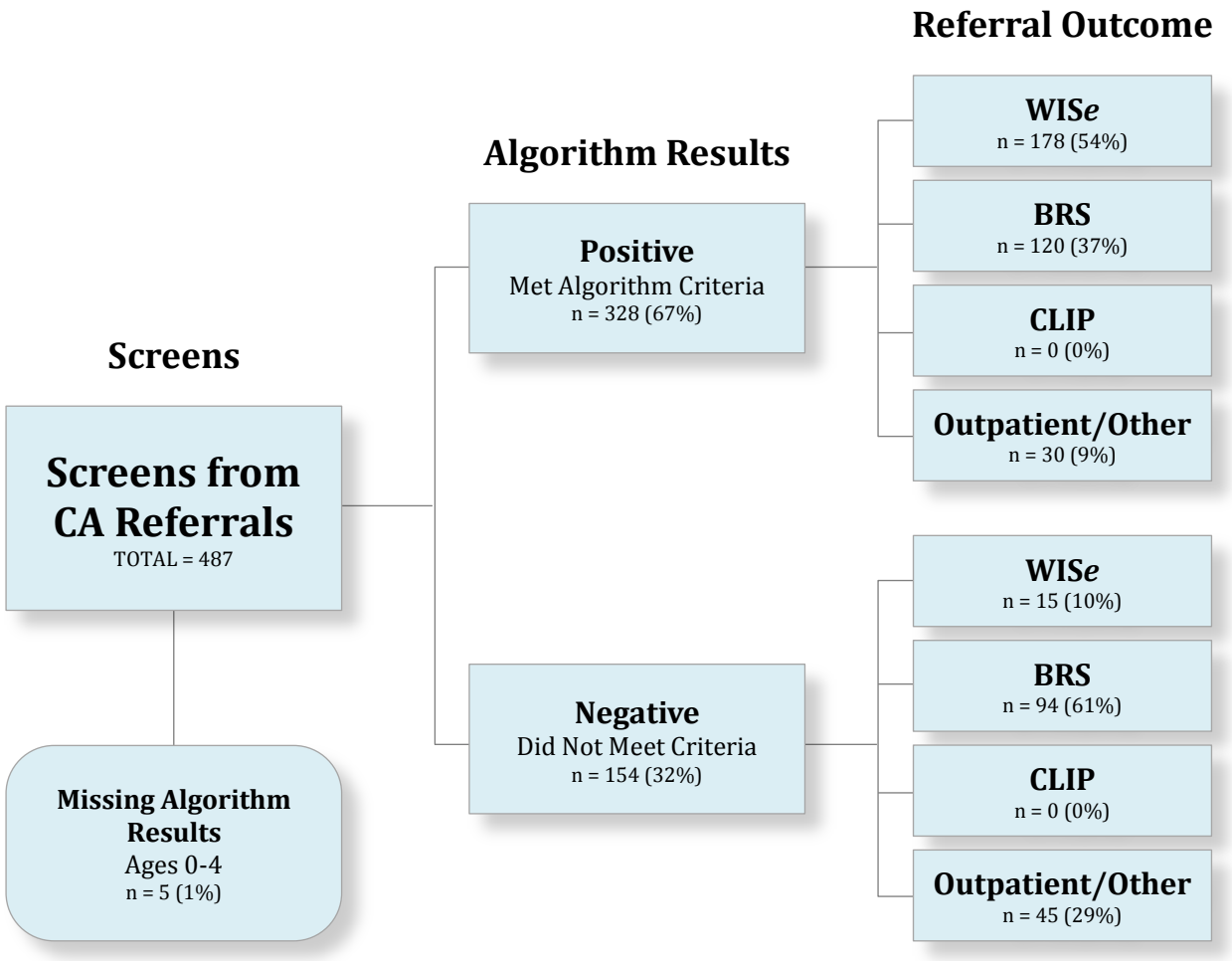
This past summer CA headquarter staff visited field offices to gain an understanding of their staffs' utilization of WISe referrals. Based on these visits, CA staff are knowledgeable on the availability of WISe and are making referrals as early as possible.

In the table below, the BHAS data currently show that about two-thirds of youth for whom the referral source is CA meet algorithm criteria for entry into WISe, and 37 percent of these youth have a referral outcome of BRS. Of the 26 screens with referral source of CLIP, the vast majority (96 percent) have a referral outcome of WISe.

WISe Screening Results, SFY 2015 – SFY 2016

July 1, 2014 to June 30, 2016





DATA SOURCE: Behavioral Health Assessment System (BHAS)

NOTE: The numbers displayed above are duplicated screens, not consumers. Counts are duplicated where an individual has multiple screens in the time frame. Subgroups may not total 100% due to rounding error.

The BHAS data system is currently undergoing modifications to more clearly track these cross–system referrals. The modifications will provide a drop down menu so that the WISe practitioner can include detail about the referral outcome, including why a youth may have screened positive for WISe but did not transition into WISe (e.g., need for placement, family opted out, WISe not yet available in the community.) DBHR, RDA, CA, and T.R. Plaintiffs' counsel will continue to work on analyzing this data and evaluating training needs to better understand why CA youth who meet algorithm criteria for entry into WISe do not transition into WISe.

Children's Long-Term Inpatient Program (CLIP): The majority of youth discharging from CLIP are transitioning into WISe services in locations where WISe is available. Prior to admission to CLIP, youth receive a CANS screen to determine whether a less restrictive level of care can meet their needs. Children and youth are to receive a full CANS assessment within the first 30 days following admission to CLIP, a CANS screen every six months while in CLIP, and another full CANS assessment is to be completed within 30 days before the youth is discharged from CLIP.

In reviewing the data, it appeared that the CLIP facilities had not been completing the six-month WISe screens. A six-month independent Recertification Review of medical necessity

for continued need for inpatient care is completed for all youth in CLIP, regardless of legal status. Re-certification services include a treatment summary that is developed in collaboration with the youth, family, Community/WISe Team, and the CLIP Treatment Team. The re-certification also describes the youth's progress in treatment, determination if less restrictive services can meet current treatment needs, the goals for continued stay, steps needed for discharge, anticipated discharge timeline, as well as input from the youth, family and community/WISe team. While Recertification Review for medical necessity is taking place, Plaintiffs' counsel is concerned that without the six-month WISe screen, the reviewing team does not have adequate data to inform its decision regarding least restrictive services. While DBHR remains committed to meeting the six-month CANS requirement, CLIP treatment plan reviews and discharge planning incorporates detailed information regarding readiness for discharge and placement options even without the CANS screen.

DBHR informed the CLIP Directors that the CANS six-month screening requirements are a contract expectation. As of September 2016, there has been monthly monitoring from the DBHR CLIP Administrator for completion of the CANS screens. The monitoring reports will be provided directly to CLIP Directors. As the roll-out of WISe progresses, the CLIP Administrator will participate in any relevant discussions involving service transitions to and from CLIP and the community as well as the administration of the CANS tool within the CLIP Programs. In addition, the State will provide status updates to T.R. Implementation Advisory Group (TRIAGe) this coming year.

CLIP Programs have made improvements since last year in entering CANS assessment data into BHAS. Full CANs assessments are up significantly from last year. The BHAS data entry issues are especially challenging for direct clinical care staff in the CLIP Programs. DBHR is addressing the BHAS data entry issues by providing face-to-face direct technical assistance to CLIP Program staff. This is already demonstrating improvements. Continued efforts are underway at all CLIP Programs and will continue until full proficiency of CANS data entry into the BHAS system is demonstrated across the entire CLIP system.

Most youth receiving full CANS at the time of discharge from CLIP receive a service recommendation of WISe as part of their discharge plan. When youth have a WISe team involved before admitting to a CLIP facility, some WISe team members are remaining involved throughout the youth's CLIP treatment by participating in treatment plan reviews and/or discharge planning, resulting in improved continuity of care from the community to CLIP and back to the community. For youth engaging in WISe for the first time, the CLIP Coordinator, CLIP facility staff, Managed Care Entities, CLIP Liaisons and BHO CLIP Designees make active efforts to have WISe teams begin working with the youth, family, and CLIP treatment teams as early as possible prior to discharge.

WISe Outcomes: From quarterly reports, data were gathered to provide information on 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 between SFY 2015 Q1 and SFY 2016 Q3, and subsequently completed a six-month CANS follow-up assessment (youth in WISe are assessed every 90 days). The

data show improvement in WISe recipients' level of functioning. This suggests that WISe is beneficial to the youth's wellbeing.

The table below reflects positive changes experienced over the first six months of WISe treatment for the 514 children and youth ages 5-20 who received an initial and follow-up CANS assessment. The top five **behavioral and emotional needs**, by proportion at intake/initial assessment, are shown. A decline at the time of the six-month reassessment represents improvement for these measures, i.e., a decrease in the proportion of children and youth with clinically significant treatment needs in these areas. A decline at the six-month reassessment represents clinical improvement.

CLINICALLY SIGNIFICANT IMPROVEMENTS OVER TIME

Behavioral and Emotional Needs

Top 5 behavioral and emotional needs at intake shown

Behavioral/Emotional Needs, *N=514*	**Intake**	**6 Mos.**
Emotional control problems	82%	58%
Attention/impulse problems	71%	60%
Mood disturbance	71%	51%
Oppositional behavior	64%	46%
Anxiety	60%	51%

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):

  Adjustment to Trauma; Conduct; Psychosis; Substance Abuse.

Risk Factors, Clinically Significant Improvement Over Time, is a table that shows the top five **risk factors** for children who entered WISe and completed an initial CANS assessment between SFY 2015 Q1 and SFY 2016 Q3 (July 1, 2014 to March 31, 2016), and subsequently completed a six-month CANS follow-up assessment. The following chart reflects the changes experienced over the first six months of WISe treatment for 514 children and youth ages 5-20. A decline at the six-month reassessment represents clinical improvement.

CLINICALLY SIGNIFICANT IMPROVEMENTS OVER TIME

Risk Factors

Top 5 risk factors at intake shown

Risk Factors, *N=514*	**Intake**	**6 Mos.**
Decision-making problems	66%	49%
Danger to others	47%	25%
Intended misbehavior	36%	26%
Suicide Risk	28%	11%
Non-suicidal self-injury	25%	11%

Definitions of top five risk factors:• Decision-Making Problems: Youth's difficulty anticipating the consequences of choices, and lack of use of developmentally appropriate judgment in decision making.• Danger to Others: Youth's violent or aggressive behavior, the intention of which is to cause significant bodily harm to others.• Intended Misbehavior: Problematic social behaviors that a youth engages in to intentionally force adults to sanction him or her (e.g., getting in trouble, suspension/expulsion from school, loss of foster home).• Suicide Risk: Presence of thoughts or behaviors aimed at taking one's life.• Non-Suicidal Self-Injury: Repetitive behavior that results in physical injury to the youth (e.g., cutting, head banging).• Other risk factors on CANS assessment that are not in the top five at intake (and not shown here): Medication Management; Other Self-Harm; Runaway.

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The following chart shows growth in **child and youth strengths** for children who entered WISe and completed an initial CANS assessment in SFY 2015 Q1 through SFY 2016 Q3, 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 514 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.

STRENGTHS DEVELOPMENT OVER TIME

Child and Youth Strengths

Top five child and youth strengths by growth over time shown

Strengths, *N=514*	Intake	6 Mos.
Educational system strengths	59%	77%
Resiliency	41%	57%
Optimism	51%	65%
Family	53%	66%
Recreation	39%	51%

Definitions of top five strengths shown:
- Educational System Strengths: School works with and/or advocates on behalf of the youth and family to identify and address the youth's educational needs, or the youth is performing adequately in school.
- 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.
- Optimism: Ability of youth to articulate a positive vision for his or her future.
- Family: Youth has a sense of family identity, and there is love and communication among family members.
- Recreation: Youth has identified and utilizes positive leisure time activities.
- Other strengths on CANS assessment that are not in the top five in terms of growth over time (and not shown here): Community Connections; Natural Supports; Primary Care Physician Relationship; Relationship Permanence; Resourcefulness; Spiritual/religious; Talents/interests; and Vocational Strengths.

WISe Statewide Rollout and Capacity Development: As of October 2016, 28 of Washington's 39 counties have started implementing WISe. The additional 11 counties are scheduled to have WISe available by June 2018. During 2017, for the new counties, their BHO will work to identify qualified agencies to start workforce recruitment and the WISe training process. Many of the remaining counties are rural areas. The WISe service delivery model will need to continue to be adaptive and responsive to the strengths and needs of these outlying areas. During this expansion, there is an opportunity to learn from other national implementation efforts and what has worked when building capacity for WISe-like services in similar rural areas. For those counties currently implementing WISe, BHOs will continue to offer oversight to their contracted provider agencies to expand capacity by hiring and training new staff for WISe teams. BHOs meet once or twice a month with their WISe providers to review implementation challenges and successes. As of April 2016, the nine BHOs across the state are reporting to DBHR bi-monthly on WISe capacity status. With fully

integrated managed care being implemented in the southwest region, HCA is the contracting agency and will continue to work with the plans to increase capacity in Clark and Skamania County. As reported in the past two annual reports, WISe capacity expansion continues to have challenges due to the behavioral health workforce shortage in Washington. This will be further addressed in Section III of the report.

As of October 2016, the counties currently implementing WISe are shaded in the map below.

The following information identifies that all BHOs and Southwest Fully Integrated Managed Care (FIMC) are in the process of implementing WISe and progress towards the initial full capacity estimate target for June 2018.

WISe Progress to Full Implementation Target by Region as of September 2016, Based on Caseload Counts Reported Directly by BHOs

Region	**WISe Caseload September 2016 (as reported by BHOs*)**	**Initial Mid-Level Monthly Service Target (by June 2018)**	**Progress to Target**
Washington State Total	**1,332**	**2,985**	**45%**
Great Rivers BHO *Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum*	63	203	31%
Greater Columbia BHO *Asotin, Benton, Columbia, Franklin, Garfield, Kititas, Klickitat, Walla Walla, Whitman, Yakima*	270	418	65%
King County BHO *King*	254	527	48%
North Central BHO *Chelan, Douglas, Grant*	24	90	27%
North Sound BHO *Island, San Juan, Skagit, Snohomish, Whatcom*	217	460	47%
Optum Health Pierce BHO *Pierce*	149	345	43%
Salish BHO *Clallam, Jefferson, Kitsap*	32	189	17%
Southwest FIMC *Clark, Skamania*	116	201	58%
Spokane CR BHO *Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens*	47	410	11%
Thurston-Mason BHO *Mason, Thurston*	160	142	>100%

NOTES: 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). *September 2016 caseload numbers shown here were reported directly by BHOs to DBHR. This differs from previous reports, in which caseload numbers were based on administrative data generated from Medicaid service records in the ProviderOne data system. Due to a transition in DBHR's data collection and reporting infrastructure, administrative data on WISe services are currently incomplete after March 31, 2016. The numbers reported here should be considered tentative counts, which may differ from counts based on administrative data once they become complete (current date unknown).

The State is 45 percent towards meeting the full implementation target for the mid-level range; last year at this time progress was 18 percent. This means that statewide there is a monthly caseload capacity to serve approximately 1,400 youth and their families. Under the mid-level target, the goal is to have a monthly caseload capacity statewide to serve 3,000 youth and their families. Progress toward the mid-level target for individual regions is identified in the table above. As the last two annual status reports have indicated, there is on-going difficulty with hiring and retaining qualified staff. BHOs and agencies continue to focus on recruitment to build additional WISe teams, some conducting national searches to identify qualified staff. Other BHOs have provided outreach to their local universities and colleges to recruit new graduates. A few WISe agencies have increased salaries to assist with staff recruitment and retention. Across most of the state, BHOs and behavioral health agencies continue to find the behavioral health workforce shortage their biggest challenge.

DBHR is in the process of meeting with each BHO and their contracted WISe agencies to learn more about regional difficulties with the behavioral health workforce shortage.

- BHO and WISe provider staff reported: Hiring is even more difficult than last year with positions open for months without any applicants.
- For two agencies, collective bargaining agreements prohibited differential pay for those staff providing WISe. Wages for staff that work a traditional work schedule such as Monday through Friday from 8 a.m. to 5 p.m. make the same salary as a WISe staff that are required to work evenings, weekends and at times on call 24/7. In addition, lived experience for peer counselors is not viewed as work experience and the salary for peer counselors can be less than the agency receptionist.
- No pay differential for staff that provide 24/7. Some are provided a per diem but receive the same salary as their peers. Again, no differential pay for agencies that are union.
- Various child-serving systems and agencies are completing for the same behavioral health workforce.

Further investigation and work will be undertaken in the next year to understand with more specificity why these workforce issues exist. For example, which recruitment strategies have been tried and found to be effective or not effective? Which supervision structures best support retaining qualified staff? As the services continue to roll out statewide, it is important to better understand if there are administrative constraints that impact providers' ability to scale up WISe services, such as regulatory, subcontracting, and licensing issues.

Some BHOs continue to voice their concern that the mid-level capacity targets identified in the July 2014 "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 original Implementation Plan, review of WISe capacity

needs should happen annually and should direct adjustments as needed. For the BHO contract, April 1, 2016 through June 30, 2017, capacity targets were set to the low-level range for implementation.

Per DBHR's request, the RDA team reviewed capacity targets in late 2015 for needed adjustments by updating the proxy data estimating the number of youth with indicators of likely needing WISe. Notably, the 2015 proxy did not validate the concerns raised by BHOs about mid-level capacity targets. There is no data indicating that there are fewer youths for whom WISe is medically necessary.

In March 2016, Plaintiffs' counsel informed the State that they were deeply troubled that they were not notified of the decision to lower contractual capacity targets until after it was already final. Plaintiffs' counsel asserted that none of the reasons for the State's decision to reduce its capacity targets to the lowest utilization estimate were based on any evidence that there were fewer youth in Washington who need WISe. Rather, the decision was based on implementation challenges, as discussed in more detail in the challenges section below. Over the next year, further work will be undertaken to understand and address these capacity issues, and capacity targets will need to be reviewed again.

Youth, Family and Caregiver WISe Survey: The statewide youth survey was conducted July through September 2016. Results from this survey are expected in December 2016. Once DBHR receives the final report, the outcomes from the survey will be disseminated.

WISe Budget: For SFY 2017, the following chart describes DSHS's budget for intensive mental health services for high needs youth to continue implementing the commitments set forth in the T.R. Settlement Agreement. The below is the requested budget and not final until enacted.

WISe Budget	FY17
State	$24,0707,00
Federal	$23,458,000
Total WISe Budget (includes Salaries & Encounters)	**$47,528,00**

WISe Case Rate Payment: In accord with the settlement agreement, WISe is being implemented incrementally with the intention that the delivery model be statewide in 2018. At the time of initial 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 made to the BHO monthly for each WISe recipient served. In addition, a capitated payment is made to the BHO on a Per Member Per Month (PMPM) basis.

The WISe case rate for SFY 2016 was $2,115.67 plus the PMPM for a WISe eligible youth. PMPMs are determined by service history and cost analysis within the defined service region. BHOs get a premium for every Medicaid eligible living in that geographic region.

BHOs use various payment methods with their contracted providers: sub capitation, allocations, or fee for services per claim, per client or case rate. In April 2016, as RSNs transitioned into BHOs, the case rate increased to $2,156.34 plus the PMPM per WISe eligible youth per month; this rate will remain until the next actuarial review is completed.

In August 2016, Mercer started reviewing WISe encounter data to determine whether a financial experience adjustment is warranted; this review will continue through December 2016 to set rates for SFY 2018, which starts July 1, 2017.

Plaintiffs' counsel have stressed their view of the importance of establishing a case rate that accurately reflects the costs of providing WISe services. Plaintiffs' counsels' view is that in order to build capacity within the system, the case rate must reimburse providers such that they can build up this service model and deliver WISe effectively. DBHR is still in the process of gathering data about how payments interact with capacity development. While rates have been identified in some BHOs as an issue, this has not been reported by all BHOs. Assessing this information is part of the work of the national consultant discussed in other places in the report. Plaintiffs' counsel are concerned that focusing on concerns or information generated by the BHOs is not sufficient to adequately investigate this question and have requested that DBHR seek information directly from providers about how payments impact their ability to build programs. Over the next year, Plaintiffs' counsel would like more information about what the BHOs report and the rate setting process, with the goal of both parties being to ensure reasonably adequate payments for WISe statewide.

Last year at this time as indicated one of the Implementation Challenges, a number of ongoing issues were encountered for the case rate payments due to established coding within Provider One, the Medicaid payment system. To resolve this issue, starting in the fall of 2015, DBHR dedicated fiscal staff to directly review, generate, and monitor WISe Service-Based Encounter payments for BHOs. This process was tested, phased in, and fully implemented in January 2016 thereby correcting the payment issue identified in last year's report.

Objective 3 - Remaining Tasks:

- Annually review with system partners, protocols related to: referral to WISe; participation in CFTs; and transitions out of WISe. Next review to be completed by December 31, 2017.
- Review data regarding youth who screen positive, for WISe but do not receive WISe services, to evaluate systemic barriers to access that should be addressed, in particular with youth in CA and JR.
- Continue to review implementation of CANS for care planning at CLIP facilities.
- Continue to build sufficient provider capacity and address workforce challenges to meet the statewide need for WISe services by June 30, 2018. (See Section III, Implementation Challenges, WISe Roll Out)
- Review WISe capacity needs annually and make adjustments to capacity targets based on data.

- Continue to post on the DBHR website, a list of qualified WISe providers by county.
- Continue to monitor capacity/utilization through fiscal reports and the BHO bi-monthly monitoring reports.
- Continue to update the QMP, when indicated, for the provision of improvement of WISe services and supports, and evaluate quality and quality improvements needed in WISe.
- Collect and analyze qualitative and quantitative data that will assist in obtaining a more detailed understanding regarding capacity challenges.
- Work with HCA, CA and CCW to ensure CCW is prepared to implement WISe services for foster youth.
- Ensure BHOs and providers have accurate information about proxy predictors of need for WISe to assist them in reaching WISe capacity targets.
- Defendants will share information with Plaintiffs' counsel regarding the Mercer rate adjustment process and efforts to ensure adequate funding for WISe services through supplemental budget requests, if necessary.

Objective 4: Coordinating Delivery of WISe Across Child-Serving Agencies

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

Progress and Accomplishments:

This past year, the interagency Memorandum of Understanding (MOU) to coordinate services was reviewed and updated with an effective date of July 30, 2016. The MOU describes the mutually supportive working partnernships amongst the various DSHS administrations; Behavioral Health Administration, CA, Developmental Disablities Services Administration, Juvenile Justice and RA and with the HCA as they relate to the community-based mental health needs and service delivery systems for children and youth with significant emotional and behavioral health needs, and their families, who are typically served by more than one state agency. Consistent with the T.R. Settlement Agreement, the MOU supports agencies continuing to develop cross-system protocols to coordinate services for these youth and their families. The MOU will be reviewed again in 2019.

DBHR continues to work closely with representatives from other administrations within the DSHS and with representatives from HCA. Below are highlighted WISe-related activities as reported from our state system partners.

Children's Administration reports the following activities over the past year:

- Continued mental health trainings for new and on-going staff have been offered statewide. There were a total of 34 Regional Core Trainings and 4 In-Service Trainings reaching over 330 staff total. The In-Service trainings were offered in Seattle, Tacoma, Yakima and Spokane.
- Updates from CA to the WISe information sheet.

- Ongoing communication with BRS contractors and Regional CA staff regarding the WISe informational sheet and WISe referral contact list.
- In person consultation with statewide BRS managers to understand local WISe implementation strengths and challenges.
- Ongoing implementation support to BRS Contractors and CA offices regarding WISe referral requirements, BHO contacts, and overall information when WISe is newly implemented in a county.
- Ongoing participation in WISe program coordination, communication, implementation planning, and dissemination including but are not limited to, Statewide FYSPRT meeting, WISe Manual Advisory Group meeting, Children's Behavioral Health Data and Quality Team meeting, TRIAGe meeting, WISe Advisory Work Group meeting, WISe Communication meeting, System of Care Leadership meeting, Transformational Collaborative Outcomes Management/CANS training, and WISe Community Training.

Health Care Authority reports the following activities over the past year:

Beginning April 1, 2016**,** HCA made several significant changes to its Medicaid/Apple Health program benefiting all clients of Washington State. These changes included policies to promote early enrollment into managed care, fully integrating physical and behavioral health in one region of the state and integrating physical and behavioral health for the foster care/adoption support population.

HCA continued its support of the elements related to the T.R. Settlement Agreement in the following ways:

- HCA continues to participate actively in the T.R. Implementation Advisory Group and related efforts.
- HCA is now responsible for WISe implementation and oversight in Clark and Skamania Counties, the first region in the state to fully integrate psychical and behavioral health. WISe continues to be provided by one WISe agency without service disruption. Agency staff continues to work closely with DBHR to ensure consistent practice in all areas.
- HCA continues to communicate with its providers and the managed care plans about appropriate prevention and early intervention activities to prevent the need for more intensive services.
- Efforts are in place to expand the provider network for lower-level mental health treatment and to ensure up-to-date information related to the WISe implementation across the state.
- HCA continues to track the use of evidence-based practices in lower-level mental health treatment across plans as well as across the entire continuum of mental health services in Clark and Skamania Counties.
- HCA participates actively in the Children's Behavioral Health Governance structure including the Executive Leadership team, the Statewide FYSPRT, and all subcommittees.

- HCA acts as a co-chair of the Children's Behavioral Health Data and Quality Team.

HCA is working with DBHR to align behavioral health quality monitoring plans for consistency across the BHOs and Managed Care Organizations (MCOs).

Juvenile Rehabilitation reports the following:

JR continues collaborative work with youth and families, and the administration supports and integrates the principles of System of Care as it partners across systems with state and local partners. These partners include other DSHS administrations, community behavioral health professionals, juvenile courts and legal advocates.

JR continued its support of the elements related to the T.R. Settlement Agreement in the following ways:

- Wraparound with Intensive Services (WISe)
  - JR has worked closely with DBHR and other system partners to inform and train JR staff in the WISe model and continue WISe implementation into the JR system.
  - A WISe webinar that entailed an overview of WISe services, including how to make referrals to WISe, the Child and Adolescent Strengths and Needs screening, cross care planning, and CFTs has been posted on the JR Homepage website for all 900-plus employees to view.
  - The JR Behavioral Health Programs Administrator and Institution and Regional Mental Health Coordinators are continuing to refine the protocol for the WISe JR youth eligible (identifier) checklist.
  - 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 Reentry Team Meeting and begin where the youth and family are interested, the referral process to WISe, if available in the community where the youth is returning.
  - A Regional Mental Health Coordinator is tracking JR referrals to WISe and reports that as of March 31, 2016, 372 youth are in WISe.
  - JR is finalizing a contract with a community agency to assist with re-enrollment into Medicaid for eligible youth releasing from JR institutions; proposed timeline is January 1, 2017

- Family, Youth, System Partner, Round Table
  - JR staff actively participates with this invested stakeholder group of family and youth, system partners, providers, community leaders, system representatives and others, in a systematic process of evaluating system-level needs and strengths, and identifying strategies for improvement.

- The JR Behavioral Health Programs Administrator is one of three Statewide FYSPRT Tri-Leads; the other two Leads are Family and Youth representatives.

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

Behavioral Health Organization staff and their contracted WISe agency staff continue to be critical system partners. The BHO contributions during implementation, and their sharing lessons learned has been essential to our building success.

Children's Behavioral Health Principles[2]: Each BHO is required to have one Performance Improvement Plan (PIP) specific to children's services. In 2014, to assist with infusing the Children's Behavioral Health Principles in the delivery of care, DBHR began approving the children's PIPs changes to the process to make these more meaningful include:

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

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

- A review of unplanned discharges from the BHO WISe Program
- Review if High-Fidelity Wraparound significantly improves emotional and behavioral functioning of Medicaid-enrolled children/youth

Quality Service Review: This past year the External Quality Review Organization (EQRO) Children's Focus was on Quality Service Reviews (QSRs) at three agencies providing WISe.

The QSR is designed to assist with reviewing cross-system coordination in several ways. First, a review of CANS items determines the level of formal and informal linkages including education, faith based and community connections. Second, Child Family Team meetings are assessed to see if identified cross-system partners are participating in meetings. Third, updates in the crisis plan are reviewed to determine if input from cross-system providers and natural supports are included. Fourth, completed transition plans

[2] Key components of the principles which can be found at https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WA%20State%20Children%27s%20BH%20Principles.pdf are included in WISe, CANS assessment, and the CFT meeting.

will be assessed. Ultimately, the QSR is designed to identify the essential requirements to implement WISe successfully and lead to improved outcomes.

In 2015, a draft of the QSR protocol was pilot tested at a WISe agency in Olympia. Based on the pilot results, revisions were made and a QSR protocol and manual were created. These materials were used to train staff implementing the protocol. The training identified other changes needed to make the tool more precise and useful. Training on the QSR occurred at the end of March 2016 through June 2016. Three WISe agencies were identified for the QSR. The QSRs were largely completed at site visits in July and August 2016; all data were collected by mid-September. The data from the three WISe agencies is now being analyzed. A draft Lessons Learned Report, drafted by Dr. Nate Israel, will be reviewed with DBHR staff, finalized, and distributed by the end of 2016.

As required by the Implementation Plan, the parties will continue to work together over the next year to ensure that QSR outcomes adequately inform program design.

Objective 4 - Remaining Tasks:

- Continue to promote Washington State Children's Behavioral Health Principles service delivery beyond WISe and in local and regional policy development through the FYSPRT governance structure.
- DBHR and CA will continue to review BRS and WISe materials annually to ensure clear guidance for identification and referral for WISe, participation on CFTs and coordination of care.
- DBHR will distribute the QSR Lessons Learned Report when finalized, anticipated by the end of December 2016.
- Review data regarding youth who screen positive for WISe but do not receive WISe services to evaluate systemic barriers to access that should be addressed, in particular with youth in CA and JR.

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:

Hiring and retaining qualified staff is a critical issue. BHOs and WISe provider agencies continue to focus on recruitment to build additional WISe teams. Across most of the state, a limited behavioral health workforce poses a significant implementation challenge. In the coming year, DBHR will work with a national consultant to identify strategies that will assist with enhancing service capacity. Recruitment and retention issues are addressed in Section III.

On-going training and coaching are key strategies to retain and support the staff currently providing WISe. Below is an overview of the trainings and support activities offered since the last report.

WISe trainings: From November 1, 2015, through September 30, 2016, under the coordination of the Washington State University (WSU) Workforce Collaborative, there were 14 two-day WISe trainings offered and **318 individuals** trained. Participants included: care coordinators, therapists, family partners, youth partners, supervisors, and other agency staff.

The collaborative, in partnership with DBHR, also held the first two-day WISe training for new trainers where **14 potential trainers** participated: ten for system partners, two for family partners, and two for youth partners.

During this same timeframe, the Youth and Family Certified Peer Counseling Training was offered on eight occasions; six regional and with statewide trainings offered and **134 individuals** completed the training.

The WSU collaborative spent the last year building their organizational infrastructure. This includes hiring the necessary staff and building key relationships with stakeholders including FYSPRTs; Portland State University (PSU), University of Washington (UW), DBHR, and a variety of community-based organizations. In late October 2016, a WISe Program Manager joined the team. The collaborative is currently in the process of recruiting and hiring for a new Executive Director with the goal to have the position filled by the end of November 2016.

Over the past year the collaborative provided workforce trainings across the state for WISe teams, Youth and Family Certified Peer Counselors, and Youth Professionals. The collaborative has also built an online presence that includes a space for information about local and regional FYSPRTs, as well as a space for Certified Peer Counselors to take an online training. The collaborative also facilitated a work group with DBHR, PSU, and representatives of BHOs to establish a framework for building local/regional WISe training capacity.

The collaborative completed a strategic planning process that resulted in a five-year strategic plan and one-year operational plan for SFY 2017. This report has been submitted to the tri-led Workforce Steering Committee and is currently under review.

Youth Voice: YouthSound (YS), formerly Youth 'N Action, has gone through a process of rebranding and reintroducing itself to communities around Washington State. Youth from around Washington submitted their ideas for a new name and voted to select YS. YS focused on four central projects during the past year: providing technical assistance to FYSPRTs, piloting the Youth Professional Leadership curriculum, planning awareness events, and building up a local YS chapter in Thurston and Mason counties. YS attends the statewide FYSPRT meetings, as well as local and regional meetings to provide technical assistance on youth engagement.

YS continued to play a lead role in the development, evaluation, and revisions of the Youth Professional Leadership curriculum, in partnership with the DBHR and Ellen Kagen (a national expert on leadership). YS hosted four pilot trainings in Spokane in December 2015 (only one-day training), Vancouver in June 2016, and King County and Walla Walla in August 2016. In all, roughly 50 youth professionals have completed the two-day pilot training.

WISe Training Evaluation: As reported last year, from the WISe training evaluation conducted by the University of Washington's Wraparound Evaluation and Research Team (UW WERT), the following recommendations were put forth**:**

- Facilitate understanding of expectations and skills of all WISe roles;
- Include of 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 are addressed through the tri-lead Workforce Collaborative, the WISe training team and additional workgroups as needed.

Improvements this year included transitioning the WISe four-day in-person training to an on-line training requirement and two-day in-person training. The new training format was in response to the request from WISe providers and BHOs to better meet their scheduling demands and better access to WISe training materials. In the two-day training, roles and function content for all WISe team members was expanded, as recommended. In addition, experiential learning for all roles and functions will be expanded.

This past year BHOs had the opportunity to request additional trainings specific to the WISe training needs in their region. Trainings requested and provided included advanced training in CFT meeting facilitation, coaching, peer support continuing education, and integrating the CANS into WISe.

The collaborative also finalized the two-day training for new WISe trainers, as well as a process for prospective trainers to co-train with the statewide training team. A draft annual needs assessment was also created to help shape and identify each BHO's training needs for the year. Coaching has also been identified as a key element of the WISe training efforts. In response to this, the collaborative hosted a two-day coaching training for lead coaches in WISe and Youth and Family Certified Peer Counselors. The training was facilitated by Ellen Kagen, a nationally recognized expert in leadership and coaching.

This past year, the WSU collaborative partnered closely with UW Wraparound Evaluation and Research Team to evaluate the WISe trainings using data from the knowledge test

(administered prior to the training and at the end) and the Impact of Training and Technical Assistance (IOTTA). More than half of the training participants were direct WISe staff, which is the target audience. Other participants included direct service providers, supervisors, and administrators.

Given the transition in training responsibilities from Portland State University to Washington State University in terms of the training coordination, logistics, and the training team itself (the System Partner trainer has changed), the collaborative needed to monitor significant changes in the IOTTA responses during the transition. UW WERT's final evaluation report compared the evaluation results between the Portland State University trainings and the WSU trainings. There were slight variations between the two sets of trainings, but no significant deviations between scores on any of the measures. This monitoring assures consistency between the trainings even as systemic changes occurred. The collaborative will continue to monitor training outcomes and make any indicated adjustment for further improvement.

In the coming year, it will be important for the collaborative, in partnership with DSHS, to implement a statewide coaching model. This will be an essential component of WISe implementation and will give WISe staff additional supports as they learn to operationalize the concepts they learn at the training. Three statewide coaches (system partner coach, family partner coach, and youth partner coach) will host monthly conference calls with identified WISe leads in every region. The regional WISe coaches will link to the agency level leads and their direct WISe staff. The coaching model is intended to align statewide efforts while offering guidance to better inform on the job coaching. The topics for the conference calls will be solicited from the regions and will be an opportunity for different regions to learn from each other and ask questions, with the support of the statewide coaches. The collaborative's new WISe program manager has extensive experience in wraparound, coaching and was formerly a WISe supervisor. The near-term goal for this newly filled position is to finalize and implement the coaching model.

Another important goal for the coming year will be to create additional training curriculum to support WISe staff beyond the introductory, two-day training. Each region will be given an annual needs assessment to prioritize the topic areas where they are most in need of additional training.

The collaborative will also be using an online Learning Management System (LMS) to make online trainings (including the existing online WISe modules) available and to create new trainings. This LMS has a user-friendly interface that allows for online trainings without purchasing additional, expensive software. The system will make trainings accessible to behavioral health staff across the state and will enable collaboration with divisions across DSHS.

Objective 5 - Remaining Tasks:

- Continue to work with the WSU Workforce Collaborative to refine the existing WISe foundational training based on the training evaluation. The training

curriculum will be advanced by developing additional required trainings. A WISe coaching model will be developed in early 2017. The WSU Workforce Collaborative will be encouraged to work with BHOs and system partners to develop annual training plans.

- Continue to evaluate training curriculum; the Workforce Collaborative will continue to oversee contracting for training evaluation.
- Enhance the WISe e-learning modules over the next year.
- Workforce development will be an on-going agenda item at FYSPRT and TRIAGe meetings.
- DBHR will work with a national consultant to identify statewide and regional priorities and strategies to support increased workforce recruitment and enhanced service capacity.

Objective 6: Maintaining Collaborative Governance Structure

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

Progress and accomplishments:

Family, Youth and System Partner Round Tables (FYSPRTs) 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.

In October 2015, the number of Regional FYSPRTs increased from six to ten to be in alignment with BHO and Fully Integrated Managed Care regions. Also at this time, funding for the regional FYSPRT contracts changed from System of Care grant or Mental Health Block Grant funding to state funds. Funding per quarter increased for deliverables related to supporting the regional FYSPRT and for travel and meeting support for the regional FYSPRT members.

This past year FYSPRT participants were invited to participate in leadership development. In July 2016, a FYSPRT Leadership Academy, facilitated by Ellen Kagen, Senior Policy Associate of the Georgetown University Center for Child and Human Development, was offered. This event provided practical guidance and support to members of the Statewide FYSPRT, which included Regional Family and Youth Tri-Leads, around leadership approaches for supporting System of Care Expansion in Washington State. Approximately 40 participants from the ten Regional FYSPRTs attended, including several participants from BHOs.

In addition, the System of Care grant supported seven family and youth leaders from across Washington to travel to Columbus, Ohio for the SAMHSA supported Grantee Meeting titled "Aligning the Movements: How Family and Youth Organizations can Work Together to Further Their Movements." Attendance at this meeting will assist in the development and support of a statewide family-run organization and youth-run organization, as well as regional and local family-run and youth-run organizations; all of which will contribute toward the sustainability of Children's Behavioral Health and System of Care values and principles.

Through this grantee meeting, family and youth leaders from across the state identified shared goals and strategies to align the family and youth movements and also attended sessions designed to strengthen each of their movements individually. Attendees included two of the family leaders and a regional FYSPRT coordinator. These leaders support the governance structure with their time and commitment as regional FYSPRT members and promote FYSPRTs within their communities and organizations.

The development of family and youth run organizations contribute to the governance structure by connecting family and youth leadership across the state. Washington State Community Connectors, a statewide family run organization, has started developing a technical assistance plan to support family engagement and leadership in the Regional FYSPRTs. Youth Sound (formerly known as Youth 'N Action), a youth run program, provided technical assistance in 2016 to multiple regional FYSPRTs to build youth leadership and engagement in the regional FYSPRTs. The current project director for Washington State Community Connectors as well as the program manager for Youth Sound, both attended this grantee meeting.

Finally, the statewide FYSPRT approved a briefing template titled the Challenge and Solution Submission Form that is used to identify barriers or solutions to be shared or solved at the statewide FYSPRT level. This form can also be utilized by the statewide FYSPRT Tri-Leads to elevate a barrier or solution to the Executive Leadership Team. In August 2016, the template for this form was distributed to the regional FYSPRTs so that it may be modified as needed and made relevant to a particular region. This will promote information-sharing across regions. In addition, this establishes a protocol to document local issues to be brought to the regional and statewide FYSPRTs, as well as the highest level of state leadership. No Regional FYSPRTs have yet utilized this form to bring anything to the statewide FYSPRT; however, access to the form has been requested to share the document with regional FYSPRTs members.

FYSPRTs activities this past year included:

- Each regional FYSPRT completed a needs assessment gathering information about the needs and strengths around services and/or FYSPRTs in their community.
- Information from the needs assessment was used to develop a strategic plan for each regional FYSPRT.

- Regional FYSPRTs continued to meet on a monthly basis to discuss local concerns, propose solutions, and improve coordination
- Regional FYSPRTs created their own website to post information and/or coordinating with Washington State University to post regional FYSPRT information on the FYSPRT tab of the Children's Behavioral Health Workforce Collaborative website. See http://wabhwc.com/fysprt

Additional contract requirements for Regional FYSPRTs include, but are not limited to:

- Expand recruitment and engagement of families and youth with diverse perspectives and document efforts to implement the regional FYSPRT Outreach Strategy.
- Engage with youth, families, and system partners to build and maintain a FYSPRT membership that includes at least 51 percent youth and family membership, BHO representation, community system partners, and other relevant stakeholder groups.
- Begin implementing a strategic plan.

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 6 - Remaining Tasks:

- DBHR will continue to review and approve BHO reports and other deliverables summarizing regional FYSPRT progress on contract requirements, including the barriers to FYSPRT implementation, and plans regarding next steps.
- Maintain similar regional FYSPRT contract language in BHO contracts when current regional FYSPRT contracts expire in June 2017.
- Continue to promote and refine the process that allows regional and statewide FYSPRTs to bring issues to the Executive Leadership Team and receive timely responses.
- Executive Leadership Team members will attend the Statewide FYSPRT meetings.
- Continue to review the protocols and procedures in the WISe Manual to oversee implementation of local WISe programs.
- Review and update the Statewide FYSPRT charter.
- Provide finance information and data to FYSPRTs, executive leadership, and elected officials.

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:

DSHS continues to monitor compliance with due process requirements and address noncompliance by requiring BHO policies to be consistent with due process regulations and policies. DBHR completed reviews of BHOs and sent letters to each BHO identifying issues of concern regarding general alignment of BHO policies with federal due process requirements and state contracts. Concerns highlighted in DBHR letters included, but were not limited to:

- Amending timelines for appealing BHO actions
- Revising and clarifying definitions of key terms such as "grievances" and "actions"
- Updating WAC citations
- Adding required elements for notices and grievance responses

Those BHOs determined to have unmet or partially met requirements were asked to submit policy revisions to DBHR within 60 days. All BHOs have been responsive and updated policies and procedures as requested.

DBHR requires in contract, that BHOs collect and report data on actions, grievances, and appeals. Effective September 9, 2016, DBHR published revised Grievance System Reporting Instructions and a new BHO reporting template. The revised reporting instructions and template are more rigorous and more explicitly align with C.F.R. and contract requirements.

Reports are reviewed and analyzed by BHO contract compliance staff members and provide input to audit activity by DBHR staff and EQRO external auditors.

As reported last year, the use of WISe-specific data regarding the notices of action, grievances, appeals and administrative hearings continues to be in the beginning phases of inclusion into the WISe quality improvement program. Data being collected from each BHO by DBHR contract compliance staff is currently being analyzed on a regular basis for adherence to contract requirements.

New federal rule requirements effective July 1, 2017 require Notice of Actions to be issued for determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The CANS screen combined with an intake or continued stay evaluation for behavioral health services

establishes the presence of medical necessity for WISe. If medical necessity is not established for WISe, a Notice of Action must be issued.

The following work was completed:

- A model notice of action template was developed for BHOs.
- Administrative rules for the grievance system were amended to reflect the transition from RSNs to BHOs, and now cover both mental health and substance use disorder services. The rules are located at WAC 388-877-0654 to 0675.

Instructions to the BHOs will complement a more comprehensive oversight plan for compliance with WISe enrollee rights and due process requirements. DBHR will continue to monitor BHO compliance with due process requirements through Extended Quality Review Organization (EQRO) compliance reviews and data analyses. The EQRO this year includes WISe grievance and appeal review at the nine BHOs; the report is to be submitted to DBHR by the end of December 2016.

For Clark and Skamania Counties, HCA's Managed Care Programs Section staff monitors all managed care contracts (including FIMC and Apple Health Core Connections) on an ongoing basis for compliance with contract terms, including access to services and network adequacy. Any quality of care or clinical issues that arise are shared with clinicians in the Medicaid Compliance Review and Analytics Section for resolution.

Staff receives notification of issues and complaints through the managed care mailbox, phone calls, and Directors Assignments, which are generated from the Governor's Office, legislative staff and other stakeholders and are researched through the Managed Care Contract and the contracted Mangaged Care Organizations (MCOs) before responding to the complainant. HCA activities to monitor and oversee MCO Grievance and Appeal Systems and Utilization Management Programs include the following:

- Quarterly receipt of MCO Grievance, Adverse benefit determination (denial), and Appeal information, including written narrative analysis. HCA plans to expand data collection so information can be tracked for FIMC enrollees in southwestern Washington and for the foster care program.
- Annual (or more frequent) review of MCO handling of enrollee grievances, adverse benefits determinations, and appeals. HCA chooses files for review from the quarterly data submitted by the MCOs. Each type of file is reviewed with its own standardized checklist to monitor if the MCO is handling these important Utilization Management and Grievance and Appeal System issues. HCA checks each file to determine contractual compliance, including if the MCO met required timelines for handling, if decisions were appropriate, if appropriate personnel made decisions and used appropriate decision making criteria, if correct enrollee letters were sent, and if enrollees were referred for care coordination activities when necessary.

- Each item on each checklist is assigned a score of met or not met and rolled up to a final score. MCOs must complete a corrective action plan for each element scored less than met.
- Review and approval of all MCO enrollee letters pertaining to utilization management and the Grievance and Appeal System. If HCA cannot approve the letter, feedback or technical assistance is provided to the MCO.
- Utilization Management Program Descriptions and program evaluations are reviewed annually and scored similarly to enrollee files; MCOs must complete corrective action plans for any scores of partially met or not met.
- Quarterly receipt of MCO Utilization Management Turnaround time reports to verify MCOs are making decisions within contractually required time frames and if not, corrective action plans are in place to improve handling.

Objective 7 - Remaining Tasks:

- Amend administrative rules and other due process provisions to be compliant with federal Centers for Medicare and Medicaid Services (CMS) rules governing Medicaid managed care, grievances, and appeals, which are effective on July 1, 2017.
- Provide BHO and WISe provider trainings about implementing due process requirements outlined in the WISe Manual for WISe-enrolled and WISe-referred BHO beneficiaries.
- Continue to establish and implement a protocol to monitor BHO and MCO reports on grievances, appeals, and administrative hearings and to correct instances of non-compliance.
- Analyze and use the data as part of the WISe quality improvement program.
- DBHR will continue to provide technical assistance and offer the recently convened Learning Collaborative on the Grievance System to the BHOs.
- Additional existing data reports on due process can be provided to Plaintiffs' counsel. The TRIAGe process and Defendants' counsel remain a resource to address specific questions about due process implementation issues.
- DBHR will continue to provide technical assistance and offer the recently convened Learning Collaborative on the Grievance System to the BHOs

III. Implementation Challenges

In addition to the issues and concerns addressed above, we anticipate several broad challenges in the coming year as outlined below according to the T.R. Implementation Plan Objectives. The categories below are current areas of focus for WISe implementation:

Rollout of WISe Services (Objective 3)

Capacity development linked to the lack of a behavioral health workforce has been an implementation challenge for the last two years. Workforce shortages, competition for

existing skilled staff and difficulty with recruitment in children's behavioral health services continues to cause challenges for WISe implementation.

At the time BHO contracts were developed DBHR recognized the capacity target for SFY 2016 was aggressive, particularly during a time when Regional Support Networks (RSNs) were transitioning to BHOs. As noted above, for the contract period of July 1, 2016 through June 30, 2017, capacity targets were reduced from the "mid-level" range to the "low-level" range with the exception of Thurston and Mason Counties who have reached their targeted capacity goal for 2018. Capacity targets will be reviewed again this coming year.

Plaintiffs' counsel expressed strong criticism of the process and explanation provided by the State for the reduction from the mid-level range to the low-level range of capacity. Specifically, Plaintiffs expressed concerns that the decision to lower the targets was made in response to capacity development challenges rather than a re-estimate of need.

Given that developing capacity throughout the state is uneven, Plaintiff's counsel underscores that it is all the more critical to take the steps necessary to better understand the barriers to building capacity, as well as to identify and implement interventions that will promote and support WISe professionals and provider organizations.

As shared in last year's Implementation Status report, there is a need to identify creative and collaborative ways to better support BHOs and WISe providers. In July 2016, DBHR, with encouragement from Plaintiffs' counsel and from BHO representatives, secured a contract with a national consultant, Suzanne Fields, with experience with Early Periodic Screening, Diagnosis, and Treatment litigation and implementation of services in other states.

Ms. Fields works through the University of Maryland School of Social Work, The Institute for Innovation and Implementation. Under the contract she will provide consultation and technical assistance in the following four areas:

- Capacity development
- Workforce development and staff retention
- Expand access and engagement
- Financial Planning

A specific work plan is scheduled to be developed by December 2016. For workforce and capacity development specifically, DBHR staff are currently gathering additional data directly from the BHOs which will be shared with Ms. Fields in an effort to identify recommended strategies to move forward. This work will also be informed by other efforts related to children's behavior workforce efforts such as the workgroup convened by Governor Inslee to review behavioral health workforce issues and E2SHB 2439, which established the Children's Mental Health Work Group.

In July 2016, Governor Inslee tasked the Workforce Training and Education Coordinating Board (WTECB) to assess workforce shortages across behavioral health disciplines. He charged WTECB with creating an action plan to address current workforce shortages as well as future demand for behavioral healthcare workers to support greater integration with primary care. WTECB assembled a project team that included the University of Washington Center for Health Workforce Studies and Agnes Balassa Solutions to collect and analyze quantitative and qualitative data to identify occupational shortages, assess the range of workforce-related barriers to improving access to behavioral health in Washington, and identify recommendations for solutions. The behavioral workforce assessment is one among a number of efforts initiated by the Governor and Legislature to improve access to and effectiveness of behavioral healthcare in the state. The report from this workgroup, due in December 2016, represents the completion of Phase I of a 22-month project and focuses on initial findings regarding barriers and short term solutions related to the behavioral health workforce. Phase II will focus on longer term solutions to the barriers identified in Phase I, and will provide to the Governor's office and appropriate Legislative committees a final report and recommendations by December 15, 2017 for the 2018 Legislative Session and beyond.

The E2SHB 2439 Children's Mental Health Workgroup convened on June 21, 2016 and sub workgroups met throughout the summer. The workgroup was tasked with reviewing challenges and barriers across three content areas: Assessment, Billing and Eligibility, Workforce, and Child Care and Education. In October 2016, recommendations from the sub workgroups were presented. Workgroup members voted on the recommendations on November 1, 2016. A report to the Legislature is due on December 1, 2016.

Outcomes from this work noted above will be presented monitored during the upcoming legislative session.

In addition, DBHR recently convened an internal workgroup, the Behavioral Health Workforce Recruitment, Retention, and Opportunities Committee (RROC) to be responsive to and assist with supporting the Department's initiatives on workforce development.

Data Reporting (Objective 3)

BHOs Data Reporting Delays

DBHR transitioned their behavioral health (mental health and substance use disorder services) purchasing to BHOs on April 1, 2016. The purchasing of services occurs primarily through managed care contracts. As a result, the division had established a new data collection system, the Behavioral Health Data System (BHDS), into which the BHOs are required to report service episodes. Reporting for services episodes is separate from CANS data collected in the BHAS system data which is included on the Statewide Performance Measures data dashboard and BHAS quarterly reports. Administrative Data, which is also included in the data dashboard, is complete through March 2016.

The BHDS data includes reporting requirements for the collective MCOs, which includes BHOs, Behavioral Health Administrative Services Organizations (ASOs), and specific MCOs to meet the DBHR's state and federal reporting requirements.

It has taken time for the BHOs to work with their data system vendors to operationalize the reporting of required data. DBHR is undertaking review of the data quality and expects to have reportable data on mental health encounters by April 2017.

Behavioral Health Assessment System

Problems with BHAS, the online reporting system for CANS data, have persisted this past year. Despite overcoming many technical challenges with the BHAS system, users continue to experience problems.

BHAS has continued to experience some specific and challenging development requirements. The reporting platform experienced challenges as we incorporated elements of CANS that are not common to other states such as the state's selection of two age-specific CANS screens and full assessments for 0-4-years-old and 5-21-years-old. Another challenge this past year was our state's transition from RSNs to BHOs and one fully integrated managed care system region. This transition required additional reporting complexity in the system. This complexity stems from having multiple MCOs serving a single region. Allowing appropriate permissions for each managed care to see only their clients within their MCO and across regions without seeing clients in other MCOs has been challenging and at the time of this report has not been completely solved. With this system upgrade, we will be prepared as other regions transition from BHOs to fully integrated Managed Care regions.

A survey of BHAS users conducted in October 2016 showed that many users entering data continue to have lingering concerns about data entered into the system. Although DBHR conducts a number of quality checks to ensure data is accurate, some users have experienced instances when reports lacked information on diagnosis and have experienced episodes when the system appeared to not save their all of their data elements.

All data that is captured in BHAS and Administrative data that is reflected in state and regional reports are reviewed and validated by DSHS RDA before dissemination. DBHR is confident the data provided is accurate yet recognizes that user functionality needs immediate attention to further the reliability of data and front end user experience.

Some front-end BHAS users continued to experience periodic 'glitchy' responses when entering data and reported instances when data entered into the system was not actually saved. These challenges come on top of expected challenges as more WISe team members were added to BHAS around the state and faced routine problems of adapting to an online reporting system. The contracting agency, Praed Foundation, and its subcontractor, RCR Technologies, met weekly by conference call with DSHS staff to address concerns. However, problems continue to exist and a general unease among users has developed into a 'problem-based narrative' where even when the system works, many users fear that data is

not getting into the BHAS system correctly. The fact that BHAS users have characterized the CANS data captured in BHAS as unreliable could have a detrimental effect on the ability to use data for quality improvement. If system users do not have faith in the accuracy of data, it is challenging, if not impossible, to use data as a way to effectively promote necessary changes in practices, protocols, policies, and training. In addition, due to concerns about data reliability, DBHR has not been able to make quarterly BHAS data publically available for FYSPRTs and others to review as intended. The lack of available and reliable data has significantly limited the ability of the State and Regional FYSPRTs to engage in one of their core governance functions.

System challenges continue to be prioritized and are now being addressed by Praed Foundation, with DBHR and RDA staff, systematically working through weekly help desk reports on conference calls. 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.

DBHR offered online and face-to-face training to WISe providers in the summer of 2016. DBHR provided face-to-face trainings for the Spokane BHO, Greater Columbia BHO, and two CLIP facilities while providing increased phone-based consultation and training to BHAS users. There are currently more than 600 people listed as active BHAS users.

An updated contract will increase the amount of contracted project management and basic infrastructure support to Praed for the continued effort to improve BHAS functioning.

The current BHAS contractor transitioned to a new server and recently made system updates. The updates were tested in a testing platform by DSHS and RCR employees to ensure that the updates address problems that users have had with the system. The new contract will allow increased in-state project management by assigning a person to oversee BHAS implementation. DBHR expects to hire for this position and to begin work by December 2016.

Due Process (Objective 7)

As reported in the last Implementation Status Report in 2015, DBHR adopted a new set of grievance and appeals rules to be compliant with federal Medicaid rules. Subsequently, the RSNs converted into BHOs and expanded from providing mental health services to also cover chemical dependency services as mandated by Laws of 2014, ch 225 (2SSB 6312). This change necessitated further state rule amendments to reflect the adoption of BHOs. In the meantime, the Centers for Medicaid and Medicare Services (CMS) published a notice for proposed amendments to 42 C.F.R. Part 438, Subpart F, and as noted in the Objective 7 "Remaining Tasks," formally adopted changes that will be effective July 1, 2017.

This series of changes has created a challenge for not only establishing clear expectations with the newly formed BHOs, but also creating systems to collect the data necessary for monitoring compliance. Upon review of BHO policies and procedures, DBHR noted that

several BHOs were in the process of making necessary revisions to comply with basic state and federal requirements and these policies and procedures have been updated. Many BHOs have expressed a need to work with substance use disorder providers to educate and orient these new service providers to managed care due process requirements, which adds further system demands in response to the BHO transition.

DBHR will continue to offer technical assistance to the BHOs to ensure consistent reporting of WISe-specific notices, grievances, and appeals. DBHR anticipates that the EQRO review due in December 2016 will highlight more specific areas of needed improvement.

Plaintiffs raised questions about compliance with the due process requirements in the settlement agreement and implementation plan: In June 2016, Plaintiffs' counsel asked for data concerning children and youth denied WISe services, including the number of Notice of Action issued for youth regarding WISe services denied, terminated or reduced; the number of state fair hearing requests (and hearings results) for youth re WISe services denied, terminated or reduced; and the number of grievances/appeals requested (and results) for youth re WISe services denied, terminated or reduced. In August 2016, the State orally provided the due process data, which consisted of only one notice of action issued statewide, and no hearings or grievances/appeals requested regarding WISe services. The lack of meaningful data raised concerns for Plaintiffs about whether RSN/BHOs and providers were complying with the settlement agreement. In August 2016, Plaintiffs' counsel formally requested a separate meeting with the State to address due process concerns, although due to both parties' schedules the meeting did not take place until the end of September 2016. Also, in September 2016, Plaintiffs sent the State a request for information related to the due process requirements in the settlement agreement and implementation plan. Plaintiffs received some information requested from State Defendants on October 21, 2016 but have not yet had the opportunity to meet with the State about the concerns before this report was filed with the court.

Plaintiffs are concerned with the length of time it took to obtain data as described above. Specifically, until seeing the draft report to the court, Plaintiffs were not aware of the efforts by DSHS to monitor compliance with due process requirements or to address noncompliance by BHOs with due process regulations and policies that began in Spring 2016. While defendants have newly raised concerns in this report about change to the federal Medicaid managed care due process regulations, proposed to take effect on July 1, 2017, Plaintiffs do not believe that these regulatory changes alter the State's existing obligations in the settlement agreement concerning data collection, notices of action, grievances and appeals, or compliance monitoring. Finally, prior to October 21, Plaintiffs had not yet seen any WISe-specific data or monitoring reports regarding compliance with due process obligations under the settlement agreement or the comprehensive oversight plan the State is developing to ensure BHOs are complying with enrollee rights and due process requirements specifically related to WISe. Based on the limited WISe-specific data provided in October, Plaintiffs have even greater concern about inconsistent practices with regards to notice of actions and due process requirements across the state.

IV. Glossary of Key Terms

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

1. **"Behavioral Health Assessment System" or "BHAS"** is an online data system to store and report on Child and Adolescent Needs and Strengths (CANS) data for Wraparound with Intensive Services (WISe).
2. **"Behavioral Health Organizations" or "BHOs"** are created by state law to purchase and administer public mental health and substance use disorder services under managed care. BHOs are single, local entities that assume responsibility and financial risk for providing substance use disorder treatment, and the mental health services previously overseen by the Regional Support Networks (BHOs).
3. **"Behavioral Health 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.
4. **"Behavior Rehabilitation Services" or 'BRS"** is a temporary intensive wraparound support and treatment program for youth with high-level service needs. BRS is used to stabilize youth (in-home or out-of-home) and assist in achieving their permanent plan. These services are offered through contracts under the Children's Administration.
5. **"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.
6. **"Child and Adolescent Needs and Strengths" or "CANS"** is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
7. **"Child and Family Team" or "CFT"** includes the youth, parents/caregivers, relevant family members, and natural and community supports.
8. **"Children's Long-term Inpatient Program" or "CLIP"** is the most intensive inpatient psychiatric treatment available to all Washington residents, ages 5-18 years of age; offers a medically based treatment approach providing 24-hour psychiatric care staffed by psychiatrists, Master-level social workers, RNs and other clinical experts.
9. "**Culturally and Linguistically Appropriate Services" or "CLAS"** – the national standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these standards will help advance better health and health care.
   https://www.thinkculturalhealth.hhs.gov/content/clas.asp

10. **"Developmental Disabilities Administration" or "DDA"** an administration of the Department of Social and Health Services that provides programs for state residents with developmental disabilities and their families.
11. **"Division of Behavioral Health and Recovery" or "DBHR"** means the DSHS-designated state mental health authority to administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.
12. **"External Quality Review Organization" or "EQRO"** provides external quality review and supports quality improvement for services provided to Medicaid enrollees in Washington; the work supports the state of Washington Health Care Authority (HCA) and Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery.
13. **"Family Youth and System Partner Round Tables" or "FYSPRTs"** provide an equitable forum for families, youth, systems, and communities to strengthen sustainable resources by providing community-based approaches to address the individualized behavioral health needs of children, youth, and families.
14. **"Fiscal Year 2015" or "FY2015'** is the state fiscal year running from July 1, 2014, through June 30, 2015.
15. **"Full partners"** are persons or entities who play an active role in the development and implementation of activities under the "T.R. v. BHOs 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.
16. The **"Governance Structure"** consists of inter-agency members on an executive team of state administrators, the statewide, regional, and local FYSPRTs, an advisory team, and various policy workgroups who inform and provide oversight for high-level policy-making, program planning, and decision making in the design, development, and oversight of behavioral health care services and for the implementation of the T.R. v. Lashway and Teeter settlement agreement.
17. "**Health Care Authority" or "HCA"** purchases health care for more than 2 million Washingtonians through two programs — Washington Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program.
18. **"Quality Management Plan" or "QMP"** prescribes the quality management goals, objectives, tools, resources, and processes needed to measure the implementation and success of the commitments set forth in the T.R. v. Lashway and Teeter settlement agreement.
19. **"Regional Service Areas" or "RSAs"** as directed by E2SSB 6312, the Health Care Authority (HCA) and Department of Social and Health Services (DSHS) have jointly decided on common Regional Service Areas (RSAs) for Medicaid purchasing of physical and behavioral health care, beginning in 2016. Map as of June 2015: http://www.hca.wa.gov/hw/Documents/2016rsa_boundaries.pdf
20. **"Rehabilitation Administration's (RA), Juvenile Rehabilitation" or "JR'"** is an administration of the Department of Social and Health Services which serves Washington State's highest-risk youth.
21. **"System of Care" or "SOC"** is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of

improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.

22. **"T.R. Implementation Advisory Group" or "TRIAGe"** is a group comprised of the Plaintiffs' counsel, Attorney General representatives, and representatives of DSHS child-serving administrations (BHSIA, CA, DDA and RA) and HCA who have knowledge relevant to the services and processes identified in the WISe Implementation Plan. TRIAGe is used as a communication mechanism between parties to enable implementation.
23. **"T.R. v Lashway 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.
24. **"Tri-Lead"** is a role, developed to create equal partnership, among a family, a transition age youth and/or youth partner, and a system partner representative who share leadership in organizing and facilitating FYSPRT meetings and action items.
25. **"Washington State Children's Behavioral Health Principles"** are a set of standards, grounded in the system of care values and principles, which guide how the children's behavioral health system delivers services to youth and families. The Washington State Children's Behavioral Health Principles are:
    - Family and Youth Voice and Choice
    - Team Based
    - Natural Supports
    - Collaboration
    - Home- and Community-based
    - Culturally Relevant
    - Individualized
    - Strengths Based
    - Outcome-based
    - Unconditional
26. "**Wraparound with Intensive Services" or "WISe**" means intensive mental health services and supports, provided in home and community settings, for Medicaid eligible individuals, up to 21 years of age, with complex behavioral health needs and their families, in compliance with the T.R. v Lashway and Teeter (formerly Dreyfus and Porter) settlement agreement.
27. "**Workforce Collaborative**" means a staffing infrastructure that operates independently and is tri-led by youth and families, state systems, and partner universities to develop sustainable local and statewide education, training, coaching, mentoring, and technical assistance.