DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: CHILDREN’S INTENSIVE IN-HOME BEHAVIORAL SUPPORT

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Title: CHILDREN’S INTENSIVE IN-HOME BEHAVIORAL SUPPORT

Authority:
- Chapter 71A.24 RCW
- Chapter 388-825 WAC
- Chapter 388-845 WAC

Developmental Disabilities – Intensive Behavior Support Services
Developmental Disabilities Services
DD Home and Community Based Waiver Services

References:
- DDA Policy 5.19, Positive Behavior Support for Children and Youth
- DDA Policy 5.20, Restrictive Procedures and Physical Interventions for Children and Youth
- CIIBS Frequently Asked Questions (FAQ)

BACKGROUND

In May 2009, the Developmental Disabilities Administration (DDA) implemented the Children’s Intensive In-home Behavioral Supports (CIIBS) Program, a federal 1915(c) Home and Community Based Services Waiver. The waiver targets children and youth ages 8 up to 21 years, with autism or other developmental disabilities and challenging behavior, at risk of out-of-home placement without intensive services for the child and family. The CIIBS core practice model is a combination of wraparound service planning and positive behavior support to meet the needs of the child and family.

The Administration has formally endorsed positive behavior support as the systematic approach for intervention and prevention of challenging behaviors. The literature indicates that positive behavior support, with parental/caregiver involvement and technical support, is an effective intervention for children and youth with developmental disabilities, including autism and other disorders, to significantly prevent and reduce severe challenging behaviors.

Using positive behavior support principles and techniques with children and youth can:

- Reduce and prevent challenging behaviors;
- Encourage family/caregiver involvement;
• Improve communication abilities;
• Enhance educational experiences;
• Expand opportunities for social interaction; and
• Avoid the need for restrictive procedures.

The state of Washington has formally endorsed wraparound service planning as a process and systems of care as an infrastructure for addressing the needs of children, youth, and families with emotional and behavioral disorders. The literature indicates that wraparound planning consistently and significantly improves outcomes for children and youth with complex needs including the reduction of out of home placement; improved mental and behavioral health; improved school success; and reduced juvenile justice recidivism.

PURPOSE

This policy describes the Administration’s expectations regarding the delivery of CIIBS services to enrolled waiver participants and their families. Procedural requirements are included regarding wraparound planning activities, delivery of contracted behavioral supports, and the provision of other waiver services.

SCOPE

This policy applies to all children and youth who receive DDA funded services through the CIIBS Home and Community Based Services Waiver.

DEFINITIONS

Challenging behavior means actions by the child/youth that constitute a threat to the child/youth’s health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the child/youth’s functioning in public places and integration with the community, or uncontrolled symptoms of a physical or mental condition. These behaviors may have been present for long periods of time or have manifested as an acute onset.

Child/Youth means ages eight (8) through twenty (20) years for the purposes of this policy.

Child and Family Team (CFT) means a group of people, chosen with the family and connected to them through natural, community, and formal support relationships. This team develops and implements the child and family’s plan, addresses unmet needs, and works toward the family’s vision.

Child and Family Team Care Plan (CFT Care Plan) means the plan developed by the child and family team designed to meet the holistic needs of the child/youth and family through formal, informal, and natural supports. This plan begins with the family vision and team mission and includes strengths, needs, goals, action steps, and documentation of measurable outcomes. Refer to Attachment B of this policy for the form used to document this plan and its elements.
Note: In cases involving outside wraparound facilitation, the CFT Care Plan refers to the document used by the outside agency that includes these same elements.

**CIIBS Case Manager** means the DDA Case/Resource Manager responsible for a caseload of up to 18 CIIBS waiver participants. The CIIBS Case Manager provides case management services and acts as the facilitator of child and family teams.

**CIIBS Coordinator** means the DDA supervisor responsible for overseeing the work of the CIIBS Case Managers and the implementation of the CIIBS program regionally.

**CIIBS Resource Manager** means the DDA Case/Resource Manager responsible for recruitment, contracting, and contract monitoring of CIIBS behavioral support and goods and services providers. The CIIBS Resource Manager provides families and case managers with information and support regarding available providers to match family needs and preferences.

**DDA Assessment** refers to the standardized assessment tool, as defined in Chapter 388-828 WAC, used by DDA to measure the support needs of persons with developmental disabilities.

**Department** means the Department of Social and Health Services.

**Developmentally-based approaches** means structured interventions, methods, and techniques that focus on each child/youth’s unique developmental profile and are respectful of and appropriate to the child/youth’s chronological age.

**Enrolled** means that all eligibility criteria, according to WAC 388-845-0030, have been met for a participant and a waiver effective date has been set for services to begin. Waiver services may not begin until a participant is enrolled.

**EPSDT** means Early and Periodic Screening, Diagnosis, and Treatment. EPSDT is Medicaid's child health component that provides a mandatory and comprehensive set of benefits and services for children up to age twenty one as defined in WAC 182-534-0100.

**Family Vision** means a statement owned by the family and written in the family’s own words that describes their vision for the future. The Family Vision becomes a basis for the Child and Family Team Mission Statement.

**Functional Assessment (FA)** means a process that evaluates:

- The overall quality of a person’s life;
- Factors or events that increase the likelihood of challenging behavior;
- Factors or events that increase the likelihood of appropriate behavior;
- When and where the challenging behavior occurs most frequently;
- The presence of a diagnosed mental illness or neurological dysfunction that may contribute to the challenging behavior; and
• The functions or purpose of the challenging behavior (what the person obtains or avoids by engaging in the behavior).

**HCBS waivers** means federal 1915(c) home and community based services waivers.

**Positive Behavior Support** means an approach to addressing challenging behavior that focuses on changing the physical and interpersonal environment and a person’s skill deficits so that the person is able to get their needs met without having to resort to challenging behavior. Positive behavior support must be emphasized in all services funded by DDA for persons with developmental disabilities.

**Positive Behavior Support Plan (PBSP)** means a plan based on the completed Functional Assessment (FA) which will help to eliminate or reduce the frequency and severity of the challenging behavior. A PBSP generally contains the following common elements:

• Recommendations for improving the general quality of a person’s life;
• Providing increased interesting activities to fill a person’s time;
• Reducing events that are likely to provoke the challenging behavior;
• Methods to teach alternative appropriate behaviors that will achieve the same results as the challenging behavior;
• Methods to develop effective strategies for responding to challenging behaviors; and
• Professional recommendations for treating mental illness and/or neurological dysfunction.

**Systems of Care** 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 complex needs and their families. Systems of care build meaningful partnerships with families and youth, address cultural and linguistic needs, and use evidence-based practices to help children, youth and families function better at home, in school, in the community and throughout life.

**Team Mission** means a statement owned by the Child and Family Team and written in the words of the team that describes the overarching goal of their work together. The Team Mission is based upon and supports the Family Vision and guides the goals and objectives of the team members.

**Wraparound planning model** means a planning process, in which a child and family team collaboratively develops an individualized plan of care, implements this plan, monitors the efficacy of the plan, and works towards success over time. A hallmark of the wraparound process is that it is driven by the perspectives of the family and the child or youth. The wraparound plan includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family’s social networks.
POLICY

A. The planning and delivery of CIIBS services and supports must consider the holistic needs of children, youth, and families and follow the ten principles of the wraparound planning model:

1. **Family-driven and youth guided.** Family and child/youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. **Team based.** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

3. **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. The Child and Family Team Care Plan (CFT Care Plan) reflects activities and interventions that draw on sources of natural support. **DSHS 10-471, Child and Family Team Care Plan**, will be used to document the plan.

4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single CFT Care Plan. The plan reflects a blending of team members’ perspectives, mandates, and resources. The plan guides and coordinates each team member’s work towards meeting the team’s goals.

5. **Community-based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

7. **Individualized.** To achieve the goals laid out in the CFT Care Plan, the team develops and implements a customized set of strategies, supports, and services.

8. **Strengths based.** The wraparound process and the CFT Care Plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. **Persistence.** Despite challenges, the team persists in working toward the goals included in the CFT Care Plan.

10. **Outcome based.** The team ties the goals and strategies of the CFT Care Plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

B. Along with positive behavior support, developmentally-based approaches should be used to support children and youth on the CIIBS waiver. This means structured interventions, methods, and techniques that focus on each child/youth’s unique developmental profile, and respectful of and appropriate to their chronological age.

C. CIIBS contracted providers are required to follow DDA Policy 5.19, *Positive Behavior Support for Children and Youth*, for the delivery of intensive services. Providers are not authorized to use or recommend restraints or restrictive physical interventions while working with a child/youth in the family home. Use of restrictive procedures and interventions during an emergency must be documented in an incident report (IR) per DDA Policy 12.01, *Incident Management*.

**PROCEDURES**

**WRAPAROUND PLANNING PROCESS**

A. **Pre-enrollment Phase** – During this phase, the CIIBS Case Manager or the referring Case/Resource Manager works with the family to gather evidence to support waiver eligibility. The process for a participant to become enrolled on the CIIBS waiver, following approval of an enrollment request, averages between 30 to 90 days. CIIBS waiver paid services cannot be delivered prior to enrollment. Previously approved DDA services, if applicable, may continue prior to waiver enrollment.

B. **Phase I - Family Engagement and Team Preparation.** During this phase, the groundwork for trust and a shared vision between DDA, waiver participants and family members, and wraparound team members is established. The activities during this phase set a tone for family involvement, teamwork, and interactions that are consistent with the principles of wraparound.

1. Prior to enrollment on the waiver, the CIIBS Case Manager, CIIBS Resource Manager, and/or the CIIBS Coordinator meets with the child and family to explain the CIIBS model of service and to hear the family’s story. The family is provided with the *CIIBS Frequently Asked Questions (FAQ)* document at this meeting. This document may be found on the DDA Internet Waiver Services webpage at [https://www.dshs.wa.gov/dda/consumers-and-families/waiver-program](https://www.dshs.wa.gov/dda/consumers-and-families/waiver-program).
a. If the family agrees to receive services according to the model, the CIIBS Case Manager obtains signatures on DSHS 20-273, The Family Agreement to the CIIBS Program. In families with more than one parent or legal guardian, signatures from both are required.

b. Releases of information for the purposes of communication and collaboration must be obtained using DSHS 14-012, Consent.

2. Once the family has agreed to receive CIIBS services according to the model, the CIIBS Case Manager begins the following activities with the child/youth and family:

a. Collects baseline information on child and family history and well-being. This includes the Family Interview, Family Interaction Matrix, and the Teacher Interview. All baseline program data forms are located on the CIIBS SharePoint Site;

b. Ensures that the family is connected with the CIIBS Resource Manager. The CIIBS Resource Manager will provide a list of all available intensive service providers in their community, elicit child and family preferences, and support them in the decision making process. The CIIBS Resource Manager will provide resource information about other relevant services as requested;

c. Support the family to create their Family Vision Statement. The Family Vision is owned and written by the family. It serves as a guide for planning and is supported by the Team Mission Statement;

d. Gather strengths and needs of the child/youth and their family members across multiple domains. Domains include home, family/relationships, social/recreational, daily living, psychological/emotional, substance abuse/addictions, educational/vocational, legal, health/medical, crisis/safety, cultural/spiritual, and financial;

e. Gather names and contact information for potential child and family team members and agree upon who will contact the potential members; and

f. Ensure all steps for waiver enrollment have been completed and that the child is enrolled.

3. Once the above activities are complete, a date is set for the first child and family team meeting to be held within 30 days.
4. Following waiver enrollment, the CIIBS Case Manager meets with the family and/or the child and family team at least every 30 days for the first 90 days and as a team at least once every 90 days thereafter.

5. The Team Mission Statement is developed at the first child and family team meeting. The Team Mission is owned and written by the team. It supports the Family Vision and guides team planning toward measurable goals and outcomes.

C. **Phase II - Initial Plan Development.** During this phase, the child and family teams begin to meet regularly as determined by the team based on the level of need (usually on a monthly basis, but not less than once every 90 days). Teams develop an initial plan for addressing prioritized needs.

1. Child and Family Team meetings include the following activities and structure:
   
   a. Establish and follow ground rules for respectful and efficient communication and collaboration;
   
   b. Review and add to the list of strengths over time;
   
   c. Identify all needs arising through the team planning process that reflect the family’s concerns and those of team members;
   
   d. Prioritize and select a few needs to avoid overwhelming the family and team members. Team members agree through consensus which needs are the most pressing and should be prioritized highest. Other identified needs that are not the highest priority are noted in the CFT Care Plan for planning at a later date. At any meeting, team members can decide to raise a lower priority need to a higher priority or prioritize new needs that arise;
   
   e. Brainstorm a variety of strategies for meeting the prioritized needs and identify those strategies that match the strengths and values of the child and family; and
   
   f. Select action steps that involve the participation of all team members and set dates for completion.

2. Document child and family team meetings as follows:
   
   a. Document the dates of all team meetings, including face to face pre-planning activities (e.g., Phase I activities), in the CIIBS Visit tab on the Waiver screen in CARE. Note “CFT” in the comments section pertaining to any CIIBS Visit Date on which a team meeting was held;
b. Document all planning activity, progress, and outcomes on the CFT Care Plan document. This is to include identified needs that were not prioritized, service requests, and related action steps;

c. Provide a copy of the CFT Care Plan to the family and team members within one week of the meeting with a request that they review the document and let you know if any corrections are needed;

d. Make any corrections needed as a result of the team’s review and redistribute the CFT Care Plan to all team members;

e. Store CFT Care Plans on the CIIBS SharePoint site according to participant name and the team meeting date. Add updated plans while maintaining a history of previous documents. All CIIBS Visit Dates for which the comment notes that a CFT team meeting was held should correspond to a CFT Care Plan on the SharePoint site.

D. **Phase III - Plan Implementation.** Teams meet regularly during this phase as determined by the team based on need, but at least once every 90 days. Plans are fine-tuned during this phase. Progress is monitored to ensure that goals are being accomplished and the process is improving the well-being of the child/youth and family. Activities during this phase include:

1. Follow the activities of the Initial Plan Development Phase and monitor progress toward meeting all identified goals;

2. Review and document accomplishments and progress made toward the achievement of the goals laid out in the plan;

3. Ensure that plans are meeting the needs of the child and family by adjusting the strategies (e.g., goals and action plans) as necessary;

4. Continue to document team meeting dates on the CIIBS Visit Screen;

5. Continue to send copies of the CFT Care Plans to team members within the one week timeframe, making any necessary changes upon team member request; and

6. Continue to store the corresponding CFT Care Plans in the previously described manner on the CIIBS SharePoint site.

E. **Phase IV - Transition.** As the CIIBS waiver continues until age 21, meetings during this phase continue to meet at least once every 90 days and involve plans for sustaining progress and accomplishments. As families become ready, they are supported to take on more and more responsibility for facilitation of the team meetings and for continuing the
progress accomplished on the CIIBS waiver in preparation for termination from the program. This phase builds upon previous progress and empowers the family to continue the strategies that work for all members. These strategies include maintaining a natural support system into the future; decreasing the involvement of professional supports; and sustaining continued growth in the areas of skill development and prevention of challenging behaviors. The following activities occur during this phase:

1. Continue activities and documentation of Phase III;

2. During the year prior to age 21 (or sooner if the youth is transitioning from CIIBS earlier than age 21), planning will include:

   a. Consideration of the level of support needed to sustain progress following the CIIBS waiver. Information in the youth’s DDA assessment; data analysis of skill development and challenging behavior; a review of progress achieved over time; and a determination of the nature of ongoing services and supports needed to maintain progress should be included in this consideration.

   b. Post-high school and vocational preparation, including support to create and implement transition goals with the youth’s Individualized Education Plan (IEP);

   c. Preparation for the youth and family to lead the planning process on their own as needed; and

   d. Referral to and assistance in securing programs or services determined necessary to meet the ongoing needs of the youth and family.

CIIBS INTENSIVE SERVICES

A. Positive Behavior Support

1. Upon enrollment in the CIIBS Waiver, families select a behavioral support provider. Behavior support is a mandatory component of the CIIBS model. CIIBS intensive services may include both behavior specialist and behavior technician services.

2. Behavior Specialists partner with families to conduct a functional behavior assessment and develop a positive behavior support plan to address challenging behavior and skill development within sixty (60) days of accepting a referral. Behavior specialists are responsible for ensuring that strategies are matched to the strengths and values of the child/youth and family. They oversee the delivery of the plan; provide training and consultation to the family, behavior technicians,
and others in the child/youth’s life; and analyze data regularly to monitor progress and adjust plans as needed in order to meet behavioral goals.

3. Behavior Technicians work directly with the child/youth and family to implement and model the positive behavior support plan to the family and others in the child/youth’s life, as designed by the Behavior Specialist. The work of the Behavior Technician must always be overseen by the Behavior Specialist.

4. CIIBS Case Managers or other designated staff review plans to ensure that behavior support providers are following DDA Policy 5.19, Positive Behavior Support for Children and Youth, in conducting their work with families. Staff will use the DSHS 10-472, Functional Assessment & Positive Behavior Support Plan Quality Review Tool, in these reviews.

5. Once the PBSP has been completed, the team will meet together to make a recommendation of hours and a schedule of support needed to implement the plan. Behavior support hours must be determined necessary and purposeful in order to accomplish the behavioral goals set forth in the plan. Team recommendations will be considered by DDA for inclusion in the child/youth’s Individual Support Plan (ISP).

   a. Families will receive a copy of the ISP and a Planned Action Notice (PAN) identifying the approved hours and description of service to be provided.

   b. Providers will receive a copy of the ISP and DSHS 16-200, Memo to Provider of Behavior Support, Counseling and Consultation Services, in order to proceed with the agreed upon plan for implementation.

   c. CIIBS Case Managers ensure that behavior support providers fully complete the following DSHS forms in their work with participants and families in a timely manner, as required by contract:

      (1) DSHS 15-383, Functional Behavioral Assessment, to conduct and record the FA;

      (2) DSHS 15-382, Positive Behavior Support Plan, to record the PBSP; and

      (3) DSHS 15-384, Provider Progress Report of Behavior Management and Consultation and Staff/Family Training and Consultation Services, to submit data and record quarterly progress toward behavioral goals.
B. Service Requests

1. Requests for CIIBS waiver services may be made verbally or in writing by families or other team members at any time during the course of a waiver year at a team meeting or by contacting the case manager between meetings. Written requests by family and team members are completed using DSHS 10-470, CIIBS Service Request. This form may also be found on the DDA Internet Waiver Services webpage at https://www.dshs.wa.gov/dda/consumers-and-families/waiver-program.

2. Requests are generally considered part of the team planning process as they are strategies for meeting the identified needs of the child/youth and family. Thus, service requests must be addressed as a part of the next child and family team meeting. If the family or a team member believes that the request cannot wait until the next scheduled meeting, a team meeting may either be scheduled sooner or the request processed prior to the meeting.

3. Within three (3) business days of all verbal or written requests for DDA services, the CIIBS Case Manager will document all requests for DDA services on the Service Request Screen in CARE along with the date and the nature of the request (e.g., specific item and purpose).

4. Service planning must include the need the request is intended to meet, as well as alternatives, and any steps necessary for meeting the need. Private insurance and State Plan Medicaid benefits must be considered prior to the use of waiver funding. Document team action steps, including assistance to apply for and access non-waiver benefits, in the CFT Care Plan. CIIBS Case Managers must provide assistance to access and coordinate waiver benefits with the Health Care Authority and other Department of Social and Health Services administrations.

5. Service request decisions are made by DDA based on a review of the following:

   a. Washington Administrative Code (WAC) governing the service;
   
   b. Required professional assessments and recommendations related to the underlying need and its relation to the service;
   
   c. Behavioral and skill building goals in the PBSP; and
   
   d. Three environmental adaptation bids or equipment cost comparisons. Cost, quality, and the environment are all considerations in determining which bid or cost comparison is the best value.
6. Document the progress toward the delivery and outcome of requested services and alternatives, in the CFT Care Plan.

7. Prior Approval requests are submitted, if necessary, once all pertinent information supporting the request has been obtained. All service decision outcomes (e.g., approval, partial approval, and denial) must be documented in a Planned Action Notice within ninety (90) days of the request. PANs for partially approved or denied services must describe the scope and basis for the denial. If decisions take longer than 90 days due to further need for planning, documentation in the CFT Care Plan should demonstrate consistent progress toward a decision and explain reasons for any delay.

EXCEPTIONS

No exceptions to this policy may be granted without the prior written approval of the Assistant Secretary.

SUPERSESSION

None

Approved:  /s/ Kathy Leitch  Date:  April 15, 2013
Assistant Secretary
Developmental Disabilities Administration