



# Wraparound with Intensive Services (WISe)

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## *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 the program 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 and partners with the identification of eligible youth and the implementation and provision of WISe. The intended audience for this manual is those directly involved in the delivery of the program, their supervisors, and administrators, in order to provide them with an understanding of:

- The required infrastructure and expectations of WISe
- The Practice Model for the core elements of WISe
  - 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. Current versions of the manual will be posted on our Children's Behavioral Health website at:

<http://www.dshs.wa.gov/dbhr/childrensbehavioralhealth.shtml>

### 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 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.
- Maximize participant’s potential to grow into healthy and independent adults.

The Washington State Children’s Mental 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 Mental 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 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 family’s vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from 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 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 competent, 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 in accommodating families by working evenings and weekends, and by responding to crises 24 hours a day, seven days a week. 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. Among these services and supports, 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 Class member's 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 and often include increased safety, stabilization, school success, and community integration; positive youth development; and support to ensure that youth and families can live successfully in their homes and communities, 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](#) and have a contract with a Regional Support Network (RSN). Additionally, agencies must be certified 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 RSN, and DBHR.

## WISe-Specific Requirements

Adherence to WISe, outlined below, will be reviewed by the WISe agency, the associated RSN, and DBHR according to the Quality Management Plan.

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 16. 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. WISe agencies will provide each participating family with a Child and Family Team (CFT), and at a minimum, access to these services as described in the Service Encounter Reporting Instructions (SERI) for Regional Support Networks:

1. Intake Evaluation
2. Intensive Care Coordination
3. Intensive Services provided in the Home and Community Settings
4. 24/7 Crisis Intervention and Stabilization Services

All mental health services offered to youth and families that are participating in WISe must be provided by staff employed at a WISe-qualified agency. Other needed services and supports are to be outlined in the single Cross System Care Plan (CSCP) that is developed by the CFT and those services will be monitored met by other members of the CFT. More information related to the CANs assessment, the delivery approach, and coding of these services can be found in sections below.

### Staffing

WISe provider agencies must have sufficient WISe qualified staff to:

- Manage the capacity-level delegated by the RSN and DBHR.
- Deliver all medically necessary mental health services (including Psychiatric/Medical)
- Fill the following roles with WISe-qualified staff for each youth/family served:
  - Clinician.
  - Care Coordinator.
  - Family Partner and /or Youth Partner who are certified peer counselors.

- Clinical Supervisor
  - Note:** Descriptions and responsibilities for of each of these roles are outlined in Appendix B.*
- Provide clinical supervision to WISE-qualified staff, utilizing the WISE supervision model (training set to begin in September 2014).
- Have available to each team:
  - In-home Behavioral Aide.
  - Psychiatric consultation.
- Maintain an average caseload size of 10 or fewer for each team.
  - ***Note:** More guidance will follow related to utilization of the Child Adolescent Needs and Strengths (CANS) data to determine caseload.*
- Provide 24/7 crisis intervention to youth and families through staff that are known to the family.
- Complete a full CANS within 30 days of intake, update the assessment every 90 days thereafter while the youth remains in WISE authorized services, and complete again at discharge from WISE services.

### Cross-System Collaboration

WISE provider agencies are required to collaborate and include other 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 family. The CSCP can encompass the individual service plan requirements found in [WAC 388-877-0620](#) and [WAC 388-877A-0135](#), but will include a variety of other activities. RSNs will work within their local communities to ensure diverse representation and appropriate communication channels. Section 6, beginning on page 29, describes relevant information regarding these RSN required coordinating bodies.

### 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

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 intake, updated CANS Full at least every 90 days, and CANS Full again upon discharge or transition to a lower level of care.
- Expected outcomes/transition activities and discharge criteria.
- Cross System Care Plan (note: see appendix H for core elements and a sample format)), including revisions and updates.
  - Expected outcomes/transition activities and transition/discharge criteria will be clearly defined in the CSCP.
- Individual Service Plan (ISP).
- Safety/crisis plan.
- CFT meeting notes (at least monthly) and records that they 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 RSNs will utilize the protocols of this section to meet requirements related to:

- The identification of youth who might qualify/benefit from WISE.
- The elements of the WISE Screening.
- Conducting a WISE Screening.

### Identification

All requests for WISE services will result in an initial screening regardless of referral source. Requests for WISE services will be processed by clinicians trained in the Child Adolescent Needs and Strengths (CANS).

Child-serving systems, such as the Department of Social and Health Services, Health Care Authority (HCA), county and community providers, and Tribal service providers will be trained to assist them in identifying and referring youth who might benefit from WISE.

In addition to screens provided in response to community-based referrals, a WISE screen must be provided when:

1. A referral is being made to a Children's Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. Youth enrolled in BRS and CLIP will be periodically screened with a minimum of one time every six months.
3. During discharge planning while in CLIP or BRS.
4. Prior to a youth's discharge from a psychiatric hospital.
5. During discharge planning from a Juvenile Justice and Rehabilitation Administration-run facility, when a Medicaid-eligible youth presents with past or current functional indicators of need for intensive mental health services.
6. A youth or family self-refers by indicating a need for more intensive services.

If the youth is not currently enrolled in Medicaid mental health services with the RSN the following will occur:

1. Establish Medicaid Eligibility. WISE is a Medicaid program and can only serve youth who are under 21 and covered by Medicaid.
2. Complete a WISE Screen to determine if the youth meets WISE level of care and may benefit from WISE. The WISE screening is conducted using the Child Adolescent Needs and Strengths (CANS) Screen, entered into the Behavioral Health Assessment System (BHAS) and:
  - Must be completed by a CANS certified screener.

- Utilizes information provided by the referent.
- Includes additional information gathered if needed and made available by others aware of the youth’s needs or from the family directly.

If a youth is currently receiving Medicaid mental health services from an RSN provider a referral to WISE can be completed in the following ways:

- The current provider can complete the WISE Screen if they are certified in CANS and will enter the results into the Behavioral Health Assessment System (BHAS).
- The current provider can make a referral to a WISE contracted provider who will complete this initial WISE Screening.

The initial WISE Screen results, generated after the CANS information is entered into BHAS, will have one of the following outcomes based on the algorithm and judgment of the certified CANS screener.

Yes on algorithm— A referral for an intake evaluation to determine Access to Care and Medical Necessity for WISE by a WISE qualified provider.

No on algorithm— A referral for an standard intake evaluation to determine Access to Care for RSN provided services with an RSN contracted provider.

No on algorithm— A referral to other community resources including to their health care plan for mental health services available under their health benefit.

## Components of a WISE Screening

When the outcome of the initial WISE Screening described above results in a referral to the WISE program, a full intake assessment and determination of the medical necessity<sup>1</sup>, in compliance with WAC [388-877-0610](#) and WAC [388-877A-0130](#), must be completed. This includes:

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### <sup>1</sup> Definition of Medical Necessity

\* “A requested service which is reasonably expected to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. Course of treatment may include mere observation, or where appropriate, no treatment at all. Additionally, the individual must be determined to 1) have a mental illness covered by Washington State public mental health services; 2) the individual’s impairment(s) and corresponding need(s) must be the result of a mental illness; 3) the intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; 4) the individual is expected to benefit from the intervention; and 5) any other formal or informal system or support cannot address the individual’s unmet need.”

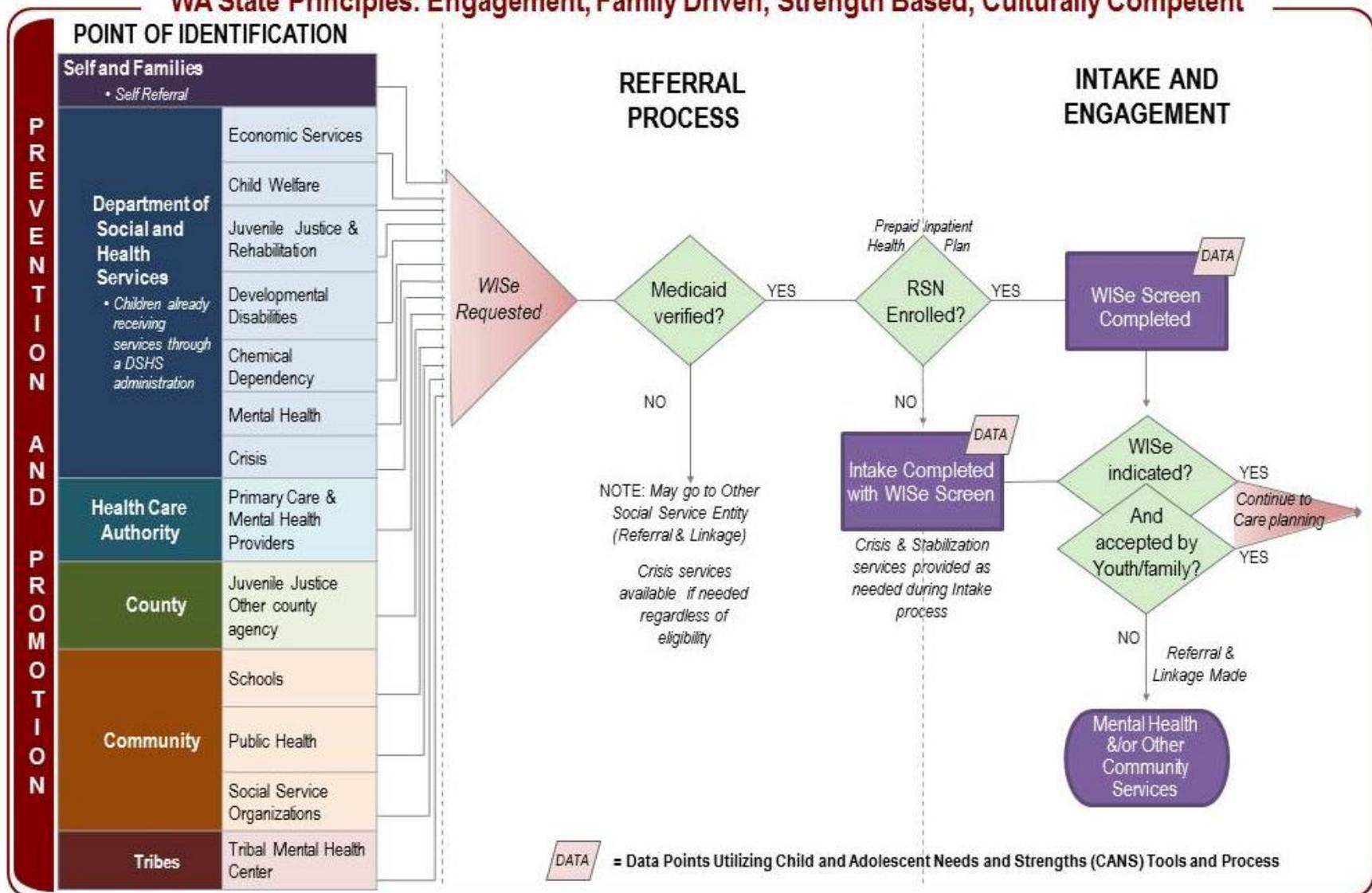
Additional guidelines in determining whether a service is medically necessary could include those that are:

- (a) in accordance with generally accepted standards of practice;
- (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the client’s presentation; and
- (c) not primarily for the convenience of the client, family or care provider.

- Completing the WISE Screen within 10 working days of receiving a WISE referral.
- A determination of whether, based on the Access to Care Standards, the youth has a covered diagnosis and functional impairment that result in eligibility for RSN funded Medicaid mental health services.
- A determination, for youth that are already receiving RSN services, of whether a new intake is needed to establish eligibility under the Access to Care Standards. This determination will be made based on RSN policies and procedures.
- Use of the full Child Adolescent Needs and Strengths Screen (CANS), and the entry of this information into BHAS, as a foundation to determine whether the youth is likely to benefit from WISE.
- It is expected that any youth who screens into WISE will necessarily meet Access to Care Standards.

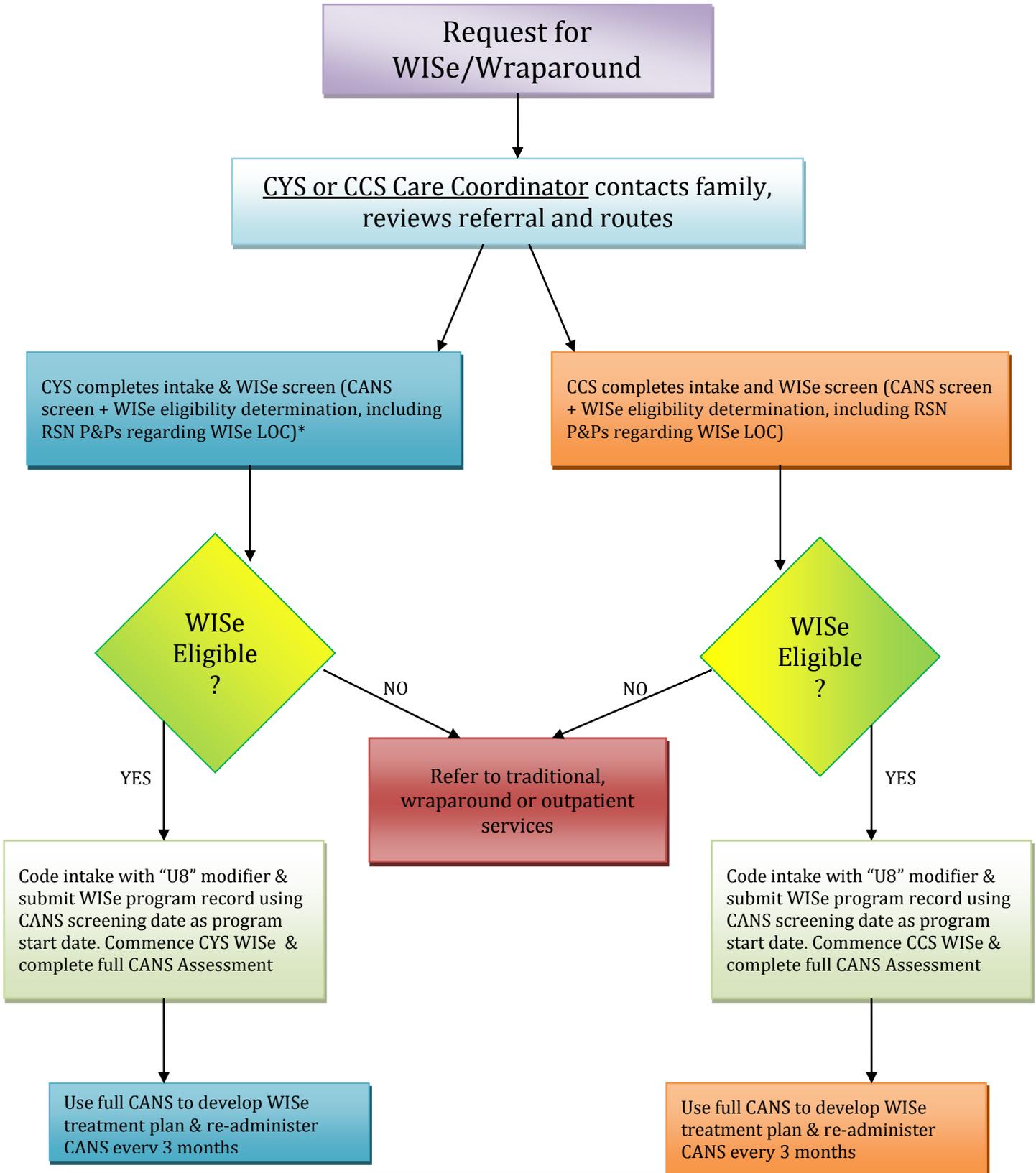
# Access Model to Wraparound with Intensive Services (WISe)

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

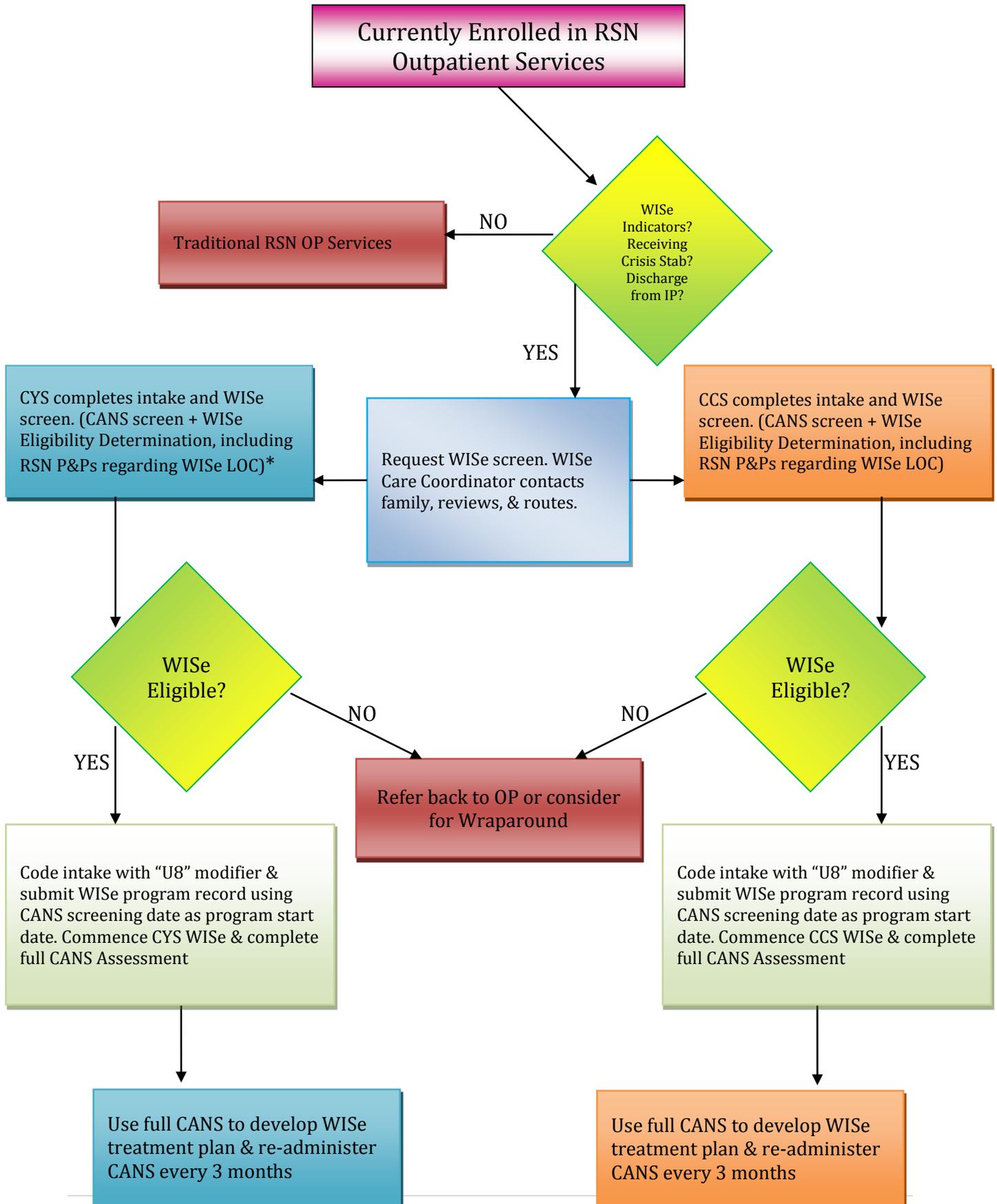


# Request for WISE or Wraparound

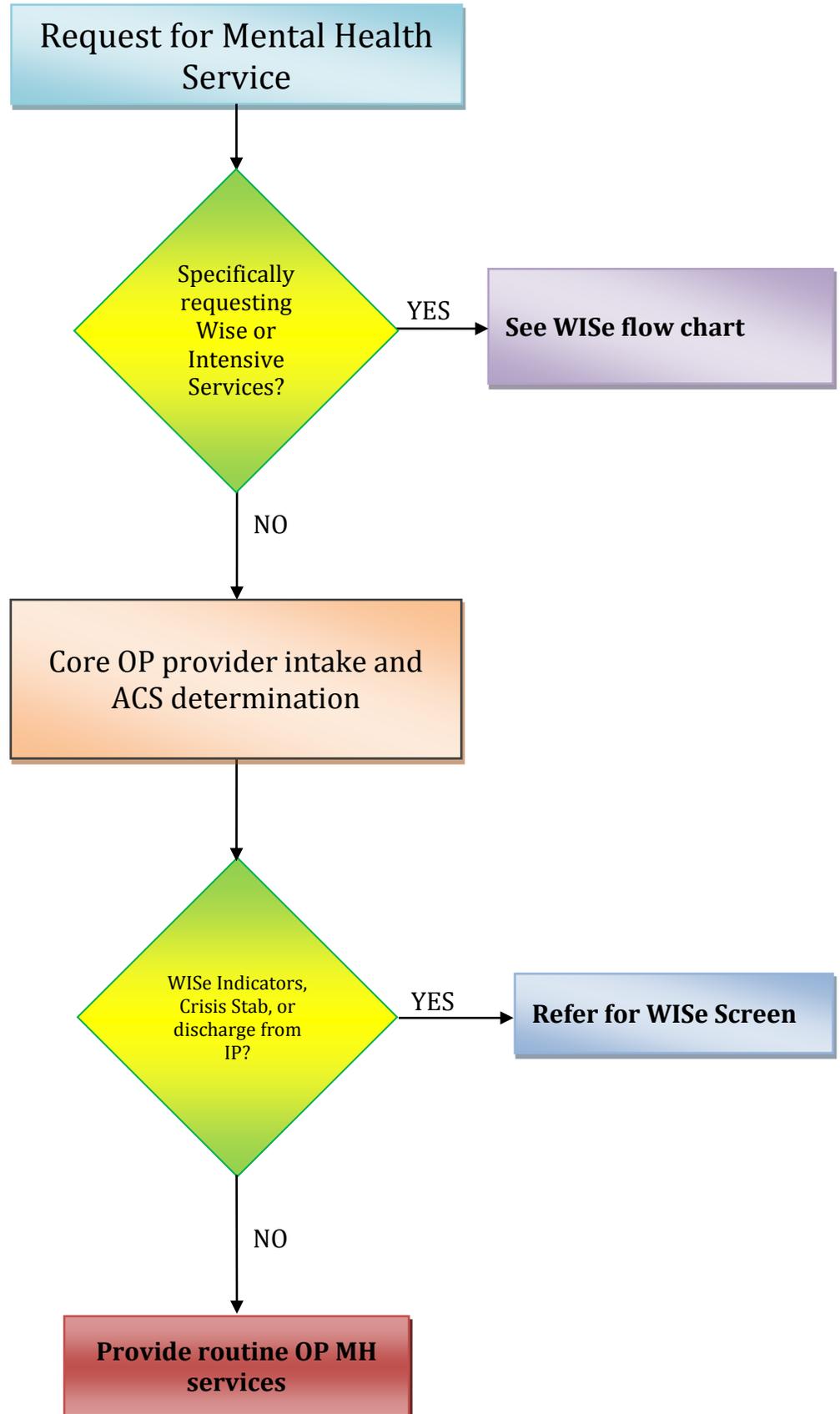
Examples from the field



# Currently Enrolled Medicaid Clients Being Considered for WISE



# Request for Non-WISE OP Mental Health Services



## 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. 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). Services are family-oriented, meaning that family members are engaged and involved with services.

#### **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 service approach must provide services differently, as many of the youth and families served have found traditional behavioral health services did not 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 provider to deliver purposeful help 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 and/or Youth Partner must be an equal partner within a WISE team, involved in meaningful interactions with the youth and family members on a regular basis.

#### *A Re-Vision Process*

Moving from:

1. A problem-saturated narrative
2. Pessimism, fear, hopelessness and demoralization
3. Crisis management
4. Chaos and pervasive emotional reactivity
5. Lack of clarity regarding realistic possibilities, options, strategies and goals

Assisting the youth and family in moving to:

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 optimism and 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 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.

Youth and families participating in WISe 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, 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) programs and supports that are offered in a variety of settings (home, community, school, etc.).

## Intensive Care Coordination

### **Engagement**

*Overview: During this phase, the groundwork for trust and shared vision among the 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 Mental Health Principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase begins to shift the 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 quickly as possible.*

### *Goals/Purpose:*

- To orient the family and youth to the WISe process
- To address pressing needs and concerns so the family and team can give their attention to the WISe process
- To explore individual and family strengths, needs, culture, and vision, and develop a family narrative that will serve as the starting point for planning
- 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 meets with the family to explain the WISE process, and how it differs from traditional care.
- The WISE Practitioner discusses with the youth and family the events, circumstances, and moments that brought the family to WISE.
- The WISE Practitioner obtains the family perspective on where they are presently, and where they would like to go in the future.
- The WISE Practitioner discusses the family's view of crises, and develops a plan to stabilize dangerous or harmful situations immediately.
- The WISE Practitioner insures the family understands any system mandates (if applicable) and ethical issues.

### **Assessing**

*Overview: In this continuation of the engagement phase, the Care Coordinator expands the discussion with the family to add context to their involvement in WISE. The coordinator helps the 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. The coordinator also listens to the family perspective for information about the family's strengths, needs, culture, and natural supports. The WISE Practitioner reviews the CANS results with the family and determines how to present this information to the team.*

### *Goals/Purpose:*

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

### *Essential Steps*

- The WISE Practitioner completes a strengths discovery and a list of strengths for all family members.
- The WISE Practitioner discusses and lists existing and potential natural supports.
- The WISE Practitioner completes a list of potential team members.
- The WISE Practitioner summarizes the family context, strengths, needs, vision for the future, and supports.
- The WISE Practitioner determines with the youth and family how the CANS information will be provided to the team.

## **Teaming**

*Overview: In this part of engagement, the coordinator helps the 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. The coordinator communicates with team members and sets a time and location for the team to meet to begin the Service Planning and Implementation phase.*

### *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:*

- A WISE practitioner explains WISE to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.
- The team will include the youth, parents/caregivers, relevant family members, and natural and community supports.
- The team will be expected to meet with sufficient regularity (30 days at minimum), as indicated in the CSCP, to monitor and promote progress on goals and maintain clear and coordinated communication.
- The CFT evaluates the efficacy of interventions and action items and adjusts these accordingly. Using the outcomes/indicators associated with each priority need included in the plan of care. The Care Coordinator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.
- The team works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and parent(s)/guardian(s)
- The team has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services
- The WISE Practitioner is expected to check in with team members on progress made on assigned tasks between meetings
- The identified WISE team facilitator sets 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 plan of care using a high-quality planning process that reflects the Washington State Children's Mental 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 an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members
- 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
- To build a set of prioritized needs, including the strategies to meet them, and to determine expected outcomes
- To assign team tasks and roles, and to set parameters for monitoring assignments
- 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 meets with the family and develops a list of possible needs of the family prior to the team meeting.
- The WISE Practitioner convenes one or more team meetings to discuss and obtain agreement on the elements of the Cross System Care Plan.
- In the team meeting, the family's vision for their future is presented.
- The team discusses and sets ground rules to guide the meetings.
- The team reviews and expands the list of strengths for the family.
- The team creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISE.
- The team reviews the list of needs and agrees which to prioritize in the initial plan.
- The team determines the intended outcomes that will transpire when the needs are met.
- The team brainstorms strategies to meet these needs, and then prioritizes strategies for each need.
- The team members receive assignments, or action steps, around implementing the strategies.
- The team evaluates and adds to the crisis plan.
- The WISE Practitioner documents the work of the team, and distributes copies to team members.

**Note:** *Cross System Care Plan example in Appendix G.*

## **Monitoring and Adjusting**

*Overview: During this phase, the initial plan 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 initial plan of care, monitoring completion of action steps and strategies and their success in meeting needs and achieving outcomes
- To use a high quality 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 WISe team continues to meet at minimum every 30 days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The team 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 team evaluates whether there is progress towards the designated outcomes. The team adjusts the outcomes to guide next steps.
- The team adds members and strives to create a mix of formal, informal, and natural supports.
- The team celebrates successes and adds to strengths as they are identified.
- CANS assessments are administered and entered into BHAS every 90 days to help track progress and to catch emerging needs.
- The WISe Practitioner maintains 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 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 treatment plan developed by a care planning team. The care planning team 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 providers 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, and training the family in managing, the youth's disorder.
- 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 including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence based practices (e.g., Family Functional Therapy, Multi-Systemic Therapy, Trauma- Focused Cognitive Behavioral 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 sequelae of past trauma, using evidence based approaches.
  - Reduce negative impact of depression and anxiety, through use of evidence 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 (biological, foster, relative, or adoptive), 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/Youth Partners, may provide direct services. Clinical treatment services are provided by a clinician, rather than a paraprofessional. Paraprofessionals and Family/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 RSN.

## 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 precipitants and methods to reduce or eliminate.
  - Establishes 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, therapists, 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 plan for rapid return home.
- Tools and resources available to manage potential risks.

### **Crisis Delivery**

Crisis services include crisis planning and prevention services 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 (biological, foster, relative, or adoptive) 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 must have capacity to respond to destabilizing events whenever the need arises. Individuals who know and work with the youth and family outside of the crisis episode will respond to the crisis episode with knowledge of the crisis plan. Crisis responders may partner with others outside the team when needed. The crisis response cannot be delegated outside of the team.

### **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 a formal plan for a purposeful exit out of WISE to a mix of 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.

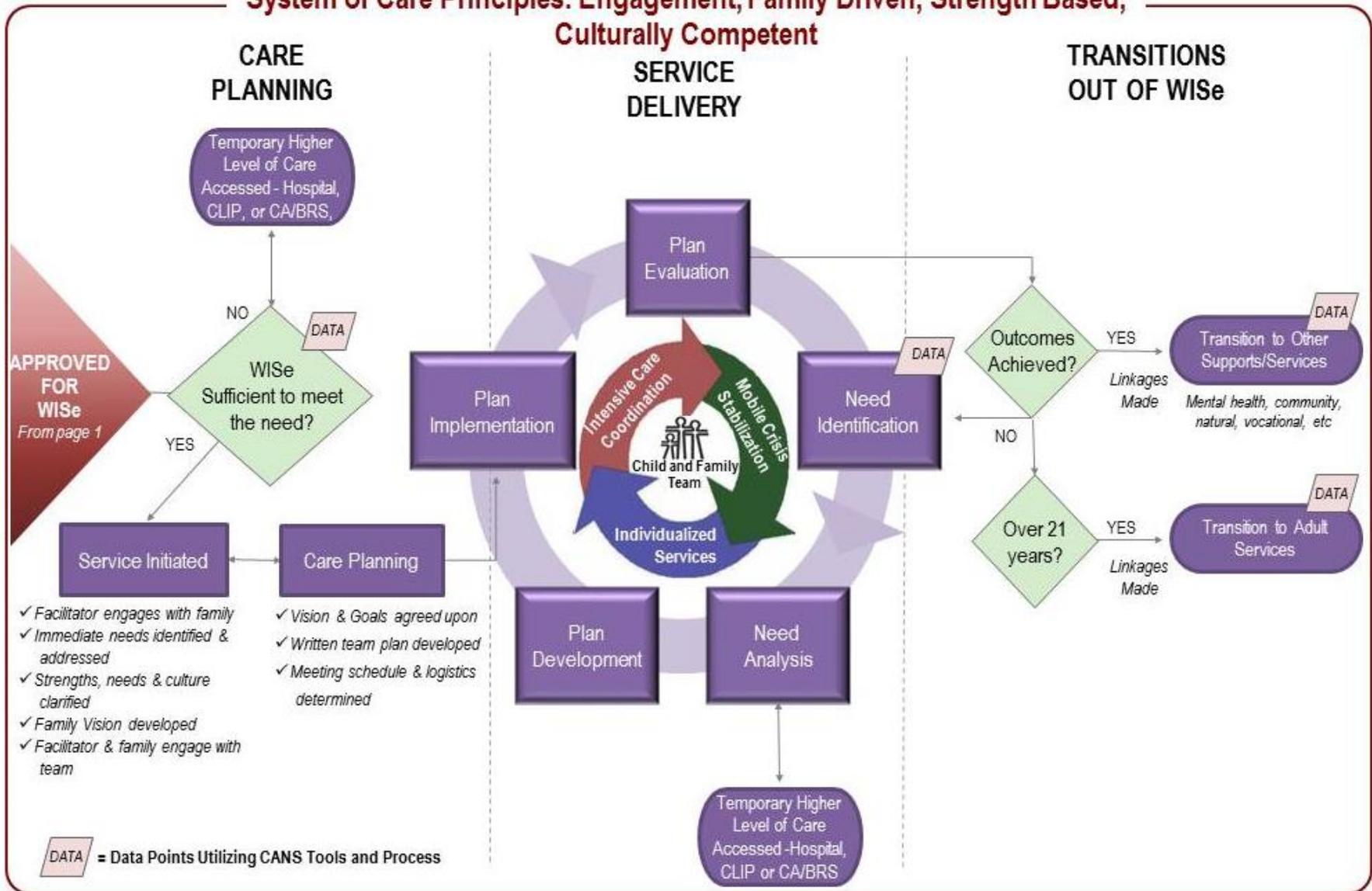
- The CFT creates a post-WISE crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-WISE crisis resources.
- New members may be added to the team to reflect identified 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/family. Formal CFT meetings reduce frequency and ultimately cease.
- The WISE guides 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 participates in preparing/reviewing 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.

*FORMAL Transition* – When a youth improves to the point where they no longer meet the WISE screening criteria, *formal* transition begins and preparations are made for the family to transition out of WISE. The family and their team will develop a detailed transition plan that identifies ongoing supports and services necessary to sustain success. This plan includes sufficient time to build individual and team efficacy by referring to the plan and acting on it independently without the need for WISE program staff. The timing of this process is determined by the team and outlined in the plan. Up to six months is allowed under the WISE model. Upon discharge from WISE, a full CANS must be completed and entered into BHAS.

**Note:** *Examples will be provided in future version of the manual.*

# 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.

### Decision-Making Guidelines

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

WISE practitioners should recommend services on the WISE service array within the scope of their practice that are needed for the maximum reduction of the mental health condition and result in the best possible functional level for the youth. Although the CANS assessment is not the sole measure of individual functioning, the CANS assessment will be utilized to evaluate the restoration of the youth to his or her best possible functional level.

### Reaching Consensus on a CFT

CFT members should use the WISE planning model described in Section 4 and the Principles to reach consensus on what WISE services and supports are necessary to correct or ameliorate a youth's mental health condition and restore the youth to the best possible functional level. When developing the Cross System Care Plan and determining the services and supports to be provided, the team should adhere to the needs and strengths identified with the CANS and utilize the preferred strategies expressed by the youth and family.

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 mental health therapist and care coordinator should help build enough consensus among the team to develop an interim service plan, for a specified period of time. The impact of the interim care plan can be assessed and monitored by the CFT and adjusted as necessary.

If the CFT **can reach** agreement on an interim service plan:

- The CFT should meet again after a specified interim 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 interim 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/complaint process to notify the RSN of any disagreements they have with specific 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/complaint should be made at the lowest level possible.

### [Right to Appeal a Denials, Reductions, or Terminations of Services.](#)

The RSN and/or agency must provide the youth and/or family with a Notice of Action advising them of their due process rights to appeal for a Medicaid Administrative fair hearing when:

- An individual screens out of WISE.
- An individual participating in WISE indicates to the RSN that there is disagreement with treatment plan recommendations made during the care planning process.
- The RSN and/or agency denies, terminates, or reduces the authorization for services to the youth and family that are included in the WISE service array and recommended by the CFT in the Cross System Care Plan.
- The updated CANS indicates the youth no longer meets the algorithm for the entry to WISE and a plan for formal transition will begin.

## Section 6: Governance and Coordination of System Partners

The Settlement Agreement for *TR 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 RSNs and WISe qualified providers maintain certain authorities and obligations under Medicaid rules. RSNs 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 RSNs, 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.

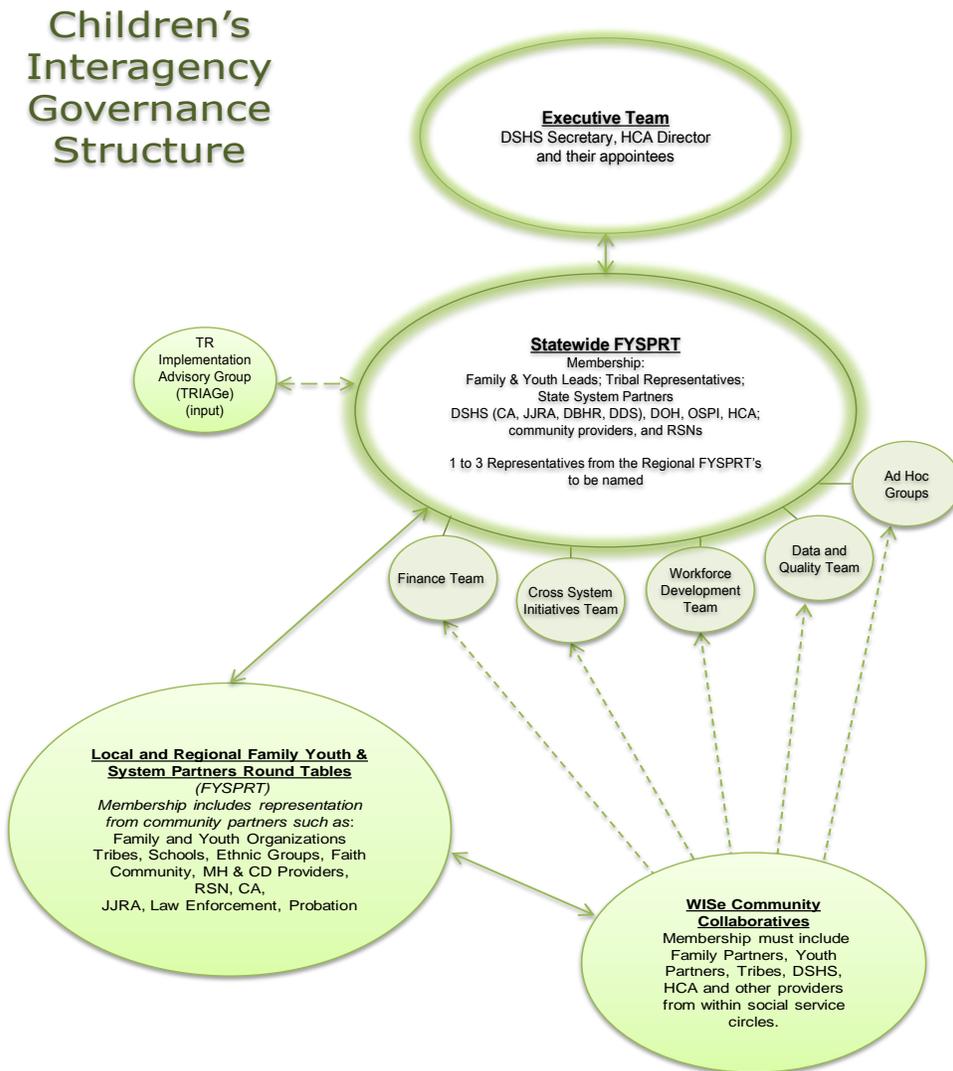
Effective system building requires a partnership between state and local stakeholders to clarify and address the ways in which state policies and practices (e.g., regulations, funding, reporting requirements) can be strengthened or altered to support local systems of care. When the partnership is effective, 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.



## 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 Regional Support Networks (RSNs) and are 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 RSN(s) 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 RSN 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 RSN 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 an RSN responsibility, however, the local Community Collaborative should have an oversight, quality assurance, and problem solving role.
4. ***Resource development and provider network management.*** The RSN 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 RSN 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: TR Settlement Agreement

### Background

*TR 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.

### What the State Has Agreed to Do

- Improve Identification, Screening, Referral and Assessment
- Develop Wraparound with Intensive Services (WISe) for Statewide Implementation
- Increase Evidence and Research Based Practices statewide
- Improve Transitions and Continuity of Care
- Provide Cross System Workforce Development and Training
- Improve Due Process for Class Members
- Improve Governance Structure and Collaboration
- Improve Quality Management, Transparency and Accountability

### Goals

To have a mental health system that will:

- a) Identify, screen 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 within a Medicaid structure that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each youth's needs consistent with the WISe program model.
- d) Employ a system of continuous quality improvement, including measures and procedures that support the continual improvement of quality; clear understanding of outcomes and costs; and transparency and accountability to families, youths, and stakeholders.
- e) Afford due process to youth denied services.
- f) Coordinate delivery of services and supports among child-serving agencies and providers to participants in order to improve the effectiveness of services and improve outcomes for families and youth.
- g) Reduce fragmentation of services for youth, avoid duplication and redundancies, and lower costs by improving collaboration among child-serving agencies (see the MOU in Appendix E);
- h) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families.
- i) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders.
- j) Minimize hospitalizations and out-of-home placements.

## B. WISe Terminology, Definitions, and Roles

### Program Activities

- **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 family's strengths and needs set the stage for collaborative teamwork within the Washington State Children's Mental 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.
- **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.
- **Teaming:** Teaming is a process that brings together individuals agreed upon by the 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.
- **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.

**WISe Care Coordinator** - a formal member of the WISe team who is specially trained to coordinate and facilitate the WISe process for an individual family and provide advanced care coordination activities within the phases and activities of WISe. The care coordinator contributes knowledge and skills related to making sure that the team process honors each member's role, responsibility and perspective. While the responsibility of preparing family members and other participants may fall to others in some areas, it is the responsibility of the care coordinator to make sure that each participant is heard and given the same consideration as others throughout the team process. Facilitation of the WISe team can be done by a qualified WISe Care Coordinator. The care coordinator is qualified by completing the WISe training, participating in technical assistance, and is involved in ongoing WISe training and coaching activities.

The WISe Care Coordinator will:

- Guide the team process.
- 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 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 is expected to identify the strengths and needs of the youth and family, provide CFT members with an overview of CFT practice, and clarify 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 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.
- 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 must be 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 member responsible for meeting facilitation may change over time once the team has learned the facilitation components of a CFT. Depending on what the family and team thinks works best; a parent, youth, caregiver or another ongoing professional support may take over facilitating the team meeting during the transition phase or after a period of skill development time.*

**The Therapist and/or Mental Health Professional** - The majority of WISE-enrolled youth will have clinical needs that may be met at least in part through the efforts of a skilled therapist or other mental health professional. While confidentiality of the details of the therapist-client (i.e., family and/or youth) relationship should be protected, the mental health professionals on the team also must have clearly defined roles in terms of meeting needs in the plan of care. WISE-affiliated clinicians should also 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 therapist 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, youth guided care.

The family partner has a collaborative relationship with the WISE Care Coordinator. 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. 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 Youth Partner** - a formal member of the WISE team whose role is to serve the youth 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 and participation in the full WISE training and technical assistance and are involved in ongoing WISE training activities. Youth Partners utilize their lived experience and connection to communities and the peer movement to bring community resources and natural supports to the CFT. Youth Partners are uniquely equipped to help the youth understand and engage in their treatment plans in a real and meaningful way. They are especially valuable and helpful in connecting youth to the community and assisting them when transitioning out of formal services. 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 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.
- Be able to share resources and information in a developmentally appropriate way to ensure that youth understand the WISE process and has 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 able to engage and collaborate with people from diverse backgrounds.
- Be able to maintain a non-judgmental attitude.
- Be certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.

**Practice Considerations and Potential Conflict**

*A WISE Family Partner, WISE Youth Partner, WISE Care Coordinator and WISE affiliated Therapist or Mental Health Professional are four different, full-time roles. Placing these roles together may result in none of them getting done well. There is also a distinct difference in the role of coordination, support and a specific therapeutic treatment modality. A duality of roles of those in the provider relationship with families (therapists) 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 WISE Care Coordinator, Family Partner and/or Youth Partner and who fully understands WISE policies, procedures and mandates. Equally importantly, 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).

**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

**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.

**Individual MH Treatment Plan** - comes from the Cross System Care Plan

## [WISe Planning Elements](#)

**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 - <http://www.dshs.wa.gov/dbhr/mhpeer.shtml>

## C. 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:

- A family member or youth 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.
- A Family 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 family (informal/natural supports).
- Bring a copy of a written agenda for everyone or write it on easel paper for everyone to see. At minimum, 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 Family Vision Statement:*

- The care coordinator and family/youth partner should talk with the family about their vision before the first team meeting and help them express this vision to the rest of the team.
- The language used by the family should be preserved in the final vision statement.
- Avoid letting team members add to the family vision but they may need clarification as to the implications.
- All team members should be given a written copy of the final vision statement and it shall be reviewed by the team regularly.

*Construct a Team Mission Statement or 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 care coordinator and family/youth partner should talk with the 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 CANS and then all team members should add to these strengths.
- Maintain a written list and add to these at each team meeting. After the first team meeting, the list should include strengths and successes.
- At the first team meeting, members may focus on descriptive and contextual strengths. As the team gets to know each other, help them formulate functional strengths to use in the plan of care.
- Avoid going back-forth between strengths and needs. Finish the strengths list before moving on.

*Develop a List of Needs or Review Current Needs:*

- The care coordinator and family partner should talk with the 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-forth between strengths and needs. Complete strengths before identifying needs.
- Avoid organizing the list of needs by person.

*Prioritize Needs:*

- Facilitate a discussion with the team about which needs should be prioritized (those 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 strategy includes specific action steps and 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 next Team Meeting:*

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

Transition

- Leaving WISE has been discussed with the team.
- Crisis drills have been practiced and the family is confident they know what to do if things go poorly.
- Families are able to articulate how to access services in

## 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

the future.

- Youth and their family members have a way to connect with other youth and families who have been through the WISE process.
- The youth and family's concerns have been considered in the transition planning.
- Youth and their family have a list of team member contact information to include phone numbers and email addresses, who they can contact if needed.
- Youth and family have written documents that describe their strengths and accomplishments.
- Youth and family have been offered a formal opportunity to celebrate their successful transition from the formal WISE program.

### Principles Evidenced in Practice

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

### Required Documentation

Each WISE site will complete the following documents for each enrolled youth and their family. Items 1-3 are to be reviewed at each Child and Family Team Meeting:

1. CANS
2. Crisis and Safety Plan
3. Cross System Care Plan
4. Child and Family Team Meeting Minutes (CFT Minutes)
5. Progress Notes

## D. WISe Capacity Attestation

\_\_Start-up    \_\_Expansion

Agency Name:

Key WISe contact person:

Phone number:

Email:

<b>Background</b>			
The WISe Capacity Attestation must be completed by an agency in collaboration with their RSN upon the initiation and any expansion of WISe within their area.			
<b>WISe Key Elements</b>			
	Yes	No	Comments
Has the agency/RSN 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 Regional Support Network (RSN).	<input type="checkbox"/>	<input type="checkbox"/>	
Agency is certified to provide all of the following services			
• 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 with expiration date			
Established on-call staff 24/7 within the WISe team?	<input type="checkbox"/>	<input type="checkbox"/>	
Established community collaborative with appropriate makeup?	<input type="checkbox"/>	<input type="checkbox"/>	
• 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"> <li>• If yes, please list tribe(s)</li> <li>• If no, please indicate plan to engage</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
Discussion with DBHR to determine approved number of WISe participants? <ul style="list-style-type: none"> <li>• If yes, please indicate the approved number of participant in comments.</li> </ul> <p><i>Formula: at least one FTE Family/Youth partner and one FTE clinician/care coordinator = 10 participants; 2 FTE family/youth and two clinician/care coordinators = 20 participants; and so on</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	Approved number:  <i>(Agency/RSN will complete another attestation prior to expanding capacity beyond this agreed upon number)</i>

**Additional Comments**

**Signatures**

Agency:      Print Name \_\_\_\_\_ Signature \_\_\_\_\_      Date: \_\_/\_\_/\_\_

RSN:            Print Name \_\_\_\_\_ Signature \_\_\_\_\_      Date: \_\_/\_\_/\_\_

**Approval**

DBHR:          Print Name \_\_\_\_\_ Signature \_\_\_\_\_      Date: \_\_/\_\_/\_\_

**Agency capacity and qualifications forwarded to Provider One**      Date \_\_\_\_\_      Initials \_\_\_\_\_

## **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 Care<sup>2</sup> 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.
  - 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).

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<sup>2</sup> 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.

**F. Period of Performance**

This MOU will be reviewed every three years.

Effective Date: 7.3.13

## F. Service Array and Coding

For service array and coding, follow the Service Encounter Reporting Instructions (SERI) for Regional Support Networks. The Service Encounter Reporting Instructions can be found on line at:

<http://www.dshs.wa.gov/dbhr/sericptinformation.shtml>

## 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)

<b>Criterion 1. Behavioral/Emotional Needs</b>
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>
<b>Criterion 2. Risk Factors</b>
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>
<b>Criterion 3. Serious Functional Impairment</b>
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

<b>1</b>	Family Vision Statement (Family)	What does better look like for the family (long term)?
<b>2</b>	Team Mission Statement (Team)	What does the team have to accomplish while they are together (short term)?
<b>3</b>	Useful Strengths (CANS)	Strengths items with a 0 or 1 on the CANS and should be used in planning
<b>4</b>	Additional Strengths (Team)	Other strengths identified by the family and team.
<b>5</b>	Background Needs (CANS)	Needs that are most likely not addressable but shift the pathway which interventions are provided
<b>6</b>	Targeted Needs (CANS)	Needs that are the focus of interventions
<b>7</b>	Needs Statements (Team)	Statements that describe the individualized needs of the youth and/or family members.
<b>8</b>	Anticipated Outcomes (CANS)	Needs that would be expected to respond as a result of effectively addressing the targeted needs.
<b>9</b>	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).
<b>10</b>	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.
<b>11</b>	Useful Strengths Activities (Team)	Planned activities that utilize the useful strengths in the planning process.
<b>12</b>	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
<b>13</b>	Strengths to Build (CANS)	Strengths Items with a 2 or 3 on the CANS.
<b>14</b>	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 for each of the following affinity groups with written materials, communication plans, and education/training specific to each:

- Regional Support Networks (RSNs)
- WISe Mental health agencies
- Children's Administration
- Juvenile Justice and Rehabilitation Administration
- Developmental Disabilities Administration
- Schools
- Pediatricians
- Child Psychiatrists
- Behavioral Health Specialists/Therapeutic Aides
- Family/Youth Organizations
- Health Care Authority and their providers
- Juvenile Court Administrators
- Crisis Teams
- Tribes
- Participating youth and families

### **Specific elements to be included are:**

- Identifying youth that may benefit from WISe
  - tools within the affinity system that can be used as triggers or flags for referral to WISe
  - when a referral is mandatory
- How to refer- whom 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