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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D., et al, Plaintiffs, vs. CLEMENT LEROY OTTER, et al, Defendants.	Case No. 4:80-CV-04091-BLW JOINT MOTION AND STIPULATION FOR APPROVAL OF SETTLEMENT AGREEMENT AND PROPOSED ORDERS

COME NOW the Plaintiffs, by and through their attorneys, Howard Belodoff of Belodoff Law Office, PLLC, and Patrick Gardner on behalf of the Young Minds Advocacy Project, on behalf of themselves and the putative class they represent, and Defendants, by and through their attorneys, Michael Gilmore, Nancy Bishop, Mark Withers, and Andrew Snook, Deputy Attorney Generals for the State of Idaho, submit the following joint stipulation and respectfully request

that the Court enter an order granting approval of the parties' stipulated Settlement Agreement as follows:

WHEREAS, Plaintiffs filed suit in August 1980 on behalf of Idaho children suffering from severe emotional disturbances against the Governor of Idaho and other state officials, alleging that Defendants were failing to provide adequate and appropriate treatment and educational programs in the least restrictive environment in violation of their rights under the United States Constitution, the Idaho Constitution, and federal and state statute;

WHEREAS, in April 1983, the parties entered into a settlement agreement, approved and entered by this Court as a consent decree, that offered the injunctive relief the class members sought in their complaint;

WHEREAS, in December 1990 and again in December 1998, the parties entered two additional consent decrees, also approved by this Court, to provide community-based mental health services to class members;

WHEREAS, in November 2007, this Court granted Defendants' Motion to Vacate the consent decrees and dismissed the case, Dkt. 705;

WHEREAS, on May 25, 2011, the Ninth Circuit issued an opinion reversing this Court's vacatur of the consent decrees and remanded to this Court for further proceedings;

WHEREAS, on August 10, 2011, this Court ordered Plaintiffs' counsel to meet and confer with Defendants to address any concerns with the consent decrees, Dkt. 731;

WHEREAS, Plaintiffs and Defendants agreed to use an alternative dispute resolution process designed to help resolve the outstanding compliance issues in this action and the Parties selected a mutually acceptable facilitator to assist in negotiations and consulted with experts;

WHEREAS, Plaintiffs and Defendants, after eighteen months of negotiations, have successfully concluded the mediation of all outstanding compliance issues and reached a stipulated Settlement Agreement that will, if implemented, achieve the purposes of the prior consent decrees;

WHEREAS, it is in the interest of the public, the parties, and judicial economy to resolve the remaining compliance issues without continued litigation;

WHEREFORE, the parties hereby move the Court to approve the Settlement Agreement and enter the proposed orders as stipulated and agreed, by and between Plaintiffs and Defendants, as follows:

1. The parties agree to the terms of the Settlement Agreement incorporated herein, as though fully set forth, and attached as Exhibit A to this stipulation.
2. The parties agree that the Agreement is reasonable and can be implemented if Defendants perform all of their obligations thereunder.
3. The parties agree the Settlement Agreement shall inure to the benefit of and be binding upon the legal representatives and any successors of the parties.
4. The parties agree to the terms of the protective order, attached as Exhibit B to this stipulation, relating to confidential information regarding class members.
5. The parties agree to administratively terminate this civil action in the Court records, without prejudice to the right of the parties to reopen proceedings for good cause shown for the entry of any stipulation or order, or for any other purposes required for implementation of the Settlement Agreement, consistent with the proposed Administrative Termination Order, attached as Exhibit C to this stipulation. Notwithstanding the administrative termination of this action, however, the parties hereby stipulate and respectfully request that the Court retain

jurisdiction to enforce the terms of the Settlement Agreement. *See Kokken v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375 (1994).

DATED this 12th day of June, 2015.

/s/ Mark V. Withers
MARK V. WITHERS
Deputy Attorney General
Attorney for Defendants

DATED this 12th day of June, 2015.

/s/ Michael S. Gilmore
MICHAEL S. GILMORE
Deputy Attorney General
Attorney for Defendants

DATED this 12th day of June, 2015.

/s/ Howard A. Belodoff
HOWARD A. BELODOFF
Next Friend and Attorney for Plaintiffs

IT IS SO ORDERED.

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 12th day of June 2015, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing and a copy of this document to the following persons:

Howard A. Belodoff, ISB No. 2290
BELODOFF LAW OFFICE PLLC

PATRICK GARDNER, CB No. 208199 Pro Hac Vice
WESLEY SHEFFIELD, CB No. 287940 Pro Hac Vice
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Deputy Attorneys General

ATTORNEYS FOR DEFENDANTS

/s/ Howard A. Belodoff
HOWARD A. BELODOFF

EXHIBIT A

EXHIBIT A

Jeff D. v C.L. "Butch" Otter, No. 4:80-CV-04091-BLW
Settlement Agreement

The Parties to this lawsuit, Jeff D., *et al.* (hereinafter "Plaintiffs") by and through their counsel of record; C.L. "Butch" Otter, in his official capacity as Governor of Idaho; Richard Armstrong, in his official capacity as Director of the Idaho Department of Health and Welfare (DHW); Sharon Harrigfeld, in her official capacity as Director of the Idaho Department of Juvenile Corrections (IDJC); Sheri Ybarra, in her official capacity as Superintendent of the State Department of Education (SDE) (hereinafter "Defendants"), make the following Agreement:

I. PURPOSE

1. The purpose of this Agreement is to direct and govern the development and implementation of a sustainable, accessible, comprehensive, and coordinated service delivery system for publicly-funded community-based mental health services to children and youth with serious emotional disturbances ("SED") in Idaho. The specific objective of this Agreement is the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide,[1] in the manner prescribed herein. As a result of this Agreement, Class Members will receive individualized, medically necessary services in their own communities, to the extent possible, and in the least restrictive environment appropriate to their needs.

2. Class Members are Idaho residents with a Serious Emotional Disturbance who are eligible under this Agreement for services and supports provided or arranged by Defendants and:
   a. Are under the age of eighteen (18);
   b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [2] and
   c. Have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician or would have been measured and documented had an assessment been conducted.

3. Class Members and their families retain the choice whether to accept or reject voluntary services offered by Defendants under this Agreement. However, this Agreement does not apply to services provided to Class Members on an involuntary basis, such as those services provided involuntarily to Class Members in the custody of the state or those services required by court order.

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[1] For the purposes of this Agreement, "statewide" means sufficient in quantity, scope, duration, and geographic distribution to meet the needs of Class Members.

[2] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

4. a. Substantial compliance with this Agreement is intended to satisfy the obligations and fulfill the purposes of the prior consent decrees entered by the District Court in this matter. Upon the District Court's approval of this Agreement, and during the periods of implementation and sustainability, the consent decrees, entered in 1983, 1990, and 1998, and the Implementation Plan, approved in 2001, and the orders related thereto, shall be deemed suspended, and Plaintiffs agree not to seek enforcement of them.

b. Plaintiffs may move the District Court to lift the suspension of the consent decrees, Implementation Plan, and orders related thereto, in the event that Defendants are failing to substantially comply with the duties and obligations under this Agreement, and in the event that this Agreement's dispute resolution process has not successfully resolved the dispute concerning the alleged non-compliance. If such a motion is filed, Defendants shall bear the burden of proving substantial compliance of this Agreement to the District Court. If the District Court finds that Defendants have not substantially complied with this Agreement, the District Court shall lift the suspension and Plaintiffs may seek enforcement of applicable portions of the consent decrees, Implementation Plan, and orders related thereto, subject to Federal Rule of Civil Procedure 60(b)(5). During the pendency of any proceedings initiated under this paragraph, each party shall continue to fulfill its duties and obligations under this Agreement.

5. This Agreement will be completed in three (3) phases, including: (1) development of an Implementation Plan, as described in paragraphs 59 through 63; (2) execution of the Implementation Plan, as described in paragraphs 64 through 68; and (3) sustained performance and compliance with purposes and terms of this Agreement, as described in paragraph 79.

   a. The projected timeline for the Agreement includes approximately nine (9) months to develop the Implementation Plan, commencing once the District Court approves the Agreement, a period of up to four (4) years to complete the Implementation Plan, and a sustained performance and compliance period of three (3) years. The Parties may agree to shorten or lengthen any of the time periods according to the modification procedure defined in paragraph 97. The sustainability period shall commence when the District Court finds that Defendants have substantially complied with the Outcomes set forth in Section VI. Any party may submit a motion to the District Court requesting this finding.
   b. Upon successful implementation of the Agreement, wherein the Defendants are in substantial compliance with the terms of the Agreement, demonstrated through sustained performance of the Agreement as described in paragraph 79, the case shall be dismissed by the District Court. Simultaneous to the dismissal, a permanent injunction will be issued that ensures the Plaintiff Class will continue to be provided the services and supports consistent with the Principles of Care and Practice Model that have been successfully developed through the implementation of this Agreement.

6. This Agreement includes four (4) components: (a) Goals, (b) Commitments, (c) Outcomes, and (d) Exit Criteria.

   a. The Goals are intended (1) to aid in interpreting the meaning and purpose of this Agreement; and (2) to guide planning, implementation, development, and sustainability of Idaho's system of care for children with a serious emotional disturbance. Although the Parties agree that the Goals will be used for the purposes of interpretation and guidance, the Goals are not enforceable as separate requirements. The Goals are not Commitments, Outcomes, or Exit Criteria, and shall not be measured as such.

   b. The Commitments are the items or actions that Defendants will pursue to achieve the intended results of the Agreement. Defendants will substantially and timely comply with all of the Commitments and timelines set forth herein, and as further described in the Implementation Plan, during the pendency of this Agreement.

   c. The Outcomes are the expected achievements or results of Defendants carrying out the Commitments. The Outcomes are the sole objective measures that, when accomplished, determine at the end of the implementation period whether Defendants are in substantial compliance with the requirements for completing implementation of this Agreement.

   d. The Exit Criteria are the expected achievements demonstrating Defendants sustained compliance with the terms of the Agreement. The Exit Criteria shall be the sole objective measures that, when accomplished, determine at the end of the sustained performance and compliance period whether Defendants are in substantial compliance with the Agreement such that the lawsuit will be dismissed.

II. BACKGROUND

7. Original Complaint: In August 1980, the Class Members, a group of indigent children with a serious emotional disturbance, commenced a lawsuit against the Defendants, including the Governor of Idaho, the Superintendent of Public Instruction, the Director of the Idaho Department of Health and Welfare, and the Administrator of State Hospital South and their successors in interest. The Director of the Idaho Department of Juvenile Corrections was joined as a Defendant in 2000. The Complaint claimed that adequate care, treatment and educational services were not being provided in violation of the Class Members' rights under the United States Constitution, the Idaho Constitution, and several federal and state statutes. The Complaint, which sought declaratory and injunctive relief, contained two primary allegations: (1) mixing of juveniles with adults at State Hospital South violated the rights of Class Members; and (2) the Defendants were required to provide

community-based mental health and specialized education services to Class Members.

8. Procedural History: Over the ensuing thirty-four (34) years, the Parties entered several court-approved consent decrees and Plaintiffs' counsel obtained court orders to fulfill the purposes of the consent decrees in the provision of mental health treatment services to the Class Members.

   a. The 1983 Consent Decree addressed separating Class Members from adult mental patients at state institutions, assessing children's mental health programs, and making facilities and programs for mental health treatment and services available in a community-based setting.
   b. The 1990 Consent Decree addressed separating Class Members from adult mental health patients at all state mental health facilities, required the provision of an array of community-based mental health services, programs and professionals, and required Defendants to provide the necessary funding to implement the 1983 and 1990 Consent Decrees.
   c. In 1993, the District Court issued its Report and Recommendation requiring a minimum annualized amount of dedicated funding in each of IDHW's seven (7) regions to begin to deliver the community based mental health services required by the 1990 Consent Decree.
   d. The 1998 Consent Decree set forth an agreed upon screening form as part of the Jeff D. class definition, addressed contracting for and conducting of an independent "Needs Assessment" of children's mental health, required Defendants to request an increase in dedicated funding to implement the Recommendations of the Needs Assessment, and required a request for funding from the state legislature to expand the capacity of community-based services and to maximize Medicaid services to comply with all of the prior consent decrees. The Needs Assessment, issued in June 1999, included 50 Recommendations. The Needs Assessment led to an Implementation Plan, which contained Background Information/Framework for Implementation, Financial Statements, 252 Priority Action Items, and Timelines and a Desired Result sections. The District Court approved the Implementation Plan in June 2001.
   e. In September 2006, the District Court held a two (2) week "final compliance hearing" to determine whether Defendants were in compliance with the terms of the consent decrees. The District Court determined that compliance would be measured by the 252 Priority Action Items in the Implementation Plan and held that Plaintiffs' counsel had the burden of proof to establish non-compliance under the evidentiary standard for civil contempt.
   f. On February 7, 2007, the District Court concluded that Defendants had complied with all but 21 of the Action Items. The District Court further held that "once the Defendants are in compliance with these Action Items, the Defendants may file a motion to vacate the consent decrees." In June 2007, the Defendants filed a motion to vacate the consent decrees.

g. On November 1, 2007, the District Court vacated the consent decrees and Implementation Plan and dismissed the case. Plaintiffs' counsel appealed the order, asserting that it was error for the District Court to measure compliance based solely upon the 252 Priority Action Items, to apply the standard for civil contempt in determining whether to vacate the decrees and to place the burden on Plaintiffs' counsel to prove non-compliance.

9. Ninth Circuit Court of Appeals Decision: On May 25, 2011, the Ninth Circuit Court of Appeals reversed the District Court's order vacating the consent decrees and Implementation Plan. The Ninth Circuit found that the District Court's use of the civil contempt burden and standard of proof was improper for a determination of substantial compliance. The Ninth Circuit further held that the Defendants were required to sustain the burden of establishing that Defendants had substantially complied with the consent decrees or to demonstrate that the facts and the laws have changed so that "it is no longer equitable that the judgment should have prospective application." The Ninth Circuit further held that the Defendants had the burden to establish that if any deviation from literal compliance with the consent decrees occurred, such deviation did not defeat the essential purpose of the consent decrees. The Ninth Circuit also held that the District Court erred in accepting the Action Items as the entire measure of compliance with the consent decrees. Finally, the Ninth Circuit held that it had no way to determine whether the District Court's findings would have been different had the District Court placed the burden of proof on the Defendants to demonstrate they had substantially complied with the Action Items. The Ninth Circuit added that the status of compliance requires overall attention to whether the larger purposes of the consent decrees have been served, not just whether there was substantial compliance with the Action Items.

10. Settlement Efforts: On remand, the District Court instructed the Parties to follow a meet-and-confer process to address concerns regarding Defendants' substantial compliance with the consent decrees and to fulfill the purposes of consent decrees. On October 5, 2013, the Parties began intensive efforts to avoid further litigation and delays by negotiating a settlement agreement that would achieve substantial compliance and fulfill the purposes of the consent decrees. The Parties agreed they would enlist the assistance of a mediator to facilitate the negotiations. Thereafter, the Parties held seventeen (17) in-person mediation sessions and numerous sessions via conference calls from October 2013 through December 2014. Through these efforts, the Parties developed this Agreement. The Parties agree that the best interests of the Class Members will be substantially advanced by resolving any material outstanding issues in this lawsuit through a negotiated settlement based on the Goals and Commitments reflected in this Agreement, rather than through adversarial litigation.

III. JURISDICTION AND AUTHORITY OF THE COURT

11. The District Court will have jurisdiction, in accordance with 28 U.S.C. §§ 1331 and 1343, to enforce this Agreement and the resulting Implementation Plan that will be developed pursuant to paragraphs 59 through 63.

12. Upon execution of this Agreement, the Parties shall submit a joint stipulation to the District Court. The Parties agree to cooperate in good faith to prepare all relevant filings, including, but not limited to, a proposed protective order regarding the handling by the Parties of confidential information and a proposed order addressing the status of this case.

13. Except as otherwise noted, the terms of this Agreement shall not take effect until the District Court issues an order approving this Agreement.

IV. GOALS

14. 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, Outcomes, and Exit Criteria. The Goals are not Commitments, Outcomes, or Exit Criteria, and shall not be measured or enforceable as such.

15. The Goals of this Agreement are to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health service delivery system that:

    a. Identifies and screens potential Class Members and links Class Members to appropriate care according to a consistent statewide procedure, regardless of entry point or referral source;

    b. Provides individualized services to Class Members consistent with the Principles of Care;

    c. Communicates with Class Members and their families about the nature and purposes of services and how to access them;

    d. Delivers a continuum of care that emphasizes high quality community-based services and supports in sufficient intensity and scope in the least restrictive environment appropriate to meet Class Members' individual needs;

    e. Coordinates delivery of mental health services among departments and agencies serving Class Members in order to reduce fragmentation of services for Class Members;

f. Measures and communicates treatment outcomes and system performance in order to improve quality care and increase accountability to Class Members, their families, and stakeholders;

g. Supports engagement and involvement of Class Members and their families throughout the system of care, including treatment planning as well as system improvement and planning efforts;

h. Develops the workforce and infrastructure necessary to meet the need for availability and access to services and supports and provide for education, training, and ongoing coaching of providers, Class Members, their families, and other stakeholders as applied to the system of care and its implementation;

i. Builds on existing strengths of the children's mental health system and uses Defendants' resources efficiently;

j. Fully accessing Medicaid and other federal funds and maximizing opportunities for Class-Member serving agencies to participate in braided funding of common services;

k. Maintains a collaborative governance structure that includes Defendants' agencies, Class Members, their families, and other stakeholders;

l. Affords due process to Class Members; and

m. Leads to improved outcomes for Class Members and their families in order to keep Class Members safe, in their own homes, and in school; to minimize hospitalizations and out-of-home placements; to reduce potential risks to their families; to avoid delinquency and commitment to the juvenile justice system in order to receive mental health services; to correct or ameliorate mental illness, reduce mental disability, and to restore functioning.

V. COMMITMENTS

16. The Defendants agree to timely fulfill the Commitments, using the Goals for the purposes of interpretation and guidance, during the pendency of this Agreement. The Commitments include tasks, actions, processes, achievements, and other concrete deliverables that are required to meet the needs of Class Members.

17. Substantial compliance with the Commitments, including timelines provided herein, is enforceable during the pendency of this Agreement.

A. Services Provided to Class Members

18. Class Members shall be provided all of the services set forth in the Services and Supports document, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts.[3]

19. The Parties agree that Class Members with more intensive needs shall be provided Intensive Care Coordination (ICC), as defined in the Services and Supports document. Under this Agreement, Class Members with more intensive needs include any Class Member who either has a qualifying Child and Adolescent Needs and Strengths (CANS) tool score, as developed pursuant to paragraphs 32 and 35, or meets one of the following criteria:
    a. Is at substantial risk of out-of-home placement due to mental health needs;
    b. Has experienced three (3) or more foster care placements within twenty-four (24) months for reasons related to mental health needs;
    c. Is involved with multiple child-serving systems related to his or her mental health needs;
    d. Is under age twelve (12) and has been hospitalized for reasons related to mental health needs within the last six (6) months;
    e. Is under age twelve (12), has been detained within the last six (6) months, and has unmet mental health needs;
    f. Has experienced more than one hospitalization for mental health needs within the last twelve (12) months; or
    g. Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within up to ninety (90) days if adequate home and community-based supports were provided.

20. Class Members who are provided ICC shall be afforded a formal Child and Family Team ("CFT") in accordance with the Practice Model, attached hereto as Appendix B.

21. Class Members who are provided ICC shall continue receiving ICC until the CFT determines that the ICC Class Member no longer meets medical necessity for ICC and has the CFT has approved a transition plan.

22. Class Members shall have access to services on a voluntary basis whenever informed consent can be obtained. Involuntary treatment or relinquishment of custody to Idaho shall not be a condition for accessing, providing, or paying for services and supports provided under this Agreement.

23. Financial need or income eligibility is not required for access to services for Class Members. Class Members' Families who have the ability to pay for care, after taking

[3] Class Members and their families retain the choice whether to accept or reject services offered under this Agreement by Defendants. This Agreement does not require Defendants to provide services to Class Members on an involuntary basis.

into account their existing financial obligations, may be required to reimburse a reasonable amount of the total actual costs of the services. No Class Member shall be denied services because of the inability to reimburse the cost of services.

24. Defendants shall establish, within six (6) months following approval of this Agreement by the District Court, an initial expected range of Class Members that will utilize the Services and Supports provided pursuant to this Agreement. Defendants shall annually update this expected Class Member service utilization range so that Class Members who need them will be provided Services and Supports under this Agreement. Defendants shall timely provide Services and Supports statewide within the annually established service utilization range.

B. Principles of Care and the Practice Model:

25. Defendants have adopted and shall implement a Practice Model for delivering publicly-funded mental health services and supports to Class Members. The Practice Model, more fully described in Appendix B, provides the framework for providing services and supports to Class Members under this Agreement. The Practice Model describes the expected client experience of care within Idaho's children's mental health system over the course of intake, assessment, treatment and transition.

26. Defendants shall provide services to Class Members in accordance with the Principles of Care and the Practice Model, as set forth in Appendix B. Defendants shall use the Principles of Care and the Practice Model to:
    a. Inform and guide the management and delivery of publicly-funded mental health services and supports;
    b. Describe the treatment and support activities that providers undertake; and
    c. Describe how services and supports are coordinated among child-serving systems and providers.

27. Defendants shall use the CFT approach for engagement, mental health treatment planning, service coordination, and case management for Class Members, as defined and described in the Practice Model.

C. Access to Care:

28. Defendants have adopted an Access Model that describes how Class Members access the full array of services and supports under this Agreement, attached as Appendix A. The Access Model provides an overarching protocol for how Class Members are identified, and how they move into, through, and out of Idaho's children's mental health system of care.

29. Defendants will use the Access Model to describe procedures or processes to:
    a. Inform, identify, and screen potential Class Members in child-serving systems, as well as other discrete groups or populations of children at heightened risk of serious emotional disorders (e.g., homeless youth);

b. Refer and allow self-referral of potential Class Members for screening and assessment;
c. Assess individuals who screen positive for unmet mental health needs and connect Class Members to services;
d. Plan for and provide timely services under this Agreement to Class Members for whom services are medically necessary, based on the assessment;
e. Provide for continuously-coordinated care for Class Members; and
f. Transition Class Members between levels of care to the adult mental health system or to the community.

30. Defendants shall amend the Access Model to include protocols for:
a. Identifying and referring potential Class Members for screening;
b. Referring potential Class Members for an assessment, including those potential Class Members identified as having unmet mental health needs as a result of the screening process as well as those potential Class Members for whom screening is optional, as described in paragraph 33;
c. Offering services to Class Members and firmly linking those who accept services to providers and care planning; and
d. Transitioning Class Members between levels of care, out of care, and into the adult mental health system, which shall include, but is not limited to:
i. a process for transitioning out of care those Class Members who no longer meet eligibility requirements pursuant to paragraph 2; and
ii. an expedited process for former Class Members to transition back into care if they meet eligibility requirements pursuant to paragraph 2.

31. Defendants may further amend or update the Access Model over time, consistent with the purposes and intent of paragraphs 28 through 30, subject to the modification process described in this Agreement, paragraph 97.

32. Defendants shall implement the Child and Adolescent Needs and Strengths (CANS) tool for use in delivering services and supports to Class Members pursuant to this Agreement. The CANS is an assessment strategy and communication tool that Defendants will use to inform: screening, assessment, care planning, level of care decisions, standardization of referrals, clinical practice, measurement of individual outcomes, resource and program management, and improvement of service access and service coordination consistent with Principles of Care and Practice Model.

33. Defendants shall develop, adopt, and administer an age-appropriate screen to children with unmet mental health needs in order to identify potential Class Members. Defendants will refer children who screen positive for an assessment. Defendants shall not require an identifying screen as a prerequisite to receiving an assessment under this Agreement. Children/youth not needing to be screened shall include those who:
a. Were previously identified as Class Members, but are not presently receiving intensive mental health services;

b. Have had a clinical mental health assessment that was completed within the last six (6) months that indicates the presence of a mental health condition;
c. IDJC or DHW's Division of Family and Community Services (FACS) identifies through assessment processes as Class Members; or
d. Request, through their parents or legal guardians, an assessment.

34. Defendants shall develop, adopt, and administer a clinical mental health assessment for potential Class Members referred for assessment, including those identified using the age-appropriate screen, pursuant to paragraph 33. Defendants will use the assessment to identify mental health diagnosis and functional impairments in order to determine whether a potential Class Member is eligible to become a Class Member. Defendants will also use the assessment to inform individualized treatment planning.

35. Defendants shall use a transparent process to establish the threshold levels of functional impairment used to identify, through use of the CANS tool, potential Class Members who are eligible (a) to become Class Members, pursuant to paragraph 2, and (b) for ICC services, pursuant to paragraph 19, in consultation with clinical expert(s), mutually agreed to by the Parties.

36. The Parties agree that Class Members shall be provided the services set forth in the Services and Supports document that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts without regard to their eligibility for Medicaid. Defendants agree to use their resources efficiently by fully accessing Medicaid funds when delivering services and supports to Class Members. Defendants will implement and administer Idaho's Medicaid program[4] to provide services to the fullest extent allowed under the Medicaid Act, including (a) services that are currently covered under Idaho's State Medicaid Plan, Idaho's Children's Health Insurance Plan (CHIP), and Idaho's Behavioral Health Plan 1915(b) waiver, and (b) those services that are Medicaid coverable, including all services and supports that are eligible for federal financial participation pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Act, 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B). Defendants shall provide information and conduct outreach activities to educate and encourage Class Members and their families to apply for Medicaid or CHIP.

37. Defendants shall make descriptions or explanations of the Services and Supports, the Principles of Care and the Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders,

[4] References to Medicaid throughout this Agreement are intended to include those services and supports provided and/or arranged for pursuant to Idaho's State Medicaid Plan, Idaho's Children's Health Insurance Plan (CHIP), Idaho's Behavioral Health Plan 1915(b) waiver, and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Act, 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B).

including, but not limited to, conspicuously posting information on Defendants' websites.

38. Defendants shall develop and implement a statewide communication plan for outreach and education of the community, stakeholders, and families about potential Class Members who are eligible to become Class Members, the nature and purposes of services pursuant to this Agreement, and how to access services.

D. Workforce Training and Development

39. Defendants shall develop and implement a workforce development plan (a) to develop and strengthen the workforce in order to deliver Services and Supports pursuant to this Agreement; and (b) to operationalize the Principles of Care and Program Model system wide. The workforce development plan shall include a proposal for how Defendants will address any identified gaps in the workforce capacity necessary to meet the needs of Class Members and deliver services within the utilization range established pursuant to paragraph 24. The workforce development 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 Class Members pursuant to this Agreement.

40. Defendants will develop a Practice Manual to guide and facilitate access to services set forth in the Services and Supports document. The Practice Manual shall be based on the Principles of Care, the Practice Model, and the Access Model. The Practice Manual shall include instructions and guidance for agency staff, providers, and other system and community stakeholders. The Practice Manual topics shall include, but need not be limited to:
    a. Goals of the system of care as described in this Agreement;
    b. Definitions;
    c. Identification, referral, screening, and assessment of Class Members;
    d. The CFT approach;
    e. Collaboration and coordination with other system and community partners;
    f. Roles and responsibilities of providers, CFT members, and agencies;
    g. The services and supports that are available;
    h. Access to services and supports;
    i. Billing and service reporting;
    j. Identification and description of decision points, to include who makes the decision and any criteria to be used in making the decision; and
    k. Procedures for reviewing, reconsidering or disputing decisions and an appeal process consistent with due process requirements.

41. Defendants will direct, through training and contracts, agency staff, providers, and other system and community stakeholders to follow the Practice Manual, developed pursuant to paragraph 40, and the Principles of Care and Practice Model when delivering services and supports to Class Members pursuant to this Agreement.

42. Defendants will educate and train agency staff, providers, and other relevant system and community stakeholders how to:
    a. Identify and refer potential Class Members for screening and assessment using the Access Model;
    b. Implement and use the CANS tool for screening, assessment, care planning, and evaluation of outcomes; and
    c. Provide services and supports consistent with the Practice Manual and the Practice Model.

E. Due Process

43. Defendants shall develop and adopt a centralized and impartial process to address and track complaints as part of the CFT approach, pursuant to paragraph 27, which may run concurrent to the formal appeal process, described in paragraphs 44 through 47. Class members and their families or legal guardians may choose, but are not required, to participate in this complaint process. This provision does not waive or replace Class Members' rights to due process as provided pursuant to this Agreement and under federal and state laws and regulations. The complaint process is intended to address Class Members' and caregivers' concerns related to their dissatisfaction with a process or a provider at the lowest or most appropriate organizational level possible. The process will include documentation of the complaint, a specific time frame to act upon the complaint, and documentation of the outcome.

44. Defendants shall provide written notice of action to a Class Member under the following circumstances:
    a. When Defendants determine that an individual is not a Class Member, following an assessment; or
    b. When Defendants deny or limit a requested service; or
    c. When Defendants reduce, suspend, or terminate a currently authorized service; or
    d. When Defendants deny, in whole or in part, payment for a service.

45. Defendants shall provide written notice that includes:
    a. The action Defendants have taken or intend to take and legal authority for the action;
    b. The rationale for the action including the written documentation consulted and relied upon which supports the action;
    c. The right to file a request for a fair hearing;
    d. The specific timeline and procedure for applying for a fair hearing;
    e. A summary of the fair hearing procedures and the citation to the rules governing fair hearing and the web address link to those procedures;
    f. The right to have assistance with an appeal and contact information for family advocacy organizations;
    g. When an expedited resolution is available and how to request an expedited resolution;

h. The right to have benefits continue, pending resolution of the appeal, how to request benefits continue, and the circumstances under with the Class Member's family may be required to pay for the continued services; and
i. The option to engage in the complaint process as described in paragraph 43.

46. Defendants shall inform Class Members of the circumstances in which they have a right to receive a notice of action and request a fair hearing through written informational materials. Defendants shall provide these informational materials with the decision and on their respective websites.

47. Defendants shall require contracted providers to comply with the notice and informing provisions of this section.

48. As part of the Quality Management, Improvement and Accountability Plan, described in paragraph 52, Defendants shall collect and report data on written notices of action, complaints, and fair hearings requests and outcomes.

F. Governance and Interagency Collaboration

49. Defendants shall establish and use a collaborative interagency Governance structure to coordinate and oversee implementation of this Agreement. The governance structure shall include an Interagency Governance Team (IGT). An initial description of the interagency Governance structure, including the IGT, is set forth in Appendix D.

50. Defendants shall adopt operational guidelines for carrying out the purposes and responsibilities of the IGT, as described in the Governance appendix.

51. Defendants shall encourage engagement and active involvement of Class Members, their families, and other community stakeholders in planning and evaluation activities related to implementation of, and performance under, this Agreement. At a minimum, Defendants shall include 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 as part of the Interagency Governance Team.

G. Quality Management, Improvement and Accountability

52. Defendants shall develop and implement a Quality Management, Improvement and Accountability (QMIA) plan for monitoring and reporting on Class-Member outcomes, system performance, and progress on implementation of this Agreement, as well as for ensuring continuous quality improvement at the clinical, program and system levels. The QMIA plan shall include goals, objectives, tools, resources, and feedback mechanisms needed to:

a. Measure, assess and report on progress on meeting this Agreement's Commitments, achieving the Outcomes, sustaining performance, and satisfying the Exit Criteria; and
b. Build on existing quality assurance and improvement processes to achieve a collaborative QMIA system for mental health programs and services across Defendants' child-serving systems.

53. The QMIA System shall develop system-wide capabilities to:
a. Consistently, routinely, and accurately monitor progress implementing this Agreement, and document the achievements or satisfaction of Commitments, Outcomes, sustained performance requirements and Exit Criteria;
b. Determine and measurably improve core-system and cross-system program administration and management competencies necessary for successful implementation of the Agreement;
c. Monitor, measure, and evaluate multi-level (e.g., clinical, provider, program, system) information on access, performance, outcomes, service quality, and cross-system collaboration;
d. Regularly communicate the information developed in subsections a-c with managers, decision-makers, supervisors, clinicians, young people and families, the public, and the parties**;**
e. Improve clinical and program quality by (i) providing feedback of clinical and program experience and data to clinicians, supervisors, and managers; (ii) identifying effective treatment practices and teaching those practices to clinicians, supervisors, and managers;
f. Make CANS data available in real time; and
g. Set goals for improving system accessibility, performance, outcomes, service quality, and cross-system collaboration over time in order to comply with the Agreement's Commitments and sustained performance requirements, and achieve the intended Outcomes and Exit Criteria.

54. Defendants shall complete development of and begin to implement the QMIA plan within nine (9) months after the District Court gives approval of the Agreement. Defendants agree to implement the QMIA plan consistent with its terms.

55. In order to accurately measure and report on progress implementing the Agreement, Defendants shall routinely measure, analyze, and publicly report (not less than quarterly or as determined in the QMIA planning process) on regional and statewide QMIA indicators and data that include, but are not limited to:
a. The number and characteristics of potential Class Members estimated, screened, assessed, and determined eligible for services and supports under this Agreement;
b. The number and characteristics of Class Members that receive any mental health services and supports;
c. The quality, scope, intensity, duration, type, funding source, and program provider of services and supports provided pursuant to this Agreement to Class Members;

d. Service quality, satisfaction, and outcomes for Class Members and their families;
e. Expenditures on each service and support segregated by agency that provides them, by region, and by key demographic data utilizing a reporting format and content uniform across systems; and
f. Number, basis, and outcomes of complaints and appeals;

56. The Parties will jointly develop, and Defendants will initiate on a jointly agreed date, a Quality Review (QR) process to be used to objectively assess and improve clinical practice and program effectiveness system wide. The QR process is an effective tool for identifying program strengths and needs and providing critical information on how to improve practice. The components of the QR process shall include, but are not limited to:
    a. Quality and outcome measures at the clinical and program levels;
    b. A representational sampling of cases, as agreed to by the Parties;
    c. Evaluation of the case sampling by a team of reviewers that will include at least one independent, neutral monitor. The evaluation includes:
        i. Interviews with Class Members and their families that agree to participate in the process, CFT members, and others associated with the Class Members who might have relevant information about the Class Members' experience of care; and
        ii. File reviews.
    d. A QR instrument and rating system to be used by the reviewing team when evaluating the case sampling; and
    e. Use of QR results to help identify best practices and support quality improvement in clinical practice and program performance.

57. Defendants shall conduct QRs on a periodic basis, as agreed upon by the Parties, but not less than annually, beginning after the start of the implementation period on the date specified in paragraph 56 and throughout the sustained performance period.

58. Defendants shall publicly report the QR results on an annual basis. As part of the annual reports, Defendants will identify "lessons learned" from the QRs with recommendations regarding steps to be taken, if any, to improve clinical and program quality.

H. Implementation Plan

59. The Parties agree to establish an implementation work group (IWG) comprised of Plaintiffs' counsel, Defendants' counsel, and children's mental health stakeholders with knowledge relevant to system beneficiaries, services and processes. The IWG is intended to help facilitate successful implementation planning as prescribed by this Agreement. The IWG will convene with sufficient frequency to develop the Implementation Plan. The Implementation Plan will be developed within nine (9) months after the District Court gives approval of the Agreement. The IWG may meet in person or by conference call as necessary.

60. Defendants shall develop an Implementation Plan working collaboratively with the IWG that provides:
    a. Sufficient specific details such that the District Court may determine from the four corners of the plan whether it is reasonably capable of achieving the terms of the Agreement; and
    b. 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.

61. The Implementation Plan shall, at a minimum:
    a. Identify and sequence tasks necessary to fulfill the Commitments and achieve the Outcomes provided in this Agreement;
    b. Develop and use quality assurance and improvement procedures to measure, assess, manage and report on the implementation process;
    c. Set clear and accountable timelines for compliance, including interim progress until compliance is achieved;
    d. Identify responsible agencies and divisions for achieving tasks identified;
    e. Outline processes for the IWG to monitor progress, provide feedback, and resolve problems in meeting Defendants' obligations under this Agreement and carrying out the Implementation Plan;
    f. Identify the staffing and financial resources necessary to fulfill the Commitments and achieve the Outcomes required by this Agreement; and
    g. Describe the communication and outreach activities that Defendants will undertake in order to inform Class Members, their families, stakeholders and the community about services and procedures provided under this Agreement.

62. Defendants shall submit the completed Implementation Plan to the District Court for approval. Prior to submission of the Implementation Plan, Defendants shall review the final proposed Implementation Plan with Plaintiffs' counsel. The Parties shall make reasonable efforts to submit a consensus plan. If the Parties cannot agree on the terms of the Implementation Plan, the disputed issue(s) may be submitted to the District Court for resolution.

63. The District Court shall approve the Implementation Plan if the Court determines the plan is reasonably capable of fulfilling the terms of this Agreement and purposes of the consent decrees and related court orders.

64. Defendants shall timely comply with the Implementation Plan approved by the District Court.

65. The Implementation Plan, including any timelines established therein, may be amended according to the modification procedures outlined in this Agreement. Defendants shall notify Plaintiffs' counsel prior to the expiration of the timeline or

when Defendants determine that a timeline will not be met. An agreement to modify timelines does not alter the substantive intent of the Commitments, but only extends the time by which the Commitments will be accomplished.

66. After approval of the Implementation Plan by the District Court, the IWG will continue to meet at a minimum of twice yearly, but more frequently if needed. During the implementation period, the IWG is intended to foster communication between the Parties by providing a forum to discuss progress on and problem-solve issues related to the Implementation Plan and Defendants' performance under this Agreement.

67. Defendants shall provide an annual report to the District Court and Plaintiffs' counsel on the progress of the Implementation Plan beginning six (6) months after the District Court approves the Implementation Plan or as otherwise agreed by the parties. The report will account for accomplishments made to date and identify potential or actual compliance issues that need attention, including a summary of proposed or actual remedial efforts made to address these compliance issues. The annual reports will use data and information developed pursuant to the QMIA provisions of this Agreement whenever possible.

68. Defendants will provide a draft of the report to Plaintiffs' counsel at least thirty (30) days in advance of filing their annual report with the District Court. Plaintiffs' counsel will provide any feedback within fifteen (15) days of receiving the draft unless the Plaintiffs' counsel request a reasonable an extension of time of up to fifteen (15) days. If the Parties are unable to reach consensus on the final contents of the status report, Defendants may proceed with filing their report, and Plaintiffs' counsel will have the option to prepare a response that will be filed with the District Court and attached as an addendum to a publicly available version of the status report.

VI. OUTCOMES

69. The Outcomes are the results the Parties expect Defendants will achieve in carrying out the Commitments and fulfilling this Agreement. Defendants shall have a period of up to four (4) years to fulfill the Commitments by completing the Implementation Plan. Upon completion of implementation, Defendants shall demonstrate they have substantially complied with the Outcomes set forth in this section. At that time, the Outcomes will be the sole objective measures that, when accomplished, will indicate that Defendants are in substantial compliance with the requirements for completing implementation of this Agreement. Any party may submit a motion to the District Court for a finding of substantial compliance with the requirements for completing implementation as measured by the Outcomes. The sustainability period shall commence when the District Court finds that Defendants have substantially complied with the Outcomes.

70. Six (6) months prior to the end of the Implementation Phase, the Parties will meet to determine whether there is any dispute as to whether Defendants are on track to meet the Outcomes.

A. Services Outcomes

71. Defendants shall:
    a. Establish and annually update the range of expected Class Members service utilization, as set forth in paragraph 24;
    b. Develop statewide capacity to timely provide Services and Supports in appropriate scope, intensity and duration to Class Members for whom it is medically necessary;
    c. Provide the full array of Services and Supports, as defined in Appendix C, statewide as needed by and clinically appropriate for Class Members;
    d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs, as described in paragraphs 18, 22, 23 and 36; and
    e. Provide ICC, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21.

B. Principles of Care and Practice Model Outcomes

72. Defendants shall:
    a. Develop, adopt, and deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care and the Agreement, as set forth in paragraphs 25 through 27; and
    b. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Principles of Care and Practice Model.

C. Access Outcomes

73. Defendants shall:
    a. Develop, adopt, and consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 28 through 36 and Appendix A;
    b. Implement and use the CANS tool statewide, as described in paragraph 32, to:
        i. Screen potential Class Members for unmet mental health needs;
        ii. Assess Class Member's individual and family strengths and needs;
        iii. Support clinical decision-making and practice; and
        iv. Measure and communicate client outcomes; and.
        v. Improve service coordination.
    c. Develop, adopt, and use statewide a uniform, age-appropriate screen, described in paragraph 33, to identify potential Class Members with unmet mental health needs;

d. Develop, adopt, and use statewide a standard mental health assessment, described in paragraph 34, to determine class membership status for potential Class Members referred for an assessment;
e. Establish threshold levels of functional impairment as measured by the CANS tool, in consultation with clinical expert(s) mutually agreed by the Parties, as described in paragraph 35, to be used by Defendants in determining eligibility (i) to become Class Members and (ii) to receive ICC services;
f. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;
g. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including, but not limited to, posting information on Defendants' websites, as described in paragraphs 36 and 37;
h. Develop and implement a statewide communication plan for outreach and education of the community, stakeholders, and families, as described in paragraph 38; and
i. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Access Model.

D. Workforce Training and Development Outcomes

74. Defendants shall:
a. Develop and implement a workforce development plan, as described in paragraph 39;
b. Develop and adopt a Practice Manual, as described in paragraph 40;
c. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;
d. Educate and train agency staff, providers, and other community and system partners, as set forth in paragraphs 41 and 42, to use and follow the Access Model, Practice Model, and Practice Manual:
    i. To identify and refer potential Class Members for screening; and
    ii. Deliver services and supports to Class Members; and
e. Educate and train agency staff and providers to use the CANS tool.

E. Due Process Outcomes

75. Defendants shall:
a. Develop, adopt, and consistently use a complaint process, as described in paragraph 43, as part of the Practice Model's CFT approach;
b. Provide written notices of action when the circumstances defined in paragraph 44 apply;
c. Provide written notices of action that comply with the criteria defined in paragraph 45;

d. Provide informational materials regarding the circumstances in which Class Members have a right to receive a written notice of action and request a fair hearing on their respective websites;
e. Make modifications to contracts necessary to establish the complaint and due process protocols as defined in paragraphs 43 through 46;
f. Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols as defined in paragraphs 43 through 46; and
g. Collect and report data on written notices of action, complaints, and fair hearing requests and outcomes.

F. Governance and Interagency Collaboration Outcomes

76. Defendants shall:
a. Establish and use an Interagency Governance Team, as described in paragraph 49 and Appendix D;
b. Adopt and use operational guidelines for the Interagency Governance Team, as described in Appendix D; and
c. Include 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 as part of the Interagency Governance Team.

G. Quality Management, Improvement, and Accountability Outcomes

77. Defendants shall:
a. Develop and implement a QMIA plan, as described in paragraph 52;
b. Develop and operate a QMIA System with capabilities consistent with the criteria defined in paragraph 53;
c. Measure and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55;
d. Jointly develop with Plaintiffs' counsel a QR process, as described in paragraph 56;
e. Conduct QRs, as described in paragraph 57;
f. Publicly report on the results of the QRs, as described in paragraph 58; and
g. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated CANS domain scores and/or relevant clinical items from the CANS tool, in each Region.

H. Implementation Plan Outcomes

78. Defendants shall:
a. Develop an Implementation Plan for this Agreement, as described in paragraphs 59 through 62;
b. Receive District Court approval of its Implementation Plan, as described in paragraph 63; and

c. Timely execute the Implementation Plan as approved or amended by the District Court.

VII. EXIT PROCESS AND CRITERIA

79. The Exit Criteria are the specific results Defendants will achieve in sustaining performance and compliance with the terms of the Agreement. Defendants shall sustain performance of the Agreement for three (3) years following the District Court's finding that implementation is complete. At the end of the three (3) year sustained performance period, Defendants shall 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 that Defendants are in substantial compliance with the terms of this Agreement such that the lawsuit herein may be dismissed.

80. Simultaneous to the dismissal, a permanent injunction will be issued pursuant to Paragraph 5b.

81. Six (6) months prior to the end of the sustained performance and compliance period, the Parties will meet to determine whether there is any dispute as to whether Defendants are on track to meet the Exit Criteria.

A. Access and Capacity

82. Throughout the sustained performance period, Defendants shall maintain the critical system infrastructure developed during the implementation period and continue to provide the full array of services and supports to Class Members statewide. In order to sustain the children's mental health system of care, Defendants shall:

a. Annually update the range of expected Class Member service utilization, as described in paragraph 24;
b. Maintain statewide capacity to timely provide Services and Supports in the appropriate scope, intensity and duration to Class Members for whom it is medically necessary;
c. Provide the full array of Services and Supports statewide, as defined in Appendix C, to Class Members for whom it is medically necessary;
d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to his or her individual strengths and need, as described in paragraphs 18, 22, 23, and 36;
e. Provide Intensive Care Coordination, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21;
f. Deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care, and the Agreement, consistent with paragraphs 25 through 27;

g. Consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 29 through 35 and Appendix A;
h. Use the CANS tool statewide to:
    i. Screen potential Class Members for unmet mental health needs;
    ii. Assess Class Member's individual and family strengths and needs;
    iii. Support clinical decision-making and practice;
    iv. Measure and communicate outcomes; and
    v. Improve service coordination.
i. Use a uniform, age-appropriate screen, described in paragraph 33, statewide to identify potential Class Members with unmet mental health needs;
j. Use a standard mental health assessment, described in paragraph 34, statewide to determine class membership status for potential Class Members referred for an assessment;
k. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;
l. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including, but not limited to, posting information on Defendants' websites, as described in paragraphs 36 and 37;
m. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;
n. Uniformly follow the complaint and due process standards and protocols described in paragraphs 43 through 46;
o. Operate the QMIA System with capabilities consistent with the criteria defined in paragraph 53;
p. Measure and regularly and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55; and
q. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated CANS domain scores and/or relevant clinical items from the CANS tool within each Region.

B. Quality and Outcomes

83. Throughout the sustained performance period, the Parties expect Defendants will maintain and improve system quality and client outcomes. Consistent with this expectation, Defendants shall monitor performance, quality, accessibility, and outcomes using (a) methods and measures developed or identified in the QMIA planning process, described in paragraph 52, and (b) the QR process, described in paragraph 56, that objectively measures and evaluates the services and outcomes for Class Members and their families. By the end of the sustained performance period, Defendants shall:
    a. Have conducted QRs consistent with the process jointly developed by the Parties, described in paragraph 56, and according to the periodic frequency as agreed to by the Parties, as defined in paragraph 57; and

b. Have publicly reported on the QR results annually, consistent with paragraph 58.

C. Monitoring Role of Plaintiff's Counsel

84. During the sustained performance period, Plaintiffs' counsel will have less formal involvement in system planning efforts. Upon the District Court's finding of substantial compliance with the Agreement's Outcomes at the end of the implementation period, the IWG will conclude its work. Notwithstanding, the Parties shall continue to meet and confer on at least a semi-annual basis as long as the District Court retains jurisdiction.

85. During the sustained performance period and until such time as the District Court grants the Defendants' motion to dismiss the case, Defendants shall provide Plaintiffs' counsel with:
   a. Annual QR reports, as described in paragraph 58;
   b. Periodic reports on regional and statewide QMIA indicators and data, identified in paragraph 55; and
   c. Information available pursuant to Section IX.

VIII. DISPUTE RESOLUTION PROCESS

A. Process

86. Any and all claims, disputes, or other matters in controversy ("dispute") arising out of or related to the implementation of this Agreement, or the breach, implementation or performance thereof, shall be resolved according to the procedure set forth below.

87. 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' Agreement and submitted to the District Court for approval.

88. If the Parties are unable to resolve the dispute within thirty (30) days, or such other time frame upon which the Parties agree, they will engage the services of a mutually-agreeable mediator for the purpose of mediating a resolution to the dispute. The 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' Agreement and submitted to the District Court for approval.

89. If, after negotiating in good faith, no resolution is reached, either Party may file an appropriate motion with the District Court in this matter. The moving Party's counsel shall provide the appropriate notice to the opposing Party's counsel of such action.

90. 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' material noncompliance with their systemic obligations under this Agreement, Plaintiffs' counsel 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. A "systemic obligation" is one that may affect all of, or a substantial portion of, the Class Members and is not represented or proven by a circumstance or condition affecting an individual Class Member. 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, as detailed in the provisions set forth herein. If an appropriately expedited dispute resolution process cannot be scheduled, or the systemic matter is not resolved through mediation, Plaintiffs' counsel may proceed directly to the District Court or may take any other necessary legal action. Plaintiffs' counsel will provide at least one (1) business day's written notice to Defendants' counsel via facsimile transmission or electronic mail and first class mail prior to initiating court action.

IX. PLAINTIFFS' COUNSEL ACCESS TO INFORMATION

91. Defendants shall afford Plaintiffs' counsel the opportunity to monitor Defendants' implementation, compliance, and sustained performance of the terms of this Agreement. Throughout the pendency of this Agreement, Defendants shall:

a. Upon request, provide Plaintiffs' counsel with funding and staffing requests by Defendants to the Governor's office, significant plans, policies, practice manuals, and agreements that have been developed to implement this Agreement unless the Governor asserts that under the deliberative process privilege and/or mental process privilege the material at issue should remain confidential. Additionally, the Superintendent of Public Instruction is a constitutional officer and reserves all rights and privileges provided to constitutional officers under Idaho law. Defendants shall prepare a privilege log of the kind required by Rule 26(b)(5) (or its successors) for any documents upon which they claim privilege. The Parties will first resort to informal dispute mechanisms if there is a disagreement whether documents are privileged. The party asserting privilege bears the burden of establishing that a document is privileged;

b. Upon request, provide Plaintiffs' counsel with access to information and documents related to publicly-funded children's mental health services that are obtained, compiled, or generated by Defendants' staff and contractors, including, but not limited to, Defendants' QMIA systems; and

c. Upon request, provide Plaintiffs' counsel access to mental health case records of Class Members that are maintained by Defendants and their agents or contractors, subject to the process set forth in paragraphs 93, 94, and 95.

92. The Parties agree to minimize the number and scope of requests for the data and information not already provided to Plaintiffs' counsel through the annual status report process, described in paragraphs 67 and 68; through the IWG, described in paragraphs 59, 60, and 66, or pursuant to the Commitments set forth in paragraphs 24, 37, 38, 39, 40, 48, 52, 53, 55, 58, and 65 of this Agreement.

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

a. Plaintiffs' counsel will make their request for that additional data and information to Defendants through the IWG. Plaintiffs' counsel's request will include:
   i. Specific data and information sought,
   ii. Specific provision(s) of the Agreement to which the data and information are relevant, and
   iii. Specific concerns the data and information are sought to address.
b. Defendants will provide access to relevant data and information that is reasonably relevant to the Agreement and the Implementation Plan, within a reasonable time period. Within five (5) 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, of no longer than thirty (30) days, needed to comply with the request.
c. Any disputes with that process regarding the relevance, necessity, availability or timing and thoroughness of production of requested data and information will be resolved through the dispute resolution process provided in this Agreement.
d. Nothing in this Agreement prevents Plaintiffs' counsel from obtaining records pursuant to the Idaho Public Records Act, Idaho Code §§ 9-337 et seq.
e. If the requested data or information directly or indirectly identifies a current or former Class Member, or health information protected by federal or state law, the process set forth in paragraphs 94 and 95 shall apply.

94. In the event Plaintiffs' counsel seek the review of confidential information contained in individual records of a Class Member, the following procedures will apply:

a. Plaintiffs' counsel will obtain a Release from the individual Class Member or his/her parent or legal guardian. Plaintiffs' counsel may use the release to directly obtain the information sought. The Parties agree that, so long as Class Member's name and contact information are known, the Release process is the preferred means to obtain confidential information.

b. If the name and/or contact information of an individual Class Member or his/her parent or legal guardian is not known to Plaintiffs' counsel but is known to Defendants, Defendants shall attempt to obtain written permission from the Class Member and the Class Member's parent or legal guardian to provide the Class Member's name and contact information to Plaintiffs' counsel so that Plaintiffs' counsel may obtain a Release in accordance with paragraph 94a.

95. If Defendants and Plaintiffs' counsel are unsuccessful in obtaining a release from the Class Member and the Class Member's parent or legal guardian, and there is no way to obtain a release, Plaintiffs' counsel may seek a court order from the District Court under a protective order authorizing the release of confidential information contained in the individual records of the Class Member, the Idaho Behavioral Health Plan, and/or the records of a provider of services. Unless substantial reasons exist to prevent disclosure, Defendants, pursuant to Idaho Code § 16-2428 or any other applicable statute, at the request of Plaintiffs' counsel, shall file a stipulation and request a court order from a court of competent jurisdiction authorizing the disclosure of the confidential information, unless the Class Member or Class Member's parent or legal guardian objects.

X. ATTORNEYS' FEES

96. The Parties will make good-faith efforts to negotiate the amount of attorneys' fees, costs, and litigation expenses to be awarded to Plaintiffs' counsel during the course of this litigation. Plaintiffs' counsel may submit their attorney fees, costs and litigation expenses to Defendants within thirty (30) days after approval by the District Court of the Agreement. Defendants will have sixty (60) days to notify Plaintiffs' counsel of their objections and for the Parties to negotiate a settlement of the amounts. If the Parties can reach agreement, Defendants will have a reasonable time to pay the negotiated amounts. In the event that the Parties cannot reach an 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' counsel may file the appropriate motion with the District Court.

XI. OTHER PROVISIONS

A. Modifications

97. This Agreement may be amended by mutual agreement of the Parties and approval of the District 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 District Court. The Parties further agree to work in good faith to obtain District Court approval of necessary amendments and modifications. In the event that an

agreement cannot be reached under this paragraph, the Parties may pursue their options under the Dispute Resolution Process.

98. By mutual agreement, the Parties may make non-substantive changes, including grammatical or formatting modifications that have no effect on the Agreement's content or meaning, without notice to the IWG or the District Court.

B. Miscellaneous

99. 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.

100. 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 bind any of the parties hereto.

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

102. Defendants or their designated signors of this Agreement and Plaintiffs' counsel represent and warrant they have full legal power and authority to enter into this Agreement and to carry out all actions required of them. Each of the signors warrants that he or she has fully read and agrees to all the terms and conditions contained herein.

103. This Agreement is a reasonable and workable compromise that can be implemented by Defendants within the stated time frames.

104. The Parties recognize and acknowledge that this Agreement must be approved by the District Court. The parties agree to cooperate in good faith in the creation of all papers submitted to the District Court to secure such approval. In the event that the District Court does not approve this Agreement or the order approving this Agreement is reversed on appeal, the Parties shall make good faith efforts to modify the Agreement so as to gain judicial approval.

105. This Agreement, once approved by the District Court, shall inure to the benefit of and be binding upon the legal representatives and any successors of the Parties.

106. If Defendants are unable to accomplish any of their obligations or to meet timelines under this Agreement due to events beyond their reasonable control (such as natural disasters, labor disputes, war, acts of God, or governmental action beyond Defendants' control), Defendants shall notify Plaintiffs' counsel within thirty (30) business days of the date upon which Defendants become aware of the impact of said 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 District Court for such amendment.

107. 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.

108. 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 PLAINTIFF CLASS:

By: _____ Date: 5-26-15
HOWARD BELODOFF
Next Friend
Belodoff Law Office PLLC
ISB No. 2290

By: _____ Date: 5-24-15
PATRICK GARDNER
Young Minds Advocacy Project
CB No. 208110

By: _____ Date: 5/21/15
WESLEY SHEFFIELD
Young Minds Advocacy Project
CB No. 287940

FOR THE STATE OF IDAHO:

By: _____ Date: 6-09-15

DEFENDANT
C.L. "BUTCH" OTTER
Governor

By: _____ Date: 5-15-2015

DEFENDANT
RICHARD M. ARMSTRONG
Director
Idaho Department of Health and Welfare

By: _____ Date: 5/14/2015

DEFENDANT
SHARON HARRIGFELD
Director
Idaho Department of Juvenile Corrections

By: _____ Date: 05/12/15

DEFENDANT
SHERI YBARRA
Superintendent
Idaho Department of Education

APPENDIX A Access Model

The Access Model describes the process by which Defendants will interact with Class Members and thereby afford them access to the full array of services and supports provided under this Agreement. Thus, the Access Model provides the system protocols for how Class Members can expect to move into, through, and out of Idaho's children's mental health system. Defendants will use the Access Model for the following purposes:

1. Inform, identify, and screen potential Class Members for mental health needs;
2. Allow children and/or their families[1] to self-refer for mental health needs screening;
3. Refer children who screen positive for mental health needs for assessment;
4. Plan for and provide timely services and supports under this Agreement to Class Members for whom services are medically necessary, based on an individualized treatment plan;
5. Provide for continuously coordinated care for Class Members; and
6. Transition Class Members to the community or other services pursuant to the individualized treatment plan.

The Access Model is guided by the Principles of Care and Practice Model.[2] The Services and Supports document[3] sets forth the services that will be available to Class Members when medically necessary and as provided in their individualized treatment plan.

A. Identification & Referral

Defendants will identify children who are current or potential Class Members based on evident substantial functional impairment and/or other characteristics indicating a need for services provided under this Agreement, and Defendants will refer those youth for an age-appropriate mental-health screening to identified screening entities.

Schools will have a checklist based upon the age-appropriate screening tool that may be used as part of a classroom management system to provide information to parents on potential mental health needs.

Children and their families may self refer by requesting a screen from agencies designated by the Defendants**.** All requests for screening will be honored, regardless of referral source.

B. Screening

Children's Mental Health (IDHW), the Idaho Department of Juvenile Corrections (IDJC), the Division of Family and Community Services (FACS), Medicaid network providers, and primary care providers will use an age-appropriate screening tool to identify children with unmet mental health needs who may be Class Members.

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[1] The term "family" is intended to mean birth-parents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, and current care givers.
[2] The Principles of Care and Practice Model are defined in Appendix B.
[3] The Services and Supports are defined in Appendix C.

Defendants will develop and administer screening tools consistent with the program needs of each agency or provider, incorporating the Child and Adolescent Needs and Strengths (CANS) tool to the fullest extent possible. Unless otherwise prohibited by law or regulation, an agency or provider will communicate the results of the screening to the child or his family, as appropriate, both verbally and in writing.

The agency or provider will timely refer children who screen positive for a full assessment, as described below. Each agency or provider shall develop and maintain written standards or guidance on what constitutes a positive screen.

Families and emancipated children may request and will be provided a full assessment even if the screening tool does not indicate mental health issues.

Any child who has previously been identified as a Class Member or has had a clinical mental health assessment within the last six months that indicates he or she is a Class Member may not require an additional screen and can be directly referred for assessment or treatment planning as appropriate.

C. Assessment & Class Member Determination

Defendants will conduct or arrange for a clinical mental health assessment to identify mental health diagnoses and functional impairments for all current and potential Class Members referred for an assessment and to identify Class Members. An assessment tool, such as the Child & Adolescent Needs & Strengths (CANS) tool, will be part of the mental health assessment that will be used to identify the functional impairments, strengths, and needs of the potential Class Member.

Potential Class Members who are Medicaid eligible will receive the clinical mental health assessment from a Medicaid mental health network provider. Potential Class Members who are not Medicaid eligible will receive the clinical mental health assessment through the Children's Mental Health Program. IDJC will conduct a clinical mental health assessment as part of the observation and assessment process for all potential Class Members committed to IDJC custody.

Defendants will identify Class Members using the assessment process. Class Members are Idaho residents with a Serious Emotional Disturbance who are eligible under this Agreement for services and supports provided or arranged by Defendants and:

a. Are under the age of eighteen (18);
b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [4] and

[4] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

c. Have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician, or would have been measured and documented had an assessment been conducted.

The results and clinical recommendations from the assessment will be provided to the person assessed and his or her family, unless such disclosure is prohibited by law or regulation. The agency or provider will also provide the results of Defendants' determination of class membership.

Class Members and families have a choice whether to accept services offered pursuant to this Agreement. Those choosing not to participate will be referred and connected with other community services.

Children who are determined not to be Class Members will be referred and connected to appropriate mental health and community services and supports.

Class members who are identified using the assessment process will be linked by the agency doing the assessment to a service provider who will affirmatively engage the Class Member and his or her family in care planning, as described below.

D. Care Planning, Intensive Care Coordination, and Case Management

Care planning for all Class Members will occur through a Child and Family Team (CFT) approach, as described in the Principles of Care and Practice Model. CFT is responsible for the initial development, subsequent reviews, and modifications of the Class Member's individualized treatment plan. The CFT will agree upon what services are needed and specified in a written individualized treatment plan. Members of the CFT, including the Class Member and his or her family, will be empowered to present their service recommendations and preferences for the individualized treatment plan.

Class Members with more intensive needs are eligible for Intensive Care Coordination (ICC), a level of care utilizing a facilitated CFT process for care planning and coordination through a single consistent care coordinator, as described in the Services and Supports document. Class Members eligible for ICC include any Class Member who either has a qualifying CANS score or meets one of the following criteria:

a. Is at substantial risk of out-of-home placement due to mental health needs;
b. Has experienced three (3) or more foster care placements within twenty-four (24) months for reasons related to mental health needs;
c. Is involved with multiple child-serving systems related to his or her mental health needs;
d. Is under age twelve (12) and has been hospitalized or detained for reasons related to mental health needs within the last six (6) months;
e. Has experienced more than one hospitalization for mental health needs within the last twelve (12) months; or

f. Who is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within up to ninety (90) days if adequate home and community-based supports were provided.

As with other services provided under this Agreement, Class Members and families have a choice whether to participate in intensive care coordination. Those choosing not to participate will be encouraged to access case management services, as described in the Services and Supports document.

Medicaid mental health network providers will provide case management and ICC when clinically indicated to Medicaid-eligible Class Members.

IDHW's Children's Mental Health program will provide or arrange for case management and ICC services when clinically indicated for Class Members who are not Medicaid eligible.

If IDHW's Division of Family and Community Services (FACS) or IDJC have legal custody of a Class Member, they are responsible to provide or arrange for case management and ICC services when clinically indicated.

E. Service Delivery

Services and Supports as described in Appendix C of the Agreement will be provided consistent with the Class Member's individualized treatment plan and the Principles and Practice Model as described in Appendix B of the Agreement. Care-planning decisions will continue to be directed by the Class Member's CFT, as informed by the functional assessment tool, clinical evaluation, medical necessity, and individual need. To the fullest extent allowed by law or regulation, a CFT will have the authority to approve services provided by agencies represented on the CFT that are recommended in the Treatment Plan. If a service is included in the treatment plan that must be authorized by an agency that is not represented on the CFT, the agency shall have up to 14 days to make an authorization determination. CFTs and non-participating agencies will be trained on what is a covered service under this Agreement to minimize denials of recommended services.

The CFT will periodically review the effectiveness of services and make changes to the individualized treatment plan at specified intervals or sooner in response to situational changes of the Class Member and family. The CFT will use an assessment tool, such as the CANS, to assess progress and the effectiveness of services and for modifications of the individualized treatment plan. Class Members and their families may move between ICC and Case Management as their needs and circumstances change.

F. Transitions

Class Members and their families will transition between levels of care and out of care based upon changing needs, changing circumstances, and effectiveness of services. Defendants shall provide discharge and transition planning to ensure coordinated care

through transitions in level of care, between providers, across child-serving agencies, into the adult mental health system, and out of care. Transition out of care shall occur when a determination is made that the Class Member no longer meets the eligibility requirements to remain a Class Member, pursuant to this Agreement, based upon mental health or functional assessment improvements.

The CFT shall assist in making referrals and linkages to other mental health and community resources, both informal and formal.

APPENDIX B Principles of Care and Practice Model

The Principles of Care are intended to guide child-serving agencies in the delivery and management of mental health services and supports for Class Members. These principles are consistent with the Legislative Intent language of the Children's Mental Health Services Act (Idaho Code 16-2402) and System of Care Values and Principles.

The Practice Model describes the expected experience of care in the six practice components provided to Class Members served by Idaho's children's mental health system. The Practice Model will be utilized by all agencies or individuals in the public sector who serve Class Members and their families.[1]

Class Members and their families retain the choice whether to accept or reject voluntary services. However, these Principles of Care and Practice Model do not apply to services provided to Class Members on an involuntary basis, such as those services provided involuntarily to Class Members in the custody of the state or those services required by court order.

A. Principles of Care

The delivery of public-sector children's mental health services in Idaho is guided by the following Principles of Care:

Family-Centered
A defining characteristic of family-centered care is family engagement. Family engagement emphasizes family strengths and maximizes family resources. Family experience, expertise, and perspective are welcomed. Families are active participants in solution and outcome-focused planning and decision-making. Families of birth, foster, and adoptive parents, and families of choice are respected and valued.

Family and Youth Voice and Choice
Family and Class Members' voice, choice, and preferences are intentionally elicited and prioritized during all phases of the treatment process, including care planning, delivery, transition, and evaluation of services. Service is founded on the principle of communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences in order to meet the individual needs of the family and Class Member.

[1] In the following Principles of Care and Practice Model sections, the term "family" is intended to mean children, youth, birth-parents, adoptive parents, guardians, extended family, family of choice, members of the family's support system, and current care givers.

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 Class Member and family, their community, and other team members.

Individualized Care
Services, strategies, and supports are individualized to the unique strengths and needs of each Class Member and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.

Team Based
A team-based approach in partnership with the family and Class Member to bring together natural supports, professionals, and others to develop a family-driven, strengths-based, and solution-focused individualized treatment plan. The team is committed to work with the Class Member and family regardless of the Class Member's behavior, and to continue to work towards the goals of the individualized treatment plan.

Community Based Service Array
An array of community-based interventions will be available and provided according to the individualized treatment plan and in the least restrictive setting to meet the Class Member's needs.

Collaboration
System partners, including local and state agencies and departments, families, and Class Members, work together to meet the behavioral health needs of Class Members involved in multiple systems. This collaboration occurs at the individual treatment planning level as well as the governance structure.

Unconditional
The team working in partnership with the family and Class Member are committed to achieving the goals of the individualized treatment plan regardless of the Class Member's behavior, placement setting, family circumstances, or availability of services in the community until the family indicates the formal process is no longer necessary.

Cultural Competency
Services are provided in a manner that is understandable and relatable to the family and Class Member. Services are provided in a manner that is considerate of family and Class Member's unique cultural needs and preferences. Services also respect the individuality of each individual.

Early Identification and Intervention
Opportunities are available to screen or assess potential Class Members and provide appropriate interventions when mental health issues are first identified.

Outcome Based
Individualized Treatment Plans contain observable, measurable indicators of success that are monitored and revised to achieve the intended goals or outcomes. State agencies and departments develop meaningful, measureable methods to monitor system improvements and outcomes.

B. Practice Model

In order to benefit from the full array of services, at whatever level appropriate and necessary to meet their needs, Class Members are best served through six key practice components that make up an overarching Practice Model. Over the course of treatment and transition, the six practice components are organized and delivered in the context of an overall Child and Family Team (CFT) approach. Many of these practice components will occur throughout a Class Member's experience in care and several will overlap or take place concurrently with other practice components. Consistent with the principle of individualized care, a Class Member's experience of care should be guided by the Practice Model and tailored according to his or her individual needs and strengths.

1) Engagement
Engagement is the process of partnering with Class Members and their families to empower them to take an active role in the change process, and to motivate them to recognize their own strengths, needs, and resources. Engaging families is the foundation to building trust and mutually-beneficial relationships between family members, CFT members, and service providers. Engagement guidelines include:

a. Families and Class Members are welcomed and provided with respect, honesty, and openness;
b. Providers demonstrate hope and an expectation that the family is capable of succeeding;
c. Family's language is used and jargon is avoided; and
d. Cultural diversity is valued and respected.

2) Assessment
Assessment is the practice of gathering and evaluating information about the potential Class Member and his or her family in order to assess strengths and needs. This discovery process may include a screening, which serves as a brief assessment for identifying children who may have needs for mental health services, as well as a more comprehensive assessment done by a mental health professional that provides an in-depth evaluation of underlying needs, available strengths, mental health concerns, and psychosocial risk factors. Assessment guidelines include:

a. Families are acknowledged as experts on their children;
b. Families are listened to, heard and valued; and
c. Strengths identification of all family members and supports is central to getting to know the family.

3) Care Planning & Implementation

Care planning is the practice of tailoring services and supports unique to each Class Member and family to address unmet needs. The care planning process engages the family, the Class Member, and others in CFT meetings to develop a written Individualized Treatment Plan designed to help the Class Member achieve a better level of functioning and reduce the impact of mental illness. The Individualized Treatment Plan will describe the Class Member's strengths and needs, short and long term goals, and will address crisis, safety, and transitions. The Individualized Treatment Plan should also specify the roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the Class Member and family. Care planning and implementation guidelines include:

a. Families and Class Members are provided written information about choices and limitations on choices;
b. Services and supports, both formal and informal, will be provided in the most appropriate and least restrictive settings within the community, with family voice and choice being the primary factor in making decisions in intervention strategies;
c. Services focus on strengths and competencies of families, not on deficiencies and problems;
d. Planned services are available and accessible to the family and are provided in a manner that causes the least amount of additional strain to the family and Class Member; and
e. Goals and tasks with measurable outcomes are established to assess change not compliance.

4) Teaming

Teaming is a process that brings together the family and individuals agreed upon by the family who are committed to the Class Member through informal, formal, and community support and service relationships. These caring and invested individuals work with and support the Class Member and the family through a CFT approach. By integrating the varying perspectives of CFT members, teaming promotes better informed and more collaborative decision-making throughout the Class Member's experience in care. A Class Member who needs Intensive Care Coordination (ICC) will have a formal CFT that includes a dedicated CFT team facilitator. Teaming guidelines include:

a. Families shall have input regarding who is on the CFT;
b. Families are full and active partners and colleagues in the process; and
c. The decision-making process is a joint process with the family and Class Member rather than a "majority rule" which decides for the family.

5) Monitoring and Adapting

Monitoring and adapting is the practice of continually evaluating the effectiveness of the Individualized Treatment Plan, assessing circumstances and resources, and reworking the Plan as needed. The CFT is responsible for reassessing the Class Member and family's needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner. Monitoring and adapting guidelines include:

a. Services are provided regardless of the Class Member's behavior, placement setting, family circumstances or availability of services;

b. Never giving up on Class Members and families while keeping them safe;
c. Understanding that setbacks may reflect the changing needs of family members, not resistance; and
d. Skills and knowledge of the family and Class Members are essential to the change process.

6) Transition

Transition is the process of moving from formal behavioral health supports and services to informal supports. The successful transition away from formal supports occurs when informal supports are in place, and the support and activities needed to ensure long-term stability are being provided. Transition guidelines include:

a. Families are key in identifying resources and supports which may be utilized for solutions; and
b. The community is recognized and respected as a key resource and support.

C. Child and Family Team Approach

All Class Members will receive care planning and service coordination through a Child and Family Team (CFT) approach. The CFT approach is a teaming process that brings together the family and individuals that the Class Member and his or her family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals. These individuals may include informal community supports, such as extended family, neighbors, friends, coaches, faith-based connections, and tribal members. CFT members may also include formal supports, such as providers, Class Member and family peer support specialists, educational professionals, and representatives from other agencies providing services to the Class Member and family.

The CFT may be small or large. At a minimum, the CFT includes the mental health provider, the Class Member, and the Class Member's parent or legal guardian. The CFT may include additional participants if the Class Member and family are involved in other child-serving systems, have complex needs, have an extensive natural or informal support system, or have multiple service providers.

The size, scope, and intensity of the involvement of CFT members is driven by the needs and desires of the Class Member and family. Members of the CFT may be added or removed as the needs and strengths of the Class Member and family change over time.

Class Members eligible for Intensive Care Coordination (ICC) will have a dedicated CFT team facilitator with training in the wraparound process for care planning.

The role of the CFT includes:

a. Collaboratively developing an Individualized Care Plan that addresses the strengths and needs of the Class Member and family and identifies the roles of all the parties involved;

b. Identifying, recommending, and arranging for all medically necessary services and supports needed by the Class Member and family;
c. Facilitating coordination of service delivery for Class Members involved with more than one child-serving system and/or multiple providers;
d. Working together to resolve differences regarding service recommendations, with particular attention to the preferences of the Class Member and family;
e. Having a process to resolve disputes and arrive at mutually agreed upon approach for moving forward with services; and
f. Reconvening to monitor and consider the outcomes in relation to the services that have been provided to meet treatment goals and to make needed adaptations over time.

D. Services

Class Members are eligible to receive all services set forth in the Service and Supports, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs.

APPENDIX C Services and Supports

The Services and Supports described herein shall be provided to Class Members based on their individual strengths and needs. Not every service will be needed or clinically appropriate for every Class Member. However, all of these services and supports must be available and accessible to every Class Member as needed or clinically appropriate on a statewide basis and shall be provided in accordance with the Principles of Care and the Practice Model described in Appendix B of the Agreement.

A. Assessment & Treatment Planning

1. Initial Assessment

Initial assessments are strengths-based evaluations of a child/youth's mental health and functioning to determine whether the child/youth is eligible for Jeff D. Services and Supports. Assessment activities include face-to-face contact for the purpose of assessing the child/youth's strengths and needs; an evaluation of the child/youth's current mental health, living situation, relationship, and family functioning; contacts, as necessary, with significant others such as family and teachers; and a review of information regarding the child/youth's clinical, educational, social, behavioral health, and juvenile/criminal justice history. The assessments should be strength based, culturally competent, and conducted in the family home whenever possible.

2. Evaluation & Testing

Specific assessments or testing including, but not limited to, psychological, behavioral, neurological, or psychiatric, to assist in the development of a treatment plan. Providers will most likely be medical professionals who are Ph.D. or Master's level providers with associated expertise. In school settings, the evaluators will be appropriately certified, credentialed, or licensed.

3. Treatment Planning

Treatment planning consists of engagement of the Class Member and family; review and discussion of the assessment; team formation; treatment plan development and modification; crisis planning; and transition planning.

a. Class Member and family team formation: A Case Manager or Intensive Care Coordinator engages the Class Member and family to elicit participation in treatment planning through a team approach that is family centered, strength based, culturally competent, and outcome focused. The Case Manager or Intensive Care Coordinator organizes the initial meeting with the Class Member and family. During the initial meeting, the Case Manager or Intensive Care Coordinator engages the Class Member and family by explaining the Child and Family Team (CFT) approach, discussing the participation of appropriate people as part of the CFT (e.g., extended family, teachers, social workers, etc.), and determining if additional assistance is required to support the family's engagement in the process. The Case Manager or Intensive Care Coordinator contacts potential CFT members identified during engagement and coordinates the schedules of the CFT meetings in a location which is preferred by the family. Engagement of the Class Member and family by the Case Manager or Intensive Care Coordinator and of CFT members continues throughout the provision of services.

b. Treatment plan development, implementation, and modification: The CFT works to develop and adopt a strength-based and individualized treatment plan. The treatment plan describes the Class Member's strengths and needs; long-range and short-term goals for the Class Member; and the services that will best help the Class Member meet the plan's goals, as well as maximize the reduction in his/her mental disability and restore him/her to his/her best possible functional level. Services included in the treatment plan are individualized and will vary from Class Member to Class Member based upon his or her strengths and needs. The services that are provided may include those listed in this document. CFT meetings are facilitated by the Case Manager or Intensive Care Coordinator. During these meetings, the Case Manager or Intensive Care Coordinator facilitates the assignment of tasks to CFT members. The Case Manager or Intensive Care Coordinator tracks completion of team assignments. The Case Manager or Intensive Care Coordinator works with the CFT to modify the individualized treatment plan when appropriate. To the fullest extent allowed by law or regulation, a CFT will have the authority to approve services provided by agencies represented on the CFT that are recommended in the Treatment Plan. If a service is included in the treatment plan that must be authorized by an agency that is not represented on the CFT, the agency shall have up to 14 days to make an authorization determination. CFTs and non-participating agencies will be trained on what is a covered service under this Agreement to minimize denials of recommended services.

c. Crisis planning: Crisis planning is conducted by the CFT and is designed to address safety concerns, predict potential areas of crises, and to identify ways to resolve a crisis should one occur. The CFT creates the crisis plan that (a) anticipates the types of crises that may occur, (b) identifies potential precipitants and ways to reduce or eliminate crises, and (c) establishes responsive strategies by caregivers and members of the Class Member's CFT involving additional community resources as appropriate, to minimize crisis and ensure safety.

d. Transition planning: Transition planning is conducted by the CFT, informed by the assessment process, and designed to ensure that Class Members are appropriately transitioned from services, either when the Class Member leaves the children's mental health system for the adult mental health system, or when the Class Member no longer needs formal supports. Transition planning includes a clear pathway and priority for connecting caregivers and Class Members, at service re-entry, to persons with whom they have worked previously. The CFT creates the transition plan and modifies it when appropriate.

B. Case Management and Intensive Care Coordination

1. Case Management

Case management refers to outcome-focused, strength-based activities that assist families and Class Members by locating, accessing, coordinating and monitoring mental health, physical health, social services, educational, and other services and supports. Case management includes both informal and formal assessment of service needs and service planning. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for Class members and their families. Case Managers shall use a CFT approach as described in the Principles of Care and Practice Model.

Case management includes face-to-face activities or collateral contacts that directly benefit the Class Member and the Class Member's family.

Case Managers shall maintain reasonable caseloads, consistent with accepted industry standards for children's mental health systems of care based on intensity of their client's acuity, needs, and strengths.

2. Intensive Care Coordination

Intensive Care Coordination (ICC) is a case management service that provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered consistent with the Principles of Care and Practice Model. ICC includes both assessment of service needs and service planning utilizing a facilitated CFT process. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for Class Members and their families.

ICC is delivered through a single consistent Intensive Care Coordinator. The Intensive Care Coordinator is responsible for coordinating multiple services that are delivered in a therapeutic manner, allowing the Class Member to receive services in accordance with his or her changing needs and strengths. The Intensive Care Coordinator is also responsible for promoting integrated services, with links between child-serving agencies and programs.

ICC also includes a treatment planning process that utilizes a formal CFT approach, as described in the Principles of Care and Practice Model. The Intensive Care Coordinator is responsible for facilitating CFT meetings for the purpose of developing outcome-focused, strength-based activities that assist Class Members and their families. The Intensive Care Coordinator is specifically trained in the wraparound process for treatment planning.

Intensive Care Coordinators shall maintain reasonable caseloads consistent with accepted industry standards for children's mental health systems of care based on intensity of their client's acuity, needs, and strengths.

Specific responsibilities of the Intensive Care Coordinator, in conjunction with the Class Member and family, are:

a. engaging the Class Member and family to elicit participation in treatment planning and services;
b. assembling the CFTs and facilitating team meetings on a regular basis;
c. collecting, organizing, and distributing to CFT members assessments and other information about the Class Member and family;
d. coordinating CFT meetings and documenting recommendations of the CFT;
e. developing and distributing the individualized treatment plan;
f. facilitating consensus from all CFT members and assisting in resolving disputes when necessary and appropriate;
g. reviewing the individualized treatment plan on a regular basis and facilitating the CFT in making modifications as needed and appropriate;

h. identifying, arranging, and monitoring services, including informal services in the community;
i. facilitating collaborative communication and decision-making across child welfare, juvenile justice, mental health, and educational systems; and
j. assisting in emergency or crisis situations, which may include responding to a call 24/7, meeting the family where the emergency is occurring, or taking the lead role in de-escalating the situation.

IDJC, which is responsible for the well-being of the children in its custody, provides intensive care coordination under a model unique to its mission.

C. Treatment Services & Support Services (Direct Services)

Treatment & Support Services (hereinafter called "Direct Services") are individualized, preferably evidence supported, strength-based interventions designed to correct or ameliorate mental health conditions and improve a Class Member's functioning. Interventions are aimed at helping the Class Member build skills necessary for successful functioning in the home, school, and community and improving the ability of the family to help him/her to successfully function in the home, school, and community. The types and intensity of interventions are based upon an Individualized Treatment Plan, and will vary over time based upon effectiveness, reassessment of needs, and modifications to the Individualized Treatment Plan.

Direct Services are delivered according to an Individualized Treatment Plan developed as described above, and consistent with the Practice Model. The Individualized Treatment Plan will have specific goals, objectives, and interventions that are the treatment and support services designed to improve the Class Member's functioning.

Direct Services include:

1. Treatment Services

a. Medication Management

Medication management services include a clinical assessment of a Class Member, the prescription of medication and follow-up reviews as part of the Individualized Treatment Plan for the purpose of evaluating the effectiveness and side effects of the medication by medical personnel. A prescriber should be involved with the CFT.

b.Psychotherapy

Individual, family, or group therapy involves outcome-based and strength-based therapeutic interventions. Services may be provided in the home, community, or an office setting. Priority is given to evidence-based therapies, such as, Cognitive Behavioral Therapy, Parent-child Interaction Therapy, and Functional Family Therapy.

c. Skills Building

Behavioral, social, communication, rehabilitation, and/or basic living skills training designed to build a Class Member's competency and confidence while increasing functioning and decreasing mental health and/or behavioral symptoms. Training is related

to goals identified in the individualized treatment plan. Examples of areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

d. Behavioral/ Therapeutic Aide Services (including mentoring)

Behavioral/therapeutic aide services focus on social and behavioral skill development, building a Class Member's competencies and confidence. These services are individualized and are related to goals identified in the Class Member's treatment plan. Services that a behavioral/therapeutic aide or mentor may provide include crisis intervention, implementation of a behavioral management plan, and rehabilitation services, such as teaching the Class Member appropriate problem-solving skills, anger management, and other social skills. Behavioral/therapeutic aides or mentors may provide assistance at any time and in any setting appropriate to meet the Class Member's needs, including home, school, and community.

e. Day Treatment

Psychotherapy and/or skills building provided in a structured group environment that includes individual or group activities, therapies, social, communication, and behavior and basic living skills training. Treatment is individualized and related to goals identified in the Class Member's individualized treatment plan. Day treatment services may be provided at any time including during the day in the Class Member's school or other community settings.

f. Intensive Home and Community-Based Services

Intensive in-home services are intensive services provided to Class Members in their home or in the community. Services are individualized, strength based, family centered, and culturally competent. All services focus on the Class Member's emotional/ behavioral needs. Services may include behavior management, therapy, crisis intervention, and parent education and training. Intensive services should be provided to, among others, Class Members at risk of out-of-home placement, including a residential program or psychiatric hospital, Class Members transitioning from an out-of-home placement back to their families or other community setting, and Class Members with significant behavioral health needs.

g. Therapeutic after-school and summer programs

Therapeutic after-school and summer programs encompass individual and related therapies and counseling in a therapeutic setting with an emphasis on social, communication, behavior and basic living skills training, psychosocial skills, and relationship problem-solving. After-school programs can be located on school grounds or other community settings.

h. Integrated substance use disorder (SUD) services for individuals with co-occurring disorders

Integrated SUD services are provided in an individual or group setting that are integrated with the Class Member's mental health treatment. Services may include residential services, intensive outpatient SUD services, education and coping skills training for the mental and SUDs and their interactive effects, and training on handling stress and relapse prevention. SUD and mental health services are integrated as described in the individualized service plan.

2. Residential-Based Treatment Services

a. Treatment Foster Care

A service that provides clinical intervention for a Class Member within the private homes of clinically trained and licensed foster families for the length of time necessary to meet the individual treatment needs of the Class Member. ICC will be provided when a Class Member is placed in treatment foster care and the CFT members will include the treatment foster parents. Treatment foster care includes services provided by a foster parent/family in order to implement the Class Member's individualized treatment plan. Treatment foster parents assist in developing an individualized treatment plan for the Class Member and support the Class Member in achieving his/her service plan goals and objectives. Treatment foster parents perform a therapeutic function in addition to supervision services. Treatment foster care services include supervision, behavioral interventions, psychosocial rehabilitation, skills training and development, participation in treatment and discharge planning, and transition services when a Class Member returns to his/her family. Transition services involving the treatment foster parents may include, among other things, facilitating visits, coaching the permanency caregivers, providing limited respite care, etc. Class Members in treatment foster care may also receive other services listed in this document that are not provided by their treatment foster parents.

b. Residential Care

A service provided by a licensed children's residential care facility that provides treatment and care in a highly-structured setting for a Class Member needing intensive treatment and supervision for the length of time necessary to meet the individual treatment needs of the Class Member. ICC will be provided when a Class Member is placed in residential care and the CFT members will include the residential care provider. The Individualized Treatment Plan will address the transition out of residential care and family involvement while the Class Member is in the residential care facility.

3. Support Services

a. Respite

Respite services are short-term, temporary direct care and supervision for a Class Member intended to relieve a stressful situation, de-escalate a potential crisis situation, or provide a therapeutic outlet for a Class Member's emotional problems. The goal is to prevent disruption of a Class Member's placement by providing rest and relief to caregivers and Class Members while helping the Class Member to function as independently as possible. Respite services are generally limited to a few hours, overnight, a weekend, or other relatively short period of time. Services can be furnished on a regular basis. Respite services can be furnished in the Class Member's home, another home, a therapeutic foster home, or other community location.

b. Transportation

Transportation services involve the transporting of a Class Member and/or his/her family/caregiver from one place to another to facilitate the receipt of services in the individualized treatment plan. The service may also include the transportation of the Class Member's family/caregiver with or without the presence of the Class Member, if provided for the purposes of carrying out the Class Member's service plan (e.g., counseling, meetings).

c. Psychoeducation & Training

Psychoeducation and training educate the family and Class Member about the Class Member's mental health needs and strengths and train the family and Class Member in managing them. The goal of these services is to foster community integration and/or avoid an out-of-home placement by teaching the family how to help the Class Member function within the family, school, and community, including by developing and implementing a behavioral plan. Services are strength based, outcome focused, culturally competent and individualized. Services may be provided individually, in the home, or through group trainings.

d. Family Support

Services provided by other parents who have lived experience and specialized training to assist and support the family in gaining access to services, and to help the family become informed consumers of services and self-advocates. Family support such as, but not limited to, mentoring, advocating, and educating may be provided one on one to the family or through family support groups.

e. Youth Support

Services provided by other youth or young adults to assist and support Class Members in understanding their role in accessing services, and in becoming informed consumers of services and self-advocates. Youth support such as, but not limited to, mentoring, advocating, and educating may be provided through youth support groups and activities.

f. Case Consultation

Case consultation is an in-person or telephonic meeting to develop, monitor, or modify a comprehensive assessment or individualized treatment plan, or to review services and progress towards objectives in the treatment plan between two or more of the following: the case manager, treating providers, physician, and other professionals or paraprofessionals involved in the Class Member's care. Case consultation includes attendance at CFT meetings or educational case conferences.

g. Flexible Funds

Funding available to meet the unique needs not otherwise paid for in an Individualized Treatment Plan. Examples of flex funding include, but are not limited to, family supports such as limited rental payments, utilities, automobile repair, and individual supports such as therapeutic behavioral incentives.

Settings: Direct Services may be provided in any setting where the Class Member is naturally located, including the home (biological, foster, relative, or adoptive), schools, recreational settings, childcare centers, and other community settings. Some of these services may also be provided via telehealth technology.

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

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

D. Crisis Response Services

Crisis services are available 24-hours a day, seven days a week in response to sudden or unexpected behavior in a Class Member that indicates the presence of acute psychiatric symptoms and the need for an immediate response. The purposes of crisis services are to identify, assess, and stabilize the situation.

a. Crisis Respite
Short term, temporary care of a Class Member by a caregiver different from the usual caregiver to stabilize a crisis situation.
b. Crisis Response Services
Services that are available 24-hours a day, seven days a week through telephonic contact with a mental health professional to determine the most appropriate response to a crisis situation.
c. Crisis Intervention Services
Face-to-face services include safely identifying and assessing immediate strengths and needs to ensure that appropriate services are provided to de-escalate the current crisis and prevent future crises. Services shall be provided consistent with an existing crisis plan using formal and informal supports, in partnership with the family. Services are available 24-hours a day, seven days a week by trained clinical staff.
d. Inpatient
Mental health and medical services provided to a Class Member admitted to a psychiatric hospital when there is an imminent risk of danger to self or others.

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

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

Providers: Crisis services are provided by a trained and experienced crisis professional or team, preferably drawn from members of the CFT.

APPENDIX D Governance

The Behavioral Health Division within the Idaho Department of Health and Welfare, the Department of Juvenile Corrections, and the Idaho State Department of Education have responsibility to serve the multiple needs of youth and families and are committed to partnering with each other and families and will participate on a supervisory team through an interagency governance structure. The interagency governance structure is intended to improve the coordination of and access to intensive mental health services for Jeff D. class members and thereby improve both effectiveness of services and outcomes for youth and their families. Governance informs decision-making at a policy level that has legitimacy, authority and accountability. The governance structure for the implementation of the Agreement is authorized under the Idaho Behavioral Health Cooperative as defined in I.C. Chapter 31, Title 39. The Administrator of the Department of Health and Welfare (DHW), Division of Behavioral Health, will lead the Governance partnership that will include partners from the Idaho Department of Juvenile Corrections (DJC), the Idaho State Department of Education (SDE), Children's Mental Health Representative (DHW), Medicaid Representative (DHW), Division of Family and Community Services (FACS) Representative (DHW), Parent of a Class Member or former Class Member currently below the age of 23, Class Member or former Class Member under the age of 23, Family Advocacy Organization Representative, County Juvenile Justice Administrator, and Private Provider Representative.

Purpose

The purpose of the Interagency Governance Team (IGT) is to collaboratively coordinate and oversee the implementation of the court approved Agreement in the Jeff D. class action lawsuit. The (IGT) shall advise the parties to the Agreement on implementation and serve as a vehicle for communication among parties, to identify and remove barriers to implementation, and monitor implementation of the Agreement.

The overarching responsibility of the Interagency Governance Team is to provide for:

- Adherence to the Settlement Agreement and Implementation Plan among constituencies,
- Steady progress in implementing agreed-upon commitments, practice improvements and quality management, improvement and accountability,
- Meaningful partnership with families, youth, and other community stakeholders,
- Effective use of data to inform progress in achieving cross-system outcomes,
- Appropriate interface with key advocates, State Legislature and the Judiciary,
- Sustainability of a shared investment including vision, empowered leadership and system improvements.

Membership

The Idaho Behavioral Health Cooperative will appoint membership to the IGT.

Articles of the Governance Agreement

a. The Interagency Governance Team will support and promote the Principles established in the Principles of Care and Practice Model as defined in Appendix B of the Agreement.
b. The Interagency Governance Team will be collaborative in nature and provide oversight on direction taken related to meeting the systemic needs of youth within its purview. The IGT will provide leadership to influence the establishment and sustainability of the Principles of Care and Practice Model statewide. The recommendations of the IGT will be timely acted on by decision-makers using their discretion and operating within their statutory authority and mission.
c. The Interagency Governance Team will, at minimum, maintain three subcommittees: 1) Family Engagement, 2) Clinical, and 3) Training. The IGT may organize additional subcommittees as necessary to carry out the purposes of the Agreement and Implementation Plan.
d. The Interagency Governance Team will meet as frequently as necessary to fulfill its purpose but at a minimum quarterly. Meetings will be open to the public and meeting notes will be distributed to each member after each meeting and posted on the appropriate website after approval by the IGT membership.
e. The Interagency Governance Team will elect a chair and vice-chair from within its membership.
f. The Interagency Governance Team will adopt operational guidelines for carrying out the above stated purposes and responsibilities.

EXHIBIT B

EXHIBIT B

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D. et al.,

Plaintiffs,

v.

CLEMENT LEROY OTTER, et al.,

Defendants.

Case No. 4:80-CV-4091-BLW

PROTECTIVE ORDER

Before the Court is the parties' Settlement Agreement, filed on the ____ day of _____, 2015 (Docket No. _____), which includes a process in paragraphs 94 and 95 regarding the Defendants' releasing to Plaintiffs' counsel of confidential information regarding Class Members protected from disclosure by federal or state law.

IT IS HEREBY ORDERED that any documents containing confidential information regarding Class Members that Defendants release to Plaintiffs' counsel in accordance with the process set forth in the Settlement Agreement shall retain those rights of privacy and protection from disclosure to which said documents are entitled by law, including the Health Insurance Privacy and Accountability Act (HIPAA) of 1996, and that the same shall remain confidential and not be used by or disclosed to any third party, entity, or person, exclusive of the members of Plaintiffs' counsels' firms and agents hired by Plaintiffs' counsel with respect to the compliance with the Settlement Agreement.

IT IS FURTHER ORDERED that all such documents or information shall only be used for the purposes set forth in the Settlement Agreement, and the production of such documents shall not constitute a waiver of any right of privacy or protection from disclosure or other claim or right of withholding or right of confidentiality to which those persons identified in the

documents may have.

IT IS FURTHER ORDERED that by complying with this Order and the relevant provisions of the Settlement Agreement, Defendants and Plaintiffs' counsel shall be deemed in compliance with all state and federal laws pertaining to the use and disclosure of confidential information and therefore are discharged from any and all liability, demands, or claims stemming from said compliance.

IT IS SO ORDERED.

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court

EXHIBIT C

EXHIBIT C

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D. et al.,

Plaintiffs,

v.

CLEMENT LEROY OTTER, et al.,

Defendants.

Case No. 4:80-CV-4091-BLW

ORDER ADMINISTRATIVELY TERMINATING CASE

The parties have successfully concluded the mediation of all outstanding compliance issues and the parties have negotiated a stipulated settlement agreement which has been approved by the Court.

Pursuant to the terms of the parties' settlement agreement, the parties shall resolve any and all claims, disputes, or other matters in controversy arising out of or related to the settlement agreement, or the breach, implementation, or performance thereof, according to the process set forth in the settlement agreement. If, after negotiating in good faith, no resolution is reached, either party may file an appropriate motion with the Court in this matter.

Pursuant to the terms of the parties' settlement agreement, the consent decrees, entered in 1983, 1990, and 1998, and the Implementation Plan, approved in 2001, and the orders related thereto, shall be suspended upon the Court's approval of the settlement agreement. Plaintiffs may move the Court to lift the suspension in the event Defendants fail to substantially comply with the duties and obligations under the settlement agreement, and in the event the settlement agreement's dispute resolution process has not successfully resolved the dispute concerning the alleged non-compliance. If such a motion is filed, Defendants shall bear the burden of proving substantial compliance with the settlement agreement. If the Court finds that Defendants have

not substantially complied with the settlement agreement, the Court will lift the suspension and Plaintiffs will then be able to seek enforcement of applicable portions of the consent decrees, the Implementation Plan, approved in 2001, and orders related thereto, subject to the availability of Federal Rule of Civil Procedure 60(b)(5) relief.

Pursuant to the terms of the parties' settlement agreement, substantial compliance with Defendants' commitments is enforceable during the pendency of the settlement agreement. In the event that Defendants are failing to substantially comply with the duties and obligations under the settlement agreement, and in the event that the settlement agreement's dispute resolution process has not successfully resolved the alleged non-compliance, Plaintiffs may file an appropriate motion with the Court according to the terms of the proposed settlement agreement.

Pursuant to the terms of the parties' settlement agreement, an implementation plan will be prepared and submitted to the Court for approval. The parties shall make reasonable efforts to submit a consensus plan. If the parties cannot agree on the terms of the implementation plan, the disputed issue(s) may be submitted to the Court for resolution. The Court may approve the implementation plan if the Court determines the plan is reasonably capable of fulfilling the terms of the settlement agreement and the purposes of the consent decrees and related orders. Following the Court's approval of the implementation plan, Defendants shall provide annual reports to the Court and Plaintiffs' counsel on the progress of the implementation plan.

Pursuant to the terms of the parties' settlement agreement, Defendants shall complete the implementation plan within four years following the Court's approval of this plan. Upon completion of the implementation plan, any party may submit a motion to the Court for a finding of substantial compliance with requirements for completing implementation of the settlement agreement as measured by objective criteria identified in the settlement agreement.

Pursuant to the terms of the parties' settlement agreement, Defendants shall sustain performance of the settlement agreement for three years following completion of implementation. At the end of this time period, Defendants may submit a motion to the Court for a finding of substantial compliance with the requirements for sustaining performance as measured by objective criteria identified in the settlement agreement. Upon the Court making such a finding, the lawsuit may be dismissed. Simultaneous to the dismissal, the parties shall make a joint motion to the Court to issue a stipulated permanent injunction protecting the interests of the Plaintiff Class.

Pursuant to the terms of the parties' settlement agreement, this Court may issue a protective order to protect confidential information contained in individual records of Class Members. To the extent the parties are unsuccessful in obtaining a release from a Class Member and the Class Member's parent or legal guardian, and there is no way to obtain such a release, Plaintiffs' counsel may seek a court order from this Court authorizing the release of confidential information. Unless substantial reasons exist to prevent disclosure, Defendants, at the request of Plaintiffs' counsel, shall file a stipulation and request a court order from a court of competent jurisdiction authorizing the disclosure of the confidential information, unless the Class Member or Class Member's parent or legal guardian objects.

IT IS HEREBY ORDERED that, based upon the stipulated settlement agreement, the Clerk of Court shall administratively terminate the above-entitled action in the Court records, without prejudice to the right of the parties to reopen the proceedings for good cause shown for the entry of any stipulation or order, or for any other purpose required regarding implementation. Therefore, the case is hereby ordered terminated, subject to the Court retaining jurisdiction to enforce the terms of the stipulated settlement agreement. *See Kokken v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375 (1994).

DATED: _____

_____
B. LYNN WINMILL
Chief Judge
United States District Court