Idaho Implementation Plan

April 29, 2016

Submitted under the

Settlement Agreement in

Jeff D. v C.L. “Butch” Otter

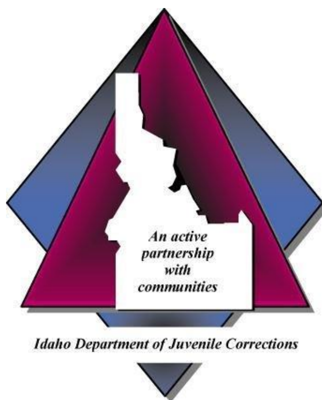
Hon. B. Lynn Winmill

U.S. District Court, Boise

No. 4:80-CV-04091-BLW

IDAHO DEPARTMENT OF

HEALTH & WELFARE



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INTRODUCTION 2
OVERVIEW 6
OBJECTIVE 1: Provide Services and Supports to Class Members 8
OBJECTIVE 2: Principles of Care and Practice Model 13
OBJECTIVE 3: Access 15
OBJECTIVE 4: Sustainable Workforce and Community Stakeholder Development 22
OBJECTIVE 5: Due Process 25
OBJECTIVE 6: Governance and Interagency Collaboration 29
OBJECTIVE 7: Quality Management, Improvement, and Accountability (QMIA) 31
GLOSSARY 35

INTRODUCTION

The Implementation Workgroup (IWG) submits this Idaho Implementation Plan ("Plan") to the District Court in conformance with the Settlement Agreement ("Agreement") filed in the case of *Jeff D. et al., vs. Otter, et al.,* the Honorable B. Lynn Winmill presiding, U.S. District Court, Boise, No. 4:80-CV-04091-BLW.

The Jeff D. class action lawsuit was filed in 1980 and sought to address two primary issues: 1) mixing adults and juveniles at State Hospital South, and 2) the provision of community-based mental health and education services to children with serious emotional disturbance. In an attempt to resolve the suit the state activity for many years was focused on the provision of community-based mental health services. In 2007, the federal district court dismissed the case. The Ninth Circuit Court of Appeals overturned the decision in 2011, reinstating the case. The federal district court advised the parties to engage in a mediation process to arrive at a solution to the suit. The parties collaborated from October 2013 to December 2014, including parent, provider and advocacy representatives, to develop the Agreement that ultimately will lead to a public children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates other features consistent with the System of Care Values and Principles.[1]

The purpose of this Plan is to implement the Agreement and therefore, the Plan shall be interpreted in compliance with the commitments, outcomes and exit criteria listed in the Agreement. The Plan shall not lessen or broaden any obligations or duties listed in the Agreement.

The Plan is the first step in completing the Agreement and satisfying the consent decrees, by developing and implementing sustainable, accessible, comprehensive, and coordinated service delivery of publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho. (Agreement, pages 2-3.)

Key to the success of the undertaking is the state's understanding that the best outcomes occur when children have access to community-based services and their families drive the care that is needed for their child. The SoC must operate in a coordinated fashion to facilitate and support family engagement and in which caretakers play an active role in the assessment and treatment process. Partners in the SoC must have sufficient information and training so they can fulfill their roles and contribute to the successful operations of the system.

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[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), http://www.tapartnership.org/SOC/SOCvalues.php

The state has developed new partnerships for initiating and maintaining cross-system coordination including information sharing and creation of uniform products and processes including communication materials, due process for operating fair hearings, complaint tracking, and quality improvement. These partners have jointly created a new dedicated website (www.YES.idaho.gov) as another opportunity to share the good news about the SoC in development and to provide a dependable information source about it for stakeholders.

In order to develop and finalize the Plan, the parties continued the collaborative efforts which led to the Agreement in the first place. Importantly, the Plan achieves a goal of being a stipulated consensus plan between the state and Plaintiffs' counsel as the result of numerous meetings over the last nine months, and culminating in a day long face-to-face finalization meeting between the Parties held on April 7, 2016. (Agreement, paragraph 62.)

Additionally, the purpose of the Plan is to provide sufficient details so that the Court may determine from the four corners of the Plan whether it is reasonably capable of achieving the terms of the Agreement and to provide routine measuring, assessment, and reporting on whether substantial and sufficient progress is being made to assure that when completed, the Commitments and Outcomes are met and the system is sustainable over time. (Agreement, paragraph 60.) The District Court shall approve the Plan if the Court determines the Plan is reasonably capable of fulfilling the terms of the Agreement and the purposes of the consent decrees and related court orders. (Agreement, paragraph 63.)

The Plan accomplishes the purpose of providing sufficient details so the Court can determine if the Plan is reasonably capable of achieving the terms of the Agreement. The implementation will occur in a phased approach over four years with the start of new and enhanced services, processes, and products being rolled out beginning in 2016 and continuing until the system of care is fully operational as described in the Plan.

The Plan keeps the same format as the Agreement to facilitate easy reference between the two documents. Therefore the Plan is divided up into Objectives 1 through 7 which directly corresponds to paragraphs A through G of the Commitments and Outcomes, including:

- OBJECTIVE 1: Provide Services and Supports to Class Members
- OBJECTIVE 2: Principles of Care and Practice Model
- OBJECTIVE 3: Access
- OBJECTIVE 4: Sustainable Workforce and Community Stakeholder Development

- OBJECTIVE 5: Due Process
- OBJECTIVE 6: Governance and Interagency Collaboration
- OBJECTIVE 7: Quality Management, Improvement, and Accountability.

Each Objective is further broken down in a logical progression, including “strategies” and “expected results” for accomplishing each Objective. The work of each of the Objectives is inter-related; therefore, each Objective should be read in the context of the whole Plan. Finally, the strategies employed are logical, straightforward and familiar. While acknowledging the complexities of developing infrastructure and new systems, the Plan is as concrete as feasible in its steps towards accomplishing the outcomes in the Agreement.

The Plan accomplishes the purpose of providing a system to provide routine measuring, assessment, and reporting on whether substantial and sufficient progress is being made to assure that the Commitments and Outcomes are being met and are sustainable. Each of the major strategies includes a timeline for accomplishing the tasks. Each of the Objectives contains internal feedback loops to a corresponding authority to take action. Although the Implementation Workgroup has already taken the lead as providing authority in assuring that progress is being made, such authority will be transferred to the Idaho Behavioral Health Cooperative as more specifically outlined in Objective 6. Thus the Plan provides for oversight and continued progress.

The state has already performed substantial work toward meeting the Commitments in the Agreement. They have organized several workgroups, have already secured additional funding for the implementation of new services as early as 2016 (expansion of respite and addition of crisis respite), and have developed the initial Quality Management, Improvement and Accountability plan.

Finally, the Plan accomplishes the purpose of fulfilling the terms of the Agreement and the purposes of the consent decrees and related court orders. The Objectives in the Plan include the identical Commitments and Outcomes found in the Agreement, and is the result of extensive collaboration between the Parties. The Plan is a consensus plan and all Parties are stipulating for the Plan’s adoption and approval by the Court.

More importantly, the Parties hope this Plan conveys the commitment of all the Parties to being successful in providing needed services to children with serious emotional disturbances.

Beginning immediately the state is establishing a dedicated team to work on the “Children’s Mental Health Reform” (CMHR) Project to bring this Implementation Plan into operations. In the first year the state will be defining a new and improved continuum of care and a detailed schedule of implementation of services/supports. In 2017 the state will implement the Principles of Care and Practice Model, the Workforce

Development plan and the Communication plan. By 2018 the state will have the full continuum of care implemented. Also in 2018 the state will implement the Access Model and will be using the CANS statewide to help in the identification of Class Members and will operate a federally compliant due process and complaint system. By 2019 the state intends to have substantially implemented the objectives in the Implementation Plan and will be measuring adherence to the various new requirements in the SoC.

OVERVIEW

The Idaho Implementation Plan is comprised of two types of objectives that will lead to the development, implementation and sustainability of a family-driven, coordinated, and comprehensive children's mental health service delivery system that is community-based:

- development of continuum of care under a new ideology with special attention to creating access to such services (objectives 1-3); and
- creation of infrastructure including resources, processes, and collaborative strategies for operating, continuously improving, and sustaining the SoC in development (objectives 4-7).

The Plan provides for a continuum of care with new and enhanced services/supports provided in sufficient intensity and scope to meet the needs of Class Members and their families and that are designed to facilitate a home and community-based approach to service delivery. Medicaid benefits are intended to be the backbone, the primary funding source for the continuum of care. Blended and braided funding opportunities will be explored and utilized when it is reasonable and advantageous to meet the needs of the Class. The CMHR Project Plan will be developed that will provide the detail needed for this implementation. (Objective 1)

A new ideology will be adopted for Idaho, described in the Principles of Care and Practice Model, that articulates the "System of Care Values and Principles" and promotes the Child & Family Team approach in operating the SoC. Involvement of Class Members and their families in the development, operation and improvement of the SoC is key. (Objective 2)

Providing sufficient access to the enhanced continuum of care is vital and will be accomplished through the use of effective tools and processes (CANS, wraparound) and through the creation of multiple pathways to assessment and services. Production and dispersal of communication materials and development of the state infrastructure to facilitate cross-system communication and processes is a key feature of the SoC in development and will be included in the Communication Plan. (Objective 3)

Idaho has areas with a shortage of mental health service professionals and needs workforce development to implement the strategies in this Plan and fulfill the commitments in the Agreement. The state will operate a workgroup to develop a Workforce Development plan. The scope of the plan will address the current and future demands for a sufficient and competent mental health workforce and the infrastructure needed to operate the SoC. The plan will also provide for education, training, and ongoing coaching of stakeholders. A Practice Manual will be developed to provide

information about requirements and to provide guidance to promote stakeholders' understanding of the features of the SoC. (Objective 4)

Class Members and their families are entitled to constitutionally and federally compliant due process. The state will work across systems to build a centralized complaint routing and tracking system and to build procedural due process safeguards that accords proper notice to Class Members and their families and fair hearings upon request. Mechanisms and products for operating a uniform complaint and due process system will be developed. (Objective 5)

A governance structure that operates through collaboration will be put in place to provide oversight and coordination of the implementation of this Plan. The structure will include representation by Class Members, Class Members' families, family advocacy, and other stakeholders. (Objective 6)

The measurement and reporting of treatment outcomes and the performance of the SoC will be accomplished through the development of a Quality Management, Improvement and Accountability (QMIA) process. This work includes the development of the QMIA Plan that will describe the development of a collaborative, cross-system, practice, performance monitoring and clinical quality improvement system. QMIA processes will also address the progress on the implementation of this Plan. (Objective 7)

OBJECTIVE 1: Provide Services and Supports to Class Members consistent with the Agreement — The agencies will progressively make available to Class Members and their families the medically necessary services/supports as described in the Agreement to match the Class Members' strengths and needs in a timely manner. The Services/Supports Workgroup, chaired by the Division of Behavioral Health, will advise the agencies responsible for compliance with the Agreement.

Expected Results of Accomplishing Objective 1*: A service array and a service delivery system, as defined in the Agreement, have been developed and implemented such that Jeff D. services and supports are timely provided to eligible youth in the appropriate scope, intensity, and duration necessary to achieve their intended purposes.*

Strategies to accomplish Objective 1:

A. Operationally define the array of services/supports that shall be provided to the Class per the Agreement by October 30, 2016.
    1. Define the services/supports available to Class Members in sufficient detail to guide the provision and reimbursement methodologies used by the state.
        a. Establish advisory Services/Supports Workgroup.
        b. Workgroup will review the services within the services/supports categories listed in Appendix C of the Agreement and make recommendations to establish the state's continuum of care for Class Members.
        c. Determine how to deliver mandated services/supports in alignment with the Principles of Care (PoC) and Practice Model (PM) and as incorporated in the Idaho Behavioral Health Authority Standards of Care.

B. Determine what services/supports are presently available, from what agency or agencies by October 30, 2016.
    1. Establish services/supports baselines by cataloging what services/supports are presently delivered to Class Members.
        a. Identify which agencies provide what services/supports.
        b. Estimate how many presumed Class Members each agency presently serves and with what services/supports.
        c. Estimate the amount, frequency and duration of services/supports received by presumed Class Members.
        d. Identify how services/supports are presently funded.

C. Determine which existing services/supports need to be modified by October 30, 2016**.**

1. Based on the outcome of Strategy A & B above, analyze existing services/supports to identify specific changes that may need to be made.
    a. Identify which services/supports need no changes.
    b. Identify which services/supports need changes.
    c. Determine specific changes for modified services/supports and what policy changes and resources (including funding) are necessary to implement those changes.
    d. Determine the timeline for implementing services/supports and integrate the timeline into the CMHR Project plan.
    e. Amend service array descriptions, if necessary.

D. Determine which new services/supports need to be added by October 30, 2016.
    1. Based on the outcome of Strategy A above, identify services/supports that are not currently available.
        a. Determine new services/supports and what authority, policy changes, and resources are necessary to implement the new services/supports.
        b. Establish the timeline for implementing services/supports and integrate the timeline into the CMHR Project plan.
        c. Amend service array descriptions, if necessary.

E. Develop reimbursement methodology and guidance for providers and contractors for the delivery and reimbursement of services/supports as defined in Appendix C between 60 to 120 days prior to the rollout of each service.
    1. Determine the funding for each service/support, leveraging Medicaid funds whenever possible (“Medicaid backbone model”), and opportunities for blended and/or braided funding.
        a. Align reimbursement strategies with the Idaho Behavioral Health Authority Standards of Care.
        b. Establish reimbursement methodologies used for each of the services/supports to be delivered.
    2. Establish provider requirements for delivery and reimbursement of services/supports.
        a. Establish provider requirements and criteria for modified and new service/supports.
            i. Align with state regulations consistent with the Principles of Care.
            ii. Where there are no state regulations, make recommendations to be responded to by administrators and directors of agencies.
            iii. Incorporate changes into mental health provider agreements, and contracts, including Idaho Behavioral Health Plan.
    3. Develop necessary billing and coding guidance for providers to be able to deliver services and supports.

a. Review existing billing requirements in each agency for the services/supports defined in Strategy A above. Where possible, make changes to billing requirements for greater consistency within and across agencies.
b. Publish coding and billing guidance in agency written materials and Practice Manual (developed in Objective 4).
c. Update coding and billing guidance in agency written materials and Practice Manual periodically based on feedback from stakeholders or as needed to maintain compliance with federal or state requirements for reimbursement.

F. Reevaluate the gaps analysis and reimbursement methodologies above, added to the lessons learned in providing services using the Medicaid backbone model, to identify ways to increase access to services statewide over time.

G. Estimate and report the number of Class Members annually.

1. Develop and implement a methodology to estimate the number of Class Members.
    a. Identify indicators for use in making estimation.
        i. Conduct literature review of common indicators or proxy indicators of serious emotional disturbance.
        ii. Identify common and proxy indicators in use across agencies.
        iii. Based on literature review of indicators of serious emotional disturbance, agencies develop consensus document listing variables agencies will use for tracking estimated Class Membership over time.
    b. Test outcome estimation against national estimations or other appropriate benchmark.
2. Establish an initial estimated range of the number of Class Members by October 30, 2016 that will utilize services/supports under the Agreement for each year of the implementation period.
    a. Report numbers of Class Members served in each year of the roll-out schedule.
3. Update estimate annually to confirm and/or modify variables that comprise methodology in order to obtain highest probability of accurate estimation.

H. Assess system capacity by January 30, 2017.

1. Develop methodology to assess the current statewide system capacity and estimate the statewide system capacity necessary to provide all of the service and supports statewide to Class Members under the Agreement.
2. Identify metrics to be used to measure current statewide and regional capacity, taking into account historical utilization data.

3. Utilize metrics to measure current statewide and regional capacity for the timely delivery of services and supports.
4. Formulate initial recommendations to inform Objective 4 of this Plan, Sustainable Workforce and Community Stakeholder Development, to establish and maintain system capacity.

I. Draft the CMHR Project Plan by September 30, 2016,
    1. Develop the CMHR Project plan that supports the workgroups including QMIA.
        a. The Project plan will include opportunities for stakeholders to provide input on the Project plan and collaboration on Project activities. Stakeholders include:
            i. Class Members and their families,
            ii. Providers, and
            iii. Advocates and other stakeholders.
        b. Updates to the Project plan will include input from the workgroups.
    2. Develop and implement a statewide transition model to move Class Members' and their families' from the current service system to the new SoC.
        a. Develop protocol for identifying and transitioning Class Members currently accessing mental health services.
        b. Develop business processes, infrastructure and transitions teams to support the transition, implementation and ongoing operations. Transition teams will be comprised of agencies' staff, providers, Class Members and their families, and Regional Behavioral Health Board representatives.
    3. Develop methods to solicit input from the Class Members and their families throughout planning, implementation and transition to identify successes and opportunities for improvement as defined by them.
    4. The state shall provide Plaintiffs' counsel with the draft CMHR Project plan 30 days before initial publication for comment.

J. Implement programmatic changes determined by strategies A through G, in this objective and outlined in the Project plan including modified services, new services and system capacity changes to meet scope, intensity, and duration necessary to achieve their intended purposes. Implementation of the full service/supports array will be completed statewide by June 30, 2019.
    1. Based on completion of strategies A through G, implement financing necessary to provide services/supports to Class Members.
        a. IDHW will use information obtained from Strategies under this Objective to implement the most effective means for funding modified and new services/supports.

b. IDJC and SDE will work with IDHW using information obtained from Strategies A and B under this Objective to determine opportunities for increasing effectiveness and efficiency in the use of state general funds to address Class Members' and their families' treatment needs and to determine the most appropriate means for obtaining financing to cover the gaps in capacity that are identified.
    i. The Interagency Governance Team (IGT), established in Objective 6, will review and monitor the funding used for Class Members' and their families' mental health services/supports and will make recommendations to the agencies' administrators and directors for the development of financing approaches that maximize the most effective and efficient use of funding for the SoC as described in the Agreement.
    ii. Study existing funding across agencies: 1) that targets education and training for consideration of reallocation toward producing remedies to identified gaps; and 2) for opportunities to blend funding in a joint effort to address identified gaps.
    iii. Seek grant opportunities with SAMHSA and other funders for system transformation and in support of activities that will fulfill the commitments under the Agreement.
    iv. Seek partnerships with universities and other learning institutions to develop opportunities for joint efforts to provide education and training that targets identified gaps. This work will be coordinated with the Workforce Development Workgroup.

OBJECTIVE 2: Principles of Care and Practice Model — The agencies adopt, implement and, once implemented, consistently provide services statewide in accord with the Principles of Care and the Practice Model, as amended over time. The work of this objective will involve stakeholders through various workgroups.

Expected Results of Accomplishing Objective 2*: Agencies and providers in the SoC serving Class Members deliver services/supports consistent with the Principles of Care and the Practice Model. Substantial fidelity to the Principles of Care and the Practice Model is sustained and documented over time. Amendments to the Principles of Care and the Practice Model over time are made in accord with the Agreement to improve client engagement, program efficiency, service effectiveness, quality of care, collaboration, and accountability.*

Strategies to accomplish Objective 2

A. Each agency will have adopted the Principles of Care (PoC) and the Practice Model (PM), by June 30, 2018, as practice standards for their agencies, contractors and providers that provide the services/supports defined in the Agreement to Class Members.
    1. Each agency reviews existing policies, contracts and standards against the PoC and PM, and identifies the changes needed.
    2. Each agency updates its contracts and standards of care as needed to reflect the PoC and PM.
    3. Incorporate the PoC and the PM into the Practice Manual developed in Objective 4, Part II.
    4. Engage stakeholders and obtain their input through the established workgroups as described in Objectives 1,3,4, and 7 and the IGT as described in Objective 6.

B. Implement the changes in practice and procedures adopted in Strategy A so that agencies and their contractors deliver services/supports statewide, and Class Members and their families participate in the SoC consistent with the PoC and PM.
    1. Develop and implement an action plan by December 30, 2016, for identifying, recruiting, educating, and supporting stakeholder involvement and engagement in system improvement and planning efforts.
        a. Expand opportunities for Class Members, their families and community stakeholders, for greater involvement and engagement at the system level for system improvement and planning efforts.
        b. Provide information about opportunities for stakeholder involvement in system improvement and planning efforts on dedicated website and through the outreach activities described in Objective 3.

c. Provide for support of Class Members and their families' in the action plan to facilitate their participation in system improvement and planning efforts.

2. Establish, use, and refine over time training and educational curricula across and among agencies and stakeholder groups that encompass the PoC and PM.
    a. Develop and use training and educational curricula for agency staff, contracted providers, system partners, and community organizations regarding roles and responsibilities, including but not limited to:
        i. identification and referral for screening and assessment;
        ii. participation on a Child and Family Team; and
        iii. Practice Manual requirements.
    b. Refine training and educational curricula over time using an iterative process to improve the effectiveness of the training so that clinicians, mental health workers, and other child-serving staff can consistently apply the PoC and PM when delivering services within the SoC.

C. Develop a methodology that supports statewide adherence and sustainability consistent with the purposes of the Agreement and the goal of improving stakeholder engagement, program efficiency, service effectiveness, quality of care, collaboration, and accountability over time by June 30, 2018.

1. Develop business processes to maintain and update the Practice Manual for sustained statewide adherence. Respond to opportunities to improve fidelity to the PoC by using the strategies listed in the QMIA objective and QMIA Plan.

OBJECTIVE 3: Access — The agencies establish and operate statewide an access system or protocols for Class Members and their families that timely identify, assess, and link them to the services/supports they need and are entitled to under the Agreement. The work of this Objective will be accomplished through the Services/Supports Workgroup, chaired by the IDHW. The work of operating an access process, as described in the following Strategies and Tasks will be described in the Practice Manual.

Expected Results of Accomplishing Objective 3: *Agencies have developed, adopted, and are consistently using the specified models, protocols, and tools necessary to identify, assess, and serve Class Members and their families. Agencies are communicating this process and are providing informative materials statewide to the community, stakeholders, and families. Class members, their families, and community stakeholders are informed about who is eligible for services under the Agreement, what services are available, and how to access services.*

Strategies to Accomplish Objective 3

A. Progressively implement use of the statewide Access Model to identify and move Class Members through the SoC. Full implementation of the Access Model will coincide with completion of CANS implementation by December 30, 2018. Creating transparency of the information pertaining to access, including additions, deletions and improvements to existing processes, products or authorities, will be accomplished through the Communication plan. The operations associated with this work will be addressed in the Practice Manual as relevant. Developing capacity and competencies for creating sufficient access to care will be addressed in the Workforce Development plan.
    1. Develop business flow diagrams that describe the existing pathways into, through, and out of the SoC for each agency's identification, screening, assessment, referral, planning, treatment, and transition process and policies.
    2. Identify Access Model requirements the agencies currently have in place including policy, administrative rules, and operations.
    3. Identify where agencies' responsibilities for serving Class Members intersect or overlap.
        a. Determine the specific functions of the agencies' programs that will operate in a coordinated manner to identify, screen, assess, refer, plan, treat, and transition Class Members across the agencies to meet requirements of the Access model.
        b. Design and adopt efficient business flow across agencies for ensuring a non-duplicative process of identifying, screening, assessing, referring and linking Class Members.

4. Administrators and directors of agencies provide the authority to develop and implement consistent agency-specific protocols necessary to operationalize the process described in Strategy A, Task 3.

B. Inform and guide the management and delivery of the services/supports by providers and contractors consistent with the Access Model and consistent with the PoC and PM by December 30, 2017.

    1. Review existing methodologies and contract requirements being followed across the agencies in relation to children and their families' access to services.
    2. Identify necessary and recommended changes to existing methodologies and contract requirements sufficient to support mental health providers and managed care contractors in delivering services consistent with Access Model and consistent with the PoC and PM.
    3. Under the direction of agencies' directors and administrators, develop a plan with timeline to make changes to policies, processes and contract requirements to align with the Access Model. This will be included in the Project plan described in Objective 1, Provide Services and Supports to Class Members, and in Objective 6, Governance and Interagency Collaboration.

C. Design and operate an identification and referral process that facilitates the identification of potential Class Members by child-serving entities including agencies, behavioral health providers, medical providers, county juvenile corrections, law enforcement, and educators, and for making referrals to the IDHW Assessment Process (described in Strategy D) by December 30, 2017. The identification and referral process will account for various levels of communication including face-to-face as well as telecommunications and will be described in the Practice Manual. The identification and referral process will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the identification and referral process will be addressed in the Communication plan. The ongoing review and refinement of the identification and referral process will be addressed in the QMIA plan.

    1. Develop and use a defined set of indicators of potential class membership to be used for systemic screening or referral to the IDHW Assessment Process. IDHW will develop protocols for accepting referrals from other child-serving systems, agencies, or individuals including accepting self-referrals from youth and/or families.
        a. Describe the steps necessary for any entity or person to participate in the identification process of potential Class Members.
            i. Develop the Checklist, as described in the Agreement that can be used by any interested person and will serve as the

mechanism for the broadest possible entryway into the SoC. The Communication plan will describe the statewide dispersal of the Checklist, making it easily available to anyone seeking to use it. Dispersal methods may include mailings, websites, public service announcements, service directories, waiting rooms, etc. The Checklist itself will provide direction for its use and referral information.

ii. Identify process and qualified users of the Screening Tool that is to be derived from the CANS. This Tool may be used to identify potential Class Members who may have unmet mental health treatment needs. Regardless of the outcome of the screening, the process necessarily includes the screener providing referral information to the potential Class Member, Class Member and the family to appropriate services using the IDHW Assessment Process. The Communication plan describes the work for reaching specific child-serving entities who will qualify as screening entities. The Workforce Development plan includes curriculums for using the Screening Tool. The Practice Manual includes guidance on how to communicate screening results to the potential Class Members and their families consistent with the PoC and PM.

iii. Develop materials designed to inform potential Class Members, Class Members and their families about their right to request services (or self-refer) under the Agreement, including screening and assessment. These materials will be developed with input from youth, families, and other community stakeholders and made available statewide and in a variety of media. Such messaging and the process for achieving it will be described in the Communication plan.

iv. Design, describe and make publicly available, the information necessary for connecting potential Class Members with positive Checklists and/or positive Screenings to the IDHW Assessment Process (described in Strategy D).

2. Collaborate to determine what constitutes a positive Checklist and a positive screen as well as what constitutes a timely referral for screening and/or assessment. Such standards will be incorporated into the Idaho Behavioral Health Standards of Care.
3. Each agency will develop and use system-specific indicators to identify potential Class Members for referral to screening or to the IDHW Assessment Process.

D. IDHW will design, operate and maintain an Assessment Process to determine Class Membership status of children and youth referred to it beginning January 1, 2018. The Assessment Process will account for receipt of referrals from all sources as described in Strategy C above. The Assessment Process will be described in the Practice Manual. Standards for the provision of an Assessment will be incorporated into the Idaho Behavioral Health Standards of Care. The Assessment Process will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the Assessment Process will be addressed in the Communication plan. The ongoing review and refinement of the Assessment Process will be addressed in the QMIA plan.

1. Define scope of Assessment Process, including incorporation of the CANS (see Strategy E for CANS implementation). Describe how the Checklist and Screening Tool are incorporated into the process to maximize opportunities to identify potential Class Members who are seeking services.
    a. Develop and implement a statewide protocol for linking children and their families to services following the Assessment Process. Among other things, the protocol will include:
        i. A process for referring and connecting children determined ineligible for services under the Agreement, and Class Members who choose not to participate in services available under the Agreement, to appropriate mental health and/or community services and supports.
        ii. A process for the assessor to link the Class Member and family to the entity responsible for engagement in the treatment planning process, described in Strategy E, consistent with the Access Model.
2. IDHW will describe sequential steps of the Assessment Process, the associated quality standards to be met in the Assessment, the minimum qualifications of assessors, and the required timelines for completion of the initial Assessment and reassessment and referral to services. In addition, IDHW will:
    a. Develop guidance for assessors to provide the full results of the Assessment and the corresponding clinical recommendations, including the determination of Class Membership, to assessed youths and their families, unless such disclosure is prohibited by law or regulation.
    b. Develop and implement a statewide protocol for determining ongoing eligibility for Class Membership and transitioning out of care consistent with the Access Model and the PM. This protocol will include a process

for determining when a Class Member no longer meets class membership requirements. This protocol will also include processes for recording and reporting determinations of ongoing class membership as data for use in the QMIA plan and for notifying Class Members and their families consistent with the due process requirements under the Agreement.

c. The guidance and protocol, described in a and b above, will be consistent with the PoC and PM and developed in collaboration with youth, families, and other community stakeholders.

E. Develop and use the CANS tool statewide, as described in the Agreement, to screen potential Class Members for unmet mental health needs, assess Class Members' individual and family strengths and needs, support clinical decision-making and practice including formulating treatment plans, measure and communicate client outcomes, and improve service coordination and quality beginning January 1, 2018. Use of the CANS tool and its purpose will be detailed in the Practice Manual. Standards for using the CANS tool will be incorporated into the Idaho Behavioral Health Standards of Care. Certification in use of the CANS tool and how it will be used in the identification, referral and assessment processes addressed above in Strategies B and C will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the CANS deployment plan and the role of the CANS will be addressed in the Communication plan. The ongoing review and refinement of the use of the CANS tool will be addressed in the QMIA plan.

1. The following activities will be completed during the development and implementation of the CANS tool(s):
   a. Training by Dr. John Lyons or a CANS certified trainer;
   b. Develop valid CMH version of CANS through workgroup model of action;
   c. Develop Checklist and screening tool;
   d. Develop Class Member profile;
   e. Develop Intensive Care Coordination (ICC) profile.
2. Design and implement a process that makes use of the CANS tool(s) for identifying, screening and assessing potential Class Members, confirming Class Membership, identifying need for ICC and facilitating the creation of a treatment plan.
   a. Develop plan for deployment of CANS including a training plan for creating and maintaining statewide capacity for use of the tool, automation of the tool and descriptions of agencies' and providers' roles and responsibilities (Strategy A, Task 3 are dependencies.)
   b. Implement statewide CANS deployment plan.

F. Develop and begin implementing by January 1, 2017, a statewide Communication plan that includes outreach and education of the community, stakeholders, and families. The effectiveness and ongoing refinement of the products, processes and activities of the Communication plan will necessarily include the input of potential Class Members, Class Members and their families and providers of services/supports.
    1. Establish and maintain products and outreach activities to provide easily accessible and publicly available descriptions or explanations of the Agreement, the Services/Supports, the PoC and PM, and the Access Model to Class Members, their families, and other stakeholders.
        a. Develop action plan for outreach activities. Examples of outreach activities include, but are not limited to, newsletters, participation in health fairs or other community events through staffing a vendor booth, distribution of information and products that include use of the new branding specifically developed for the children's SoC, providing speakers at public and professional events.
        b. Communications: Develop focused communications to specific stakeholder groups in the SoC. Examples of some of the recipients of these communications may include but are not limited to the State Planning Council on Behavioral Health, the seven (7) Regional Behavioral Health Boards, the Idaho Hospital Association, the Idaho Psychiatric Association, the Idaho Psychological Association, the Psychiatric Rehabilitation Association, the National Association of Social Workers-Idaho Chapter, the Idaho Counseling Association, the Idaho Primary Care Association, the Idaho Academy of Family Physicians, the Idaho Association of Community Providers, and the population of behavioral health professionals and paraprofessionals who provide publicly-funded behavioral health services. Additional examples of stakeholders include but are not limited to: legislators, law enforcement entities, Medicaid regional nurse reviewers, magistrates, probation officers, educators, IDHW navigators, public health nurses and public health community outreach workers.
        c. Social Marketing Communications: Engage community advocacy organizations such as, but not limited to, NAMI, Idaho Federation of Families on Children's Mental Health, Idaho Parents Unlimited and the Idaho Association of Community Providers for opportunities to partner in development of communication materials and events to promote awareness and interest in the SoC and how to access it. Examples include but are not limited to topic-specific email alerts, individual meetings with organizations, live webcasts – with interactive question

and answer sessions, webinars, summaries of state-sponsored planning meetings posted on state websites.

   d. The Communication plan will include development and implementation of a schedule for creating and distributing communication products and conducting and hosting communication events based on the communications tasks described above.

3. Conduct initial and periodic review of printed and electronic materials to identify opportunities to improve the effectiveness of the communications.
   a. Solicit responses and input from Class Members, their families and other stakeholders regarding communication products, processes, and outreach activities to obtain feedback for finalization or improvement of the Communication plan, communication products, processes, and outreach activities.
   b. Finalize or update communication products and events.
   c. Develop and execute schedule of implementation for updated products, processes, and outreach activities.
4. Build a new website, hosted by IDHW, to be jointly managed by the agencies, dedicated to the SoC, in order to publicly provide relevant information including descriptions of the SoC as a whole, specific services, resources, and topics of interest to stakeholders, youth and families.
   a. Establish protocols and standards for content management.
   b. Include interactive features to provide public opportunity for making inquiries and obtaining responses that will directly answer the inquiry or provide information on where the answer can be obtained.
   c. Include calendar of events to provide public notice of related meetings and actions.
   d. Include relevant information requested by Class Members and their families.
   e. Post information about and link to the jointly managed dedicated website and on each agency-specific website.

OBJECTIVE 4: Sustainable Workforce and Community Stakeholder Development — The agencies participate in workforce development and stakeholder education to create the infrastructure necessary to provide education, training, coaching, supervision, technical assistance and mentoring to providers and community stakeholders in order to enable them to consistently and sustainably provide quality care in accord with the Practice Manual as described in the Agreement. The work of this Objective will be led by the Workforce Development Workgroup.

Expected Results of Accomplishing Objective 4: *The workforce meets the needs of Class Members and their families for services/supports under the Agreement. The workforce has adequate training and support to identify, engage, and link Class Members to services; to use the CANS tool in screening, assessment, and clinical practice; and to deliver the full array of services/supports that are medically necessary, consistent with the PoC and PM, and the individualized strengths and needs of eligible youth. The agencies have developed, adopted, and are consistently using a Practice Manual to guide clinical and programmatic activities statewide. A sustainable infrastructure is in place for ongoing education, training, and technical assistance for providers who serve Class Members pursuant to the terms and conditions of the Agreement. Stakeholders understand their various roles in the SoC.*

Strategies to Accomplish Objective 4

Part I

A. Establish a Workforce Development Workgroup by June 30, 2016.
    1. Recruit workforce development champions and interested community stakeholders for Workforce Development Workgroup.
    2. Set workgroup charter, objectives, deliverables and schedule of initial meetings.
    3. The Workforce Development Workgroup is charged with drafting the Workforce Development plan (WDP).

B. The WDP shall describe the expected nature, scope, capacity, and structure of the workforce that is needed, now and in the future, for a mental healthcare workforce that is capable of consistently meeting the requirements of the Agreement over time. The initial WDP shall be completed by February 28, 2017.
    1. Define short and long-term goals and strategies for building training curricula, providing technical assistance, coaching and mentoring, developing monitoring and feedback procedures, and for funding these efforts, for stakeholders in the SoC.
        a. Include strategies and identify resources necessary to operationalize the PoC and PM within the workforce in the delivery of services/supports to Class Members. Ensure strategies are

coordinated and consistent with work performed to develop methodology in Objective 2, Strategy C.

    b. Include goals and strategies to sustain education, training, and technical assistance on ongoing basis, including the means for funding these activities.
    c. Include strategies for integrating data and information gathered from QMIA system (described in Objective 7) to refine curriculums over time in order to highlight best practices and address needs for additional guidance or training within the workforce.

2. Collaborate with Services/Supports Workgroup to identify gaps in services relating to workforce capacity and incorporate plans for solutions addressing such gaps in the Workforce Development plan. This task is dependent upon the completion of Objective 1, Strategy B.
3. Identify and develop strategies to address present and future workforce capacity needed to deliver services/supports to Class Members.

C. Implement the Workforce Development plan consistent with the Agreement requirements beginning May 1, 2017.

1. Devise and activate schedule of training and education events.
2. Operate iterative process of testing the effectiveness of training and education events using evaluation tools that, among other things, solicit feedback from attendees and continuously modify training curricula as needed to further define the Workforce Development plan.
3. Integrate data and information gathered from QMIA system to help inform decision-making in this iterative process.
4. Develop and execute testing of the Practice Manual to validate the clarity, readability, accuracy and adequacy of the content of the Manual. Modify as needed to achieve improvements.
5. Coordinate planning efforts among agencies, leveraging training and education opportunities for stakeholders' participation in achievement of Workforce Development plan's objectives.

D. Measure the implementation of the Workforce Development plan over time for adherence with the Agreement and to identify opportunities to improve performance and outcomes of the plan. Design and implement remedial measures including incentives and sanctions, as needed, so that providers maintain substantial adherence with the PoC and PM over time.

Part II

A. Establish workgroups as needed over time to develop versions of the Practice Manual.

1. Identify and solicit the input of appropriate stakeholders to participate in the development of the Practice Manual, including stakeholders from the Services/Supports workgroup.
2. Define scope of the Practice Manual.
3. Select policy experts to author the Practice Manual.
4. Integrate guidance, policies, and protocols developed by the agencies in Objectives 1, 3, and 5.
5. Establish a review and approval process for sections of the Practice Manual by June 30, 2016.
6. Publish the initial version of Practice Manual consistent with paragraph 40 of the Agreement after review and approval by July 1, 2017.

B. Define Practice Manual update process. Begin development of Practice Manual by July 30, 2016 to operationalize the PoC and PM, consistent with the requirements of the Agreement, to guide and facilitate access to and delivery of services

C. Progressively implement the Practice Manual to be completed by July 1, 2019.

1. Develop a training curriculum for the Practice Manual.
2. Educate, train and provide technical assistance to agencies' staff, relevant contractors, and providers on the Practice Manual.
3. Integrate training events' objectives, content and schedule with the Workforce Development plan.
4. Provide ongoing technical assistance to providers on compliance with the Practice Manual.
5. Identify and implement necessary modifications to applicable state contracts, administrative rules and agency policies. Include requirements for training to the Practice Manual, delivery of services consistent with the Practice Manual, and communication of information and provision of education, training, coaching, supervision, technical assistance and mentoring of providers and other community stakeholders.

OBJECTIVE 5: Due Process— The agencies will develop and operate constitutionally and federally-compliant fair hearing systems, and also will create and operate a centralized complaint routing and tracking system. Furthermore, the agencies will implement a process for reviewing compliance to applicable regulations, rules, and policies regarding due process requirements, and periodically report on the metrics of operating this system. The work of this objective will be led by IDHW in consultation with Idaho Deputies Attorney General. The work of this Objective does not apply to services provided to Class Members on an involuntary basis, such as services provided involuntarily to Class Members in the custody of the state or those services required by a Court Order. See Agreement paragraph 3 and Appendix B, third introductory paragraph. This entire process will be included in the Practice Manual and will be coordinated with the Quality Management, Improvement, and Accountability (QMIA) goals, plans, or results listed in Objective 7 to avoid a duplication of efforts with this Objective.

Expected Results of Accomplishing Objective 5*: Due process mechanisms exist and afford Class Members' and their families' due process of law in exercising their rights under the Agreement and federal and state laws and regulations. Class Members' and their families' concerns or complaints relating to informing, access, service appropriateness, service effectiveness, quality, and accountability are timely and fairly heard and resolved. Due process procedural mechanisms and associated outcomes will be documented and tracked for compliance and continuous quality improvement.*

Strategies to Accomplish Objective 5

A. Operate a standardized complaint and administrative hearing system beginning October 1, 2018.
    1. Develop and implement notices.
        a. Review requirements for notice of agency action as found in current state or federal law, and in any state or federal law related to services/supports addressed in Objective 1.
        b. Draft and finalize notice of agency action and any other relevant notice or document, to send to applicants or participants of services/supports addressed in Objective 1. Class Members and their families will be afforded procedural due process safeguards including proper notice consistent with the requirements of paragraph 45 of the Agreement. As part of this process, a standardized template or model notice will be developed and implemented.
        c. Enter into contractual or other arrangements to implement sending the finalized notices or other documents to applicants and participants of services/supports addressed in Objective 1.

d. Modify agencies' contracts, in instances where noticing activities are delegated to an agency contractor, to integrate the template or model notice and any other requirements discovered pursuant to the activities conducted in Strategy A, Task 1.b into contractor's system.

2. Finalize and implement a standardized complaint response system for services/supports addressed in Objective 1.
   a. Review current complaint response system(s) related to agency action.
   b. Compare current complaint response system(s) related to agency action, to state and federal law and case law relevant to the services/supports addressed in Objective 1, and note any differences.
   c. Develop and finalize the complaint response system for services/supports addressed in Objective 1, so they will be in compliance with current state law, and with any relevant state and federal law and paragraph 43 of the Agreement.
   d. Coordinate the finalized complaint response system to work in conjunction with the administrative hearing rights and procedure.
   e. Draft statutes and/or administrative rules as needed to implement the finalized complaint response system for services/supports addressed in Objective 1 and present such to the Idaho legislature for adoption.
   f. Modify agencies' contracts in instances where complaint system activities are delegated to an agency contractor, to align and incorporate the contractor's functions into the standardized complaint response system.
3. Finalize and implement standardized administrative hearing rights and procedures for services/supports addressed in Objective 1.
   a. Adopt a uniform definition of agency action to include:
      i. determination that the individual is not a Class Member;
      ii. denial or limitation of a requested service or services;
      iii. reduction, suspension, or termination of a currently authorized service;
      iv. substitution of an alternative service for a prescribed service;
      v. termination, suspension, or delay of services; or
      vi. denial, in whole or in part, of payment for a service.
   b. Develop and finalize the administrative hearing rights and procedures for services/supports addressed in Objective 1, so they will be in compliance with the Idaho Administrative Procedures Act, current state law, and with any relevant state and federal law and paragraphs 44, 45, and 46 of the Agreement.
   c. Develop and finalize the administrative hearing rights and procedures for services/supports addressed in Objective 1, so the process is

standardized across agencies. The Class Members and their families will be accorded a meaningful opportunity to be heard which includes a hearing, the right to present evidence and confront and cross-examine witnesses, prehearing disclosure of the evidence on which any decision was based, the right to have the assistance of an advocate or legal counsel to represent them and a timely decision.

   d. State agencies will coordinate the finalized administrative hearing rights and procedures so they work in conjunction with the finalized complaint response system developed in accordance with Strategy A, Task 2.
   e. Draft statutes and/or administrative rules as needed to implement the finalized administrative hearing rights and procedure for services/supports addressed in Objective 1 and present such to the Idaho Legislature for adoption.
   f. Develop a sufficient amount of contractual or other necessary arrangements with the Idaho Attorney General's Office (or private hearing officers as applicable), to allow processing of additional administrative hearing requests related to services/supports addressed in Objective 1.

4. Develop and implement informational materials.
   a. Identify and review federal requirements and media platform options to inform participants of rights related to complaints and administrative hearing rights and procedures related to services/supports addressed in Objective 1.
   b. Determine depth of information needed for each identified media platform and any other mechanisms identified pursuant to Strategy A, Task 4.a. As part of this process, agencies will consult with and consider input from Plaintiffs through Young Mind Advocacy as representative for Plaintiffs.
   c. Identify which media platforms for which to develop informational materials for rights relevant to complaints and administrative hearing rights and procedures related to services/supports addressed in Objective 1.
   d. Develop and adopt informational materials that will be standardized to the extent possible across agencies.
   e. Incorporate or implement the finalized informational materials into each media platform and provide such materials to Class Members and their families through other mechanisms identified pursuant to Strategy A, Task 4.b.

f. Develop protocol and written guidance for agency staff, contractors and providers on informing potential and actual Class Members and their families about their due process rights.

B. Conduct system tracking and reporting beginning October 1, 2018.

1. Review the current complaint tracking system(s).
2. Compare current complaint tracking system(s), to standards for complaint tracking systems found in state or federal law relevant to services/supports addressed in Objective 1, and note any changes.
3. Review current feedback processes regarding outcomes from administrative hearings.
4. Develop and finalize a complaint tracking system in conformance with the Agreement, and in conformance with state or federal law.
5. Compare current feedback processes regarding outcomes from administrative hearings, to standards for feedback processes from administrative hearings found in state or federal law relevant to services/supports addressed in Objective 1, and note any changes that are needed.
6. Develop and finalize a feedback process regarding outcomes from administrative hearings in conformance with the Agreement, and in conformance with state or federal law.
7. Implement current services/supports addressed in Objective 1 into finalized complaint tracking and administrative hearing feedback systems.
8. Implement results of tracking and fair hearing feedback system into QMIA plan as outlined in Objective 7.
9. Use finalized process to periodically report on compliance with the due process protocols as defined in the Agreement.

OBJECTIVE 6: Governance and Interagency Collaboration: Establish governance and interagency collaboration within the authority of the Idaho Behavioral Health Cooperative (IBHC) to collaboratively coordinate and oversee the implementation of the Agreement.

Expected Results of Accomplishing Objective 6: *Governance is in place that provides leadership, problem-solving, information sharing, cooperation among agencies, transparent decision-making, and accountability for meeting the Agreement outcomes.*

Strategies to accomplish Objective 6

A. IDHW authorizes the CMHR Project team and CMHR Project sponsorship by May 30, 2016, to provide structure and framework for initiating, planning, executing, controlling, and closing the Project work needed to achieve the Agreement outcomes and exit criteria.
    1. Initiate Project, obtain resources, and determine Project methodology.
    2. Complete Project planning activities including the development of a Project plan by September 30, 2016, which includes an implementation strategy, milestones, tasks, timelines, governance, stakeholder engagement, communication and training plan, plan for transition to operations and project closeout.
    3. Set up tools for Project and stakeholder communications, stakeholder engagement, interagency collaboration and reporting.
    4. Establish interagency workgroups to develop, design and make recommendations for the SoC elements such as: CANS, PoC and PM, Workforce Development plan, Communication plan, services/supports, Practice Manual.
    5. Oversee execution of Project work, manage tasks and timelines, maintain Project and interagency communications, manage deliverables, risks, identify decisions needed.
    6. Complete Project reporting to sponsors, IGT and stakeholders.
    7. Inform decision-making, facilitate meetings, aide in collaboration.

B. Establish and implement the Interagency Governance Team (IGT) by July 30, 2016.
    1. Develop Project and operational governance plan outlining the Project team's authority, decision-making and accountability within the overall SoC.
    2. IBHC charters the IGT. Charter outlines IGT purpose, goals, roles and responsibilities, length and scope of membership, accountability, authority and decision-making, meeting schedules, format, reporting, and support.

3. Recruit members required to effectively meet the goals outlined in the charter.
    a. Membership will include, at a minimum, a current or former Class Member representative, a parent or family member of a current or former Class Member representative, and a children's mental health consumer or family advocacy organization representative.
    b. Utilize established stakeholder groups to recruit members.
4. Establish IGT operational guidelines, reporting and integration with Project team and QMIA Council (described in Objective 7) who will inform decision-making, status on implementation, make recommendations and identify barriers.
5. IGT monitors the execution of the Idaho Implementation Plan, provides direction and resolution management, aides in removing barriers and promotes collaboration.

OBJECTIVE 7: Quality Management, Improvement, and Accountability (QMIA) — The agencies develop and implement a QMIA plan to establish and maintain a collaborative QMIA system that includes monitoring, measuring, assessing, and reporting on Class Member outcomes, system performance, and progress on implementation and completion of this Agreement. The collaborative QMIA system will increase system-wide capabilities for quality improvement at the clinical, program and system levels associated with increasing effectiveness of services and improving access to services. The parties jointly develop a Quality Review process to be used to objectively assess and improve clinical practice and program effectiveness system-wide.

Expected Results of Accomplishing Objective 7: *The agencies sustainably operate a QMIA System that monitors, measures, assesses, and reports on Class Member outcomes, system performance and implementation of the Agreement, and improves quality at the clinical, program and system levels over time. The agencies routinely measure, analyze, and publicly report on regional and statewide QMIA indicators and data. The agencies have conducted and publicly reported the results of at least one Quality Review. Over time, cost-effectiveness is increased and access to care is improved.*

Strategies to accomplish Objective 7

A. Develop and implement a QMIA plan establishing the elements of a performance monitoring and clinical improvement system for Idaho's child-serving SoC by March 31, 2016. The QMIA plan will describe a plan of action for developing a collaborative, cross-system, practice, performance monitoring, and clinical improvement system that is capable of achieving the criteria described in the , Agreement, paragraph 53.
    1. The QMIA workgroup, established in response to the Agreement, will develop the QMIA plan.
        a. Develop a QMIA workgroup, to include:
            i. workgroup membership;
            ii. responsibilities;
            iii. objectives; and
            iv. deliverables.
    2. Complete development of the QMIA plan by March 31, 2016.
    3. Begin implementation of the QMIA plan no later than the end of the month following approval of the Idaho Implementation Plan by the District Court.
    4. Periodically review and, if needed, adapt the QMIA plan. Revisions of the QMIA plan will be consistent with the Agreement and the Idaho Implementation Plan, as amended, during the pendency of this case.

B. Adapt and enhance existing quality assurance infrastructure and activities relating to Idaho's children's SoC beginning June 1, 2016.
    1. Develop an enhanced, effective and collaborative quality assurance (QA) infrastructure to support the development of a coordinated practice, performance monitoring and clinical improvement system consistent with the PoC and PM.
        a. By August 30, 2016, establish the QMIA Council, an interagency committee responsible for reviewing management and monitoring reports at the program data and system level and for making recommendations for system performance to the IGT.
        b. Beginning in September 2016, establish QA subcommittees and advisory groups based on needs identified by the QMIA Council to address specific aspects of quality improvement within the child serving SoC and guided by the QMIA plan.
    2. Evaluate the agencies' existing quality assurance and improvement processes. Assess current capabilities for achieving criteria defined in the Agreement, paragraph 53, and consistent with the PoC and PM.
        a. Define baseline of current QA infrastructure and activities for children's mental health services for each agency.
        b. Develop consistent definitions and terms across child-serving systems of care. Clarify existing measures and indicators.
        c. Perform self-assessment to evaluate the strengths and needs of management in meeting the Agreement requirements and establishing a continuous quality improvement agency culture.

C. Monitor, assess, report, and adjust system performance using performance metrics beginning June 1, 2016.
    1. Develop metrics as indicators of system performance, known as "Key Quality Performance Management Indicators", in the following areas:
        a. Process: Interactions between children, youth, and families and providers, including diagnosis, treatment, and the quality of care delivered: indicators will assess quality factors related to planned changes in children's mental health services processes.
        b. Client outcomes: Effects of mental health care on children, youth, and families: indicators will assess if clients and families are engaged in care, getting better as a result of care, how they are getting better, and what issues need continued efforts to improve the quality of care.
        c. System impact: The context in which care is delivered: indicators will assess the development of core system and cross-system management and competencies and evaluate system and

infrastructure strengths and needs. Information gathered will assist in identifying and prioritizing actions necessary to improve the system.

2. Submit "Key Quality Performance Management Indicators" to IGT for approval and adoption by agencies.
3. By July 1, 2017, develop and begin implementing methodology for prioritizing data collection of QMIA performance metrics. Periodically review and, if needed, revise prioritization methodology.
4. Throughout the implementation period and the sustained performance period, prepare and deliver quarterly and annual QMIA reports using performance metrics.

D. Develop a Continuous Quality Improvement culture within the Children's SoC beginning June 1, 2016.

1. Provide quality and performance information in as close to real time as possible to decision-makers at every level of the system. Develop and employ system-wide methodology to support decision-makers to use this information in making service planning and delivery decisions. Create opportunities for high performing individuals or programs to share or model proven or promising practices.
2. Incorporate Performance Improvement Projects into agencies' QA activities.
   a. Establish performance planning with goals and objectives.
   b. Describe performance measurement.
   c. Identify and execute continuous quality projects relevant to the goals of the Agreement, the goals of the agencies, and the goals of Class Members and their families.
   d. Link the strategies listed in the Implementation Plan, the agencies' efforts to accomplish those strategies, and the performance of the SoC.
   e. Develop conclusions emanating from the continuous quality project outcomes into recommendations to the QMIA Council for action as needed.
3. Develop and implement process for initiating quality improvement projects when findings that result from monitoring indicate needed system performance improvement.
4. Develop and utilize a Quality Review process to objectively assess and improve clinical practice and program effectiveness system wide, consistent with the requirements in the Agreement.
   a. By end of the first year of the implementation period, develop a Quality Review action plan jointly with Plaintiffs' counsel.

5. Before end of the implementation period, complete at least one Quality Review process. Evaluate the utility and cost-benefit of integrating the Quality Review technique or process into the QMIA system for regular use.

E. Provide accountability by monitoring Idaho's progress toward completion of Outcomes and Exit Criteria required by the Agreement beginning June 1, 2016.
    1. Develop and implement methodologies to assess and report on:
        a. The availability of services and supports to determine if existing capacity is sufficient to meet the needs of Class Members;
        b. The provision of services, supports, and the SoC to determine if it is consistent with the PoC and PM, and the Access Model;
        c. The impact of the Workforce Development plan;
        d. The implementation of due process procedures and use of related information for the purposes of system improvement; and
        e. The development of Idaho's Children's SoC through interagency collaboration and coordination.

GLOSSARY

Agency: state agencies whose principal executive officers are Defendants.

Algorithm: a set of instructions for a process that leads to a predictable result; set of rules to be followed in calculations or other problem-solving operations; business flow diagrams.

Behavioral Health Authority Standards of Care: Best practice standards published by the Division of Behavioral Health used to guide the delivery of behavioral health services. The standards carry the intention of serving as a consistent base for the provision of high quality behavioral health care in Idaho, by providing increased awareness, understanding and utilization of best-practice service and treatment modalities. Careful consideration has been paid to: a) evidence-based behavioral health practices; b) widely accepted standards of behavioral health care; c) Idaho Administrative Rule (program specific); d) state contractual requirements; e) current practice; f) need throughout the state; and g) input from community providers, consumers, and stakeholders.

Blended funding: a method for using multiple funding streams to support a common group of activities on behalf of a defined population in need. Blended funding involves commingling the funds into one "pot" where program needs can be met. When funding is blended, it goes into the "pot" and when it is pulled back out to pay for an expense, there is no means for the fiscal manager to report which funding stream paid for exactly which expense.

Braided funding: a method for using multiple funding streams to support a common group of activities on behalf of a defined population. The term braided is used because multiple funding streams are initially separate, brought together to pay for more than any one stream can support, and then carefully pulled back apart to report to funders on how the money was spent.

CANS Workgroup: A group of stakeholders, including parents, providers and advocates, who function in collaboration with agency representatives to perform research and analysis on the specific topic of the Child Adolescent Needs & Strengths (CANS). Purpose: create a version of the CANS tool that will be useful across multiple child-serving systems for the purposes of assisting in assessment, treatment planning, and outcome measurement processes.

Idaho Behavioral Health Plan (IBHP): Idaho Medicaid's managed care outpatient behavioral health plan that is a carved out program from the overall fee-for-service medical assistance program.

Potential Class Member: Any Idaho resident with unmet mental health needs who has not yet reached their 18th birthday and who has not yet been determined to be a Class Member.

Project Plan (CMHR Project Plan): The (Children's Mental Health Reform) Project Plan is the planning document the state will develop that will drive the execution of the work described in this Implementation Plan. It will clarify the scope of the project, define tasks, specify timelines, identify dependencies, and will contain all planning documents for the purposes of tracking and documenting progress on the implementation.

Project Team (CMHR Project Team): The CMHR Project Team is led by the Division of Behavioral Health. The Team is formed of IDHW staff who have been assembled for the specific purpose of creating and executing the CMHR Project Plan. The team members will return to their usual work roles following the completion of the Project.

Provider: any person or entity, associated with an agency as defined above, in a role of directly furnishing a service/support to a Class Member or Class Member's family.

QMIA Council: A quality management, improvement and accountability entity within the Jeff D. governance structure that is a cross-agency collaborative made up of executive level staff and children's mental health stakeholders with responsibilities specific to meeting the terms of the Agreement. See QMIA plan for complete list of goals and responsibilities.

QMIA Workgroup: A group of stakeholders, including parents, providers and advocates, who function in collaboration with agency representatives to perform research and analysis on the specific topics of quality management, improvement and accountability (QMIA) so that such concepts can be operationalized in the SoC in development. Purpose: to make recommendations regarding QMIA plan including how to monitor and report on Class-Member outcomes, system performance, and progress on implementation of this Agreement, and ensure continuous quality improvement at the clinical, program and system levels.

Services/Supports Workgroup: A group of stakeholders, including parents, providers and advocates, who function in collaboration with agency representatives to perform research and analysis on the specific topic of the services and supports described in Appendix C of the Agreement. Purpose: to develop a series of draft products and recommendations to the state for taking action to fulfill the requirements regarding the provision of all the services and supports listed in Appendix C of the Agreement. The scope of this workgroup includes defining all the services/supports, development of a Practice Manual, and all associated policy work needed to establish the authority to offer and pay for the services/supports and invoke formal oversight processes.

Workforce Development Champion: Promoter and advocate who provides leadership for the state's approach to addressing the need for sufficient workforce capacity to operate the SoC as designed.

Workforce Development Workgroup: A group of stakeholders, including parents, providers and advocates, who function in collaboration with agency representatives to perform research and analysis on the specific topic of workforce and community stakeholder development. Purpose: develop a Workforce Development plan that shall meet two objectives as delineated in the Agreement: (a) develop and strengthen the workforce in order to deliver the services and supports (as described in Appendix C of the Agreement); and (b) operationalize the PoC and PM (as described in Appendix B of the Agreement) system wide. The plan shall include a proposal for how the state will address any identified gaps in the workforce capacity necessary to meet the needs of children with serious emotional disturbance and deliver services to all children with emotional disturbance who will access publicly funded services. This plan shall also include a strategy to develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to public and private providers who serve children with serious emotional disturbance.