Exhibit 1

T.R. v. DREYFUS, No. C09-1677 – TSZ

SETTLEMENT AGREEMENT AND PROPOSED ORDER

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I. PURPOSE AND OBJECTIVES OF THIS AGREEMENT

1. The purpose of this Agreement is to direct the development of a sustainable service delivery system for intensive home and community based mental health services to Medicaid eligible children and youth, in substantial compliance with Title XIX of the federal Social Security Act, and specifically the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of Medicaid, 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B). The specific objective of this Agreement is the development and successful implementation of a five-year plan that delivers Wraparound with Intensive Services (WISe) and supports statewide,[1] consistent with the principles and goals stated herein, in a sustained manner over time. Further, this Agreement is intended to result in all eligible Class members receiving timely WISe services that are medically necessary.

2. This Agreement includes three components: (1) goals, (2) commitments, and (3) exit criteria. (1) The goals are intended to provide structure and guidance for planning, implementation and sustainability; aid in interpreting the meaning and purpose of the commitments and exit criteria; and to guide future development of the service delivery system.[2] The goals are not commitments or exit criteria, and shall not be measured as such. (2) The commitments are the items or actions that Defendants will do to implement the Agreement and achieve its objective and intended result. Defendants will substantially comply with all of the commitments as set forth herein, and as further described in the Implementation Plan, during the

[1] For the purposes of this Agreement, "statewide" means sufficient in quantity, scope, duration, and geographic distribution to meet the needs of Class members in each Prepaid Inpatient Health Plan (PIHP) service area.

[2] The State of Washington acknowledges that there may be future changes to the State's Medicaid-funded mental health delivery system. This Agreement transcends any future changes to the structure of that delivery system. Accordingly, any reference to PIHPs within this Agreement or its appendices is intended to include any successor entity with which the State of Washington contracts.

pendency of this case. (3) The exit criteria are the sole objective measures that, when accomplished at the conclusion of this case, determine whether Defendants are in substantial compliance with the terms of this Settlement Agreement such that the case shall be dismissed.

II. BACKGROUND

3. Plaintiffs brought this lawsuit entitled *T.R. et al. v. Susan Dreyfus et al.* (the "T.R. Litigation"), now known as *T.R. et al. v. Kevin Quigley and Dorothy Teeter*, filed November 24, 2009, case no. C09-1677-JPD, seeking certification of a class and declaratory and injunctive relief against the Secretary of the Washington State Department of Social and Health Services (DSHS), now Kevin Quigley. The lawsuit was subsequently assigned to the Hon. Thomas Zilly, Senior District Court Judge, as case number C09-1677-TSZ.

4. On July 23, 2010, this case was certified as a class action for purposes of all causes of action in Plaintiffs' Complaint to include all persons under the age of 21 who now or in the future (1) meet or would meet the State of Washington's Title XIX Medicaid financial eligibility criteria; (2) are determined and documented by a licensed practitioner of the healing arts operating within the scope of their practice as defined by Washington state law, to have a mental illness or condition, or had a screen or an assessment been conducted by such practitioner, would have been determined and documented to have a mental illness or condition; (3) have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and (4) for whom intensive home and community based services coverable under Title XIX Medicaid and eligible for Federal Financial Participation, have been, or would have been recommended by a licensed practitioner in order to correct or ameliorate a mental illness or condition.

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

6. On January 6, 2011, the parties began intensive efforts to negotiate the settlement of this case, with the assistance of mediators Theresa Wakeen, J.D., of Seattle, and Kathleen Noonan, then Clinical Professor of Law at the University of Wisconsin Law School in Madison. Thereafter, the parties held more than 30 direct mediation sessions from March 2011 through February 2012.

7. Through these efforts, the parties developed and signed an Interim Agreement, approved by this Court on March 7, 2012, and extended by stipulation and order on June 28, 2013. The objective of this Interim Agreement was to establish the infrastructure and necessary collaboration towards the readiness to provide WISe and supports.

8. The Interim Agreement will expire on the date the Court orders final approval of the settlement Agreement. Any obligations or commitments that parties agree are necessary have been expressly set forth in this Agreement.

9. The parties agree that the best interests of the Class will be substantially advanced by the settlement of the *T.R.* Litigation based on the commitments reflected in this Agreement, rather than by a trial on the merits.

10. The Defendants will seek resources, including legislative appropriation, sufficient to accomplish the commitments and exit criteria of the Agreement. Defendants agree that the lack of appropriations is not a defense to accomplishing the commitments and exit criteria of the Agreement. The services described herein are Medicaid services and nothing in this Agreement is

intended to, nor does it, impair the rights of children to receive EPSDT as mandated by state and federal law.

III. JURISDICTION AND AUTHORITY OF THE COURT

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

12. This Agreement settles all claims against the State Defendants in this lawsuit.

13. The parties to this Agreement acknowledge that the Plaintiff Class, and others thereby affected, must be provided with notice that is reasonably calculated to apprise them of the terms of this Settlement Agreement and an opportunity to be heard regarding the Agreement. Immediately following the execution of the Agreement, the parties shall jointly develop the content of the written notice to be communicated to the Plaintiff Class, as well as negotiate the terms of how such notice shall be provided to them. Should the Parties agree on this notice process, they will jointly recommend it to the Court and Defendants shall pay the reasonable cost of providing notice of the Agreement. In the event the Parties fail to agree on the process, each shall provide its proposal to the Court at the initial Rule 23(e) hearing, together with their respective recommendations for paying the costs of providing Notice of the Agreement.

14. Upon execution of this Agreement, Plaintiffs shall apply to the Court by application and/or motion for a preliminary determination of the fairness, reasonableness, and adequacy of the settlement Agreement herein. That application to the Court for entry of an order will be substantially in the following form:

a) Requesting the Court's preliminary approval of the Agreement (which includes the Stipulated Judgment) as being fair, reasonable and adequate as to members of the Class;

b) Approving the proposed procedures for giving notice to members of the Class of the Agreement;

c) Approving the form and content of such notice to members of the Class of the Agreement; and

d) Scheduling a fairness hearing seeking final approval as to the fairness, reasonableness and adequacy of this Agreement and asking that the Stipulated Judgment be entered.

15. After adequate notice of the subject matter of this suit and the proposed settlement terms of this Agreement and an opportunity to be heard regarding those terms has been provided to the Plaintiff Class and others thereby affected, and after expiration of the time set for comment and the receipt of same, the Court shall hold a hearing to determine whether to grant final approval of this Agreement as being a fair, reasonable and adequate settlement of the *T.R.* Litigation and to enter the accompanying Stipulated Judgment. Except as otherwise noted, the terms of this Agreement shall not take effect until the Court issues its order approving this Agreement.

IV. GOALS

16. The goals are intended to (a) provide structure and guidance for the planning, implementation, future development, and sustainability of the service delivery system; and (b) aid in interpreting the meaning and purpose of the commitments and exit criteria. The goals are not commitments or exit criteria, and shall not be measured as such.

17. The goal of the service delivery system for putative Class members is to have a system that will:

a) Identify and screen putative Class members and link eligible youth to the WISe program;

b) Communicate to families, youth and stakeholders about the nature and purposes of the WISe program and services, who is eligible for the program, and how to gain access to the WISe program and services regardless of the point of entry or referral source;

c) Provide timely statewide mental health services and supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Class member's needs consistent with the WISe program model and state and federal Medicaid laws and regulations;

d) Deliver high quality WISe services and supports facilitated by a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to families, youths, and stakeholders;

e) Afford due process to Class members denied services;

f) Coordinate delivery of services and supports among child-serving agencies and providers to Class members in order to improve the effectiveness of services and improve outcomes for families and youth. Reduce fragmentation of services for Class members, avoid duplication and waste, and lower costs by improving collaboration among child-serving agencies;

g) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families;

h) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders;

i) Minimize hospitalizations and out-of-home placements;

j) Correct or ameliorate mental illness;

k) Reduce mental disability and restore functioning;

l) Keep children safe, at home, and in school making progress; avoid delinquency; promote youth development; and maximize Class members' potential to grow into healthy and independent adults; and

m) Use available approaches that have been effective at achieving these outcomes.

V. COMMITMENTS

18. Defendants agree to fulfill the commitments contained within this Section during the pendency of this case as guided by the goals in this Agreement.

19. Substantial compliance with all of the Commitments and timelines approved by the Court are enforceable during the pendency of this case. Timelines may be modified during implementation subject to the process described in paragraph 95(a). An agreement to modify timelines, without more, does not alter the substantive intent of the Commitments, but only extends the time by which the Commitments will be accomplished.

A. WISe Access and Service Delivery

20. Defendants will provide the following Medicaid covered mental health services to Class members: (1) Intensive Care Coordination, (2) Intensive Home and Community Based

Services, and (3) Mobile Crisis Intervention and Stabilization Services. In Washington, these services are referred to collectively as WISe, and are defined in Appendix A.

21. Defendants will provide the WISe program and services, including Child and Family Teams (CFTs), to Class members, in accordance with the WISe Program Model, which is defined in Appendix B.

22. Defendants will provide Class members access to the WISe program and services in accordance with the WISe Access protocol, as amended, a description of which (diagram and narrative) is set forth in Appendix C.

23. Defendants will use the WISe Access Protocol to:

a) inform, identify and screen putative Class members in any child-serving system;

b) refer and allow self-referral of youth for a WISe screen;

c) plan for and provide WISe to those youth for whom WISe is medically necessary, based on the WISe screen; and

d) provide for continuity of care[3] for youth receiving WISe, particularly for those in transition.

24. Defendants may amend or update the WISe Access Protocol over time consistent with the purposes and intent of this paragraph and subject to the process described in paragraph 95(b).

25. Defendants will make descriptions or explanations of WISe easily accessible to youth, families and other stakeholders, to include posting information on Defendants' web sites.

[3] Continuity of care means the provision of continuously coordinated care, with an existing provider for those in the course of treatment, for Class members through transitions between providers or service areas and across child-serving agencies so that services are provided in a manner that does not interrupt medically necessary care or jeopardize the individual's health, safety, and wellbeing.

26. For the purposes of the Agreement, the Defendants aggregated historical data regarding actual children who had a mental illness or condition and a functional impairment that the Parties considered similar to potential Class members. This aggregated data set is called the "Population Proxy", hereinafter, "Proxy". The Proxy is attached hereto and incorporated herein as Appendix D. The Proxy does not directly identify individual Class members. Rather, the parties chose the Proxy's functional impairments and service utilization characteristics because they are data that are presently known or collected that are indicative of a child or youth who may be at risk and needing the WISe Program and services described in this Agreement. As more recent or additional data becomes available particularly with respect to children and youth who have an Individualized Education Program (IEP), Defendants will refine the Proxy subject to the process described in paragraph 95(b).

27. The Defendants will build statewide capacity over five years to provide WISe services to all youth for whom WISe is medically necessary. The Defendants will use a transparent process to establish the identification and referral protocol, and the WISe screening algorithm, an algorithm used to identify youth eligible for the WISe program, in consultation with clinical expert(s) mutually agreed to by the parties and input from the Implementation Advisory Team (IAT).[4] Within 90 days of court approval of this Agreement, Defendants will establish an initial estimated range of the number of youth that will utilize the WISe program, and schedule increased capacity over a five year period as part of the Implementation Plan, considering:

[4] The Implementation Advisory Team is a group comprised of the Plaintiff counsel, Attorney General representatives, and representatives of Defendants' child-serving systems with knowledge relevant to the services and processes Defendants utilize to comply with this Agreement. The IAT is utilized as a communication mechanism between parties to enable implementation.

a) The number of children currently in out-of-home placements with a need for mental health treatment;

b) the Proxy functional indicators that were most likely to result in out-of-home placement; and

c) estimated rates of those specific indicators to create an estimate of utilization by PIHP.

28. The WISe Program and services are a less restrictive alternative to Behavioral Rehabilitation Services (BRS) and the Children's Long-term Inpatient Program (CLIP), and WISe will be provided if a youth is determined eligible. Defendants will provide a WISe screen, to all youth prior to approval for BRS or CLIP to determine medical necessity for the WISe Program and if the youth's needs can be safely met in a less restrictive environment. Youth enrolled in BRS and CLIP will be periodically screened, no less frequently than every six months and at discharge, to determine if they can be transitioned to the WISe program.

29. Defendants will administer a WISe screen to all putative Class members who are referred to the WISe program using the Child and Adolescent Needs and Strengths (CANS) tool as part of the screening process to determine whether WISe is medically necessary.

B. State Fiscal Year 2014 Services and Services to Named Plaintiffs

30. Defendants will identify specific locations and provide services, subject to existing resources and PIHP capacity, by transitioning existing intensive services to WISe beginning January 2014 according to initial range of estimated service utilization to be further developed in the implementation plan.

31. Defendants provided named Plaintiffs reassessment during the Interim Agreement. Defendants will continue to provide medically necessary services to address the identified needs

of the eligible named Plaintiffs. Eligible named Plaintiffs will be included among youths served by the WISe Program in FY 2014, or provided comparable services and supports.

C. Workforce Development and Training

32. Defendants will establish a workforce development collaborative that operates independently and is co-led by youth and families, state systems, and partner universities to develop sustainable local and statewide education, training, coaching, mentoring, and technical assistance to support agencies in providing WISe to fidelity standards.

33. Defendants will develop a WISe workforce according to a WISe workforce development plan.

D. Due Process for Class Members

34. Defendants will require through contract that Prepaid Inpatient Health Plans (PIHPs) provide a Notice of Action advising Class members of their due process rights when any of the following apply:

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

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

35. Defendants will modify regulations to describe Class members' adequate notice and due process rights.

36. Defendants will provide information in the benefits booklet of the circumstances in which individuals have a right to receive a notice of action and request a fair hearing.

37. Defendants will provide directives to PIHPs regarding the delegation of authority to Community Mental Health Agencies (CMHA) to deny, terminate, or reduce services.

38. Defendants will require the PIHP to monitor for service reductions, terminations and denials of services by CMHAs. Defendants will require all PIHPs to collect data that tracks Notices of Action issued and Grievances and Appeals filed and to analyze the information on grievances and appeals as part of the PIHP quality improvement program. Defendants will monitor compliance and address concerns when they are identified.

E. Governance & Collaboration

39. Defendants will establish Agreement(s) with child-serving systems across DSHS and HCA to:

a) require collaboration and coordination of care for putative Class members;

b) require that local and regional representatives be invited to and participate in CFTs for children who are enrolled in WISe and served by multiple agencies;

c) coordinate funding sources, to the extent permissible by the state legislature and federal law, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and establish systems to achieve sustainability of WISe;

d) develop cross-system training and technical assistance;

e) develop data-informed quality improvement processes; and

f) increase family and youth participation in all aspects of policy development and decision-making for the WISe program.

40. Defendants will use a sustainable family, youth, and inter-agency Governance Structure to inform and provide oversight for high-level policy-making, program planning, decision-making, and for the implementation of this Agreement. An initial description of the

Governance Structure is set forth in Appendix E. The Governance Structure can be modified using the process described in paragraph 95(b).

41. The executive team of the Governance Structure will be used to make decisions about how its child-serving agencies meet the systemic needs of the plaintiff Class.

42. Defendants will engage family, youth and local community representatives through Family Youth and System Partner Round-Tables (FYSPRT) and other methods. The family, youth, and local community representatives will act as full partners[5] in the governance committees and groups.

43. Defendants, with input from the Implementation Advisory Team, will make recommendations through the Governance Structure to improve the coordination and delivery of Title XIX and WISe services to Class members.

44. To the extent relevant to the scope of this Agreement, Defendants will maintain the following items consistent with the principles as defined in the WISe Program Model in Appendix B:

a) Governance structure

b) Contracts with PIHPs

c) Practice guidelines

d) Policies related to WISe services

e) Workforce development and training materials

f) Communication materials

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

g) Quality management activities

h) WISe services

i) Memoranda of Understandings with other child-serving agencies

j) Regulations in the Washington Administrative Code.

F. Quality Management

45. Defendants will have a Quality Assurance Plan (QAP) developed by the children's behavioral health data/quality team, with input from the Implementation Advisory Team and appropriate stakeholders, and as needed, from consultants. The QAP is intended to describe, among other things, how quality assurance tools and activities developed under this Agreement may overlap with other existing quality assurance systems, programs, and activities.

46. Defendants' QAP will include all of the quality management goals, objectives, tools, and resources needed to measure the implementation and success of the Commitments in this Agreement.

47. The QAP will address WISe-related integration of data activities across Defendants' agencies that serve Class members.

48. Defendants will develop data-informed measures for the number of children identified, screened and assessed to WISe. The Defendants will monitor and publically provide these data throughout the duration of the Agreement.

49. The development of the QAP shall be completed and adopted within one year of the date of this Agreement. Defendants will complete implementation of the QAP within three years of the date of this Agreement. Once implemented, Defendants will maintain their quality assurance system in substantial compliance with the Agreement.

50. Defendants will regularly provide information developed from the quality assurance system to participants in the Governance structure, in order to inform data-driven, policy-level funding decisions, resource allocation, workforce development, contracting, program development, and accountability to stakeholders.

51. Defendants will routinely and transparently measure, analyze, and communicate Quality Assurance indicators and data that include, but are not limited to:

a) the number and characteristics of putative Class members at key points as they enter and progress through the WISe program;

b) the scope, intensity, and timeliness of WISe screens, assessments, or services provided to putative and actual WISe recipients in relation to their needs;

c) the degree to which screens, assessments, and services are authorized and provided consistent with Settlement Agreement and the WISe Program over time; and

d) short and long-term outcomes, consistent with measures developed for the children's mental health system, for those youth who received WISe and those who are screened out.

52. Defendants will provide guidance and timelines for increasing access to WISe over time, and providing adequate services for all WISe clients. Defendants may adjust their guidance as needed over time to reflect changed circumstances.

53. Defendants will require PIHPs that fall substantially below the statewide standards to implement a Corrective Action Plan, in accordance with the timeline included in the PIHP contracts.

54. Defendants will develop and make use of Quality Service Reviews (QSRs) as follows:

a) Within 36 months, complete QSRs in three locales (one low, one medium, and one high performing program or provider) to:

i. Assess WISe individual child and system performance, including fidelity to the WISe Program;

ii. Provide WISe program quality improvement data and opportunities; and,

iii. Develop and refine a QSR model or process for future quality assurance use.

b) Six months after QSRs are initiated, provide a written quality review report of "lessons learned" regarding subsections i—iii above, with recommendations regarding steps to be taken, if any, to improve the WISe Program.

G. Implementation Plan and Process Commitments

55. Defendants will develop an Implementation Plan beginning on the date the Court gives its preliminary approval of the Settlement Agreement, and will complete the Implementation Plan within six months after the Court gives its final approval of the Agreement.

56. Subsequent to the development of the initial range of estimated service utilization, the Defendants will periodically refine the range of estimated service utilization by:

a) Analyzing outcomes of all youth screened for WISe, to ensure that there is no systematic screening out of children who would have benefited from WISe;

b) Tracking out-of-home placements of youth with mental health needs who are and are not provided WISe after screening, and for those youth not screened;

c) Modifying the identification and referral process and the WISe screening algorithm if the process is systemically excluding eligible youth who are subsequently placed in out-of-home placement.

57. Defendants will develop the Implementation Plan using the Governance Structure, with input from the Implementation Advisory Team, and will:

a) Identify and sequence tasks necessary to fulfill the Commitments and achieve the Exit Criteria;

b) Estimate expected WISe utilization among PIHPs and a roll-out schedule to achieve it;

c) Set clear and accountable timelines through June 30, 2018;

d) Assign responsibility for achieving tasks;

e) Establish processes to monitor and provide feedback on progress:

i. in meeting their obligations under this Agreement, and

ii. of implementation, including any need to adjust or amend the Implementation Plan;

f) Establish a collaborative method to problem-solve challenges encountered; and

g) Describe the communication and outreach activities to inform the community, stakeholders, and families about WISe.

58. Defendants will submit to the Court for approval the completed Implementation Plan, which shall be reasonably capable of fulfilling the Commitments and achieving the Exit Criteria.

59. Beginning November 15, 2014, and each year thereafter, Defendants will provide the Court, the Plaintiffs, and the public with an Implementation Status Report that describes Defendants' progress in meeting their obligations under this Agreement. The Implementation

Status Report will include accomplishments and remaining tasks, and identify potential or actual problems as well as remedial efforts to address them.

60. Defendants will provide a draft of the report to counsel for Plaintiffs thirty days prior to filing the Implementation Status Report. Plaintiffs will provide any feedback within fifteen days of receiving the draft. If the parties are unable to reach consensus on the final contents of the Implementation Status Report, they may engage Kathleen Noonan to mediate the dispute. If Ms. Noonan is unavailable, the parties will identify an alternative mutually agreed mediator. If the parties do not reach agreement through mediation, Defendants may proceed with filing their Implementation Status Report, and Plaintiffs will have the option to prepare a response that will be filed with the Court and attached as an addendum to the publicly available version of the Implementation Status Report.

61. Defendants will comply with the Implementation Plan that is approved by the Court, and amended, pursuant to this Agreement.

62. Defendants will develop a WISe manual based on the National Wraparound Initiatives to guide and facilitate access to WISe. Manual topics should include, but need not be limited to: Goals of the system as described in this Agreement; definitions; identification, screening and assessment of youth; the wraparound process; collaboration and coordination with other system and community partners; roles and responsibilities of providers, team members, and agencies; access to needed supports and services; Medicaid billing and service reporting; identification and description of decision points, to include who makes the decision, decision making criteria, and procedures for reviewing, reconsidering, or appealing any decision; and dispute resolution. The Defendants may make modifications to the WISe manual that are consistent with the purpose and intent of this paragraph and subject to the process described in paragraph 95(b).

63. Defendants will direct, through training and contracts, PIHPs, service providers, and allied agencies and partners to follow the WISe Manual when delivering WISe to Class members.

64. Defendants will train and educate PIHPs, service providers, and allied agencies and partners how to:

a) identify youth for WISe screening;

b) implement and use CANS for assessment, care planning, and evaluation of outcomes; and

c) provide WISe services consistent with the WISe manual and the WISe Program Model.

VI. EXIT PROCEDURE AND CRITERIA

EXIT PROCEDURE

65. The Parties anticipate Defendants will complete implementation of this Agreement on or about June 30, 2018, and that the Parties' obligations herein will terminate, if at that time Defendants demonstrate they have substantially complied with the following exit criteria. At that time, the exit criteria set forth in this section will be the sole objective measures that, when accomplished, will indicate the State of Washington is in substantial compliance with the terms of this Agreement such that the lawsuit herein will be dismissed.

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

EXIT CRITERIA

A. WISe Access and Service Delivery Exit Criteria

67. Defendants:

a) Have adopted and are using consistent procedures statewide to identify putative Class members for possible eligibility for the WISe Program and Services;

b) Have adopted and are using the WISe access protocol statewide to identify, screen, assess, refer, and link Class members to WISe program and services;

c) Are providing the full WISe service array statewide;

d) Have adopted and are using consistent procedures to inform putative Class members and other stakeholders about the WISe Program, eligibility, and access;

e) Have adopted, and trained providers to use the WISe manual;

f) Have developed a WISe manual that describes the WISe Practice Model for practitioners and instructs providers on WISe documentation and operational requirements;

g) Require PIHPs to provide the WISe Program and services pursuant to amended PIHP contracts;

h) Are using CANS statewide to;

i. assess individual and family strengths and needs;

ii. support clinical decision-making and practice; and

iii. measure and communicate the outcomes of the WISe program.

i) Established a range of estimated service utilization and are providing WISe statewide within that range;

j) Built statewide capacity to provide WISe services to all youth for whom WISe is medically necessary;

k) Have achieved improved outcomes for youth in the WISe program, as measured by improvements in CANS domain scores and/or relevant clinical items from the CANS; and

l) Provided education and training on identification and referral for youth to WISe using the Access protocol.

B. Due Process Exit Criteria

68. Defendants have:

a) Made modifications to contracts necessary to establish the due process protocol as defined in paragraph 34;

b) Modified regulations that describe Class members' adequate notice and due process rights;

c) Clarified Notice of Action and grievance protocols and incorporate them into the Communication Plan and Benefits Booklet;

d) The Division of Behavioral Health and Recovery has in place a process to monitor and periodically report on PIHP's compliance with the Notice of Action and grievance protocol.

C. System Collaboration and Governance Exit Criteria

69. Defendants:

a) Have developed and are using cross-system protocols or allied system agreements to coordinate services and participate in CFTs for Class members, consistent with a Memoranda of Understanding between DSHS administrations and HCA;

b) Have developed and are using a mechanism to provide cross-system training and technical assistance on the implementation of CANS and WISe for agencies and providers of child-serving agencies; and

c) Have provided access and services to youth jointly served by BRS and mental health agencies consistent with the WISe Program model and the Access protocol.

70. Defendants have adopted and are using a Governance Structure similar to that presented in Paragraphs 40-41. Defendants:

a) Have chartered and convened the groups identified in the inter-agency governance structure;

b) Have included in the charters a stated recognition of youth- and family-voice and values; and

c) Have included youth and families in governance and policy development per the Governance structure as initially described in Appendix E.

D. Implementation Plan Exit Criteria

71. Defendants:

a) Received court approval of its Implementation Plan, as described in paragraphs 55-58; and

b) Executed the Implementation Plan as approved or amended.

E. Quality Management Exit Criteria

72. Defendants:

a) Developed and are using a Quality Assurance Plan;

b) Are presently operating a quality assurance system consistent with the Quality Assurance Plan;

c) Have a publicly accessible children's behavioral health measures of statewide performance (a data dashboard) including each of the indicators, for putative and actual Class members, updated quarterly;

d) Measure and report annually the number of youth who are identified, screened, assessed and receive WISe, reported by PIHP;

e) Required at least one PIHP annual Performance Improvement Project (PIP) to be focused on improving mental health services to Medicaid funded children and youth; and

f) Completed the one time QSR in three locales and produced the written report on "lessons learned."

VII. DISPUTE RESOLUTION

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

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

75. If the parties are unable to resolve the dispute within 30 days, or such other time frame upon which the parties mutually agree, they will engage the mediation services of Kathleen

Noonan for the purpose of mediating a resolution to the dispute. If Ms. Noonan is unavailable, the parties will identify an alternative mutually agreed mediator. That meeting will be at a mutually agreeable time and place, and, with the assistance of the mediator, the parties will use their good-faith, best efforts to discuss and resolve the dispute. Any agreement reached in this forum will be formalized as an addendum to the parties' Settlement Agreement and submitted to the Court for approval.

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

77. If, after participating in good faith at the mediation, no resolution is reached either party may file an appropriate motion with the United States District Court in this matter. The moving parties' counsel shall provide the appropriate notice to the opposing partie's counsel of such action.

78. In the event that Plaintiffs' counsel reasonably believes that there is a systemic risk of imminent harm to a broad group of Class members as a result of Defendants' substantial noncompliance with their systemic obligations under this Agreement, Plaintiffs will make a good faith effort to consult with Defendants' counsel to discuss the potential harm resulting from an alleged failure to meet their systemic obligations. If the issue or issues are not resolved within a reasonable amount of time given the severity and imminence of harm, parties may engage in an expedited mediation process, using Kathleen Noonan as detailed in the dispute resolution provisions set forth herein. If an appropriately expedited dispute resolution process cannot be scheduled, or the systemic matter is not resolved through the mediator, Plaintiffs may proceed

directly to the Court or may take any other necessary legal action. Plaintiffs will provide at least one business day's written notice to Defendants' counsel via facsimile or email and first class mail prior to initiating court action. "Imminent" is defined as "about to occur at any moment; impending" (Webster's II New College Dictionary, 1995). A "systemic obligation" is one that may affect all, or a substantial portion of, the Class and is not represented or proven by a circumstance or condition affecting an individual Class member.

VIII. SCOPE OF RELEASES AND WAIVERS

79. Defendants admit:

a) The WISe services array, as defined in Appendix A, is covered under Washington's Medicaid state plan to the extent that services are eligible for federal financial participation as Medicaid-covered services;

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

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

80. Beyond the admissions in the previous paragraph, this Settlement Agreement is not to be construed as an admission of liability or wrongdoing by Defendants. Defendants assert that they have meritorious defenses in response to the allegations of the Plaintiffs' Class. Defendants have entered into this Agreement solely for the purpose of settling and compromising Plaintiffs'

claims, to avoid the expense and diversion of resources caused by protracted litigation, and to further terminate the claims asserted against Defendants once this Agreement is implemented.

81. In consideration of the covenants and undertakings set forth herein and intending to be legally bound thereby, it is stipulated and agreed by Plaintiffs and the Defendants, represented by their authorized signatories, that all of Plaintiffs' claims for relief against the Defendants which were asserted in the Complaint filed on November 24, 2009, or First Amended Complaint filed on October 27, 2011, shall be resolved on the terms as set forth in this Agreement.

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

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

84. Nothing in this Agreement shall be deemed to limit the ability of Disability Rights Washington (DRW) to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, et seq., and the regulations promulgated thereto, 42 C.F.R. § 51 et seq., the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, et seq., and the regulations promulgated thereto, 45 C.F.R. § 1386 et seq., and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.

IX. PLAINTIFF COUNSEL ACCESS TO INFORMATION

85. The Parties agree to minimize the number and scope of requests for data and information not already provided to Plaintiffs through the Implementation Status Report process

or to the Implementation Advisory Team pursuant to commitments set forth in paragraphs 25, 27, 48, 50, 51, 54(b), 59, and 60 of this Agreement.

A. Non-Confidential Implementation Data and Information

86. Should Plaintiffs seek any data and information concerning Defendants' progress in implementing this Agreement not otherwise available as described in the previous paragraph:

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

i. Specific data and information sought,

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

iii. Specific concerns the data and information are sought to address.

b) Should Defendants agree the data and information requested are relevant to the Settlement Agreement, Defendants will provide access to relevant data and information within their control within a reasonable time period. Within ten (10) business days of receipt of a request for additional data or information under this paragraph, Defendants will provide a letter that acknowledges such receipt, and give an estimate of the time and costs needed to comply with the request. Plaintiffs will pay reasonable copy costs for records not otherwise provided under paragraph 85.

c) Any disputes within that process regarding the relevance, necessity, availability, or timing and thoroughness of production of requested data and information will be resolved through dispute resolution (Section VII herein).

d) Nothing in this Agreement prevents Plaintiffs from obtaining non-confidential records pursuant to the Washington State Public Records Act, RCW 42.56.

B. Confidential Information Contained In Class Member Individual Records

87. In the event Class counsel seek the review of confidential information contained in the individual records of a Class member not named as a party in this proceeding, the following procedures will apply:

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

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

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

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

X. ATTORNEYS' FEES AND COSTS

89. The parties will make good faith efforts to negotiate the amount of attorneys' fees, costs, and litigation expenses to be awarded to Plaintiffs' counsel, after March 7, 2012. In the event that the parties cannot reach agreement with respect to attorneys' fees, costs, and expenses, they will submit the matter for mediation to a mutually agreeable mediator. If attempts to mediate are not successful, plaintiffs may file the appropriate motion with the District Court.

90. The Parties affirm that an agreement as to attorneys' fees, costs, and expenses to be paid to Plaintiffs and their counsel for the litigation and mediation period up to and including March 7, 2012, was finalized on July 31, 2012. The Parties agree that the motion for an order approving those fees, costs, and expenses may be submitted to the Court for approval under Federal Rule Civil Procedure 23 (h) together with any agreement on fees, costs, and expenses incurred since March 7, 2012.

XI. OTHER PROVISIONS

91. The Parties agree those materials contained in the several appendices to this Agreement, as they are referenced in the main body of the Agreement, are included and fully incorporated into this Agreement as if fully set forth herein.

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

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

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

95. Modifications

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

b. Where indicated in this Agreement, by reference to this paragraph, identified documents may be substantively modified at the discretion of the Defendants and without Court approval. For these documents, Defendants will provide proposed changes to the Implementation Advisory Team (IAT) 60 days prior to adoption, for input from the IAT no later than 30 days prior to adoption.

c. Non-substantive changes, including grammatical or formatting modifications that have no effect on the document's content or meaning, may be modified without notice to the IAT.

96. Frustration of purpose/force majeure. If the Defendants are unable to accomplish any of their obligations or meet timeframes under this Agreement due to events beyond their reasonable control (such as natural disaster, labor disputes, war, acts of God or governmental action beyond state control), Defendants shall notify Plaintiffs' counsel with ten (10) business days of the date upon which Defendants become aware of the event and describe the event and its

effect on performance. If performance is expected to be delayed or the event frustrates the purpose of the Agreement, the parties shall negotiate in good faith to amend the Agreement and seek approval of the Court for such amendment.

97. Severability. The provisions of this Agreement are severable. If any court holds any provision of this Agreement, including any provision of any document incorporated by reference, invalid, that invalidity shall not affect the other provisions of this Agreement.

98. The parties agree that this Agreement is intended to be interpreted to provide flexibility and economic efficiencies in the implementation of the Patient Protection and Affordable Care Act of 2010, P.L. 111-48.

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

100. If, for any reason, the Court does not approve this Agreement and the Stipulated Judgment as a fair, reasonable, and adequate settlement of the T.R. Litigation as between the Plaintiffs and Defendants, this Agreement shall be null and void.

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

COUNSEL FOR PLAINTIFFS T.R., S.P., C.A., T.F., P.S., T.V., E.H., E.D., L.F.S., AND THE PLAINTIFF CLASS

By: _____ Dated: 8/27/13

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By: _____ Dated: 8-27-13

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By: _____ Dated: 8/27/13

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FOR THE STATE OF WASHINGTON

By: _____ Dated: Aug 22, 2013

DEFENDANT
KEVIN W. QUIGLEY
Secretary
Washington State Department of Social
and Health Services

By: _____ Dated: August 22, 2013

DEFENDANT
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COUNSEL FOR DEFENDANTS:

By: _____ Dated: Aug 19, 2013

JOHN K. MCILHENNY, JR.
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_____ Dated: Aug. 19, 2013

ERIC NELSON
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APPENDIX A

Wraparound with Intensive Services (WISe)

1. Intensive Care Coordination

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

Intensive Care Coordination provides:

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

ICC service components consist of:

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

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

Referral, monitoring and related activities: The care coordinator

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

Transition: The care coordinator:

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

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

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

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

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

Direct Services includes, but is not limited to:

- Educating the child's family about, and training the family in managing, the child's disorder;
- In-home functional behavioral assessment;
- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the child's family and others how to implement behavioral strategies, and in-home behavioral aids who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan’s effectiveness to clinical professionals;
- Therapeutic services delivered in the child’s home including, (but not limited to) therapeutic interventions such as (a) individual and/or family therapy; and (b) evidence based practices (e.g., Family Functional Therapy, Multi-Systemic Therapy, Trauma-Focused Cognitive Behavioral Therapy, etc.). These services are designed to:

- Improve self-care, including by addressing behaviors and social skills deficits that interfere with daily living tasks and with avoiding exploitation by others;
- Improve self-management of symptoms, including assisting with self-administration of medications;
- Improve social functioning, including by addressing social skills deficits and anger management;
- Support the development and maintenance of social support networks and the use of community resources;
- Support employment objectives, by identifying and addressing behaviors that interfere with seeking and maintaining a job;
- Support educational objectives, through identifying and addressing behaviors that interfere with succeeding in an academic program in the community; and
- Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

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

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

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

3. Mobile Crisis Intervention and Stabilization Services (MCIS)

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

Services include:

- Crisis Planning that, based on child's history and needs, (a) anticipates the types of crises that may occur, (b) identifies potential precipitants and creates plan to reduce or eliminate, and (c) establishes responsive strategies by caregivers and members of child's team to minimize crisis and ensure safety;
- Assessment of (a) precipitants of crisis, (b) behaviors that are occurring, (c) child and family safety, (d) what kinds of resources are available to address immediate problems, and (e) what strengths of the child and family can be used to address crisis;
- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions;
- Referral and coordination with (a) other additional services and supports necessary to continue stabilization or prevent future crises from reoccurring, and (b) any current providers and team members, including care coordinator, therapists, family members, primary care practitioners, or school personnel; and
- Post-crisis follow-up services (stabilization services) provided periodically up to 14 days after initial crisis occurs to (a) ensure continued safety, delivery of additional services identified as necessary to prevent future crises, and, (b) if placed out of home, coordinate services from out-of-home provider and child's treatment team to facilitate plan for rapid return home.

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

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

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

APPENDIX B

WISe Program Model

A. Purpose of the WISe Program

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

B. Washington State Children's Mental Health Principles

Washington State will operate a Medicaid-funded mental health system that delivers services to children and youth guided by the following principles:

- **Family and Youth Voice and Choice**: Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.

- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

- **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

C. WISe Program Activities

Program activities embrace Washington State Children's Mental Health Principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the child and family the following six components over the course of treatment and transition.

- **Engagement**: Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
- **Assessing**: Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.

- **Service Planning and Implementation:** Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.
- **Teaming:** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
- **Monitoring and Adapting:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
- **Transition:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

D. Child and Family Team

Each child in the WISe program will have a Child and Family Team (CFT). The CFT facilitates cross system coordination and drives the treatment planning process to ensure that services and supports are provided in accordance with the WISe Program. The role of the CFT, as further described in the WISe manual and PIHP contracts, includes:

- Collectively developing a single, unified, cross-system care plan that addresses the strengths and needs of the youth and family and the mandates of all of the parties involved.

- Identifying creative and nontraditional approaches, including formal and natural supports, for meeting the needs of the youth and family.
- Determining medical necessity for services provided under the Mental Health Individual Service Plan.
- Working together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and parent(s)/guardian(s).
- Having a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- Reconvening to consider the outcomes in relation to the services that have been provided and to make needed adjustments over time.

E. WISe Services

Defendants will provide the Medicaid covered mental health services to class members to include: (1) Intensive Care Coordination, (2) Intensive Home and Community Based Services, and (3) Mobile Crisis Intervention and Stabilization Services. In Washington, these services are referred to collectively as WISe, and are defined in Appendix A.

WISe Access Protocol – Narrative and Diagram

The WISe Access Protocol provides guidance on how to access WISe services, as defined in Appendix A, and outlines the administrative practices and procedures necessary to operationalize the WISe Practice Model, as described in Appendix B. The WISe Access Protocol is intended to describe the movement of clients into, through, and out of a system of care. Washington State will use this protocol for the following purposes:

- Inform, identify and screen putative class members in any child-serving system;
- Refer and allow self-referral of youth for a WISe screen;
- Plan for and provide WISe to those youth for whom WISe is medically necessary and make alternative referrals for other youth, based on the WISe screen; and
- Provide for continuity of care for youth receiving WISe, particularly for those in transition.

POINT OF IDENTIFICATION

Prepaid Inpatient Health Plans (PIHPs), providers, and other child serving systems[1] will identify youth likely to screen into WISe and refer those youth to identified screening entities. Screening for WISe services is essential, although not limited to, instances where there is a:

1. Request for out-of-home treatment or placement substantially related to unmet mental health needs;
2. Step-down request from institutional or group care; or
3. PIHP crisis intervention and the individual presents with past or current functional indicators of need for intensive mental health services.

Youth and families may self-refer by requesting a screen for WISe services. All requests for a WISe screen will be honored, regardless of referral source.

REFERRAL AND INTAKE PROCESS

1. A family or other Point of Identification will contact the PIHP or a PIHP contracted

[1] Examples of child-serving systems include the Division of Social and Health Services, schools, Primary Care Physicians, Juvenile Justice, non-specialized Community Mental Health Agencies, Crisis Teams, Healthy Options, and Fee for Service providers, among others.

Community Mental Health Agency (CMHA) directly to request screening for WISe when a child may meet the screening criteria for WISe.

2. The PIHP system will check for Medicaid eligibility, complete a WISe screen, and for clients not currently served by a PIHP will complete the intake process.
3. Clients that screen into WISe will be eligible for services funded through the 1915(b) waiver program.
4. Youth who are not Medicaid eligible or WISe indicated will be referred and linked to other mental health, social and/or community services. Crisis services are available to all youth, regardless of eligibility.
5. Youth and families have a choice whether to participate in the WISe Program. Clients who accept WISe services will proceed to care planning. Those choosing not to participate will be referred and linked with mental health and other community services.

CARE PLANNING

1. Clients involved with two or more child serving systems will be encouraged to engage in the WISe Process for the development of a cross system care plan.
2. The PIHP system will assemble the client's Child and Family Team (CFT). The CFT is responsible for developing the client's unified cross-system care plan, which is based on the youth's Child and Adolescent Needs and Strengths (CANS). Members of the CFTs will be empowered to present their service recommendations in development of the service plan.
3. Clients currently receiving intensive services, prior to CANS implementation, will be assessed utilizing the CANS tool during their regularly scheduled re-authorization.

SERVICE DELIVERY

1. Services will be provided based on the established Individual care plan and level of care decisions will continue to be directed by the CFT, CANS assessment, clinical evaluation, medical necessity and individual need.
2. Progress will be reviewed monthly at a minimum by the CFT or individual therapist and the plan revised as indicated.
3. The PIHP provider, with input from the CFT, will update the CANS data system

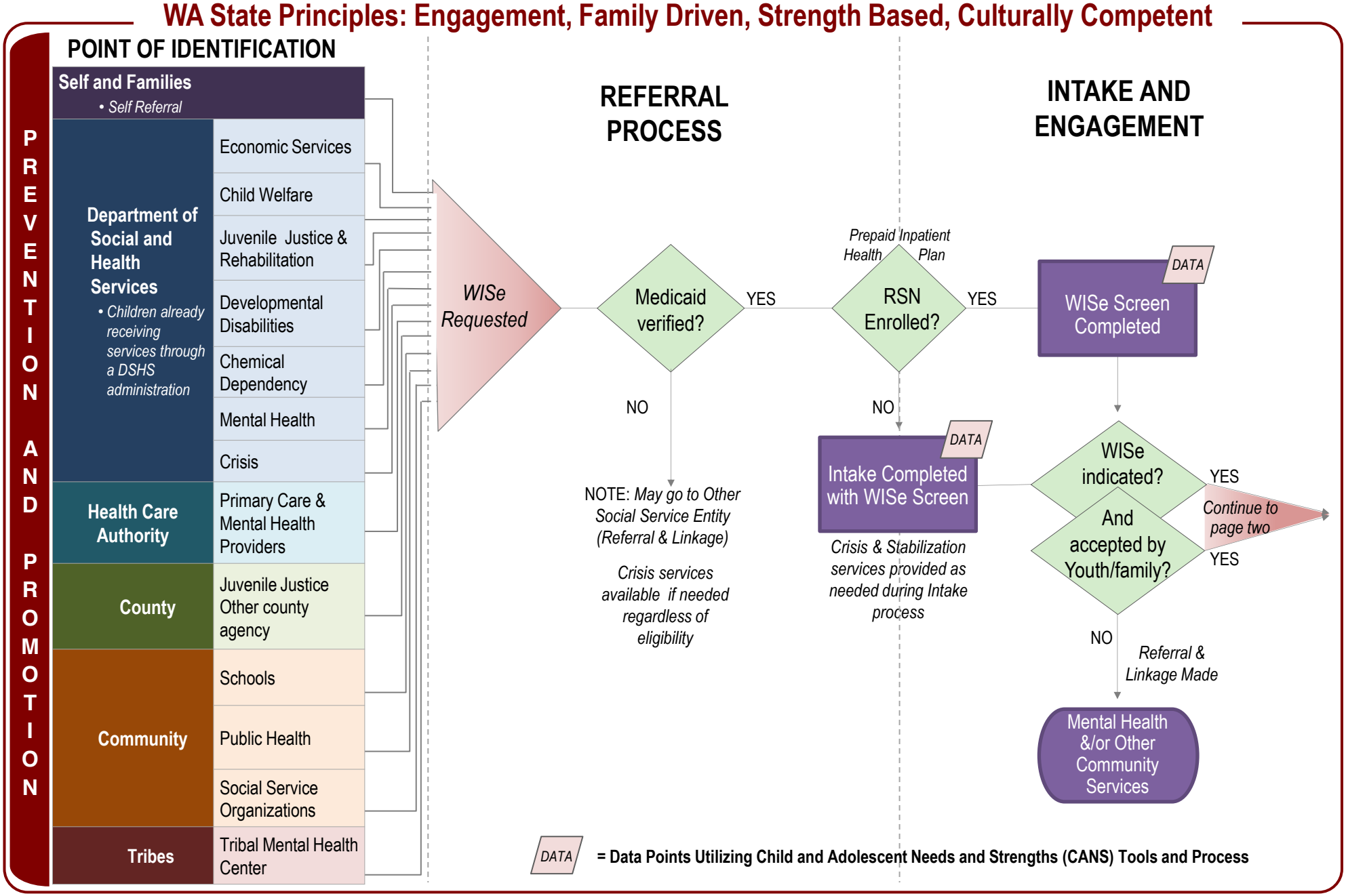
every three months to capture progress.

TRANSITIONS

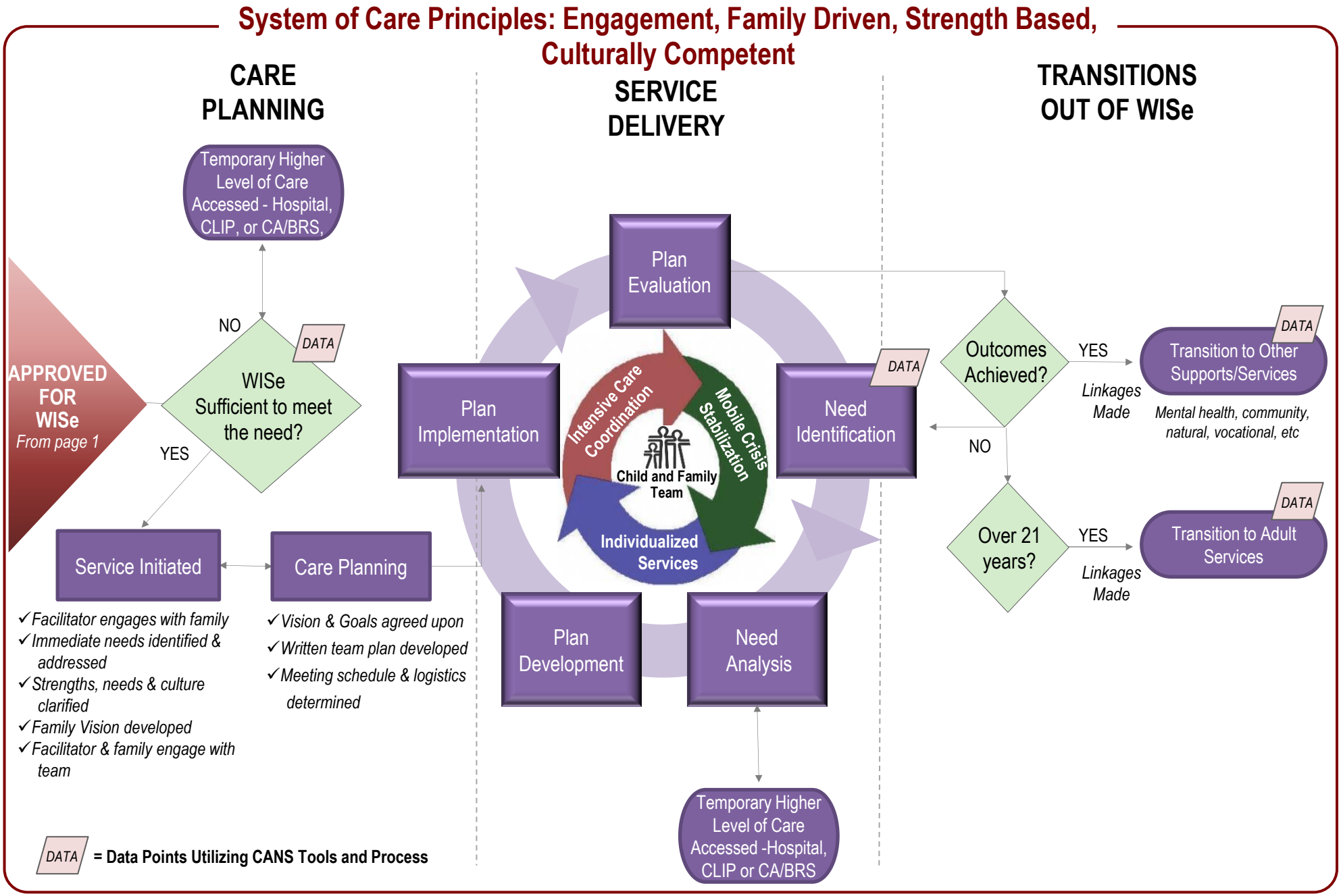
1. Discharge and transition planning will be based on assessment of outcomes during the ongoing review process of the CFT and/or treatment process.
2. Continuous coordinated care will be ensured through transitions in providers, PIHPs and across child serving agencies.

Access Model to Wraparound with Intensive Services (WISe)

Appendix C



Access Model to Wraparound with Intensive Services (WISe)



Proxy – Narrative and Table

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

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

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

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

To allow consideration of the broadest potential set of functional proxy indicators, our estimates focused on data for State Fiscal Year (SFY) 2011.

Medicaid population identification. The list below summarizes the medical coverage categories that were used to define the Medicaid population. We then determined the population of Medicaid children and youth under the age of 21 based on the persons age in their first month enrolled in Medicaid in SFY 2011. Eligibility data was derived from the "Client by Month" data table in the ProviderOne Operational Data Store (ODS).

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

Based on these medical coverage categories, we identified 783,693 children and youth who were enrolled in Medicaid for at least one month in SFY 2011 and were under age 21 in their first month of Medicaid enrollment in that year.

Mental health need definition. Mental health needs were flagged based on the occurrence of any one (or more) of a set of criteria based on diagnoses, psychotropic medication receipt, and service utilization. With regard to diagnosis, clients were flagged if any of the diagnoses listed in the table below were found in their medical and behavioral health service encounters in SFY 2011.

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

With regard to receipt of psychotropic medications, children were flagged if they had a filled prescription in SFY 2011 for medication in any one or more of the following therapeutic classes:

- Antipsychotic
- Antimania
- Antidepressant
- Antianxiety
- ADHD

In addition to the diagnosis and medication based indicators of mental health need, we treated use of the following mental health related services in SFY 2011 as a definitional indication of a mental health service need:

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

Based on these criteria, we flagged with a mental health need 86,913 of the 783,693 children and youth under the age of 21 who were enrolled in Medicaid for at least one month in SFY 2011.

Functional proxy flag definitions. For the population of Medicaid children and youth under age 21 with indications of a mental health service need, we used a set of “functional proxy flags” to indicate that the

child should be screened for need for intensive home- and community-based services. A child with any one (or more) of the selected functional proxy flags is counted as appropriate to be screened for need for intensive home- and community-based services. Functional proxy measures are based on the child's experiences in SFY 2011. The set of functional proxy flags are described in greater detail below:

1. Child Long-Term Inpatient (CLIP) stay in SFY 2011.
2. State mental hospital (including Child Study Treatment Center) stay in SFY 2011.
3. Community inpatient mental health admission in SFY 2011.
4. Children's Administration (CA) Behavioral Rehabilitation Services in SFY 2011
5. CA Other Intensive Services in SFY 2011 (primarily consists of services related to treatment foster care, CHAP and SAY)
6. In a CA placement in SFY 2011 and experienced 3 or more lifetime out of home placements
7. Received JRA services in SFY 2011, including institution stays, community placement, parole or dispositional alternatives
8. Adjudicated in SFY 2011 with one of the following dispositions (from the AOC data via the WSIPP criminal recidivism database):
    a. Convicted, including sentencing to JRA or county juvenile detention facilities
    b. Diverted or deferred
9. Received RSN crisis services in SFY 2011
10. Homeless: identified based on ACES living arrangement codes and includes status of "homeless without housing" or a shelter stay at any time in SFY 2011
11. Psychotropic medication polypharmacy: had at least 60 days in SFY 2011 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.
12. Two or more medical inpatient admissions with a primary mental illness diagnosis on the claim
13. Two or more medical outpatient Emergency Department visits with a primary mental illness diagnosis on the claim
14. DBHR-MH service use at/above the 90th percentile based on count of outpatient encounters
15. Drug overdose diagnosis in a medical claims or encounters. Identified by the following ICD-9-CM criteria: 909.0, 965.00, 965.01, 965.02, 965.09, 965.1, 965.7, 965.8, 965.9, 967.6, , 967.8, 967.9, 969.0, 969.1, 969.2, 969.3, 969.4, 969.5, 969.6, 969.7, 969.8, 969.9, 970.0, 970.1, 970.8, 970.9, E850.0, E850.1, E850.2, E850.3, E850.4, E851, E852.5, E852.8, E852.9, E853.0, E853.1, E853.2, E853.8, E853.9, E854.0, E854.1, E854.2, E854.3, E854.8, E980.0, E980.1, E980.2, E980.
16. Anorexia/Bulimia diagnosis in medical claim or encounter: 307.1, 783.0, 307.51
17. Suicide attempt or self-injury in medical claim or encounter: E950 to E959
18. *Possible* suicide attempt or self-injury in medical claim or encounter: E980 to E989
19. Alcohol or other drug use treatment need, identified by the occurrence of any of the following:
    a. A medical claim or encounter with diagnosis of a substance use disorder
    b. Substance abuse treatment or detox service use
    c. An arrest for a substance-related offense in the Washington State Patrol database (includes DUI/DWI, drug possession, and related offenses)

Based on these criteria, we identified 22,674 Medicaid children and youth under the age of 21 in SFY 2011 with a mental health service need who met one or more of the 19 functional proxy criteria listed above. This is the size of the population estimated to need screening for intensive home- and community-based mental health services.

TABLE 1

Functional Proxy Profile for Persons Under 21 on Medicaid in FY 2011 Meeting Mental Health Need Criteria

April 2013 • DEPARTMENT OF SOCIAL AND HEALTH SERVICES RESEARCH AND DATA ANALYSIS DIVISION

	Medicaid + Mental Health Need Flag	
	NUMBER	PERCENT OF TOTAL*
MENTAL HEALTH INPATIENT STAY (FY 2011)		
DBHR-MH Child Long Term Inpatient (CLIP)	91	0.4%
DBHR-MH State Mental Hospitals	221	1.0%
DBHR-MH Community Inpatient	1,290	5.7%
CHILDREN'S ADMINISTRATION ENCOUNTERS (FY 2011)		
Behavioral Rehabilitation Services	1,228	5.4%
Other Intensive Services	565	2.5%
In CA placement in FY 2011 with 3+ lifetime CA out-of-home placements	3,887	17.1%
OTHER RISK INDICATORS (FY 2011)		
JRA Services	941	4.2%
Convicted, deferred or diverted	6,634	29.3%
RSN Crisis Encounter	4,696	20.7%
Homelessness	2,507	11.1%
Four or more Psychotropic Medications prescribed for at least 60 days in FY 2011	2,833	12.5%
Two or More Medical Inpatient Admissions with primary MI Dx on claim	474	2.1%
Two or More Emergency Room Visits with primary MI Dx on claim	1,489	6.6%
DBHR-MH utilization in FY 2011 at or above the 90th percentile	4,327	19.1%
Drug overdose diagnosed in medical claim/encounter	507	2.2%
Anorexia/bulimia diagnosed in medical claim/encounter	541	2.4%
Suicide/self-injury diagnosed in medical claim/encounter	502	2.2%
Possible suicide/self-injury diagnosed in medical claim/encounter	187	0.8%
Alcohol drug treatment need flag	6,620	29.2%
ANY FUNCTIONAL PROXY, MEDICAID POPULATION AGE 0-20, WITH MH NEED FLAG, FY 2011	**22,674**	**100%**
MEDICAID POPULATION AGE 0-20 WITH MENTAL HEALTH NEED FLAG, FY 2011	**86,913**	
TOTAL UNDUPLICATED POPULATION OF MEDICAID CLIENTS AGED 0-20, FY 2011	**783,693**	

Children's Mental Health Governance Structure

Narrative

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

The overarching responsibility of the Governance Structure is to provide for:

- adherence to the Settlement Agreement among constituencies,
- steady progress in implementing agreed-upon commitments, practice improvements and quality oversight,
- meaningful partnership with families and youth,
- effective use of data to inform progress in achieving cross-system outcomes,
- appropriate interface with the State Legislature and key advocates, and
- sustainability of a shared investment and liability, i.e. vision, fiscal support, empowered leadership and system improvements.

Governance will be managed by an Executive Team lead by Assistant Secretaries of the Children's Administration, Behavioral Health and Service Integration Administration (for the Division of Behavioral Health and Recovery), Developmental Disability Administration, Economic Services Administration, Juvenile Justice and Rehabilitation Administration, and Health Care Authority (Medicaid).

The structure of the Children's Mental Health governance will consist of chief operating bodies with clear roles and reporting guidelines:

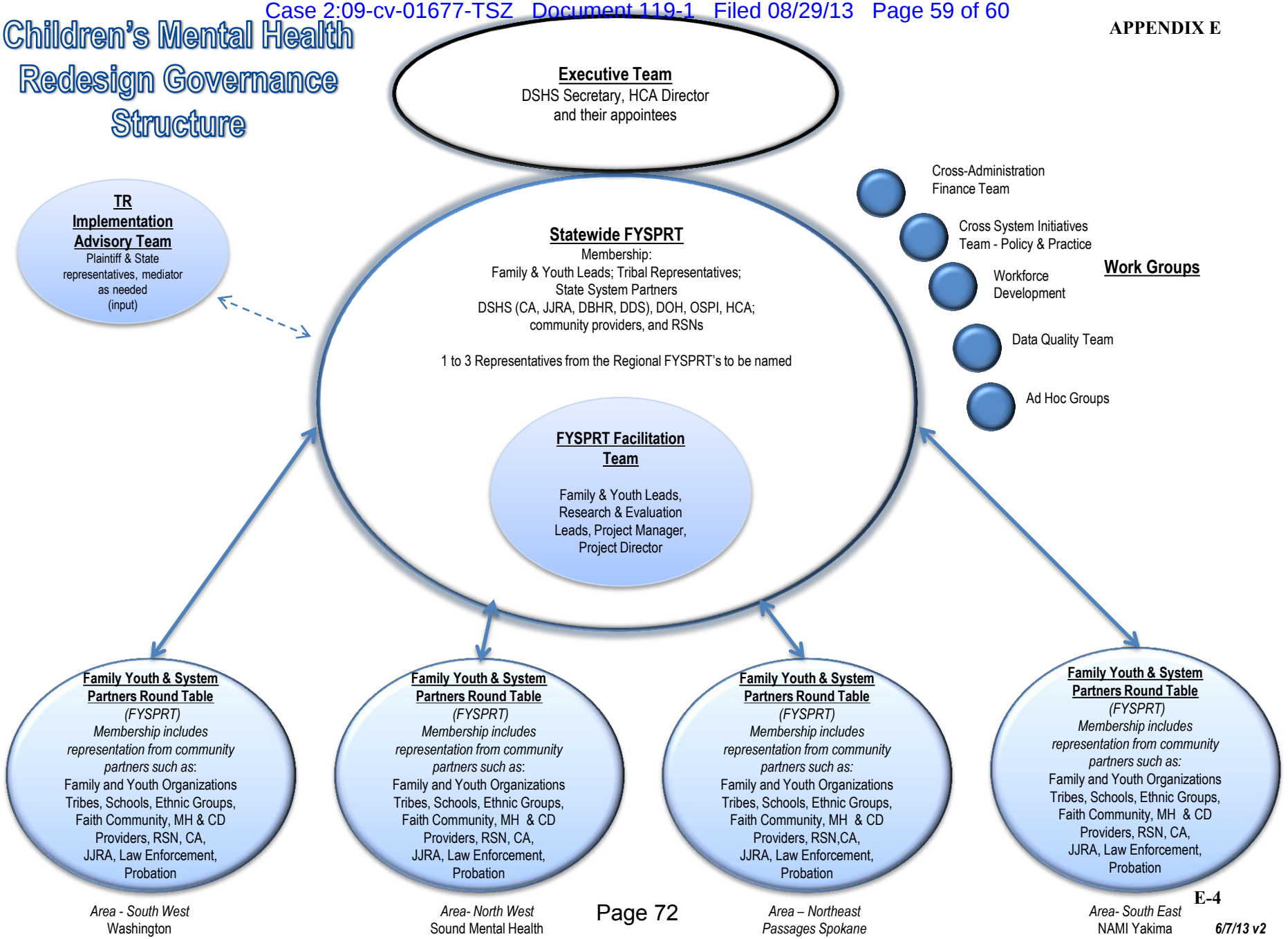
1. **Executive Team**: The role of the Executive Team is to provide leadership, problem-solving, and decision-making regarding progress in implementing system-wide practice improvements, fiscal accountability, and quality oversight.
2. **Family, Youth, and System Partner Round Tables (FYSPRTs):** FYSPRTs are comprised of family and youth, governmental/tribal partners, and others who are interested in and committed to the success of youth and families. Regional FYSPRTs identify local needs, and develop a plan to bring those needs forward to the Statewide FYSPRT, with recommendations about how to meet those needs.
3. **Work Groups**: Throughout the implementation, various work groups will be needed to operationalize the Agreement. These Work Groups will be comprised of, but not limited to, representatives from DSHS, HCA, Office of the Superintendent of Public Instruction (OSPI), Department of Health (DOH), Washington Tribes, youth and families, Regional Support Networks (RSNs), and service providers.
    a. **Children's Mental Health Cross-Administration Finance Team**: The Finance Team is a cross-system team created to address alignment of funding sources, costs of expanding service capacity and improving cost effectiveness.
    b. **Cross System Initiatives Team – Policy and Practice:** The Cross System Initiatives Team works on behalf of the Governance structure to address cross system issues and initiatives through the facilitation and development of policies and procedures based on WA Children's Mental Health Principles.
    c. **Workforce Development Workgroup:** This group develops and strengthens a workforce that operationalizes the Washington Children's Mental Health Principles and WISe Program Model.
    d. **Children's Behavioral Health System of Care (SOC) Data Quality (DQ) Team:** The mission of the DQ Team is to provide a forum for developing and refining data collection and management strategies related to screening, assessment, performance measurement and quality improvement relevant to children's behavioral health in Washington State. Reporting, outcomes evaluation, and other types of accountability activities are another aspect of the Team purpose. Working in an inclusive and

transparent fashion the Team will assure integration of data activities across systems involving children, youth, and families.

e. **Ad Hoc Groups:** As implementation proceeds, ad hoc groups may be utilized. These groups may include the Office of Indian Policy, DSHS Indian Policy Advisory Committee, and other administrations and divisions as needed.

4. **Implementation Advisory Team**: The Implementation Advisory Team is a group comprised of the Plaintiff Counsel, Attorney General representatives, and representatives of Defendants' child-serving systems with knowledge relevant to the services and processes Defendants utilize to comply with this Agreement. The IAT is utilized as a communication mechanism between parties to enable implementation.

Children's Mental Health Redesign Governance Structure



Regional Family Youth System Partner Round Tables with Local Family Youth System Partner Round Tables