T.R. vs. Dreyfus Interim Agreement

Communications Plan

Background

This communications plan was developed in response to the T.R. vs. Dreyfus, a Medicaid and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) lawsuit regarding intensive children's mental health services for children and youth with serious emotional challenges. The suit was filed in November 2009 alleging the State of Washington was inadequately serving Medicaid-eligible children and youth who have serious emotional impairments. Washington State pursued mediation with the plaintiff attorneys which resulted in an interim agreement signed on March 7, 2012 which requires WA to fulfill several commitments by June 2013. The commitment about the communications plan states the State of Washington will:

> **"develop a flexible statewide communications plan for *outreach and education of the community, stakeholders, and families about eligible children and youths and the WIYS [Washington Individualized Youth Services] array* to be developed within six months of a signed agreement in concert with the implementation plan. Information will be provided with appropriate translations and other necessary accommodations to promote recipient understanding."**

The children and youth who are eligible are those with the most serious emotional challenges who are struggling in their daily lives as a result (have a functional impairment) and are often involved in one or more child-serving systems.

WIYS, or intensive mental health services, include:

- Intensive care coordination
- In-home and community-based services such as in-home therapy, therapeutic mentoring, behavioral supports, peer-to-peer supports
- Mobile crisis and stabilization.

Implications

Informing the community, stakeholders, and families about eligible children and youth is critical for the State to meet its obligations under Medicaid/EPSDT to provide outreach and education to children and youth who are Medicaid-eligible. Inherent in the action of informing any audience of individuals who may qualify for certain services and the nature of those services is the natural outcome that more individuals will be made aware of and access services than are doing so currently. Current funding and system structures do not support an increased number of children and youth being identified, or an increased number of children and youth receiving more intensive mental health services. The interim agreement does not include expansion of services.

Given that available funding is limited and will not increase dramatically in the near future; communication must be be targeted to meet that reality. While the communications plan will be triggered after we have plans for additional funding to support additional services, we also need to provide pragmatic parameters to both what we say and how broadly we communicate the message at any time. Any message developed will inevitably reach individuals with a wide range of mental health needs that extend beyond the class of children/youth with the most severe mental health impairments who would be likely to require intensive mental health services and their families, guardians and the child-service providers serving them. Communications will need to contain information about both mental health coverage options for children and youth receiving Medicaid:

- up to 20 outpatient visits per year through the medical managed care and fee for service plans (offered through the Health Care Authority [HCA]) for individuals who have more primary and secondary mental health needs, and
- for those who have more serious mental health impairments, an broader unlimited mental health benefit offered through Department of Social and Health Services (DSHS) and its contracted mental health managed care entities, the Regional Support Networks (RSNs).

Providers for both mental health benefit packages (in many cases the same provider/Community Mental Health Agency or CMHA) will need to also be well informed about which benefit to access when and how to manage the transition between benefits. When an individual requests screening for intensive mental health services and are clearly not eligible for RSN services, the mental health provider will refer appropriately. Likewise, medical mental health benefit providers who serve children and youth will need to know what type of individual is best served by them and the RSN system. Existing strategies of training and informing these providers will be utilized. RSNs and Healthy Options (HO) Medicaid managed care medical plans are in process of developing memoranda of understanding to inform the basis for determining the best mental health benefit to access when for consumers. The Health Care Authority and DSHS are partnering on the best way to plan for the broader implications and manage the impacts of additional individuals requesting and accessing mental health services.

Child-serving systems outside of primary care and mental health providers who interact regularly with individuals with a range of mental health needs such as schools, juvenile justice, child welfare, developmental disabilities, and DSHS eligibility workers also would greatly benefit from additional clarity about the systems so they may make the first referral of a family as appropriately as possible.

Given the implications of increasing demand for services, we recommend beginning communications with a targeted audience and message, and then expanding more broadly with a wider audience and message as funding increases. This targeted- to-broad communication planning methodology will be reflected throughout this document.

Planning

Planning for this T.R. Communications Plan has involved and will continue to involve:

- Division of Behavioral Health and Recovery (DBHR) Communications and Program Staff
- Aging and Disability Services Administrations (ADSA) Headquarters Communications Staff
- HCA and DSHS Programs and Communications Staff
- ADSA Translation Services
- Children's Mental Health Committee comprised of RSN Children's Care Coordinators and Family Representatives
- DSHS partners – Children's Administration (CA), Developmental Disabilities (DDD), Juvenile Rehabilitation Administration (JRA), Economic Services Administration (ESA), Fostering Well Being Program
- Regional Medical Consultants (primary care providers) for child welfare
- DSHS Refugee Services
- Washington Provider Council / Designated Community Mental Health Agency Representative

- Family and Youth Lead Representatives for the Systems of Care Regional Family, Youth, and System Partner Round Tables
- Washington Governor's Juvenile Justice Advisory Council Director
- DBHR Leadership and program staff, including the Systems of Care Facilitation Team
- Department of Early Learning
- ADSA Indian Policy and Advisory Committee
- Department of Corrections, Youthful Offender Program
- T.R Settlement Design Team (plaintiff lawyers)
- Office of the Superintendent of Public Instruction (OSPI)

Future consultation will include:

- Department of Health/Maternal & Child Health
- Children's Long-term Inpatient Programs (CLIP) Parent Steering Committee
- Statewide Family Youth and System Partner Roundtable (FYSPRT)

Scope

The scope of this communications plan has two primary components.

1. The specific commitment made by the State to develop a communication plan is focused on the identification of eligible children and youth and connecting them to intensive mental health services as appropriate.
2. A broader communication with Medicaid eligible individuals regarding both Medicaid mental health service options available to them.

Additionally, DSHS and HCA is actively planning and developing communication about the T.R. Interim Agreement to address the significant transitions in executive and legislative positions that will occur this January when Washington will have a new Governor, DSHS/HCA Executive staff, and key legislators and staffers.

The Communication Plan is an integral part of the overall T.R. Interim Agreement Implementation Plan and will be used to provide guidance to communication regarding the overall implementation. This plan focuses on formal communication elements for outreach and education. Other communication channels exist on informal levels and enhance those discussed within this plan. This plan is not intended to limit, but to enhance communications practices. Open, ongoing communication between stakeholders is critical to the success of improving the children's mental health system.

Audience

The audience for each of the two scopes of communication both varies and overlaps. Given the implications and impact of broader communication, this plan demonstrates both a targeted audience and an expanded audience for when additional funding is identified to support increased accessibility to services. The targeted audience is intended to focus on the T.R. Proxy identifiers and possible functional indicators of impairment for individuals who are ages 0 – 20, receiving Medicaid, and have a broad mental health flag. A 2011 report identified the highest proportions of functional impairments of these 19,652 youth with service data from 2008 as:

- Alcohol or drug treatment need (30.5%)
- Convicted, deferred, or diverted in juvenile justice system (29.4%)
- Four or more psychotropic meds in one month (23.2%)
- DBHR/RSN costs above the 90% percentile (19.7%)
- Child welfare-involved with 3+ lifetime out-of-home placements (19.7%)
- RSN Crisis encounter (12.1%)
- Other medical claims with MH indicators (10%)
- Homelessness (8.2%)
- Children's Administration (CA) Behavioral Rehabilitation Services (7.5%)
- DBHR/RSN Community Psychiatric Inpatient Stay (6.6%)
- Juvenile Rehabilitation Administration Services (4.2%)
- Other CA Intensive services (3.4%)

This list is in line with the June 2012-released SAMHSA guide for child-serving organizations regarding identification of mental health and substance use problems of children and adolescents, which targets:

- Child welfare
- Early care and education
- Family, domestic violence, and runaway shelters
- Juvenile justice
- Mental health and substance abuse treatment for co-occurring disorders
- Primary care
- Schools and out-of-school programs

Although, the 2011 proxy data did not include data from schools (children with an Individualized Education Plan [IEP] or 504 Plan) or who were in detention only, these systems are represented, however, in the targeted audiences further defined later in this document.

Implementation Strategy

Message Framework

The Message Framework is the method that the outreach and education activities and the TR Implementation work will utilize to consistently demonstrate a unified message that is also tailored to the specific task, document, or key commitment. The Messaging itself is a two-way process of creating the most effective message possible, listening to the audience about what works and what doesn't, and adapting the message. The ***Message Framework (MF)*** is a way of coordinating and tracking messages, talking points, and audiences, in a snapshot that is easily shared and updated. The Message Framework then becomes a reference point for all levels of administration and staff. The foundational pieces, the top three lines, do not change (or at least not often). The remaining sections capture current thinking on the message, and are the parts that will be adapted to reflect adjustments in goals and input from audiences. Each Message Framework will be posted on the DBHR Children's Mental Health SharePoint Communications site and accessible to all, with the most current at the top. Each TR work group will complete a Message Framework and review all other current messages as way to inform the development and/or updating of their Message Framework. Regular review of draft MFs will be conducted by DBHR, FYSPRTs and necessary ADSA/HCA communications staff. All efforts will be made to keep the development process clear, simple, and straightforward.

An [incomplete] example Message Framework is included below in Figure 1 specifically for the communication about outreach and education for eligible children and youth and intensive mental health supports and services.

Figure 1

Draft Message Framework Example for TR commitment communication regarding eligible youth and intensive services (called Washington Individualized Youth Services [WIYS] in the T.R. Interim Agreement)

Positioning **Statement** of the philosophy that drives your work	Children and youth with serious emotional challenges and their families work together with providers and natural supports to identify their plan and get better.				
Tagline Key words or phrase to capture what makes this project special	Promoting Child and Family Teams and access and availability of coordinated intensive mental health services for Medicaid-eligible children and youth				
Elevator Speech A 2-sentence summary of what your project does	We are promoting recovery and resiliency of children and youth with serious emotional challenges through the increased engagement of children, youth and their families with a Child and Family Team. The team works to identify tailored services and supports to keep children and youth in their home and community, monitors and adapts the plan, and transitions away from formal supports.				
Audiences [examples ->]	Families	Youth	Providers/RSNs	JRA/DD/CA/JJ	Schools/PCPs
Audience Interests	Access, Where, what, How hard to get, Consumer	(Have youth identify) What is available where I live? How will it help	enough funding, how to bill, how to report, quality of care, workforce development, Clinical	Ability to refer easily, connecting with current services in each system and be well-coordinated,	Which kids do I refer where?

	partnership, Coordinated?– not just another service	me? What is my role/voice? How do I access?	appropriateness	who pays for what, EBPs	
Benefits and attributes Key messages about what your project offers	Medically necessary services to children and youth ages 0 – 20 and their families in a coordinated/team, and one-plan approach	Medically necessary services to children and youth ages 0 – 20 and their families – with specific knowledge and training about youth in transition needs, and services informed by youth in general	Provide services to children, youth, and families in the right dose at the right time, by providers who are trained well in a coordinated, efficient team process.	Intensive services and supports to kids you serve that will better meet their needs than the current RSN system. Statewide accessibility and accountability to provide those services. Coordination and CFTs is key.	Intensive services and supports to kids you serve that will better meet their needs than the current RSN system. Statewide accessibility and accountability to provide those services. Coordination and CFTs is key.
Features Talking points, or detailed messages about the benefits	Services are provided through RSNs. You may self-refer by calling your RSN. This is what intensive MH services are (description). This is what a CFT is (description). Etc. Family peer support available.	Services are provided through RSNs. You may self-refer by calling your RSN. This is what intensive MH services are (description). This is what a CFT is (description). Etc. Youth peer support available.	Support will come in the form of billing instructions, training, and quality of care tools for providers as well as the state. CFT facilitation and participation is key.	Services are provided through RSNs. You may self-refer by calling your RSN. This is what intensive MH services are (description). This is what a CFT is (description). Etc. Parent and youth peer support available.	Services are provided through RSNs. You may self-refer by calling your RSN. This is what intensive MH services are (description). This is what a CFT is (description). Etc. Parent and youth peer support available.
Key Channels main strategies for sharing the message	Flyers, parent support organizations, website, CSOs, schools, PCPs, blogs	Youth support organizations, schools, JJ, PCPs. Need flyers.	Email newsletters, provider/RSN meetings, trainings	Join existing meetings and channels of communication, email newsletters, trainings	Join existing meetings and channels of communication, email newsletters, trainings, flyers

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Additional Information needed for Message Development and Communication:					
Responsible staff					
Selected Methods					
Process to implement method					
Timing					
One time or repeated?					
Who releases and who is contact?					
Translations?					

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Completing the Message Framework

DBHR leads will work with key partners in ADSA, DSHS and HCA, RSNs, provider and family representatives, and system partners to complete the Message Framework. This work includes:

1. Identification of the message
2. Identification of the audience – see targeted audience list in **Roll-Out** Section below
3. Match the message to the audience
4. Plan how to deliver the message – see **Method** section below
    a. Identify and review existing brochures and pamphlets and see where modification are required.
    b. Identify formal expectations of contractors for communication of message
5. Identify each step – process of implementing the message

a. DBHR, ADSA, DSHS and HCA Communications staff review
b. Interpretation Process
    i. For translations in the eight primary languages, ADSA HQ requires 10 days to obtain a bid and get the materials translated.
    ii. HCA will translate their primary materials as needed.
c. DSHS Visual Communications office consultation is required for all DSHS flyers and brochures. They will assist with formatting, clarity of communication, and overall presentation.
d. DBHR Website development requires work with the website development staff to support this work.

6. Plan for releasing the message – identify who is the responsible person and contact person for each one
7. Plan for handling responses to the messages and requests for information.
8. Plan for the frequency of communication and follow-up messages
9. Plan for reviewing test messages with key audience members
10. Monitoring how well the message is getting out and what people are hearing
11. Adjust the message in response to the feedback.

Method

DSHS, HCA, and family, youth and system partners all have many existing channels of communication. It is essential that this communication plan builds upon existing methods of communication and be as efficient as possible through the use of free and low-cost communication. The methods listed below in Figure 2 may be used for either targeted or broad audiences, depending on the purpose, and are not exhaustive.

Figure 2.

Methods of Communication

Target Individuals/Groups	Methods
Youth and families	• Contact with Consumer and advocacy groups such as NAMI, A Common Voice in Pierce County, Passages in Spokane, YouthNAction, WA Dads, Thurston Mason Family Group, Regional Family Youth and System Partner Roundtables (FYPSRTs), Passion for Action (foster youth), Foster Parent Association of WA (FPAWS) through webinars, email, and newsletters • Updated brochures – “Parents Guide”, Benefits booklet, general flyers to be picked up in multiple community locations • DBHR Office of Consumer Partnerships Distribution lists of interested parents and youth around the state who are key knowledge holders in their communities • Accessible downloadable flyers and brochures on the DBHR and HCA websites. • Updated information on DSHS/HCA websites • United for Youth training (in King county) • Sharing information in key community settings: Faith based organizations, YMCAs, local community service organizations identified through RSN and/or United Way • Hospitals/ERs to have flyers • CLIP providers/ CLIP Parent organizations • Refugee assistance programs (DSHS’ and faith-based

	organizations) • Spanish and Korean radio connections • HCA/Medicaid outreach materials • Refugee Foster care programs (Unaccompanied Minors Program – URM) – flyers to share with foster parents • JRA Youth Voice • Juvenile Justice 101 guide for families (King county model, Somali version, other counties starting)
Providers – Community Mental Health Agencies and child welfare intensive In-home services group home providers	• Youth community mental health provider communications and meetings called by RSNs with their contracted providers • Children's Administration intensive service provider meetings and newsletters • Community Mental Health Provider council – meetings and newsletters • Children's Long-term Inpatient Program (CLIP) Directors meetings • Hospital associations (targeted to Children's psychiatric hospitals) • Health Care Authority (HCA) listserve for providers, by provider type
RSN cross-system connections – Regional meetings RSNs, Juvenile justice, schools, child welfare, DDD	• Regional/local Cross agency system trainings held by RSNs • Shared resources/shared kids/CLIP review type regional meetings • In-service trainings in regional locations • Academy training for CW workers • RSN outreach and engagement with system partners • RSN Training and technical assistance with providers and partners (i.e. wraparound principles training in GCBH) • Family Youth and System Partner Roundtables
Community Service Offices / front-line eligibility staff	• System navigation meetings for Medicaid/CSO workers (King county) • Webinars with Provider One 800 number/referrals • DSHS first Friday forums (King) • Refugee Resettlement Assistance Agencies – email distribution of flyers and quarterly statewide meeting, local provider meetings in Spokane, Seattle, Tri-Cities, Vancouver, and Yakima
Primary Care	• Physician Assistant Line (PALS) • Informational packets to regional medical providers from RSNs • Information provided on psychotropic medications trigger referrals to MH services • Health Care Authority communications • HCA EPSDT screens • Continuing education courses (CEUs) • Pediatric association meetings and conferences • Department of Health (DOH) Learning Collaboratives
Juvenile justice representatives	• Office of Juvenile Partnerships' Behavioral Health Committee - conferences and meetings • Washington State Juvenile Court Administrators, Probation Officers and court workers meetings/conferences • JRA meetings with Diagnostic Mental health coordinators in

	counties (or current equivalent) • Models for Change • Integrated Case Management (ICM) pilots • Academy trainings for JRA
Early Education	Email newsletters/information to: • Department of Early Learning - regional family resource coordinators and assessment/intervention teams • Head Start • Child Care Action Council • Child care centers at community colleges/universities • Department of Health/Maternal & Child Health key contacts
Education	Email newsletters/information to: • OSPI contact lists for programs such as Readiness to Learn • Email lists for school counselors, nurses, and special education teachers and coordinators • Training with key school staff on how school screenings serve as indicators for mental health referral at conferences/meetings
People who connect with Transition age youth	• State hospitals – communication with social workers • Community mental health agency training to identify individuals 18-20 who are eligible for EPSDT services • Training for CA social workers to understand MH services/supports available for transition age youth • YMCAs, Youth outreach organizations, homeless youth programs
Law enforcement	• Mental health first aid training • Designated community liaisons – share information with them
General information	• DBHR/CMH website • Flyers, handouts, and guides for providers and families • Email distribution lists (including the 1088 listserve) • Medicaid services brochures and benefits booklet
Tribes	• IPAC – ADSA Subcommittee meetings every other month • Follow WA Centennial Accord Communication Protocol • Share email with OIP key contacts from each Tribe
Individuals who have primary languages other than English	• Spanish and Korean radio stations • All flyers and brochures need to be translated into the eight primary languages as established by ACES (Spanish, Russian, Chinese, Vietnamese, Korean, Laotian, Somali, and Cambodian) • For refugees in the DSHS Refugee program, additional language translation will be needed (Burmese, Bhutanese, and Iraqi are the current top three languages)

Roll-Out Strategy

A measured roll-out strategy of communications will be developed based on the level resources for services and supports that are identified through achieving a new level of efficiencies with mental health services across DSHS and redirected or new resources. The table below is an initial design for this roll-out strategy of the communication.

The phases of the roll-out strategy are defined as:

Phase	funding	description
Phase 1	no new money	DBHR, RSN, CMHAs providing services to children, and state hospitals and CLIP providers identify who the likely eligible children and youth who have a high level of likelihood of being eligible for CFT and intensive services and work to identify if the child/youth has appropriate services
Phase 2	early ramp up / small amounts of money	Key partners and system knowledge holders who work regularly with children and youth with complex needs and have a high likelihood of identifying a child or youth in need of intensive mental health services
Phase 3	intermediate ramp up/ moderate amount of money	Broader audience who will have some occasional intersections with children and youth with complex needs and need to understand both the mental health services available through the medical plans as well as through the RSNs or a moderate degree of challenge for implementation
Phase 4	full implementation/ fully funded	General public announcements and outreach to social service organizations who meet the needs of children and families who are likely to be Medicaid eligible and could have mental health needs requiring early intervention through intensive mental health services OR a high degree of challenge for implementation

Entities and Groups	Targeted People/Entities for Communication	Timing or Phase
DBHR/ADSA		
	All-staff	phase 1
	RSN Administrators	phase 1
	Children's Mental Health Committee	phase 1
	RSN Customer Services staff	phase 1
	Community Mental Health Agencies	phase 1
	State hospitals	phase 1
	Contracted Children's Long-term Care Providers	phase 1
	Residential Chemical Dependency Treatment Providers	phase 2
	Association of County Human Services for sub-contracted Outpatient CD services	phase 2
	Prevention and Intervention Contracts - Subcontracts	phase 3
	Fostering Well-being (ADSA staff working on behalf of foster kids)	phase 1

	DBHR contracted Recovery Line	phase 2
	Children's Mental Health Redesign Listserve members	phase 2
Family and Youth		
	Children's Mental Health Committee	phase 1
	State and Regional Family Youth and System Partner Roundtables	Phase 1
	Family advocacy organizations (i.e. NAMI, FPAWS, A Common Voice, WA-Dads)	Phase 2
	Youth advocacy organizations (i.e. Youth N Action, Passion for Action, JRA Youth Group)	Phase 2
	Behavioral Health Advisory Committee	phase 2
	All Medicaid enrolled individuals 0 - 20	phase 4
	General Public	Phase 4
Children's Administration		
	CA Supervisors for CWS	Phase 2
	CA CWS Social Workers	Phase 2
	BRS Coordinators	Phase 2
	Intensive Services Contractors	Phase 2
	Guardian ad Litems and Court Appointed Special Advocates	
	Office of Family and Children Ombudsman	Phase 3
Developmental Disabilities		
	DDD Case Managers	phase 2
	DDD Children's Intensive In-Home Behavioral Support Program managers	phase 2
	DDD Additional staff not notified serving individuals 0 - 20	Phase 3
	DDD contracted providers	phase 3
Juvenile Rehabilitation		
	JRA Institutional Mental Health Staff and Consultants	phase 2
	JRA Community Office Mental Health Staff	phase 2
	All JRA institutional and parole staff	phase 3
	Contracted service providers (evidence based programs)	phase 3

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Health Care Authority		
	Medicaid Medical Assistance Customer Service Center	phase 2
	Healthy Options Managed Care Plans	phase 1
	Children's psychiatric hospital social workers and intake staff	phase 2
	Fee-for-Service and Medical plan (HO) mental health providers	phase 2
	Hospital Association	phase 3
	Regional Medical Consultants	phase 2
	Primary Care Association	phase 3
	PALS Line (Physicians Assistance Line)	phase 2
	Provider One call line staff	
Economic Services Administration		
	Workfirst Social Workers	phase 3
	Eligibility Workers and Supervisors	phase 3
	Eligibility team for JRA youth being released	phase 3
	Refugee Service Agencies	phase 3
Juvenile Justice		
	law enforcement	phase 3
	Juvenile court managers	phase 2
	juvenile court probation managers	phase 2
	juvenile court workers	phase 2
	Juvenile court detention manager and mental health staff	phase 2
	juvenile court administrators	phase 2
	Juvenile Justice 101 training for parents	phase 2
Schools		
	Office of the Superintendent of Public Instruction staff	phase 2
	Prevention/Intervention specialists (for CD/MH)	phase 2
	Special Education Directors at the Educational Service Districts (ESDs)	phase 2
	School Guidance counselors	phase 2
	School nurses	phase 2
	Associate Superintendents of Student Support at the school districts	phase 2

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	Community colleges and technical schools	phase 4
Department of Health		
	Children with Special Needs - Public Health Program in King County	phase 3
	More to come	
Department of Early Learning		
	Early Support for Infants and Toddlers staff	phase 3
	Regional Family Resource coordinators	phase 3
	Regional Early intervention providers and assessment teams	phase 4
	Child Care Action Council	phase 4
Department of Corrections		
	Youthful Offender Program	phase 3
Domestic Violence and Homeless Shelters		
	Washington State Coaltion Against Domestic Violence	phase 3
	Washington State Coalition for the Homeless	phase 3
Advocacy organizations		
	Team Child	phase 2
	Disability Rights Washington	phase 2
	Northwest Health Law Advocates	phase 2
Broad Community Support Entities		
	United Way agencies	phase 4
	Faith-based organizations	phase 4
Tribes		
	Centennial Accord Protocol for Communication with Tribal Leaders	phase 2

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Office of Indian Policy Staff & Directors of Health and Recovery, Indian Child Welfare, and Family Services at each Tribe	phase 2

Conclusion

This is Communication plan is a critical component for clearly informing youth, families, providers, child-serving systems and partners about how to refer the appropriate children and youth to intensive mental health services in the Medicaid funded mental health system. It is imperative that the plan remain flexible and dynamic in order to best meet the needs of the children, youth and their families and be responsive to the available and changing system structure and supports.

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