

## **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<sup>1</sup> 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.<sup>2</sup> The Services and Supports document<sup>3</sup> 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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<sup>1</sup> 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.

<sup>2</sup> The Principles of Care and Practice Model are defined in Appendix B.

<sup>3</sup> 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;<sup>4</sup> and

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<sup>4</sup> 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.