

**SETTLEMENT AGREEMENT-**  
**Between HCA, DSHS and DRW**

**re:** Discharge Planning for Individuals Civilly Committed at Western or Eastern State Hospital

**SETTLEMENT AGREEMENT**

The goal of this Settlement Agreement is to avoid costly and time-consuming litigation on behalf of individuals who are or will be civilly committed at Western or Eastern State Hospital. The parties to this Settlement Agreement are Disability Rights Washington (DRW), the Health Care Authority (HCA), and the Department of Social and Health Services (DSHS) (hereinafter “Parties”).

**I. Principles**

While not intended to be separately enforceable, the Parties agree to a set of principles and values that will inform the Settlement Agreement, including the agreed-upon remedies and Improvement Plan. These principles and values include:

1. This settlement agreement is intended to better provide civil patients in Washington with community services that will assist them to discharge timely from the hospital and live in the most integrated setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization.
2. Title II of the Americans with Disabilities Act (ADA) requires that public entities administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. 42 U.S.C. §§ 12101 et seq.; *Olmstead v. L.C.*, 527 U.S. 581 (1999); 28 C.F.R. § 35.130(d). Further, a “public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. § 35.130(6)(7).
3. Washington recognizes and supports the Congressional finding that “the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency.” See 42 U.S.C. § 12101 (a)(7).
4. People with behavioral health disabilities in the civil commitment system should not experience undue delays in being discharged from inpatient settings to the community or to independent living.
5. Community-based services and outpatient treatment should be available in the most integrated setting appropriate and should be consistent with the individual’s informed choice.

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## **II. Recitals**

1. This agreement is not and shall not be construed as an admission on any issue or as an admission of liability by the State of Washington. Washington denies liability. This agreement does not create or waive any third-party rights.
2. The terms in this agreement are goals that the State agrees to make best efforts to meet. The State has already made a number of improvements and has invested substantial funds in that effort, and the State's intent through the use of the policy goals, performance goals, and performance measures below is to make additional system reforms over the duration of this agreement.
3. The parties agree that the performance goals and performance measures herein are intended to implement the identified policy goals. If the State does not meet any particular performance goal, or performance measure in this agreement, or if the state does not comply with monitoring requirements listed in section V.A, and/or the stakeholder engagement commitments in sections VI.A.3 and IV.B.5, the Parties shall meet as described in the Dispute Resolution section to determine the underlying reasons, whether adjustments need to be made to that goal, whether the State has developed the infrastructure necessary to improve its performance and reach the performance goal or measure, whether to provide additional time for accomplishment of the goal or measure, and whether to increase the term of this agreement. Any modification must be mutually agreed by the parties and shall be in writing. The State has authority to enter into this contract and is subject to contractual remedies.
4. The State shall collect and maintain data and records on each of the performance goals and performance measures in this agreement, in order to document that the requirements of this agreement are being properly implemented and shall make such data and records reasonably available to the DRW on at least a biannual basis.

## **III. Definitions**

1. The term "Claim(s)" includes any and all claims that could be brought by Disability Rights Washington as an organizational plaintiff in a civil lawsuit in either state or federal court alleging that individuals civilly committed at Western or Eastern State Hospitals are being denied access to services and supports necessary to timely discharge to the most integrated setting appropriate to their needs. Except that "claim(s)" referenced herein do not include

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claims related to timely provision of Home and Community Based waiver-funded services or Roads to Community Living Demonstration Project services to clients of the Developmental Disabilities Administration. By entering into this agreement, the State does not concede any litigation position in any future litigation not directly related to this agreement about whether DRW has met the threshold necessary to have associational standing.

2. The term “civil patients” refers to individuals who are currently civilly committed for 90 days or more to Western State Hospital or Eastern State Hospital.
3. “Hospital” means Western State Hospital or Eastern State Hospital.
4. Disability Rights Washington or DRW means DRW.
5. The term “the State” for the purpose of this agreement means the Washington State Department of Social and Health Services and the Health Care Authority.
6. The term “integrated community setting” means a setting that typically includes the following characteristics-
  - a. It supports the individual’s access to the greater community, including opportunities to work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community. The degree of access supported shall be similar to the access enjoyed by individuals not receiving support services;
  - b. It is in the individual’s own home or is another setting that is selected by the individual.
  - c. It ensures an individual’s rights to privacy, dignity, respect, and freedom from coercion and restraint;
  - d. It optimizes individual initiative, autonomy, and independence in making life choices, including in daily activities, physical environment, and personal associations; and,
  - e. It facilitates individual choice regarding services and supports and who provides them.
7. The term “Program of Assertive Community Treatment” or “PACT” refers to an evidence-based practice designed to provide comprehensive treatment and support services to individuals with serious and persistent mental illness.

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8. The term “own home” means living in one’s own dwelling, or in a shared living arrangement selected by the individual, and not in a licensed residential or long-term care setting.

**IV. Improvement Plan**

The Parties agree that the State will develop and implement the following:

A. Consistent Discharge Planning

1. *Policy Goal:* Discharge planning starts with the presumption that most civil patients discharging from a state hospital can live in an integrated community setting. The goal of discharge planning is to provide individuals with the option to live in their own homes or a setting that is the most integrated setting appropriate for their needs. To this end, a plan is developed to assist the individual to achieve outcomes that promote the individual’s growth, well-being, and independence in the most integrated setting appropriate for the individual, based on the individual’s strengths, needs, goals, and preferences.
2. *Policy Goal:* The State will create discharge plans recommending and facilitating timely discharge to the most integrated community setting appropriate for the individual.
3. *Stakeholder Engagement:* Within 120 days of the effective date of this Settlement Agreement, the State will engage current and former patients, family members, advocates, community mental health and supported housing providers, Managed Care Organizations/Behavioral Health Administrative Services Organizations, and other community system partners to provide feedback and input to inform changes to the discharge planning process needed to achieve Policy Goals described in paragraphs IV.A.1 and IV.A.2 above.
4. *Performance Goal:* The State will make changes to the discharge planning process that are needed to achieve the Policy Goals described in paragraphs IV.A.1 and IV.A.2, including by utilizing stakeholder input obtained via the stakeholder engagement process described above. The State will create updated uniform state hospital discharge planning policies, procedures, and documentation standards (hereinafter “updated discharge planning process”) and will implement the updated discharge planning process. This will be completed within 15 months of the effective date of this agreement.

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The updated discharge planning process will be uniform across both State Hospitals and, consistent with paragraphs IV.A.5- IV.A.7, will include, but not be limited to, the following elements:

- a. begins at the admission of the civil patient;
  - b. begins with the presumption that most civil patients discharging from a state hospital can live in their own home;
  - c. is developed and implemented through a person-centered discharge planning process in which the individual has a primary role and is based on the principle of self-determination;
  - d. is documented in a written discharge plan that:
    - i. identifies the individual's strengths, preferences, needs, and desired outcomes;
    - ii. identifies the specific supports and services that build on the individual's strengths and preferences to address the individual's needs and achieve desired outcomes;
    - iii. identifies providers to deliver needed supports and services;
    - iv. specifically documents any steps or action that need to be taken for the individual to transition to the most integrated setting appropriate to their needs, and
  - e. sets forth a plan for taking those steps or actions that is ongoing and updated as appropriate.
5. *Members of Discharge Transition Team:* Discharge planning will be conducted by Discharge Transition Teams that include the patient, and may include:
- a. The patient's assigned hospital social worker and/or discharge social worker;
  - b. MCO representative, a Home and Community Services representative, a DDA representative, prospective providers, and, as appropriate, other persons knowledgeable about resources, supports, services and opportunities available in the community;
  - c. A peer bridger; and,
  - d. with the consent of the individual, other persons whose involvement is relevant to identifying the strengths, needs, preferences, capabilities, and interests of the individual and to devising ways to meet them in the most integrated setting appropriate for the individual.
6. *Timely Discharge Planning:* For activities within the control of the state, the state will adopt discharge planning policies that include the requirement that, absent unusual circumstances:

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- a. referrals and transfers of case information to other discharge planning individuals and service providers will occur within seven business days of the event that made the referral or transfer appropriate; and
  - b. The following timeframes apply:
    1. A Community Transition/Discharge initial evaluation will be completed within 14 days of arrival at the hospital;
    2. A referral for early engagement will be made within 30 days of arrival at the hospital.
    3. CARE Assessments will be initiated within 7 days of getting the referral.
    4. AL TSA determinations of financial eligibility will be initiated within 7 days of getting the application.
    5. AL TSA Referral packets will be sent within 7 business days of the client being determined financially and functionally eligible.
    6. Discharge readiness assessments conducted by professional staff, including discharge reviews conducted pursuant to RCW 71.05.232, will be initiated within 7 days of the determination that such an assessment is necessary.
    7. Required court and/or prosecutor discharge-related notifications will be sent within 7 days of the determination that such notification is necessary.
    8. Discharge-related off-campus visits or meetings will be scheduled within 7 days of the determination by social work staff that the visit or meeting is necessary or useful.
  - c. The discharge planning policies adopted pursuant to this agreement shall identify and list required timelines for any other significant typical discharge related tasks and activities within the control of the state that are not identified or referenced above.
7. *Complex Case Staffing* will occur as needed in all cases when there are barriers to timely discharging a patient to the most integrated setting appropriate. The state hospital policies and procedures will have a complex case staffing protocol that will include, at a minimum:
- a. Regularly scheduled meetings of a complex case staffing committee with participation of appropriate staff members and administrators from:
    1. the State Hospitals;
    2. Home and Community Services;
    3. Developmental Disabilities Administration;

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4. the Health Care Authority; and
    5. liaisons from the Managed Care Organizations, Behavioral Health Administrative Service Organizations, and other community providers, when appropriate.
  - b. Each Hospital will conduct a complex case staffing no less than twice per month.
  - c. The State will provide DRW with a designated staff contact who will refer for a complex case staffing particular individuals identified by DRW for review.
  - d. With patient permission, the designated staff contact will keep DRW apprised of progress on referred cases.
8. *Performance Goal:* The State will develop and deploy a digital discharge planning system to be used by the hospitals. The system will have the same terminology, definitions, data collection, and reporting capabilities for both hospitals.
  - a. The digital discharge planning system will, at a minimum, track:
    1. the date of the person’s initial 90 or 180-day civil commitment.
    2. The date an initial discharge evaluation is conducted;
    3. Whether the individual is identified as clinically eligible for early engagement via the initial discharge evaluation;
    4. the date of the clinical determination that the person no longer requires active psychiatric treatment in an inpatient level of care;
    5. the date notice is provided, pursuant to RCW 71.05.365, to the behavioral health administrative services organization, managed care organization, or agency providing oversight of long-term care or developmental disability services that is responsible for resource management services for the person in the community that the person no longer requires active psychiatric treatment in an inpatient level of care;
    6. all typical discharge planning activities, and the extent to which those activities are timely completed;
    7. needed services and supports as determined via the individual’s Person-centered discharge planning process.
  - b. Project milestones include:
    1. Project Design will be completed in 9 months,
    2. Project Development will be completed in 15 months,
    3. Testing Training & Technical Documentation will be completed in 21 months,
  - c. System will “Go Live” in 24 months, the system status will transition to “maintenance” in 27 months. The overall performance goal will be completed in 36 months.

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#### **B. PACT, Early Engagement, and Supportive Housing**

1. *Policy Goal:* Timely discharge planning resulting in discharges to the most integrated setting appropriate for the individual's needs and in accordance with individual's preferences will occur in all cases. Discharge plans will include documentation that reflects the individual's treatment goals, clinical needs, and the individual's informed choice, including geographic preferences and housing preferences.
2. *Performance Goal:* The State will evaluate and assess the need for PACT expansion, including the needs of patients discharging from the state hospital. The State will contract with the University of Washington and RDA to conduct this assessment. The assessment may include a review of geography, workforce, client need, population density, and the model. The assessment will be based on reliable data, including utilization data and other material data. The State will monitor the implementation of current PACT expansion efforts and evaluate whether additional PACT expansion is necessary. This will be completed in 6 months of the effective date of this agreement.
3. *Performance Goal:* The State will update the forms relevant to discharge planning, including Psychosocial Assessments, the initial discharge evaluation, and discharge reevaluations to include consideration of Supportive Housing, PACT, vocational supports, long-term care supports, peer supports, and the early engagement process described in IV.B.4. This will be completed in 15 months of the effective date of this agreement.
4. *Performance Goal- Early Engagement:* The State will begin discharge planning at admission with the presumption that civil patients discharging from the hospital can live in their own home.
  - a. All discharge plans will be developed using a person-centered discharge planning process, and will have documentation of linkages to timely, appropriate behavioral and primary health care, consistent with patient choice, in the community prior to discharge. Linking patients to appropriate community providers shall begin as soon after admission as possible.
  - b. Discharge planning discussions with the patient will be documented in every patient's clinical record. Required documentation will include, at a minimum, the hospital treatment team's recommendation for a discharge setting with supporting rationale, information on the patient's expressed preference of setting and if known long-term plans and details of

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information and resources shared with the patient about possible discharge settings. Where the hospital's clinical staff and the patient disagree on the appropriate discharge setting or supporting services, the disagreement will be noted in the clinical record. The state will track instances where the state's final recommendation of the discharge setting in an order for conditional release, or in a petition for a less restrictive alternative or assisted outpatient treatment, does not match the patient's preference, and shall be provided at least biannually to DRW.

5. *Stakeholder Engagement:* within 90 days the effective date of this agreement, the state will work with current and former patients, family members, advocates, community mental health and supportive housing providers, Managed Care Organizations/Behavioral Health Administrative Services Organizations, and other community system partners to evaluate and identify opportunities for productive early engagement with patients, their support network, and cross-system partners, and to develop policies, procedures, and cross-system roles that enable early engagement in discharge planning and the discharge planning process.
6. *Performance Goal:* The State will assign Peer Bridger specialists upon admission to engage with each patient. If requested by the patient, a Peer Bridger will work with patients throughout hospitalization and discharge planning process. This will be implemented in 2 months of the effective date of this agreement..
7. *Performance Goal:* Peer Bridgers will be available periodically on Treatment Malls or wards and at evening groups. This will be implemented in 2 months, or after the hospitals can safely open the Treatment Malls and provide group activities, whichever occurs last.
8. *Performance Goal:* The State will provide training to BHA and BH/ASO & MCO hospital liaison staff on all available community-based services and supports and eligibility requirements and will assure that appropriate and timely referrals are made to community-based services and supports, including to supportive housing, PACT, and vocational supports. The training content should be made available to DRW for review prior to implementation. This will be implemented in 3 months of the effective date of this agreement..
9. *Performance Goal:* The State will review existing MCO/BHASO contract language to identify areas that can improve alignment with the Policy and Performance Goals above. This will be completed in 6 months of the effective date of this agreement.
10. *Performance Goal:* The State will provide technical assistance to Supportive Housing providers to promote collaboration with legal advocacy organizations to address barriers

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to securing housing. This will be implemented in 1 month of the effective date of this agreement.

#### C. Vocational Support Services

1. At least annually, the Division of Vocational Rehabilitation (DVR) will provide training to hospital staff on the vocational rehabilitation process and services. The training will include, but is not limited to, information on the:
  - a. Purpose of the VR program;
  - b. Confidentiality of information;
  - c. Referral Procedures;
  - d. Application procedures;
  - e. Eligibility requirements;
  - f. Scope of potential VR services that may be available; and
  - g. Financial needs criteria
2. DVR will assign a vocational rehabilitation counselor liaison to each hospital to facilitate outreach activities, and to provide DVR services to eligible patients.
3. DVR and hospital staff will collaborate effectively with cross-training that builds overall expertise in providing patients with a successful pathway to education and employment.
4. Interested patients will be encouraged to apply for DVR services when they are beginning the active discharge planning process. The assigned rehabilitation counselor will take an application, determine eligibility, and provide substantial vocational counseling and guidance in order to identify a solid vocational goal. If possible, an Individualized Plan for Employment (IPE) will be developed prior to release which would then be incorporated into the BHA Western and Eastern State Hospital discharge documents.
5. Upon the patient being discharged, the assigned rehabilitation counselor will take responsibility for transferring the patient's case file to a local DVR office and will collaborate with the newly assigned VR counselor to promote individual engagement and follow through and a successful transition to the local VR office.

#### D. Education

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1. *Policy Goal:* Civil patients discharging from the state hospital are fully informed about community-based behavioral health programs and services including PACT, supportive housing, Peer Bridgers, and vocational supports.
2. *Policy Goal:* The members of the legal system working with patients discharging from the state hospital (e.g., Judiciary, Patients' Counsel, Advocacy Groups) are educated about community-based behavioral health programs and services. The State will invite community partners, including Supportive Housing and PACT providers, to conduct regular in-reach activities to share information about their services with civilly committed state hospital patients as soon as the patient's condition permits.
3. *Performance Goal:* The State will develop informational material to achieve policy Goals IV.D 1 and IV.D 2. Informational materials will include, at a minimum, information regarding PACT, Supportive Housing, state funded rental assistance, Peer Bridgers, vocational supports, and other programs for distribution to civil patients. This will be completed in 3 months of the effective date of this agreement.
4. *Performance Goal:* The State will implement periodic group education sessions (either in-person, virtually, or through recorded materials) where civil patients can learn about resources and programs in the community and for living independently, including information about the benefits of supported housing and facilitating visits. The information will be provided by individuals who are knowledgeable about community services and supports, including supportive housing. This will be implemented in 4 months of the effective date of this agreement.
5. *Performance Goal:* The State hospital Social Workers will regularly discuss/provide updated information about community services and programs with the civil patient as part of the discharge planning process (including Supportive Housing and PACT, as appropriate.) This will be implemented in 15 months of the effective date of this agreement.
6. *Performance Goal:* The State will create a Patient and Family Resource website available to the public. The website will include information about the discharge planning process, how family members can participate in the discharge planning process, and available community-based services and supports including supportive housing programs, PACT, personal care services, peer supports, vocational supports, and/or other formal and informal supports. This will be completed in 9 months of the effective date of this agreement.
7. *Performance Goal:* The State will provide periodic educational materials and trainings to the legal system (Judiciary, Patients' counsel, NJP, etc.) on the array of community

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behavioral health and long-term care services and program options available, such as Supportive Housing and PACT, including information about eligibility, description of services, limitations, etc. The training content will be made available to DRW for review prior to implementation. This will be implemented in 4 months of the effective date of this agreement.

## **V. Implementation**

### **A. Monitoring**

1. Beginning within 180 days of the execution of this agreement, the State will report quarterly to DRW on the number and percentage of persons discharged from a State Hospital civil setting who received the following services upon discharge:
  - a. Medicaid coverage
  - b. PACT services
  - c. Supportive housing services
  - d. Supported employment services
  - e. Any HCA-funded community-based mental health services
  - f. Any HCA-funded community-based SUD treatment services, among persons with an identified SUD treatment need
  - g. AL TSA or DDA in-home personal care services
  - h. AL TSA or DDA community residential services
  - i. Community Behavioral Health Rental Assistance (CBRA)
2. Reporting under Section V.A.1 will be based on available linked administrative data and will be subject to a 6-month reporting lag to allow source data to sufficiently mature. Where appropriate, percentages will be based on denominators of persons eligible for services based on their post-discharge medical coverage status.
3. The state will report biannually to DRW on the number and percentage of persons civilly discharged from the State Hospitals who received timely discharge planning. Prior to deployment of the digital discharge planning system described in IV. A. 8 (above), the state may conduct sampling to determine the number and percentage of cases in which typical discharge planning activities are timely completed.
4. The State will provide additional contextual information, such as data on civil patient census trends, to inform interpretation of trends in post-discharge utilization of services and supports.

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#### **B. Performance Measures**

1. The state hospital will refer 90% of civil patients to the MCO/BH-ASO within 3 working days of the patient being added to the active planning list.
2. The state hospital will complete an initial discharge evaluation for 80% of civil commitment patients within 14 days of admissions and 90% within 30 days of admission.
3. The state hospital will refer 90% of individuals that it identifies as clinically eligible for early engagement on the initial discharge evaluation within 30 days of admission.
4. The state hospital will refer 90% of state hospital patients to peer bridgers.
5. 90% of individuals who have been deemed clinically appropriate for supported housing services will receive information on supported housing resources and eligibility, and, if requested, will be referred to a supported housing provider.

Data on performance measures 1 through 5 will be provided to DRW biannually. The parties will confer following the first year of this agreement, and will reach agreement on subsequent additional performance measures demonstrating additional reasonable increases in the percentage of civil patients who receive timely discharge planning and who receive supported housing services upon discharge.

#### **C. Remedies**

1. *Progress Evaluation and Technical Assistance:* At the second biannual meeting and the fourth biannual meeting referenced in paragraph 5, section VI, the parties will discuss the progress the State has made in implementing this agreement. After these meetings, either party may decide unilaterally that the State will retain technical assistance. The state will seek permission to retain Client Services Mngt, P.C. or another mutually agreed upon alternative, through a sole source contract if consistent with state law at the State's expense to serve as an independent technical assistance provider to review the State's implementation progress and make recommendations for further improvements. If a sole source contract is not approved, the state will issue a procurement for this work. This section does not apply if the State provides written notice to DRW at least 30 days in advance of a scheduled meetings that it has already retained the named technical assistance provider to review the State's implementation progress and provide recommendations for further improvements. If a technical assistance provider is utilized under either of these conditions, the State will share the results of the review and

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recommendations with DRW. Nothing in this section obligates the State to retain a technical assistance provider a second time.

*Specific Case Review* The State will appoint an individual case resolution coordinator to serve as a point of contact for addressing concerns with respect to an individual patient regarding timely discharge or discharge to segregated settings. Within their federally mandated Protection and Advocacy authority, DRW may notify the coordinator or the State's counsel of concerns regarding discharge planning for specific individuals. The State will review and make diligent efforts to promptly resolve those concerns. The State will provide a written response within 7 days to identify what steps have or will be taken.

2. *Dispute Resolution* Any claim, dispute, or other matter in controversy (dispute) arising out of or related to this Agreement, or the breach, implementation, or performance thereof, shall be resolved according to the procedure set forth below:
  - a. 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.
  - b. If the Parties are unable to resolve the dispute within thirty (30) days of notice of the dispute, or such other time frame upon which the Parties mutually agree, they may engage the services of Kathleen Wareham, or another mutually agreed mediator, for the purpose of mediating a resolution to the dispute. The State will bear the cost of the mediation, unless otherwise agreed.
  - c. Any party may file an action to seek contractual remedies regarding the terms of this agreement in the Superior Courts of Thurston, Pierce, or Spokane County after participating in dispute resolution. All issues and questions concerning the construction, validity, enforcement and interpretation of this Agreement shall be governed by, and construed in accordance with, the laws of the State of Washington, without giving effect to any choice of law or conflict of law rules or provisions that would cause the application of the laws of any jurisdiction other than the State of Washington.
  - d. Specific performance of any term in this contract is not available to a specific patient or class of patients.
  - e. There are no third party beneficiaries of this contract.

**VI. General Terms**

1. Waiver of Claims DRW agrees that for the duration of this agreement it will refrain, and is estopped, from asserting state or federal Claims as an organizational plaintiff against DSHS

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and HCA with any agency or court regarding the subject of this Agreement if the State is in substantial compliance with the terms of the agreement.

2. **Implementation** The State will make reasonable efforts to request funding and other resources necessary to implement and achieve the Performance Goals under the Settlement Agreement, including requesting funds to be included in the Governor's budget.
3. **Modification** This Settlement Agreement may be modified upon the consent of the Parties.
4. **Protection and Advocacy** As the designated protection and advocacy system for the State of Washington, Disability Rights Washington shall have access authorized by the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10805 and regulations promulgated thereto, to conduct monitoring and investigations. Nothing herein shall be construed to limit DRW's federally mandated access authority.
5. **Meetings at least biannually** The parties will convene upon request by either party and at minimum on a Biannual basis to review quarterly data and progress towards meeting the Performance Goals and performance measures in this agreement.
6. **Computation of Time** Where there is a reference to a time period following a Performance Goal, the start date of the period is the day after full execution of this agreement. Any timeframe that is expressed in days is measured in business days.
7. **Duration of the Agreement.** The State will complete implementation of this Agreement no later than January 1, 2026. The Performance Goals and Performance Measures set forth in this agreement will be the sole objective measures that, when accomplished, will indicate the State of Washington is in substantial compliance with the terms of this Agreement. At any time prior to the expiration of this Agreement, the parties may mutually agree to terminate this Agreement.
8. **Waiver.** Breach of the provisions of this Agreement may be waived only by an instrument in writing executed by the waiving party. The waiver by any party of any breach of this Agreement shall not be deemed to be or construed as a waiver of any other breach, whether prior, subsequent, or contemporaneous, of this Agreement.
9. **Construction.** This Agreement has been jointly drafted and shall be construed according to the fair intent of the language as a whole and not for or against any party. None of the Parties hereto shall be considered to be the drafter of this Agreement or any provision thereof for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause the provision to be construed against the drafter thereof.

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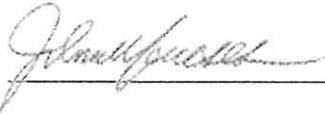
10. Further Assurances. Each of the Parties agree, without further consideration, and as part of finalizing the Settlement hereunder, that they will in good faith promptly execute and deliver such other documents and take such other actions as may be necessary to consummate the subject matter of this Agreement.
11. Changes to Applicable Laws. In the event federal or state law relevant to the terms in this Agreement change, the Parties agree to meet to discuss the affected terms, and decide whether to modify or strike the affected terms in order to reasonably leave the other provisions intact.
12. Frustration of Purpose/Force Majeure. If the State is unable to accomplish any of their obligations or meet timeframes under this Agreement due to events beyond their reasonable control (such as natural disaster, labor disputes, war, acts of God, or governmental action beyond state control), the State shall notify DRW within ten (10) business days of the date upon which the State becomes aware of the event and describe the event and its effect on performance. If performance is expected to be delayed or the event frustrates the purpose of the Agreement, the Parties shall negotiate in good faith to amend the Agreement.
13. Entire Agreement. This Agreement contains the entire agreement among the Parties relating to this Settlement. No agreements, representations, oral statements, understandings, or courses of conduct that are not expressly set forth in this Agreement shall be implied or will be binding on the Parties unless made in writing and signed by all of the Parties.
14. Counterparts. This Agreement may be executed by exchange of executed faxed or PDF signature pages, and any signature transmitted in such a manner shall be deemed an original signature. This Agreement may be executed in two or more counterparts, each of which shall be deemed to be an original, but all of which, when taken together, shall constitute one and the same instrument.
15. Binding Effect. This Agreement binds and inures to the benefit of the Parties hereto, their assigns, heirs, administrators, executors, and successors-in-interest, affiliates, benefit plans, predecessors, and transferees, and their past and present shareholders, officers, directors, agents, and employees.
16. Fees and Costs and Expenses. The State agrees to settle DRW's expenses, including attorney's fees and costs, related to the Claims in this Agreement in the amount of \$432,435 for work completed and costs incurred. The payment shall be made within thirty (30) business days following the execution of Agreement in accordance with instructions to be provided by DRW. DRW acknowledges that this is a complete and final release of such claims for DRW's expenses, including costs and fees, for this work.

**SETTLEMENT AGREEMENT-**  
**Between HCA, DSHS and DRW**

**re:** Discharge Planning for Individuals Civilly Committed at Western or Eastern State Hospital

Dated: November 29, 2022

WA DSHS

By: 

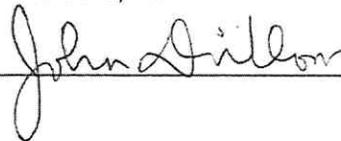
Dated: November 29, 2022

WA HCA

By: 

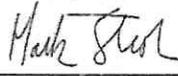
Dated: December 2, 2022

PERKINS COIE, LLP

By: 

Dated: November 30, 2022

DISABILITY RIGHTS WASHINGTON

By: 

Dated: 12/2/22

BAZELON CENTER FOR MENTAL HEALTH LAW

By: 