

Wraparound with Intensive Services (WISe)

Program, Policy, and Procedure Manual

The Washington State Wraparound with Intensive Services (WISe) Program is designed to provide comprehensive services and supports to eligible clients. The purpose of this manual is to direct the development of a sustainable service delivery system for providing intensive mental health in home and community settings to Medicaid eligible children and youth.

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Section 1: Purpose and Goals

Washington State's Wraparound with Intensive Services (WISe) is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, up to 21 years of age, (herein referred to as "youth") with complex behavioral health needs and their families. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.

The implementation of WISe will be statewide by June 30, 2018. The purpose of this manual is to create consistency across Washington State's service-delivery system for providing intensive mental health services in home and community settings to Medicaid eligible youth who screen in for these services.

The manual will assist the community mental health system and allied agencies, as well as other formal, informal, and natural supports with the identification of eligible youth and the implementation and provision of WISe. It is intended to provide an understanding of:

- The required infrastructure and expectations of WISe
- The Practice Model for the core elements of WISe, in each of the following phases:
 - Engagement
 - Assessing
 - Teaming
 - Service Planning and Implementation
 - Monitoring and Adapting
 - Transition

This manual is a living document. It will continue to be refined and revised as we learn from communities through the WISe roll out. The most current version of the manual will be posted on our Children's Behavioral Health website at: <http://www.dshs.wa.gov/dbhr/cbh-wise.shtml>.

Version 1.6 of this manual was updated at a time of multiple transitions. Referenced links, documents, and Washington Administrative Codes (WACs) are still in the process of being updated. Until future versions of the manual are released, this manual transcends any future changes to the structure of the mental health delivery system. Accordingly, any reference to the delivery system within this manual or within referenced materials is intended to include any successor entity.

OBJECTIVE:

The specific objective of this manual is to develop and successfully implement Wraparound with Intensive Services (WISe) statewide by June 30, 2018. This manual will provide guidelines to ensure consistency in the goals, principles, and the delivery of the program, as WISe becomes available over the next five years in communities across the state.

We believe implementing this program, utilizing the Washington State Children’s Behavioral Health Principles (previously named the Mental Health Principles) outlined below, will:

- Reduce the impact of mental health symptoms on youth and families, increase resiliency, and promote recovery.
- Keep youth safe, at home, and making progress in school.
- Help youth to avoid delinquency.
- Promote youth development, maximizing their potential to grow into healthy and independent adults.

The Washington State Children’s Behavioral Health Principles are outlined below. These principles guide the implementation of WISE and provide the foundation for the practice model and clinical delivery of intensive services.

[Washington State Children’s Behavioral Health Principles](#)

Washington State’s Department of Social and Health Services (DSHS) and Health Care Authority (HCA) believe that youth and families should have access to necessary services and supports in the least restrictive, most appropriate, and most effective environment possible. Washington State is committed to operating its Medicaid funded mental health system that delivers services to youth, in a manner consistent with these principles:

- **Family and Youth Voice and Choice:** Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth’s and family’s vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from the youth’s and family members’ networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based:** Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.

- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **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 youth and family, their community, and other team members.
- **Outcome-based:** Based on the youth and family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional:** A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

Section 2: Agency Infrastructure

Wraparound with Intensive Services (WISe) is a range of Medicaid-funded service components that are individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based. WISe is for youth who are experiencing mental health symptoms that disrupt or interfere with their functioning in family, school or with peers.

WISe team members demonstrate a high level of flexibility and accessibility by working at times and locations that ensure meaningful participation of family members, youth and natural supports, including evenings and weekends. WISe also provides access to crisis response 24 hours a day, seven days a week, by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan. The service array includes intensive care coordination, intensive treatment and support services, and crisis outreach services, provided in home and community settings, based on the individual's needs and the developed plan. Mental health services and supports will be available that are sufficient in intensity and scope, based on available evidence of effectiveness, and individualized to each youth and their family's unique needs. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized to each youth and family. They often include: increased safety, stabilization, school success, and community integration; and support to ensure that youth and families can live successfully in their homes and communities and make positive and informed decisions regarding their care and lives, with an avoidance of hospitalizations and out-of-home placements.

This section will outline the infrastructure requirements an agency must have in place to be eligible for consideration as a WISe provider.

Federal and State Requirements

The services provided under WISe are Medicaid services, and therefore require agencies to meet all applicable federal standards related to the provision of mental health services covered under Medicaid. Agencies interested in becoming a WISe provider must hold a current Behavioral Health Agency License, issued by the Division of Behavioral Health and Recovery (DBHR), under [Chapter 388-877 WAC](#). Agencies must also have a contract with a Behavioral Health Organization (BHO) or a Fully Integrated Managed Care Organization, (herein collectively referred to as the "Managed Care Entity(s)", or "MCEs" throughout this manual, unless otherwise specified). Additionally, agencies must be certified, or have sub-contracts or Memorandums of Understanding (MOUs) in place, to provide all of the following services under [WAC 388-877A](#):

- Individual treatment services
- Family therapy services
- Case management services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Recovery support—Peer support services

The list above is intended to direct the minimum certification requirements. If an agency provides other services, additional certification standards may apply. The monitoring of these requirements will continue to be completed by DBHR's Licensing and Certification staff. Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated Managed Care Entity (MCE), and DBHR.

WISE-Specific Requirements

Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated MCE, and DBHR according to the Quality Management Plan (see Appendix J for link).

Agencies interested in becoming a WISE provider must meet standards related to:

1. Access
2. Practice model
3. Service array
4. Staffing
5. Community oversight and cross-system collaboration
6. Documentation

Access and Practice Model (items one and two) will be discussed in detail in subsequent chapters, beginning on pages nine and 13. The requirements for items three through six in the list above are as follows.

Service Array

Agencies providing WISE must have capacity to provide a wide array of services within the agency, or through sub-contracts or an MOU. WISE agencies will provide each participating youth and his or her family with a Child and Family Team (CFT), and at a minimum, access to these services (provided in home and community settings), as described in this document, the Service Encounter Reporting Instructions (SERI) for Behavioral Health Organizations, and as described in the larger Encounter Data Reporting Guide, for Fully Integrated Managed Care Organizations:

1. Intake Evaluation
2. Intensive Care Coordination
3. Intensive Services
4. 24/7 Crisis Intervention and Stabilization Services

Mental health services offered to youth and families that are participating in WISE should typically be provided by staff employed at a WISE-qualified agency. The CFT has the responsibility to identify needs and develop the most appropriate and normalized strategies to meet these needs, including referral and coordination with other services and systems. Other needed services and supports are to be outlined in the single Cross System Care Plan (CSCP) that is developed by the CFT and will be monitored by the members of the CFT.

Note: See the WISE Service Requirements Section for further information on services.

Staffing

WISe provider agencies must have sufficient WISe qualified staff to:

- Manage the capacity-level delegated by the MCE and DBHR.
- Deliver or coordinate all medically necessary mental health services (including Psychiatric/Medical).
- Provide each youth/family served with:
 - Mental health therapies (i.e., family, individual treatment, etc.).
 - Care coordination.
 - Peer counseling through Family Partner and/or Youth Partner who are certified peer counselors, or qualify for certification.
Note: Descriptions and responsibilities for staff that provide each of these services are outlined in Appendix B.
- Provide clinical supervision to WISe-qualified staff.
- Have available to each team:
 - In-home Behavioral Aide.
 - Psychiatric consultation.
- Maintain an average caseload size of 10 or fewer participants, with a maximum of 15 at any given time, for each Care Coordinator.
 - *Note: More guidance will follow related to utilization of data to determine caseload.*
- Provide 24/7 crisis intervention (see Section 4 for details) to youth and families, preferably through staff that are known to the youth and family.
- Complete a full CANS within 30 days of the WISe screen, update the full CANS assessment every 90 days thereafter while the youth remains in WISe authorized services, and complete a full CANS again at discharge from WISe services.

Cross-System Collaboration

WISe provider agencies are required to collaborate and include other child serving system partners, as identified in the Point of Identification section of the Access Model (hereafter system partners) on CFTs, as applicable to each youth and family. The agency is to work with the youth and family and system partners to develop a single Cross System Care Plan (CSCP) for the youth and family. The CSCP can encompass the individual service plan requirements found in [WAC 388-877-0620](#) and [WAC 388-877A-0135](#), but will likely include a variety of other activities. Medicaid services must be prescribed clearly, according to Medicaid documentation standards, regardless of whether the individual service plan is incorporated into the CSCP or a separate document. Behavioral Health Organizations and Fully Integrated Managed Care Organizations will work within their local communities to invite diverse representation and establish appropriate communication channels. Section 6 describes relevant information regarding these regionally-required coordinating bodies and how they fit within the governance structure to inform and provide oversight for high-level policy-making, program planning, decision-making, and for the implementation of the T.R. Settlement Agreement.

The website link for WISE informational materials that have been developed for specific system partners, and other identified child-serving formal and informal supports, is located on Appendix I.

Documentation

WISE provider agencies must maintain the following administrative documentation, in addition to that required for Behavioral Health Agency licensing:

- Quality Management Plan
- WISE infrastructure monitoring
- Calculation used for caseload management and capacity
- Child and Family Team requirements (Cross System Care Plan {CSCP}, plan reviews, progress, revisions, CFT meeting sign-in sheets, and CFT minutes)

WISE provider agencies must maintain the following documentation for each WISE-qualified provider's personnel:

- Skill development and implementation support
- Training, recertification and competency demonstration
- Coaching
- Supervision

In addition to documentation requirements for behavioral health agencies, and compliance with Medicaid regulation, WISE provider agencies must ensure the following WISE-specific documentation can be found in each client's record:

- Completed CANS Screen, CANS Full within 30 days of the WISE screen, updated CANS Full at least every 90 days, and CANS Full again upon discharge or transition to a lower level of care.
- Cross System Care Plan (note: see Appendix H for core elements and a sample format), including revisions and updates.
 - The CSCP must address the needs found within the ISP, or could include all required elements of the Individual Service Plan (ISP) within the CSCP.
 - Expected outcomes/transition activities and transition/discharge criteria will be clearly defined in the CSCP.
- Expected outcomes/transition activities and discharge criteria.
- All necessary Releases of Information
- Safety/crisis plan.
- CFT meeting notes:
 - From the meetings that occur at least monthly
 - Notes should include a list of attendees (the youth and/or family are required to be present for a meeting to occur). Participation of young children will be decided upon by the CFT, as appropriate.
 - A record that notes were shared with all members of the CFT within a week of each meeting.

Section 3: WISE Access Protocol

This section provides uniform standards on the administrative practices and procedures for providing access to WISE and its services. WISE providers and MCEs will utilize the protocols of this section to meet requirements related to:

- The identification of youth who may qualify/benefit from WISE.
- The WISE referral process.
- The components of the WISE Screening and Intake Process.

Identification

Child-serving systems, such as agencies that fall under the auspice of the Department of Social and Health Services (DSHS)(i.e., Children’s Administration, Rehabilitation Administration, Development Disabilities Administration), Health Care Authority (HCA), school personnel, county and community providers, and Tribal service providers will be informed to assist in the identification and referral of youth who might benefit from WISE. Consideration for referral begins with youth who are Medicaid eligible, under age 21 and who have complex behavioral health needs. Other indicators to consider for a WISE referral may include, but are not limited to:

1. Youth with involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, developmental disabilities, special education, substance use disorder treatment).
2. Youth for whom restrictive services have been requested, such as psychiatric hospitalizations, residential placement or foster care placement, due to mental/behavioral health challenges.
3. Youth at risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
4. Youth who have been significantly impacted by childhood or adolescent trauma.
5. Youth prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
6. Youth with a history of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
7. Youth exhibiting risk factors such as suicidal ideation, danger to self or others, behaviors due to mental/behavioral health challenges.
8. Youth whose family requests support in meeting the youth’s mental/behavioral health challenges.

Information sheets with more detailed factors to consider are under development, and will be specific to the identified affinity groups (see Appendix I). Once developed, a link to these materials will be included in Appendix I.

Referrals

Anyone can make a referral for a WISE screen, including the youth and family. All Medicaid-eligible youth, under the age of 21, who might benefit from WISE should be referred for a WISE Screen.

A referral for a WISE screen **must** be made for Medicaid-eligible youth in the following circumstances:

1. When a youth is referred to Children’s Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS or receiving CLIP services: no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from a psychiatric hospital.
4. When a step-down request has been made from institutional or group care.
5. When a youth receives crisis intervention or stabilization services, and there are past and/or current functional indicators of need for intensive mental health services.

If a youth **is currently** receiving Medicaid mental health services from a MCE’s provider, a referral for a WISE Screen can be completed in the following ways:

- The current provider can complete the CANS screen, if they are certified in the CANS, or
- The current provider can make a referral to a WISE-contracted provider agency that will complete the CANS Screening.

If a youth **is not currently** receiving Medicaid mental health services from a MCE’s provider, a referral to WISE can be most easily completed by contacting the WISE referral contacts for each county, found in the following link: <http://www.dshs.wa.gov/dbhr/cbh-wise.shtml>. In addition, referrals for a WISE screen may be made directly to a MCE or any MCE provider.

WISE Screening and Intake

All referrals for a WISE screen to the MCE, any MCE provider or other WISE referral contact, should result in a WISE screening, regardless of referral source. A WISE screen must be offered within 10 working days of receiving a referral.

All WISE screens will include:

1. Information gathering that utilizes the information provided by the referent (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or its service delivery.
2. Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled out the full CANS assessment. The CANS screen must be completed by a CANS-certified screener (<https://canstraining.com>).

*Note: Training materials, related to how to enter CANS into BHAS can be found at: <https://www.wa-bhas.org>.

**Note: For children age 4 and younger, WISE providers will use the CANS 0-4.

3. Entering the CANS Screen into the Behavioral Health Assessment System (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISE.

For any youth who is **not currently enrolled in a MCE**, for behavioral health services, in addition to the WISE screen, the following intake eligibility determinations must be made:

1. Establish Medicaid eligibility. WISE is a Medicaid program and can only serve youth who are under 21 and covered by Medicaid.
2. Establish that the youth meets qualifying criteria under the MCE's contracted standards. All youth who meet the CANS algorithm will be determined to meet WISE level of care.

All youth, ages 5-20, who meet the CANS algorithm and are eligible for mental health services through an MCE will be offered entry to WISE (or WISE-like services until full implementation in June 2018). For those children under 5 years of age, this decision shall be made based on clinical judgment and in accordance with authorization standards and protocols established in each MCE.

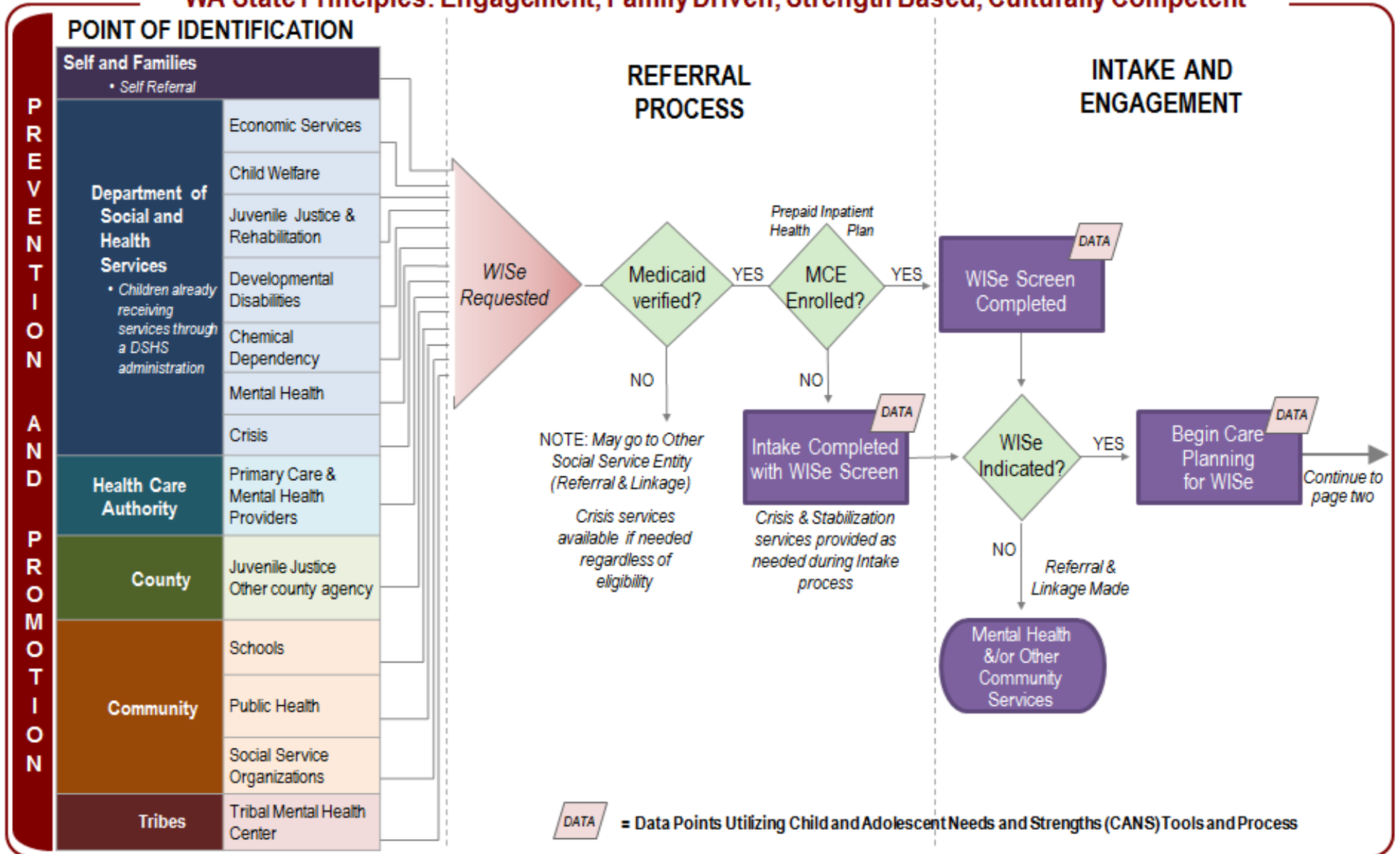
At this point, initial engagement to begin planning, facilitating, and coordinating services will occur. Initial engagement is typically done by a Care Coordinator and Youth Partner and/or Family Partner (depending on the youth and family's preference). WISE may be declined or accepted by any youth (over the age of consent) and/or a legal decision-maker for each youth.

Youth who are not enrolled in a MCE and do not meet intake eligibility requirements will be referred to other community resources, including their health care plan for mental health services. All youth receiving or eligible for MCE services, but who do not meet the CANS algorithm, will be referred to and offered other services.

Note: Per existing requirements, MCEs and/or WISE providers are responsible for providing information and access to crisis services to the youth and/or family, while they await the WISE screen and intake.

Access Model to Wraparound with Intensive Services (WISe)

WA State Principles: Engagement, Family Driven, Strength Based, Culturally Competent



Section 4: WISE Service Requirements

What is Different about WISE?

Primary setting

WISE services are not intended to be facility-based. Instead, WISE services are provided in the home and in community locations, and at times and locations that ensure meaningful participation of family members, youth and natural supports. WISE is targeted to youth and families with intensive and complex mental health needs. Assessment, treatment and support services are provided in the youth and family's natural setting, where needs and challenges present themselves (such as the home, school and community).

Focus on Youth and Family Voice Utilizing a Strength-based Approach

Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Supports and services are delivered in a way that honors the value of family-driven and youth-guided care. Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

Flexible and Creative Services

WISE is intended to be provided in creative and flexible ways. Those served through WISE tend to come into services with complex needs and involved histories. This approach must provide support differently, as many of the youth and families served have found traditional behavioral health care unable to meet their behavioral health needs. Others remain at risk of more restrictive care, in spite of having received effective traditional mental health services. This circumstance requires the WISE team to deliver purposeful support without delay, with a "take action" mentality, moving from a 'compliance practice model' to a needs-driven intensive and flexible service-provision approach.

Involvement of Family Partners and Youth Partners (Certified Peer Counselors) is Essential

Family Partners and Youth Partners who have lived experience must be meaningfully involved in the provision of WISE. The Family Partner and/or Youth Partner must be an equal team member with the Care Coordinator and Mental Health Clinician. The Youth Partner and/or Family Partner meet with the youth and/or family on a regular basis to provide support in addressing the needs of the youth and family, as defined in the Cross System Care Plan (CSCP). Youth Partners and Family Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS. See Appendix B for more detailed information related to the role of Family Partner and Youth Partner.

WISe assists youth and families in moving toward:

1. Increased optimism and hope that a better life is possible
2. An enhanced sense of the power gained by family members to influence the direction, quality and outcomes of their lives
3. Increased clarity regarding realistic possibilities for a better life
4. The development of a realistic family vision as evidenced by the family's ability to create statements which accurately reflect the better life they prefer and believe is possible

[Providing Intensive Care Coordination and Services Using a Wraparound Model](#)

WISe will be implemented through the support of a statewide system of care to the fullest extent feasible. It is delivered using a wraparound approach, to improve collaboration among child-serving agencies. It focuses on the individual strengths and needs of each participating youth and family.

Once authorized by the MCE for WISe, youth and families participating will have access to a wide array of services and supports to address their specifically identified needs. Although the intensive care coordination and services available under WISe are funded by Medicaid (see appendix F for links to Reporting Instructions), the program's model is intended to draw in other resources through teaming with both formal (e.g., service providers and representatives of schools and child-serving agencies) and informal (e.g., family, friends, and community members) supports and programs that are offered in a variety of settings (home, community, school, etc.).

[Intensive Care Coordination](#)

Intensive Care Coordination is a service that facilitates assessment of, care planning for, and coordination and monitoring of services and supports, through the phases below.

While WISe is a team-based approach, it is typically the role of a Care Coordinator to facilitate and coordinate services and supports. Through each of the following phases (adapted from the nationally recognized Wraparound phases) other WISe Practitioners* should be partnering to most effectively meet the needs of the youth and family.

** WISe Practitioners– a term used to describe the collection of WISe-certified staff roles, required for each team (the Care Coordinator, the Family Partner and/or Youth Partner, and the Mental Health Clinician)*

The key to successful Intensive Care Coordination is also holding central to a key wraparound principle that “Needs are not Services.”

Engagement

Overview: During this phase, the groundwork for trust and shared vision among the youth, family, and WISe team members is established, so people are prepared to come to meetings and collaborate. The tone is set for teamwork and team interactions that are

consistent with the Washington State Children’s Behavioral Health Principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase begins to shift the youth and family’s orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. This phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as soon as possible.

When a youth is coming into WISE from another program or placement (i.e., CLIP, BRS, an inpatient hospitalization, or a juvenile justice facility), this phase is especially important, prior to discharge, to assist in successfully transitioning youth back into to the community.

Goals/Purpose:

- To **address pressing needs and concerns**, prior to forming a Child and Family Team when necessary, so the youth, family and team can give their attention to the WISE process
- To explore the results of the CANS and the individual’s and family’s strengths, needs, culture, and vision, and develop a youth and family narrative that will serve as the starting point for planning
- To orient the family and youth to the WISE process
- To gain the participation of team members who care about and can aid the youth and family, and to set the stage for their active and collaborative participation on the team
- To ensure that the necessary procedures are undertaken so the team is prepared to begin an effective WISE process

Essential Steps

- The WISE Practitioner(s) meet with the youth and family to explain the WISE process, and how it differs from traditional care.
- The WISE Practitioner(s) discuss with the youth and family the events, circumstances, and moments that brought the youth and family to WISE.
- The WISE Practitioner(s) obtain the youth and family perspective on where they are presently (including listening for both needs and strengths), and where they would like to go in the future.
- The WISE Practitioner(s) discuss the youth’s and family’s view of crises, and develops a written plan to stabilize dangerous or harmful situations immediately.
- The WISE Practitioner(s) ensure the youth and family understand any system mandates (if applicable) and ethical issues.

Note: *For services under this phase of the intervention to be Medicaid compliant, an initial Individual Service Plan, under the direction of a Mental Health Professional, must be in place that directs the ongoing assessment and team development of services.*

Assessing

Overview: In this continuation of the engagement phase, the WISE Practitioners expands the discussion with the youth and family to add context to their involvement in WISE. The WISE Practitioners helps the youth and family to understand that their input is central to the WISE process, and that their preferences at all phases of care planning and implementation will be prioritized. This includes helping the youth and family understand and incorporate any legal mandates into their plan. The WISE Practitioners also listens to the youth and family perspective for information about the youth's and family's strengths, needs, culture, and natural supports. A WISE Practitioner reviews the CANS results with the youth and family and determines how to present this information to the team.

Goals/Purpose:

- To continue meeting and engaging to further understand the youth and family's story and context
- To begin initial documentation of strengths, needs, and natural supports (including CANS scores)
- To complete a youth- and family-approved narrative

Essential Steps

- The WISE Practitioner(s) complete a strengths discovery and a list of strengths for all family members.
- The WISE Practitioner(s) discuss and lists existing and potential natural supports.
- The WISE Practitioner(s) complete a list of potential team members.
- The WISE Practitioner(s) summarize the youth and family context, strengths, needs, vision for the future, and supports.
- The WISE Practitioner(s) determine with the youth and family how the CANS information will be provided to the team.

Teaming

Overview: In this part of engagement, the WISE Practitioners help the youth and family to reach out to persons who can commit to being part of the WISE Child and Family Team (CFT). The team is essential to successful planning and intervention.

Goals/Purpose:

- To engage other team members
- To explain the team process and elicit commitment to the process from team members
- To make necessary meeting arrangements

Essential Steps:

- The WISE Practitioner(s) explain WISE to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.
- The CFT will include the youth, parents/caregivers (see definitions in Appendix B), relevant family members, and natural and community supports.
- The CFT will be expected to meet with sufficient regularity (every 30 calendar days, at a minimum), as indicated in the CSCP, to monitor and promote progress on goals and maintain clear and coordinated communication.
- The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP. A WISE Practitioner guides the team in evaluating whether selected strategies are promoting improved health and wellness for the youth and successfully assisting in meeting the youth and family's identified needs.
- The CFT works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and family
- The CFT has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- The WISE Practitioner(s) are expected to check in with team members on progress made on assigned tasks between meetings.
- The WISE Practitioner(s) set a time, date and location for the team meeting.

Service Planning and Implementation

*Overview: During this phase, team trust and mutual respect are built while the team creates an initial Cross System Care Plan using a high-quality planning process that reflects the Washington State Children's Behavioral Health Principles. In particular, youth and family should feel that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of success. The team also reviews and expands the crisis plan to reflect **proactive** and **graduated** strategies to prevent crises, or to respond to them in the most effective and least restrictive manner. This phase should be completed during one or two meetings that take place within 1-2 weeks. The rapid time frame is intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.*

Goals/Purpose:

- To create a CSCP using a facilitated process that elicits multiple perspectives and builds trust and shared vision among team members, with an ever present focus that the youth and family drive the plan
- To base care planning in relationship to high needs and identified strengths, as indicated on the CANS
- To establish a Team Mission that guides the planning direction and builds cohesion in the work of the team members and empowers the youth and their family

- To build a set of prioritized needs, including the strategies to meet them, and to determine expected outcomes
- To identify team tasks and roles, and document commitments and timelines
- To establish ground rules to guide team meetings
- To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan

Essential Steps:

- The WISE Practitioner(s) meet with the youth and family and develops a list of possible needs of the family prior to the team meeting, based on the results of the CANS assessment.
- The WISE Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family’s vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISE.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT determines the intended outcomes that will transpire when the needs are met.
- The CFT brainstorms strategies to meet these needs, and then prioritizes strategies for each need.
- CFT members agree upon assignments, or action steps, around implementing the strategies.
- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.

Note: See the Cross System Care Plan example in Appendix G.

Monitoring and Adapting

Overview: During this phase, the CSCP is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented; all the while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team’s mission is achieved and WISE is no longer needed.

Goals/Purpose:

- To implement the CSCP, monitor completion of action steps, strategies, success in meeting needs, and achieving outcomes
- To use a facilitated team process to ensure that the plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies
- To maintain awareness of team members’ satisfaction and “buy-in” to the process, and take steps to maintain or build team cohesiveness and trust

Essential Steps:

- The CFT continues to meet at a minimum of every 30 calendar days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The CFT adjusts strategies to meet changes in the needs and outcomes. The team adds, subtracts and modifies strategies to create the most effective mix of services and supports.
- The CFT evaluates whether there is progress towards the designated outcomes. The team adjusts the outcomes to guide next steps.
- The CFT adds members and strives to create a mix of formal, informal, and natural supports.
- The CFT celebrates successes and adds to strengths as they are identified.
- Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
- The WISE Practitioner(s) maintain ongoing communication outside of the team meetings to best monitor “buy-in”, and to ensure that all members’ perspectives are heard.

Intensive Services Provided in Home and Community Settings:

Intensive services (“direct services”) provided in home and community-based settings are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a youth's functioning. Interventions are aimed at promoting health and wellness and helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community.

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health condition produces impaired functioning (including family life, community life, education, vocation, and independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the youth's ability to live and participate in the community and to function independently by building social, communication, behavioral, and basic living skills. WISE Practitioners should engage the youth in home and community activities where the youth has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service.

Direct services include, but are not limited to:

- Educating the youth's family about the mental health challenges the youth is experiencing, and how to effectively support the youth.
- In-home functional behavioral assessment.
- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies, and in-home behavioral aides who assist in implementing the behavior plan, monitor its effectiveness, and report on the plan's

effectiveness to clinical professionals.

- Therapeutic services delivered in the youth’s home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Family Functional Therapy, etc.). These services are designed to:
 - Improve self-care, by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others.
 - Improve self-management of symptoms including self-administration of medications.
 - Improve social functioning by addressing social skills deficits and anger management.
 - Reduce negative effects of past trauma, using evidence-/research- based approaches.
 - Reduce negative impact of mental health disorders, such as depression and anxiety, through use of evidence-/research- based approaches.
 - Support the development and maintenance of social support networks and the use of community resources.
 - Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job.
 - Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community.
 - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

Settings: Direct services will be provided in any setting where the youth is naturally located, including the home, schools, recreational settings, childcare centers, and other community settings wherever and whenever needed, including in evenings and on weekends.

Availability: Direct services will be available in the amount, duration, and scope necessary to address the medically necessary identified needs.

Providers: Non-clinical direct services are typically provided by paraprofessionals under clinical supervision. Peers, including Family Partner and/or Youth Partners, may provide direct services. Clinical treatment services are provided by a qualified clinician, rather than a paraprofessional. Paraprofessionals and Family Partner and/or Youth Partners may provide a follow-on “care extension” role for clinical services (e.g., to provide support to caregivers’ efforts to manage behavior, support to youths’ skill building to develop emotional regulation skills, etc.).

Authorization: The full array of WISE services may be provided, as medically necessary, once WISE is authorized by the MCE.

Crisis Planning and Delivery

Crisis Planning

Effective crisis planning is a critical component of an effective care plan. A Crisis Plan includes the following elements:

- Crisis identification and prevention steps, including CFT member's roles related to proactive interventions to minimize the occurrence and severity of crises.
- Crisis response actions using a tiered approach to address the severity level of the crisis situation.
- Clear behavioral benchmarks that change over time to reflect progress, changing capacities and changes in the youth/family's expectations.
- A post-crisis plan for evaluating the management of the crisis and overall effectiveness of the plan.

Services include:

- Crisis planning that, based on youth's history and needs:
 - Anticipates the types of crises that may occur.
 - Identifies potential precipitating events and methods to reduce or eliminate.
 - Establishes individualized responsive strategies by caregivers and members of the youth's team to minimize crisis and ensure safety.
- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions.
- Referral and coordination with:
 - Services and supports necessary to continue stabilization or prevent future crises from occurring.
 - Any current providers and team members including a care coordinator, clinicians, youth partner, family partner, family members, primary care practitioners, or school personnel.
- Post-crisis follow-up services (stabilization services) provided periodically to:
 - Ensure continued safety and delivery of services necessary to prevent future crises.
 - Coordinate services between the out-of-home provider (if the youth is placed out of home) and the youth's treatment team to facilitate a plan for rapid return home.
- Tools and resources available to manage potential risks.

Crisis Delivery

Crisis services include crisis planning and prevention services, telephone support, as well as face-to-face interventions that support the youth in the community.

Settings: WISE crisis services are typically provided at the location where the crisis occurs, including the home or any other setting where the youth is naturally located, including schools, recreational settings, childcare centers, and other community settings.

Availability: WISE mobile crisis and stabilization services are available 24 hours a day, 7 days a week, 365 days a year.

Providers: Each WISE provider agency must have capacity to respond to destabilizing events whenever the need arises. Individuals who know the youth and family's needs and circumstances, as well as their current crisis plan, will respond to the crisis episode and are preferably drawn from the team. Crisis responders may partner with others outside the team if necessary, and when it is written into the crisis plan.

Transition

Overview *During this phase, plans are made by the team for a purposeful transition out of WISE services, to a mix of formal and natural supports in the community. The focus on transition is continual during the WISE process, and the preparation for transition is apparent even during the initial engagement activities.*

Goals/Purpose:

- To plan a purposeful transition out of WISE in a way that is consistent with the Principles, and that supports the youth and family in maintaining the positive outcomes achieved in the WISE process
- To ensure that the cessation of WISE is conducted in a way that celebrates successes and frames transition proactively and positively
- To ensure that the family is continuing to experience success after WISE and to provide support if necessary

Essential Steps:

- The CFT creates strategies within the CSCP for a purposeful exit out of WISE to a mix of possible formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). At the same time, it is important to note that focus on transition is continual during the WISE process, and the preparation for transition is apparent even during the initial engagement activities.
- The CFT creates a post-WISE crisis plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-WISE crisis resources.
- New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-WISE participation with the team/youth and family. CFT meetings reduce in frequency and ultimately cease.
- The WISE Practitioner(s) guide the CFT in creating a document that describes the strengths of the youth, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. The CFT prepares/reviews necessary final reports (e.g., to court or participating providers).

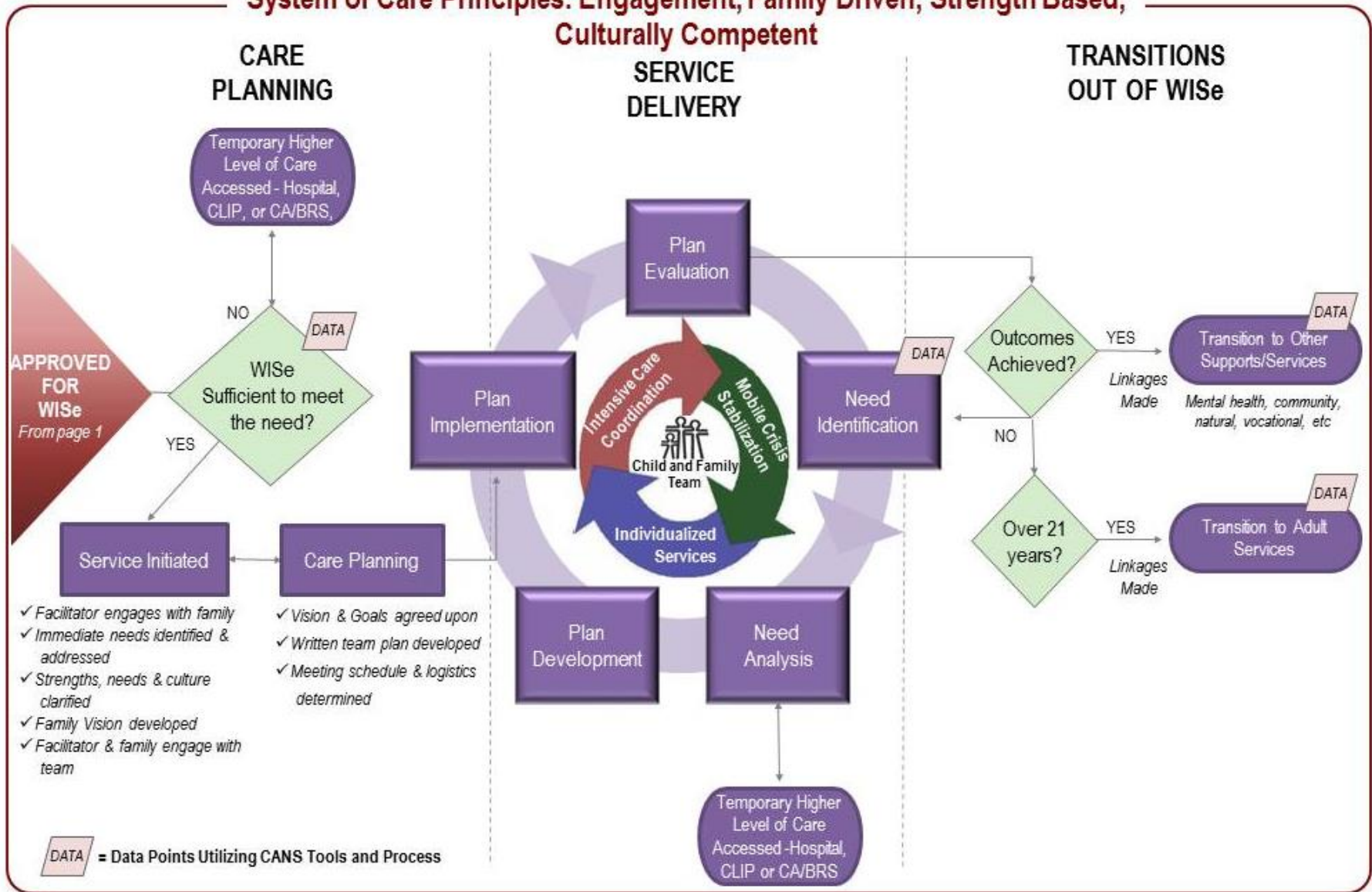
- The CFT is encouraged to create and/or participate in a culturally appropriate “commencement” celebration that is meaningful, to the youth, family, and team, and that recognizes their accomplishments.

CFTs use the CANS to monitor for an increase of strengths and a reduction of needs. The CFT, using clinical judgment and supervision, will determine the beginning of the transition window, and make preparations for the youth and family to transition out of WISE. The timing of transition is determined by the CFT and outlined in the CSCP. Up to six months are allowed under the WISE model. Upon discharge from WISE, a full CANS (coded as discharge) must be completed and entered into BHAS.

Note: *When there is sufficient CANS data within BHAS, the Department will examine the development and use of a Reliability Change Index to inform the CFT as to when it may be appropriate for a youth to begin transitioning out of WISE.*

Access Model to Wraparound with Intensive Services (WISe)

System of Care Principles: Engagement, Family Driven, Strength Based, Culturally Competent



Section 5: Client Rights

Decisions and Dispute Resolution

This section is intended to explain the decision-making and appeal procedures for individuals seeking or receiving WISE services. This section of this manual does not alter any Medicaid or due process rights contained in state or federal law.

Reaching Consensus on a CFT

Youth participating in WISE are entitled to any services on the Medicaid mental health service array that are necessary to correct or ameliorate a mental health condition. These include services needed to build on strengths that reduce, eliminate, or improve a mental health condition, as well as services needed to prevent the condition from worsening.

CFT members should use the WISE planning model described in Section 4 and the Principles when developing the Cross System Care Plan to reach consensus on the services and supports necessary to reach the youth's best possible functional level. The team should also adhere to the needs and strengths identified with the CANS and utilize the preferred strategies expressed by the youth and family. Although the CANS assessment is not the sole measure of individual functioning, the CANS assessment will be utilized to evaluate the progress of the youth in reaching his or her best possible functional level.

The CFT should attempt to reach consensus about what services and supports should be provided, when to increase or reduce services and supports in frequency or amount, and when to terminate services. If there is disagreement among CFT members during the care planning process, the WISE Practitioners should help build agreement among the team to develop a plan, for a specified period of time. The impact of the plan can be assessed and monitored by the CFT and adjusted as necessary.

If the CFT **can reach** agreement on a plan:

- The CFT should meet again after a specified timeframe has passed.
- The CFT should look at the outcomes in relation to the services that were provided.
- Using the decision-making guidelines described above, paying particular attention to the needs and preferences of the youth and parent(s)/guardian(s), the care coordinator should help the CFT determine whether they are able to reach a consensus on continuing with the services or whether to make changes.

If the CFT **cannot reach** agreement on services to be provided on an interim basis, or whether interim services should continue, the:

- Care Coordinator should ensure the youth and family is aware of how to use the grievance process to notify the MCE of any disagreements they have with specific mental health treatment recommendations made during the care planning process.

- The team will invite agency administrative or supervisory staff to the next CFT meeting to assist in finding resolution to the dispute. This process may escalate up the chain of authority until consensus is reached on the matter. All attempts at finding a solution to a grievance should be made at the lowest level possible.

[Right to Appeal a Denial, Termination, Reduction, or Suspension of Services.](#)

The MCE and/or provider agency must provide the youth and/or family with a written Notice of Action advising them of their right to request an appeal and to obtain an administrative fair hearing when:

- An individual is screened for WISE and not found to need that level of care, or assessed and found no longer eligible for WISE.
- An individual participating in WISE indicates to the MCE that there is disagreement with treatment plan recommendations found in the Individual Service Plan, made during the care planning process.
- The MCE and/or agency denies¹, terminates², or reduces³ or suspends⁴ the authorization of services to the youth and family that are included in the Medicaid mental health service array and recommended by the CFT in the Cross System Care Plan.

These rights are further explained in the [Washington Medicaid Behavioral Health Benefits Booklet](#), WAC 388-877A-0400 to 0460 for BHOs, and in WAC 182-538 for Fully Integrated Managed Care Organizations.

[Types of Appeals.](#)

Appeals are sent to the MCE. There are two types of appeals a youth or family member/caregiver can file to challenge a denial, termination, reduction or suspension of services: a *standard* or *expedited* appeal. An appeal must be filed within 90 calendar days from the date on the notice of action. A youth, family member/caregiver or mental health care provider or other authorized representative acting on the individual’s behalf can ask for either type of appeal.

- **Standard (decision within 45 calendar days):** For a standard appeal, a decision must be issued by the MCE no later than 45 days after the appeal is filed. The MCE may extend this time by up to 14 days based on a request an extension.

¹ A “**denial**” is the decision not to offer an intake or a decision by the Managed Care Entity (MCE), or their formal designee, or not to authorize covered medically necessary Medicaid mental health services.

² A “**termination**” is a decision by a MCE, or their formal designee, to stop the previously authorized covered Medicaid mental health services. A decision by a provider to stop or change a covered service (in the Individualized Service Plan) solely based on clinical judgment is not a termination.

³ A “**reduction**” of services is the decision by a MCE to decrease the amount duration or scope of previously authorized covered Medicaid mental health services. The decision by a provider to decrease or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a reduction.

⁴ A “**suspension**” of services is the decision by a RSN, or their formal designee, to temporarily stop previously authorized covered Medicaid mental health services. The decision by a provider to temporarily stop or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a suspension.

- **Expedited (decision within 3 working days)**: An expedited appeal is available to a youth or family member, or their mental health care provider who believes that the youth's life, health or major ability to function could be seriously harmed by waiting for a standard appeal. An expedited appeal must be decided no later than 3 working days after the appeal request.
 - If the mental health care provider asks for an expedited appeal, or supports the youth or family in asking for one, and indicates that waiting 45 days could seriously harm the youth's health, the MCE will automatically grant an expedited appeal.
 - If a youth or family member asks for an expedited appeal without support from their mental health care provider, the MCE will decide if the youth's health requires one. If the MCE does not agree with the request, the state will decide the appeal within 45 days.

Process for Filing an Appeal and a Fair Hearing

At this stage, there are two levels:

- **Level 1**: An appeal is filed with the MCE, and
- **Level 2**: The State Medicaid Fair Hearing. When an appeal is filed, someone from the MCE who was not involved in the initial decision will review the appeal and provide a written decision within 45 days, unless an extension has been requested. After the MCE makes a decision about the appeal, if the decision is unfavorable to the youth or family, he/she/they may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271).

In order to request a fair hearing, a youth or family member must first use either the grievance process (described below) or the appeal process and receive a decision from the MCE. If the decision is unfavorable, a fair hearing must be requested within 90 calendar days after the MCE issues its decision. A youth or family member may also obtain a state fair hearing if:

- The MCE did not provide a written response within the allowed time frames; or
- There has been a violation of WA State Department of Social and Health Services rules.

How to Request a Hearing:

For a **standard hearing**, the youth, a family member, their mental health provider, authorized representative, or an Ombuds, should mail a written appeal to the address below. A verbal request can be made but it must be followed in writing.

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 98504

For an **expedited hearing**, the youth, a family member, their mental health provider, authorized representative, or an Ombuds should contact the Office of Administrative Hearings by telephone at the numbers (listed above).

Continuing Services During the Appeal

If a youth is currently receiving services, his or her services will be continued during the appeal process and fair hearing when:

1. The appeal or fair hearing request is filed within 10 calendar days from the date the notice of action is mailed;
2. The appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services; and
3. The youth or family asks for continuing services.

Grievances on Other Issues

A youth or family member can file a complaint on any matter with which they are dissatisfied. This is called a “grievance.” Such a grievance is used by an individual or their representative to express dissatisfaction in person, orally, or in writing about any matter other than an action to deny, terminate, reduce or suspend services. If the grievance is filed first with the provider agency and the agency's written decision is not favorable to the individual, the individual may then choose to file the grievance with the MCE. If the MCE's written decision is not favorable to the individual, the individual can request an appeal or go straight to an administrative hearing.

Help for Youth, Families, and Caregivers

If youth, families, or caregivers request help with filing an appeal or grievance, they should be referred to the Regional mental health Ombuds.

Below is a list of additional legal or mental health advocates where they may be referred:

TeamChild
(206) 322-2444 (Headquarters)
<http://www.teamchild.org>

Northwest Justice Project
1-888-201-1014

Disability Rights Washington
1-800-562-2702 (ask for a “Technical Assistance” appointment)

Section 6: Governance and Coordination of System Partners

The Settlement Agreement for *T.R. vs. Quigley and Teeter* states that Washington State will “maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders,” as a central mechanism for ensuring success of settlement agreement implementation, as well as overseeing implementation of Wraparound with Intensive Services (WISe).

It must be recognized that MCEs and WISe qualified providers maintain certain authorities and obligations under Medicaid rules. MCEs maintain risk-bearing responsibility for Medicaid funded mental health services, including managing access and authorizations for services and/or levels of care. Community mental health agencies, under contract with MCEs, retain responsibility for the coding and documentation of services. These obligations cannot be compromised through the interests of a community collaborative structure.

The overarching responsibility of the Governance Structure is to provide for:

- Adherence to the Settlement Agreement among constituencies.
- Steady progress in implementing agreed-upon commitments, practice improvements and quality oversight.
- Meaningful partnerships with families and youth.
- Effective use of data to inform progress in achieving cross-system outcomes.
- Appropriate interface with the State Legislature and key advocates.
- Sustaining a shared investment and liability, i.e. vision, fiscal support, and empowered leadership for system improvements.

WISe is intended to operationalize the system of care (SOC) values in service delivery to a specific class of children, youth, and their families with complex behavioral health needs. To be effective, coordination of such programmatic and system efforts by stakeholders, including youth, families, and system partners, will require structures and functions at the state, regional, and local levels. The system of care concept emphasizes the importance of local control and ownership of the system. The more “local” a system is, the more likely it will reflect community strengths, needs, values, and day-to-day realities.

Effective system building requires a partnership between state and local stakeholders to clarify and address the ways in which state policies and practices (e.g., regulations, funding, reporting requirements) can be strengthened or altered to support local systems of care. When the partnership is effective, system builders at both levels view themselves as part of the same system-building team.

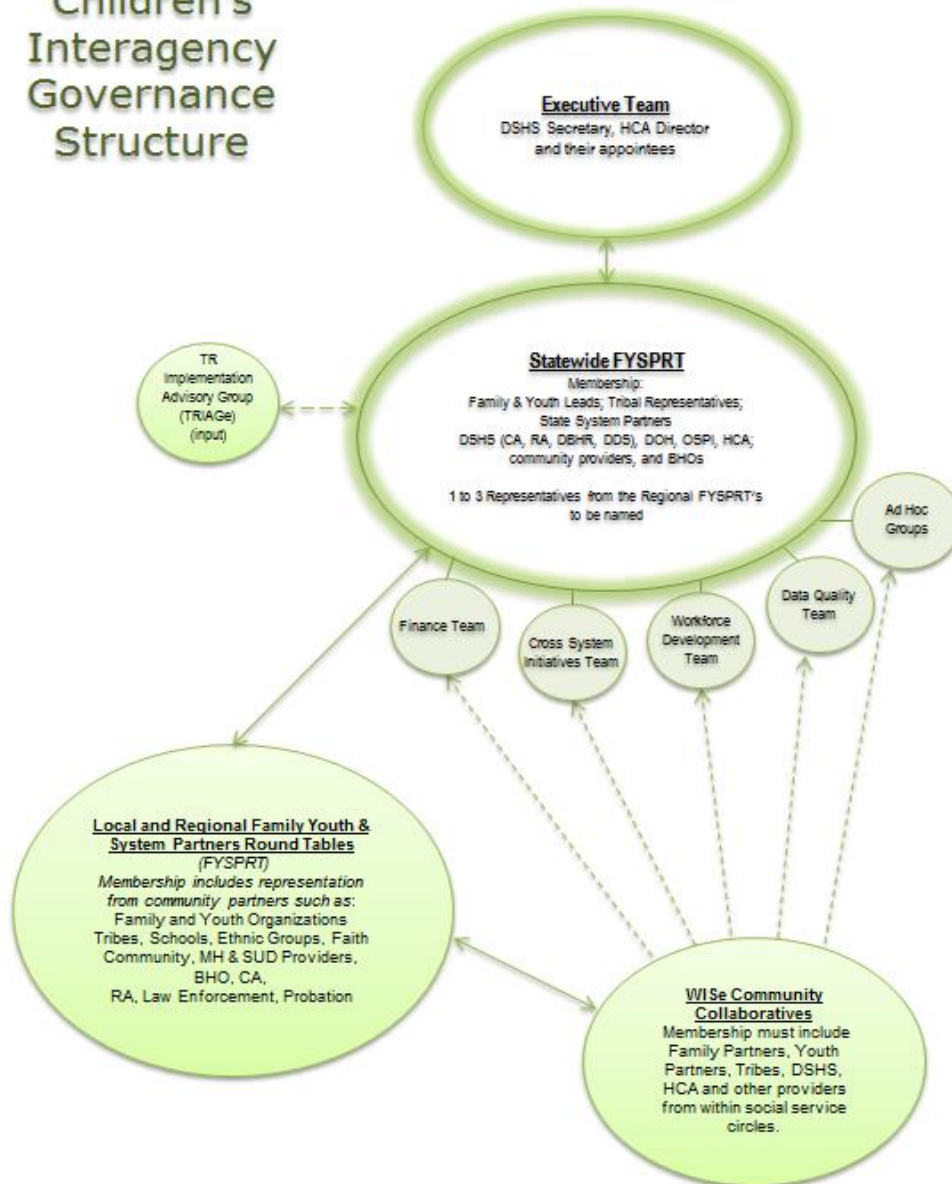
Governance and cross-system collaboration will be essential to ensure:

- Collaboration and coordination of care for putative Class members.
- Participation by local and regional representatives in Child and Family Teams (CFTs) for youth who are enrolled in WISe and served by multiple child-serving systems.

- Coordination of funding sources, to the extent permissible by the state legislature and federal law, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and establish systems to achieve sustainability of WISE.
- The development and provision of cross-system training and technical assistance.
- The development of data-informed quality improvement processes.
- Full representation and participation of family and youth in all aspects of policy development and decision-making for WISE.

The figure below describes the system structures and the functions for which they will be responsible.

Children's Interagency Governance Structure



Updated 4/1/2016

Local Coordination

As described in earlier sections of this manual, implementation of WISE and the provision of WISE will be managed by “Qualified WISE providers,” provider agencies who hold contracts with one or more MCE that is responsible for the provision of behavioral health services to youth with serious and complex needs. However, given the need for cross-agency coordination and collaboration (as well as comprehensive and holistic care plans that include an array of formal and informal supports and strategies), on behalf of youth who often have multi-system involvement, the MCEs will define the relevant, geographically defined region(s) or community(ies), and convene a local Community Collaborative for local implementation and oversight.

Community Collaboratives

Community Collaboratives need to have youth, family and system partner membership. Once a geographically defined area for WISE implementation and oversight is established, the MCE that seeks to build WISE capacity has choices in establishing the collaborative structure. These options include:

- ***Finding an existing collaborative body.*** Many communities may already have collaborative structures in place that can be tapped into for building cross-community support for local WISE implementation. Linking with an existing collaborative structure may be more efficient and effective.
- ***Creating a new collaborative body.*** Existing collaborative structures may not have the right mix of participation, decision-making processes or focus to be appropriate for WISE. In this case, a collaborative body can be established that will provide a platform for launching WISE locally.

Characteristics and Functions of WISE Community Collaboratives

- ***A representative group of stakeholders who are able to collectively take responsibility for WISE oversight.*** Some steps in WISE implementation are non-negotiable. These include the participation of families, youth, DSHS, HCA, Tribes and other system providers. Other participants are critical but should be tailored to the strengths, needs and context of the community.
- ***Relevant expertise with representatives who are able to participate in decision making.*** WISE Community Collaboratives should include a range of representatives from within social service circles, and should also include representatives with a range of perspectives outside of those circles.
- ***Efficiency of effort.*** Keeping the collaborative body together requires attention to efficiency. Be mindful of people’s time spent in meetings, and the relevance of the issues and decisions considered. Decisions put in front of the group should be decisions that group members are authorized to make; it is also important to remember that everyone wants to feel useful.
- ***Match structures to meet the purpose.*** Effective implementation and oversight of WISE will require a blend of structure and participation. WISE represents change at the practice or direct family level, while concurrently forcing change at the management and system

levels. Decisions about how to implement the right-sized partnership structure must be made. Some communities develop very simple structures in which mid-managers meet twice monthly for the purposes of reviewing data and conducting open discussion about challenges. Other communities will develop more complex structures that entail multiple levels of participation (managers, administrators, practitioners, supervisors, families and staff types) that address the mechanical aspects of WISE but also include fairly ambitious system change and improvement activities.

Roles and Functions of Community Collaboratives

Although there is flexibility in the way in which local WISE efforts can be monitored, the Community Collaborative must collectively oversee a range of specific implementation factors, including:

1. ***Convening local child-serving agencies, providers, youth and families.*** The Community Collaborative brings regional and local agency representatives together with youth and families to oversee issues that may include (but not be limited to):
 - a. Ensuring that local/regional agency staff understand expectations around **participation on CFTs**, and that for WISE youth, a single, coordinated, **Cross System Care Plan** is the basis for holistic and comprehensive planning and implementation across systems.
 - b. Ensuring that agency staff who participates on CFTs will do so in a manner that is in keeping with Washington State CMH Principles (See Section 1.).
 - c. Ensuring expectations and policies for screening, referral, assessment and enrollment in WISE are followed.
 - d. Sharing of data/information.
 - e. Contributions of agency-specific resources to the WISE participants.
 - f. Identification of cross system partners that must participate in WISE trainings and workforce development efforts.
2. ***Developing local or regional communications*** that help community members, including local families understand and refer to WISE in their community.
3. ***Referral, enrollment and assignment.*** The MCE must ensure that families and other stakeholders have a clear pathway to enter WISE. This includes ensuring local referents understand referral procedures and enrollment criteria, ensuring there are adequate certified CANS screeners, setting a process to ensure that families are gaining access to WISE in a timely fashion, and ensuring that families are matched to qualified WISE Providers. How youth are assigned a WISE provider is ultimately a MCE's responsibility, however, the local Community Collaborative should have an oversight, quality assurance, and problem-solving role.
4. ***Resource development and provider network management.*** The MCE and WISE provider agency will work with the Community Collaborative to evaluate the sufficiency of the community resources on an ongoing basis and fill the gaps as appropriate. The Community Collaborative is expected to include and work in partnership with local/regional Children's Administration, Juvenile Justice and Rehabilitation Administration, Developmental Disabilities Administration, school systems, faith-based organizations, community representatives, and other natural supports to develop strong, positive working

relationships to ensure the array of services and supports is adequately accessible and of high quality. Network sufficiency considerations also include geographic sufficiency, an adequate array of services in home and community settings, culturally and linguistically diverse providers, substance abuse treatment providers, and providers capable of offering Evidence-Based Practices.

5. ***Ensuring adequacy of family and youth participation in WISE at all levels (i.e., Policy, Management, and Service).*** Youth and family members who have lived experienced (1. caring for a youth with intensive mental health needs or 2. as a youth with intensive mental health needs and who have been through the public mental health system) have a unique ability to connect with other families, provide needed information, and assist families to navigate the service delivery systems.
6. ***Regular review of barriers and concerns*** including identifying and acting to remedy deficiencies in the array of services and supports and collaboration among local stakeholders. Barriers unresolved at the local level should be advanced to the Regional FYSPRT and the appropriate Workgroup within the Governance Structure.
7. ***Regular review of data related to WISE.***
 - a. Local data on WISE quality, as outlined in the QA plan.
 - b. Local data on WISE service utilization (e.g., patterns, attention to outliers, use of home and community versus restrictive services, patterns by child-serving system and locality).
 - c. Local data on outcomes, including: youth, family, and system outcomes.

Note: Although the above types of data and a process for review is largely a state and MCE function, the Community Collaborative should also have access to summary level information and use it to problem solve and help improve the local WISE implementation as is appropriate per their responsibilities (see above).

Appendices

A. Background: T.R. Settlement Agreement

Background

T.R. vs. Quigley and Teeter, a Medicaid lawsuit regarding intensive children’s mental health services for youth, was filed in November 2009. The lawsuit was based on federal EPSDT (Early and Periodic Screening, Diagnosis and Treatment) statutes, requiring states to provide any medically necessary services and treatment to youth, even if the services have not been provided in the past. After several years of negotiations, a full settlement agreement was reached with the plaintiffs. With this settlement agreement, Washington has committed to build a mental health system that will bring this law to life for all young Medicaid beneficiaries who need intensive mental health services in order to grow up healthy in their own homes, schools, and communities.

Who is in the Class (and thus eligible for Wraparound with Intensive Services)?

All persons under the age of 21 who now or in the future:

1. Meet or would meet the State of Washington’s Title XIX Medicaid financial eligibility criteria;
2. Have a mental illness or condition;
3. Have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and
4. For whom intensive mental health services provided in the home and community based would address or ameliorate a mental illness or condition.

Goals

To have a mental health system that will:

- a) Identify and screen putative Class members and link eligible youth to the WISE program.
- b) Communicate to families, youth and stakeholders about the nature and purposes of the WISE program and services, who is eligible for the program, and how to gain access to the WISE program and services regardless of the point of entry or referral source.
- c) Provide timely statewide mental health services and supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Class member’s needs consistent with the WISE program model and state and federal Medicaid laws and regulations.
- d) Deliver high quality WISE services and supports facilitated by a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to families, youths, and stakeholders.
- e) Afford due process to Class members denied services.
- f) Coordinate delivery of services and supports among child-serving agencies and providers to Class members in order to improve the effectiveness of services and improve outcomes for

families and youth. Reduce fragmentation of services for Class members, avoid duplication and waste, and lower costs by improving collaboration among child-serving agencies

- g) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families.
- h) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders.
- i) Minimize hospitalizations and out-of-home placements.
- j) Correct or ameliorate mental illness.
- k) Reduce mental disability and restore functioning.
- l) Keep children safe, at home, and in school making progress; avoid delinquency; promote youth development; and maximize Class members' potential to grow into health and independent adults.
- m) Use available approaches that have been effective at achieving these outcomes.

B. WISe Terminology, Definitions, and Roles

Phases

- **Engagement:** Engagement is the process that lays the groundwork for building trusting relationships and a shared vision among members of the Child and Family Team that includes the family, natural supports and individuals representing formal support systems in which the youth is involved. Team members, including the family, are oriented to the WISe process. Discussions about the youth's and the youth and family's strengths and needs set the stage for collaborative teamwork within the Washington State Children's Behavioral Health principles.
- **Assessing:** Information gathering and assessing needs is the practice of gathering and evaluating information about the youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of youth.
- **Teaming:** Teaming is a process that brings together individuals agreed upon by the youth and family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
- **Service Planning and Implementation:** Service planning is the practice of tailoring supports and services unique to each youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the youth, family, and caregivers.
- **Monitoring and Adapting:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
- **Transition:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

Roles

Family - people who are committed, "forever" individuals in the identified youth's life with whom the youth also recognizes as family; a family is defined by its members, and each family defines itself.

Parent – biological, step or adoptive. If this is not applicable or unclear, the youth should identify who they consider their parent.

Caregiver – a family member or paid helper who provides direct care for the identified youth.

Youth - the statewide-accepted term to describe children, adolescents, teenagers, and young adults.

Care Coordinator - a formal member of the WISE team who is specially trained to coordinate and facilitate the WISE process for an individual youth and family and provide advanced care coordination activities within the phases and activities of WISE. The Care Coordinator is typically the facilitator of the CFT, and ultimately responsible for leading the team through the phases and activities of WISE both during and outside of the meetings. The Care Coordinator contributes knowledge and skills related to making sure that the team process honors each member's role, responsibility and perspective. The Care Coordinator is qualified by completing the WISE training, participating in technical assistance, and is involved in ongoing WISE training and coaching activities. Generally, the Care Coordinator will:

- Facilitate CFT meetings.
- Guide the team process.
- Be the central point of communication.
- Encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems.
- Utilize consensus-building techniques to meet the needs of the youth and family.
- Establish and sustain an effective team culture by inviting CFT members to propose, discuss, and accept ground rules for working together.
- Engage all CFT members and identify their needs for meeting agency mandates. The Care Coordinator identifies the strengths and needs of the youth and family, provides CFT members with an overview of CFT practice, and clarifies their role and responsibilities as a team member in this process.
- Increase the “natural supports” in CFT membership and the youth/family’s integration into their community. This is accomplished by getting to know the family history, culture, and resources, and by helping the youth and family to identify and engage potential supports. Examples of natural supports include friends, extended family, neighbors, members of the family’s faith community, co-workers. The goal is to have more natural and informal supports on the team than formal supports.
- Work with the Youth Partner and/or Family Partner to identify family support, peer support or other “system” and community resources that can assist the youth and family with exercising their voice in the CFT process, if needed.
- Prepare for meetings:
 - Develop a meeting agenda with the youth, family, and other CFT members.
 - Schedule meetings at a place/time that is accommodating (comfortable and convenient) to the youth and family and available to all CFT members.
 - Prepare visual aids or tools to facilitate the meeting process.
 - Inform all CFT members of the date, time and location of each meeting.
- Contact CFT members who are unable to attend a meeting, in advance, to elicit their input.

- Ensure all CFT members receive an updated copy of the care plan, documentation of progress, CFT meeting activities, discussions and task assignments within 7 days after the CFT meeting.
- Maintain team focus on scope of work for the WISE team and progress/movement toward transition.
- Be sensitive to the needs of team members when working in rural areas where getting members together physically may be challenging. The Care Coordinator is creative in establishing a team that may meet via phone or through teleconferencing.
- Ensure respect for the input and needs of the youth when forming the team.
- Inform the youth and family of their rights (including Due Process) and obtaining all necessary consents and releases of information.
- Acknowledge and celebrate successes and transitions.

It is important to note that the team facilitation may change during the transition phase in order to allow for family members and/or youth to become facilitators of their own meetings - depending on what the family and team thinks works best.

The Mental Health Clinician- is a provider and resource for the WISE team. The majority of WISE-enrolled youth will have clinical needs that may be met at least in part through the efforts of a skilled clinician. A clinician is a person providing outpatient mental health services (as described in WAC 388-877A; section one) to a WISE enrolled youth. While confidentiality of the details of the clinician-client (i.e., family and/or youth) relationship should be protected, the clinical professionals on the team also must have clearly defined roles in terms of meeting needs in the plan of care. WISE practitioners should be trained and supported to use effective treatment elements that connect to the youth and family’s strengths and preferences, when therapy or some other mental health service is included in a Cross System Care plan. The role of the clinician in WISE is expanded upon in “The Role of the Clinician Employed in a Wraparound Program” available at: [http://www.nwi.pdx.edu/NWI-book/Chapters/Manners-4d.2-\(clinician-role\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Manners-4d.2-(clinician-role).pdf)

The Family Partner - a formal member of the WISE team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the WISE process. They are qualified through their lived, personal experience as the parent of a youth with complex emotional/behavioral needs, hold a peer certification, and have participated in the full WISE training and technical assistance and is involved in ongoing WISE training activities.

Family Partners have a strong connection to the community and are very knowledgeable about resources, services, and supports for families. The Family Partner’s personal experience raising a youth with emotional, behavioral, or mental health needs is critical to earning the respect of families and establishing a trusting relationship that is valued by the family. The Family Partner can be a mediator, facilitator, or bridge between families and agencies. Family Partners ensure each family is heard and their individual needs are being addressed and met. The Family Partner should communicate and educate agency staff on the importance of family voice and choice and other key aspects of family driven care.

The Family Partner has a collaborative relationship with the Care Coordinator, Clinician, and Youth Partner. Together they establish mechanisms to keep each other informed, make sure the family partner knows when new families are enrolled, as well as when and where team meetings will occur, and insure all newly enrolled families have the opportunity to have support from a Family Partner, if they choose. In the absence of a Youth Partner, the Family Partner will not fulfill that role. The Family Partner collaborates with the Care Coordinator to establish the trust and mutual respect necessary for the team (including the family) to function well.

The Family Partner will be:

- A biological/adoptive/step parent, kin or other “forever” person in the parent role – who has been the primary caregiver of a youth with emotional or behavioral challenges.
- Willing to use their own lived experiences to provide hope and peer support to other families experiencing similar challenges.
- Committed to ensuring that other parents have a voice in the youth’s care and are active participants in the WISE process.
- Able to share resources and information in an individualized manner so that families understand the WISE process and have access to information regarding their child’s care.
- Able to engage and collaborate with people from diverse backgrounds.
- Able to maintain a non-judgmental attitude towards youth, families and professionals. Ability to maintain a stance of appreciation and acceptance of parents, including their choices.
- Certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.

The role of the Family Partner in WISE care coordination is fully spelled out in ***“How family partners contribute to the phases and activities of the wraparound process,”*** available at <http://www.nwi.pdx.edu/pdf/FamPartnerPhasesActivitiesStandalone.pdf>.

The WISE Practitioner – a term used interchangeably to describe the collection of WISE-certified staff roles, required for each team (the Care Coordinator, the Family Partner and/or Youth Partner, and the Mental Health Clinician).

The Youth Partner – an equitable member of the WISE team whose role is to partner with the youth to help support their engagement and active participation in making informed decisions to drive the WISE process. They are qualified through their lived experience and knowledge of community resources and the wraparound or WISE process. The Youth Partner is a mediator, facilitator, and cultural broker between youth and agencies.

Youth Partners utilize their lived experience and connection to communities and the peer movement to bring resources and informal supports to the CFT. Youth Partners work in collaboration with the other WISE Practitioners. Youth Partners ensure each youth is heard and their individual needs are being addressed and met. The Youth Partner communicates with and educates agency staff on the importance of youth voice and choice, and the power and benefits of

peer involvement- particularly in transition age youth. Youth Partners serve as a peer advocate to help empower youth in gaining the knowledge and skills necessary to be able to guide and eventually drive their own treatment. Youth Partners also conduct CANS assessments, if CANS certified.

Youth Partners will:

- Be a person with **lived experience** as a participant in Children’s Mental Health Services
- Be willing to use their own lived experiences to provide hope and peer support to other youth experiencing similar challenges.
- Demonstrate leadership experience and diplomacy in resolving conflicts and integrating divergent perspectives.
- Have knowledge of community resources and supports
- Build relationships with community members and organizations to connect the youth with resources.
- Be able to share resources and information in a developmentally appropriate way to ensure that youth understand the WISE process and have access to information regarding their care.
- Be committed to ensuring that youth have voice and choice in their own care and are active participants in the WISE process.
- Be certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.

Practice Considerations and Potential Conflict

The National Wraparound Initiative views the Family Partner, Youth Partner, Care Coordinator and Clinician as four different, full-time roles. Placing these roles together may result in none of them being done well. There is also a distinct difference in the role of coordination/ facilitation, support and a specific therapeutic treatment modality. A duality of roles of those in the provider relationship with youth and families (clinicians) acting as coordinators, is not always optimal and has been known to cause confusion, conflicts and frustration for families, youth and team members.

WISE Supervisor – an individual responsible for supervising a Care Coordinator, Family Partner and/or Youth Partner and who fully understands WISE policies, procedures and mandates. Equally important, a WISE supervisor should have experience in the role in which he/she is supervising, have received specific training in being a high-quality supervisor, and use a structured, directed model for supervision including observation of practice and review of records.

WISE Agency Administrator – a champion for WISE, providing the appropriate level of support and flexibility for this work aligning it with other agency books of business and the system of care.

Child and Family Team (CFT) - A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the

family's plan, address unmet needs, and work toward the family's vision and team mission, monitoring progress regularly and using this information to revise and refine the plan of care.

Family Organization - a family run and family led grass roots, non-profit community organization providing connection, empowerment and education to families and their communities to assure improved outcomes for youth experiencing significant behavioral health challenges and to fulfill a significant role in facilitating family/youth voice in local, state and national policy making.

Youth Organization - a youth-led non-profit organization dedicated to improving the services and systems that foster and promote positive growth of youth and young adults by using peer support and uniting the voices of individuals who have lived through and experienced obstacles in child-serving systems. Typically focus on activities such as increasing youth participation in service planning, delivery, coordination and evaluation; awareness of challenges young people with cross-systems needs face as adolescents and young adults; and youth involvement in community councils/organizations.

Documents

Child and Adolescent Needs and Strengths Assessment (CANS) - a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. All CANS (screen and full) must be entered and maintained in the Behavioral Health Assessment System (BHAS).

Child and Family Team Meeting Minutes (CFT Minutes) - A document that captures the details of a Child and Family Team meeting including a list of team members present, ground rules, family vision, team mission, strengths, needs, outcomes, action items and next team meeting date and time.

Crisis and Safety Plan - A family friendly, one to two page document that the CFT creates to address potential crises that could occur for the youth and their family and to ensure everyone's safety. It should include 24/7 response, formal and natural supports, respite/back-up care, details of what leads to crises, successful strategies that have worked in the past, as well as strengths-based strategies that prevent and avoid escalation toward a crises

Cross System Care Plan - An individualized comprehensive plan created by a Child/Family Team that reflects treatment services and supports relating to all systems or agents with whom the child is involved and who are participating on the CFT. This plan does not supplant, but may supplement the official individual service plan that each system maintains in the client record.

Individual Service Plan – A document that outlines the progression and planning of an individual’s treatment. This plan must include the requirements found in [WAC 388-877-0620](#) and [WAC 388-877A-0135](#).

[WISe Planning Elements](#)

Youth and Family Vision - A statement constructed with only the youth and family’s voice and describes how they wish things to be in the future (including long-term goals, hopes and dreams), individually and as a family.

Team Mission - A statement crafted by the CFT that provides a one to two sentence description of what the team needs to accomplish while they are together and to know when the WISe program has been completed.

Mission statements are written in the present tense as if they are true today.

Strengths - Strengths are the assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. In WISe, strengths help family members and others to successfully navigate life situations; thus, a goal for the WISe process is to promote these strengths and to use them to accomplish the goals in the team’s plan of care.

Needs - Anything that is necessary, but lacking. A need is a condition requiring relief and something required or wanted. Needs are not considered services.

Outcomes - Youth, family and/or team goals stated in a way that can be observed and measured as indicators of progress related to addressing an identified need.

Strategies - Ideas, plans and/or methods for achieving the desired outcome. When coming up with strategies in the WISe process, a brainstorming process is applied.

Action Steps - Statements in a Cross System Care plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

[Services and Supports](#)

Formal supports - Services and supports provided by individuals who are “paid to care” under a structure of requirements for which there is oversight by state or federal agencies or national professional associations, or.

Informal supports - Supports provided by individuals or organizations through citizenship and work on a volunteer basis under a structure of certain qualifications, training and oversight.

Natural Supports - Individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers and neighbors who are not "paid to help."

Peer Support – State certified peer counselors who work with their peers, mental health consumers and the parents of children with serious emotional disturbances. They assist consumers and families with identifying goals and taking specific steps to achieve them such as building up social support networks, managing internal and external stress, and navigating service delivery systems. *As defined by Washington DSHS - <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/peer-support>*

C. Guidance on Team Functioning and Facilitation of WISE

The Approach

The WISE approach in the state of Washington will strive toward quality and consistency of practice within the Washington States Children’s Behavioral Health Principles.

WISE Team Meeting Facilitation Components and Team Structure

Each team meeting must include the following facilitation components:

- The youth and/or a family must be present for a meeting to occur.
- Team meetings are held at times and locations to ensure meaningful participation of family members, youth and natural supports. Participation of young children will be decided upon by the CFT, as appropriate.
- A Family Partner and/or Youth Partner will be available to all family and youth.

WISE Process

Facilitate Introductions and Review Agenda:

- Allow the youth and family to introduce themselves first. Consider having other team members include their role (formal supports) or how they know the youth and family (informal/natural supports).
- Bring a copy of a written agenda for everyone or write it on easel paper for everyone to see. The agenda should be an outline of the facilitation components listed here so that everyone can begin to learn the process.

Set Ground Rules or Review Ground Rules:

- A discussion about ground rules to refer to during difficult times should take place at the first meeting.
- “Ground Rules” is not a common term and may need to be explained.
 - Examples include: cell phone ringer off, one person talks at a time, use respectful language when talking about concerns and needs, be on time, etc.

Review the Youth and Family Vision Statement(s):

- The WISE Practitioners should talk with the youth and family about their vision(s) before the first team meeting and help them express this vision(s) to the rest of the team.
 - Generally, there should be one collective vision for the youth and family. However, there are times that the youth may have a separate vision than the family.
- The language used by the youth and family should be preserved in the final vision statement.
- Avoid letting team members add to the youth and family vision. Team members may, however, need clarification as to the implications.

- All team members should be given a written copy of the final vision statement and should be reviewed by the team regularly.

Construct a Team Mission Statement and Review Team Mission:

- The team should formulate a mission statement that is focused on what they need to accomplish during their time together and how they will know when they are done.
- All team members should add to the mission statement.
- Consider recording major themes and edit final statement at a later time.
- All team members should be given a written copy of the final mission statement and it shall be reviewed by the team regularly.

Develop a List of Strengths and Review Strengths:

- The WISE Practitioners should talk with the youth and family about their strengths prior to the first team meeting and help them list their strengths for the team.
- The initial list of strengths should come from the youth and family and the CANS, and then all team members should add to these strengths.
- Maintain a written list of strengths and add to these at each team meeting. After the first team meeting, the list should also include successes.
- At the first team meeting, members may be focused on descriptive and contextual strengths. As the team gets to know each other, WISE Practitioners can assist the team in formulating functional strengths to use in the plan of care.
- Avoid going back-and-forth between strengths and needs. Finish the strengths list before moving on.

Develop a List of Needs and Review Current Needs:

- The WISE practitioners should talk with the youth and family about their needs, as indicated on the CANS, and help them list these at the first team meeting.
- Team members should state all concerns or identified problems in needs language: “I need..., we need..., they need..., etc.”
- Needs are not services. Team members should be redirected to state the real need(s).
- Avoid going back-and-forth between strengths and needs. Complete strengths before identifying needs.
- During the brainstorming of needs, avoid organizing the list of needs by person.

Prioritize Needs:

- Facilitate a discussion with the team about which needs should be prioritized (including those domains with 2's or 3's on the CANS) to work on over the next 30/60/90 days.
- Typically, teams work better with less than 5 needs prioritized at one time.
- Avoid a numeric ranking of each need by importance.

Develop Outcome Statements for Prioritized Needs:

- Teams may need a lot of guidance with this at first.
- Use the SMART test.
- Avoid wasting time with specific wording at the team meeting. You can rewrite the statements after the team meeting and revisit the final statement for group approval.

Brainstorm Strategies:

- Brainstorm multiple strategies for one outcome statement at a time.
- Devise strategies to help achieve each desired outcome and meet the identified need.
- Encourage the youth and family to select which strategies they think would work best for them and fit with the culture of their family.
- Include strategies that draw from the strengths of the youth and family.

Assign Action Steps:

- Each selected strategy includes specific action steps and should be assigned to a specific team member(s).
- When appropriate, all team members are given action steps for the strategy that will help achieve the outcome statement and meet the need.

Summarize and Agree on the Plan:

- The meeting facilitator summarizes the entire plan for the team and solicits feedback about missing components or needs.
- Following the team meeting, the Cross System Care Plan is documented and given to each member of the team.

Schedule the next Team Meeting:

- The next team meeting is scheduled while all team members are present.
- Meetings will be scheduled *at least* every 30 calendar days.

Transition

- Transitioning out of WISE should be discussed with the

SMART GOALS

When developing outcome statements for prioritized needs, remember the SMART test.

Specific

Linked to a rate, number, percentage, or frequency

Measurable

Has a reliable process to measure progress toward the achievement of the goal, objective, or outcome

Achievable

It can be done with a reasonable amount of effort

Realistic

The person has the necessary skills to do it

Time-Limited

Has a finish/start date clearly stated and defined

team from the beginning.

- Crisis drills should be practiced, and the youth and family should be confident they know what to do if things go poorly.
- The youth and families should be able to articulate how to access services in the future.
- The youth and family should have a way to connect with other youth and families who have been through the WISE process.
- The youth and family's concerns should be considered in the transition planning.
- The youth and family should have a list of team members' contact information, to include phone numbers and email addresses, who they can contact if needed.
- The youth and family should have written documents that describe their strengths and accomplishments.
- The youth and family should be offered a formal opportunity to celebrate their successful transition from the WISE program.

[Principles Evidenced in Practice](#)

The ten Washington State Children's Behavioral Health Principles are the guide to practice-level decision-making.

D. WISE Capacity Attestation

	<input type="checkbox"/> Start Up	<input type="checkbox"/> Expansion	
Agency Name:	Agency RUID#:		
Agency Address(es)	County/Counties Serving:		
Key WISE contact person:	Phone number and email:		
Background			
The WISE Capacity Attestation must be completed by the Managed Care Entity (MCE) upon the initiation and any expansion of WISE within their area.			
WISE Key Elements			
	Yes	No	Comments
Has the MCE met with DBHR to address local issues?	<input type="checkbox"/>	<input type="checkbox"/>	
Agency holds current Behavioral Health Agency License, issued by the Division of Behavioral Health and Recovery (DBHR),	<input type="checkbox"/>	<input type="checkbox"/>	
Agency has a contract with a MCE.	<input type="checkbox"/>	<input type="checkbox"/>	
Agency is certified to provide all of the following services	<input type="checkbox"/>	<input type="checkbox"/>	
• Individual treatment services	<input type="checkbox"/>	<input type="checkbox"/>	
• Family therapy services	<input type="checkbox"/>	<input type="checkbox"/>	
• Case management services	<input type="checkbox"/>	<input type="checkbox"/>	
• Psychiatric medication services	<input type="checkbox"/>	<input type="checkbox"/>	
• Crisis mental health services—Outreach services	<input type="checkbox"/>	<input type="checkbox"/>	
• Recovery support—Wraparound facilitation services.	<input type="checkbox"/>	<input type="checkbox"/>	
• Recovery support—Peer support services	<input type="checkbox"/>	<input type="checkbox"/>	
WISE program staff have attended the WISE training?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please list staff, role and training date			
• If no, please indicate training plan			
Family partners are peer certified (or qualify for certification)?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list			
• If no, please indicate plan to certify on staff list			
Youth partners are peer certified (or qualify for certification)?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list			
• If no, please indicate plan to certify on staff list			
WISE staff certified in CANS on each team?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list			
Established protocols for responding to crisis, in line with Section 4 ?	<input type="checkbox"/>	<input type="checkbox"/>	
Established community collaborative with appropriate	<input type="checkbox"/>	<input type="checkbox"/>	

makeup? <ul style="list-style-type: none"> • If yes, list members and affiliation • If no, please attach a written plan to establish this structure with a completion date. 			
Tribal relationship established? <ul style="list-style-type: none"> • If yes, please list tribe(s) • If no, please indicate plan to engage 	<input type="checkbox"/>	<input type="checkbox"/>	
Discussion with DBHR to determine approved number of WISE participants? <ul style="list-style-type: none"> • If yes, please indicate the approved number of participant in comments. 	<input type="checkbox"/>	<input type="checkbox"/>	Requested capacity number: DBHR Approved number: <i>(MCE will complete another attestation prior to expanding capacity beyond this agreed upon number)</i>

Additional Comments

Signatures

Managed Care Entity:

Print Name _____ Signature _____ Date: __/__/__

Approval

DBHR:

Print Name _____ Signature _____ Date: __/__/__

Agency capacity and qualifications forwarded to Provider One	Date _____	Initials _____
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E. MEMORANDUM OF UNDERSTANDING

AMONG

WASHINGTON'S DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS):
BEHAVIORAL HEALTH AND SERVICE INTEGRATION ADMINISTRATION (BHSIA),
CHILDREN'S ADMINISTRATION (CA),
DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA),
ECONOMIC SERVICES ADMINISTRATION (ESA)
JUVENILE JUSTICE AND REHABILITATION ADMINISTRATION (JJRA),
AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)
AND
WASHINGTON HEALTH CARE AUTHORITY (HCA)

A. Background

Washington State has a longstanding commitment to improve the Children's Mental Health System. The development of this Memorandum of Understanding (MOU) is predicated on three significant initiatives which have recently added clarity and opportunity to reinforce the priorities of the effort to positively reshape the system for children and youth with significant emotional and behavioral health needs, and their families.

1. In 2009, *T.R. vs. Dreyfus & Porter*, a Medicaid federal class action lawsuit, was filed alleging children and youth with serious emotional disturbances in Washington State have insufficient access to intensive services provided in home and community settings. In March 2012, the State signed an Interim Agreement committing to infrastructure development for a home and community based system of care which provides culturally responsive services and supports that are individualized, flexible and coordinated to meet the needs of the child and family.
2. In 2011, Washington was awarded a federal System of Care expansion planning grant to fund detailed system change planning from October 2011 through September 2012. A subsequent four-year implementation grant was awarded and provides additional funding and support for infrastructure change from October 2013 – September 2016.
3. In 2012, ESSHB 2536, Evidence-Based Practices (EBP) for Children and Juvenile Services directs evidence-based and research-based practices be identified and implemented for prevention and intervention services for children and juveniles in child welfare, juvenile justice and mental health.

B. Purpose

This MOU describes the mutually supportive working partnerships between BHSIA, CA, DDA, JJRA, ESA, and HCA as they relate to the community-based mental health needs and service delivery systems for children and youth with significant emotional and behavioral health needs, and their families, who are served by more than one administration in order to have ready access.

C. Agreements:

This Memorandum is entered into by the above named agencies consistent with the **WA Children's**

Mental Health Principles:

1. Family and Youth Voice and Choice
2. Team based
3. Natural Supports
4. Collaboration
5. Home and Community-based
6. Culturally Relevant
7. Individualized
8. Strength Based
9. Outcome-based
10. Unconditional

These Principles provide a framework for the success of cross system work on behalf of children, youth and families served through the Medicaid funded behavioral health system and in compliance with the *T.R. vs. Dreyfus & Porter* Interim Agreement.

D. The parties mutually agree that:

1. Working together cooperatively and collaboratively develops the best possible foundation for shared outcomes to be successfully achieved.
2. Planning will strive to balance mandates, interests and resources of participating agencies.
3. An integrated system of effective services and supports for treating children and youth with significant emotional or behavioral health needs must:
 - a. Be based in organizations that are accountable for costs and outcomes.
 - b. Be delivered by teams that coordinate medical, behavioral, and long-term services.
 - c. Be provided by networks capable of addressing the full range of needs.
 - d. Emphasize primary care and home and community based service approaches while reducing the need for institutional levels of care.
 - e. Provide information regarding available services, supports and client rights.
 - f. Provide access to qualified providers.
 - g. Respect and prioritize consumer preferences in the services and supports they receive.
 - h. Align financial incentives to support integration of care.
4. Specific activities for collaboration are:
 - a. To set up practices and procedures consistent with the WA Children's Mental Health Principles and **WISE Program Model** established under this MOU to guide inter and intra-agency efforts to collaborate and coordinate delivery of care in order to improve the effectiveness of services and outcomes for mutual children, youth and their families.
 - b. To require relevant local and regional representatives of the above named collaborating child-serving agencies and systems to be invited and to participate in Child and Family Teams (or care planning teams) for children and youth enrolled in WISE.

- c. To align funding sources, within funding restrictions, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and sustain funding for WISE.
- d. To develop cross system training and technical assistance for the parties' respective staff and relevant stakeholders, including Washington Tribes, to address information sharing, the coordination of programs and services, enhancement of working relationships and increase the use of evidence-based practices across disciplines.
- e. To develop data-informed quality improvement processes (utilizing the Measures of Statewide Performance) in order to strengthen and sustain the System of Care⁵ over time.
- f. To increase youth and family participation in all aspects of policy development and decision-making this will lead to increased relevance and system transparency.

E. Governance Structure

The interagency governance structure is intended to improve the coordination of access to intensive community-based mental health services and thereby improve both effectiveness of services and outcomes for youths and their families. Governance informs decision-making at a policy level that has legitimacy, authority, and accountability.

The structure of the Children's Mental Health Governance will consist of chief operating bodies with clear roles and reporting guidelines:

1. Executive Team - The role of the Executive team is to provide leadership, problem solving and decision making regarding progress in implementing system-wide practice improvements, fiscal accountability and quality oversight.
2. Regional Family, Youth, System Partner Round Tables (FYSPRTs) identify local needs and develop a plan to bring those needs forward to the Statewide FYSPRT, with recommendations about how to meet those needs.
3. Work Groups comprised of but not limited to representatives from DSHS, HCA, Office of the Superintendent of Public Instruction (OSPI), Department of Health (DOH), Washington Tribes, youth and families, Regional Support Networks (RSNs), and service providers.
 - a. Cross Systems Initiatives Team - Policy and Practice - Works on behalf of the Governance structure to addresses cross system issues and initiatives through the facilitation and development of policies and procedures based on WA Children's Mental Health Principles.
 - b. Children's Behavioral Health Data and Quality (DQ) Team - The mission of the Team is to provide a forum for developing and refining data collection and management strategies related to screening, assessment, performance measurement and quality improvement relevant to children's behavioral health in Washington State. Reporting, outcomes evaluation, and other types of accountability activities are another aspect of the Team purpose. Working in an inclusive and transparent fashion the Team will assure integration of data activities across systems involving children, youth and families.

⁵ A "system of care" (SOC) is an organizational philosophy and framework that is designed to create a network of effective community-based services and supports to improve the lives of children and youth with, or at risk of, serious mental health conditions and their families.

- c. Children's Mental Health Cross-Administration Finance Team - A cross-system team to address the need of aligning funding sources, costs of expanding service capacity and improving cost effectiveness.
- d. Workforce Development - Develops and strengthens a workforce that operationalizes the WA Children's Mental Health Principles and WISE Program Model.
- e. Ad Hoc Groups (Office of Indian Policy; DSHS Indian Policy Advisory Committee, other administrations and divisions as needed).

F. Period of Performance

This MOU will be reviewed every three years.

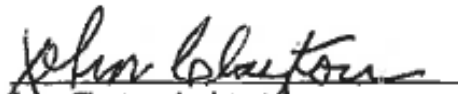
Effective Date: 7.3.13

Signatories

All signatures are affixed on behalf of all programs and sub-divisions within each respective department. Each signatory agency is committed to implementing the systemic changes necessary to support an integrated system of care for children, youth and families in Washington.

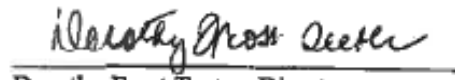

Jane Beyer, Assistant Secretary
Behavioral Health and Service Integration
Administration


Bill Moss, Assistant Secretary
Aging and Long-Term Support
Administration

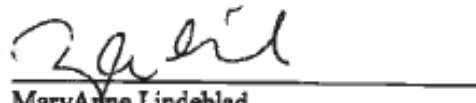

John Clayton, Assistant Secretary
Juvenile Justice and Rehabilitation
Administration


Jennifer Strus, Acting Assistant Secretary
Children's Administration


Evelyn Perez, Acting Assistant Secretary
Developmental Disabilities Services
Administration


Dorothy Frost Teeter, Director
Health Care Authority


David Stillman, Assistant Secretary
Economic Services Administration


MaryAnne Lindeblad
Medical Director

F. Service Array and Coding

For service array and coding, follow the Service Encounter Reporting Instructions (SERI) for Behavioral Health Organizations. The Service Encounter Reporting Instructions can be found online at:

<https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information>

For Fully Integrated Managed Care Organizations follow the instructions in the Encounter Data Reporting Guide. This document can be found online at:

http://www.hca.wa.gov/medicaid/healthyoptions/documents/encounter_data_reporting_guide.pdf

G. Washington's Draft Provisional CANS Algorithm

7/24/14

A child will be recommended for Wraparound with Intensive Services (WISe) if:
Criterion 1 AND (Criterion 2 OR Criterion 3)

Criterion 1. Behavioral/Emotional Needs
1a. Rating of 3 on "Psychosis" OR
1b. Rating of 2 on "Psychosis" and 2 or 3 on any other Behavioral/Emotional Needs item OR
1c. 2 or more ratings of 3 on any Behavioral/Emotional Needs items OR
1d. 3 or more ratings of 2 or 3 on any Behavioral/Emotional Needs items
<i>Note: Behavioral/emotional needs items we plan to include in our screener: Psychosis; Attention/Impulse; Mood</i>
<i>Disturbance; Anxiety; Disruptive Behavior; Adjustment to Trauma; Emotional Control</i>
Criterion 2. Risk Factors
2a. Rating of 3 on "Danger to Others" or "Suicide Risk" OR
2b. One rating of 3 on any Risk Factor item OR 2 or more ratings of 2 or 3 on any Risk Factor item
<i>Note: Risk factors included: Suicide Risk; Non-Suicidal Self-Injury; Danger to Others; Runaway;</i>
Criterion 3. Serious Functional Impairment
3a. 2 or more ratings of 3 on "Family", "School", "Interpersonal" or "Living Situation" OR
3b. 3 or more ratings of 2 or 3 on "Family", "School", "Interpersonal" and "Living Situation"

H. Cross System Care Plan

WISE and CANS: Cross System Care Plan - Elements for Teams

1	Family Vision Statement (Family)	What does better look like for the family (long term)?
2	Team Mission Statement (Team)	What does the team have to accomplish while they are together (short term)?
3	Useful Strengths (CANS)	Strengths items with a 0 or 1 on the CANS and should be used in planning
4	Additional Strengths (Team)	Other strengths identified by the family and team.
5	Background Needs (CANS)	Needs that are most likely not addressable but shift the pathway which interventions are provided
6	Targeted Needs (CANS)	Needs that are the focus of interventions
7	Needs Statements (Team)	Statements that describe the individualized needs of the youth and/or family members.
8	Anticipated Outcomes (CANS)	Needs that would be expected to respond as a result of effectively addressing the targeted needs.
9	Target Outcomes Statements (Team)	Measurable indicator of progress. What the end result looks like when the need is met. SMART (Specific, Measurable, Achievable, Realistic, Timeline).
10	Strategies and Interventions (Team)	Selected interventions, services, EBP, formal, informal or natural support, and processes that the family and team selects to meet the targeted needs and achieve the desired outcome.
11	Useful Strengths Activities (Team)	Planned activities that utilize the useful strengths in the planning process.
12	Action Steps for Team Members (Team)	Specific list of action items that each team member will do in order to initiate and support the strategy / intervention and achieve the desired outcome
13	Strengths to Build (CANS)	Strengths Items with a 2 or 3 on the CANS.
14	Strengths Building Activities (Team)	Planned activities to identify or build strengths.

Cross System Care Plan of Example

Name:

Demographic Information:

Record Information:

Family Members:

Parent Partner:

Youth Partner:

Team Members:

Other Information:

Family Vision Statement (family and youth):

Team Mission (all team members):

Strengths (all team members):

Background Needs (CANS):

Targeted Need (CANS) #1:

Score:

0 1 2 3

Change:

0 1 2 3

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions:

- 1.
- 2.
- 3.

Targeted Need (CANS) #2:

Score:

0 1 2 3

Change:

0 1 2 3

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions:

Steps:

- 1.
- 2.
- 3.

Team Member Action

Targeted Need (CANS) #3:

Score:

Change:

Individualized Needs Statement:

0 1 2 3

0 1 2 3

Outcome Statement (SMART):

Interventions:

Team Member Action

Steps:

- 1.
- 2.
- 3.

Targeted Need (CANS) #4:

Score:

Change:

0 1 2 3

0 1 2 3

Individualized Needs Statement:

Outcome Statement (SMART)

Interventions:

Team Member Action

Steps:

- 1.
- 2.
- 3.

Targeted Need (CANS) #5:

Score:

Change:

0 1 2 3

0 1 2 3

Individualized Needs Statement:

Outcome Statement (SMART):

Interventions:

Team Member Action

Steps:

- 1.
- 2.
- 3.

Other Anticipated Outcomes:

(Other CANS domains expected to improve as a result of addressing the targeted needs)

Useful Strengths (CANS):

Useful Strengths Activities (all team members):

Strengths to Build (CANS):

Strengths to Build Activities (all team members):

I. Affinity Groups

Materials will be developed to support each of the following affinity groups with written materials, communication plans, and education/training specific to each:

- Community mental health agencies
- Children's Administration
- Rehabilitation Administration
- Developmental Disabilities Administration
- Schools
- Pediatricians
- Child Psychiatrists
- Participating Youth/Youth Organizations
- Health Care Authority and their providers
- Juvenile Court Administrators
- Crisis Teams
- Tribes
- Participating Families/Family Organizations
- Chemical Dependency Agencies
- Children's Long Term Inpatient Programs

As developed, these materials can be found at the following website: www.dshs.wa.gov/dbhr/cbh-wise.shtml

Specific elements to be included are:

- Identifying youth that may benefit from WISE, and when a referral is mandatory.
- How to refer; who to contact/what information is needed.
- Individual roles and responsibilities of cross-system partners.
- What to expect in the WISE model and how to participate including how to utilize and contribute to a single Cross System Care Plan.

J. Quality Management Plan

The Quality Management Plan (QMP) for WISe prescribes the quality management goals, objectives, tools, resources, and processes needed to measure the implementation and success of the Commitments set forth in the *T.R. v. Quigley and Teeter* Settlement Agreement dated December 19, 2013 (DKT 119-1, paragraphs 18 – 64). The QMP is based on the requirements set forth in the Settlement Agreement at paragraphs 45 – 54 (Quality Management Commitments) and is informed by the terms of the WISe Implementation Plan dated August 1, 2014. Complete implementation of the QMP will occur on or before December 19, 2016. This Plan is intended to be a working document.

A copy of the Quality Management Plan can be found online at:

<https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/QMP%20FINAL-updated5.2015.pdf>