



Service Delivery, Policy, Procedure and Resource Manual

Washington State Wraparound with Intensive Services (WISE) is a service delivery model designed to provide comprehensive services and supports to individuals twenty years of age or younger, and the individual's family. The purpose of this manual is to direct the development and maintenance of a sustainable and consistent service delivery system for providing intensive behavioral health in home and community settings to Medicaid eligible children, youth, and their families.

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Section 1: Purpose and Goals

Washington State's Wraparound with Intensive Services (WISE) is based on System of Care (SOC) values and is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals who are twenty years of age or younger, (herein referred to as "youth") with complex behavioral health needs and their families. SOC values are family driven and youth guided, community based and culturally and linguistically appropriate. The goal of WISE is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements while receiving behavioral health treatment services. As of June 30, 2018, WISE has been implemented in all 39 Washington State counties and is available statewide.

The purpose of this manual is to create consistency across Washington State's service delivery system for those providing intensive in home and community behavioral health services to Medicaid eligible youth. The WISE service delivery model is intended to be individualized, and tailored with room for flexibility, creativity and youth and family voice and choice

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

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

This manual is a living document and will be reviewed annually. Most current version of the manual will be posted on our [Children's Behavioral Health website](#).

Objective

This manual will provide guidelines to ensure consistency in the goals, principles, service delivery, and quality of WISE across the state. We believe implementing the WISE service delivery model, utilizing the Washington State Children's Behavioral Health Principles (previously named the Mental Health Principles), will:

- Promote recovery, increase resiliency and reduce the impact of behavioral health symptoms on youth and families.
- Keep youth safe, at home, in the community and making successful progress in school.
- Promote youth development, maximizing their potential to grow into healthy and independent adults.

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

Washington State Children's Behavioral Health Principles

Washington State's Health Care Authority (HCA) believes 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 behavioral health system that delivers services to youth, in a manner consistent with these principles:

- **Family and Youth Voice and Choice:** Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth's and family's vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from the youth's and family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.



- **Collaboration:** The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based:** Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome-based:** Based on the youth and family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional:** A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

What is different about WISE?

Focus on youth and family voice utilizing a strength-based approach

The WISE provider intentionally seeks out youth and family voice, choice and preferences during all phases of the process, including planning, delivery, transition, and evaluation of services. Supports and services are delivered in a way that honors youth-guided and family-driven care. Together, the WISE provider, youth, and family will plan and deliver services and supports 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.



Primary setting

WISE services are intended to be provided in the home and in community locations, and at times and locations that ensure meaningful participation of youth, family members, and natural supports. Telehealth is also an option for service delivery and should be guided by youth and family choice (see note on COVID-19 on page 78). WISE is tailored for youth with intensive and complex behavioral health needs. Assessment, treatment, and support services are provided in the youth and family's natural setting, where needs, strengths, and challenges present themselves (such as the home, school and community).

Flexible and creative services

WISE is intended to be provided in timely, creative, individualized and flexible ways. Those served through WISE tend to come into services with complex needs and involved histories. This approach must provide unique methods of support, as many of the youth and families served have found traditional behavioral health care unable to meet their needs. Others remain at risk of more restrictive care, even after receiving traditional behavioral health services.

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

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



Section 2: Agency Infrastructure

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

WISE team members demonstrate a high level of flexibility and accessibility by working at times and locations that ensure meaningful participation of family members, youth and natural supports, including evenings and weekends. WISE also provides access to crisis response 24 hours a day, seven days a week, by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan. The service array includes intensive care coordination, intensive treatment and support services, and mobile crisis outreach services. The service array is provided in home and community settings and based on the individual's needs and a plan developed using a wraparound process by a Child and Family Team (CFT). Behavioral health services and supports will be available that are sufficient in intensity and scope, including those based on available evidence of effectiveness, and individualized to each youth and their family's unique needs. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized to the goals identified and prioritized by each youth and family. Potential areas to include in goal setting can include:

- increased safety, stabilization, school success, and community integration
- support to ensure that youth and families can live successfully in their homes and communities
- gathering information and resources to support youth and families to make informed decisions regarding their care and with a goal of avoiding hospitalizations and out-of-home placements whenever possible

Federal and State Requirements

This section will outline the infrastructure requirements an agency must have in place to be eligible for consideration as a WISE provider. The services provided under WISE are Medicaid funded services, and therefore require agencies to meet all applicable federal standards related to the provision of behavioral health services covered under Medicaid. Agencies interested in becoming a WISE provider must hold a current Behavioral Health Agency License, issued by the Department of Health.

In order to be paid for providing WISE, approved agencies need a contract with an MCP or a Fee for Service (FFS) contract with HCA. Approved WISE agencies can have both types of contracts. Additionally, agencies must be certified to provide, or have sub-contracts or Memorandums of Understanding (MOUs) in place, to provide all of the following services:



- 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 (for example peer counseling)

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 Department of Health's Licensing and Certification staff. More information can be found on the [Department of Health website](#).

WISE-Specific Requirements

Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated MCP, and DBHR according to the WISE [Quality 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 22 and 36. 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 intensive, therapeutic, home and community-based services within the agency, or through sub-contracts or an MOU. WISE agencies will provide each participating youth and their parent/caregiver and family or support network with a Child and Family Team (CFT) and at a minimum, access to these services:

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



The above listed services are to be as described in this document, the [Integrated Managed Care or IMC Service Encounter Reporting Instructions \(SERI\)](#), and as described in the larger [Encounter Data Reporting Guide](#).

Behavioral health services offered to youth and families that are participating in WISE should typically be provided by staff employed at a WISE-qualified agency and provided in accordance with WAC 246-341-0726. However, services and supports are not limited to only those provided by the WISE agency. The CFT has the responsibility to identify needs, consistent with youth and family voice, and develop strategies to meet these needs, including referral and coordination with other services and systems. When the CFT determines a core component of WISE should be provided by another agency that is not WISE certified, (for example youth would prefer to remain with their current therapist based on specialized treatment needs, and the therapist is not at the WISE agency), the CFT has the responsibility to coordinate with the youth's MCP and obtain MCP approval. Other needed services and supports (such as substance use disorder treatment or Applied Behavioral Analysis), including those provided by system partner agencies, are to be outlined in the **single** Cross System Care Plan (CSCP) that is developed and monitored by the CFT. This includes any medically necessary services covered under [EPSDT \(Early and Periodic Screening, Diagnostic and Treatment\)](#) and identified on the Individual Service Plan, which would also be linked to the CSCP and coordinated through the WISE team.

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

Staffing

WISE provider agencies must have sufficient WISE qualified staff to:

- Manage the capacity-level identified by the MCP
- For WISE FFS manage capacity identified by DBHR
- Deliver or coordinate all medically necessary behavioral health services, including but not limited to, intensive services, substance use, Applied Behavioral Analysis, psychiatric consultation/medication management.
- Provide each youth/family served with:
 - Mental health therapies (i.e., family, individual treatment, etc.).
 - Care coordination.
 - Peer counseling through Family Partner and/or Youth Partner who are certified peer counselors, or qualify for certification.

Note: Descriptions and responsibilities for staff that provide each of these services are outlined in Appendix B.

- Provide clinical supervision and support in participation for ongoing trainings and coaching with the WISE- Workforce Collaborative (see Appendix K for the framework).
- Have psychiatric consultation available to each team.
-

- Maintain an average caseload size per Care Coordinator of 10 or fewer participants, with a maximum of 15 at any given time, for each Care Coordinator.
- Provide 24/7 mobile crisis intervention (see Section 4 for details) to youth and families, preferably through staff that are known to the youth and family.
- Meet timelines for completing WISE CANS (Child and Adolescent Needs and Strengths) screens, initial Full CANS, and re-occurring Full CANS every 90 days, which include entering the information into the Behavioral Health Assessment System (BHAS).

Cross-System Collaboration

WISE provider agencies are required to collaborate and include other child serving system partners (child welfare, juvenile justice, education, developmental disabilities support, etc.) on CFTs, as applicable to each youth and family, as identified in the Point of Identification section of the Access Model (hereafter system partners). The agency is to work with the youth, family and system partners to develop a single Cross System Care Plan (CSCP) for the youth and family. The CSCP can encompass the individual service plan requirements and will likely include a variety of other activities. Medicaid services must be prescribed clearly, according to Medicaid documentation standards, regardless of whether the individual service plan is incorporated into the CSCP or a separate document.

The MCPs will work within their local communities to invite diverse representation and establish appropriate communication channels for engaging family, youth, and local community representative in the Child Youth and Family Behavioral Health Governance Structure to inform policy-making and program planning. Section 6 describes the requirements to identify regional processes on how MCPs coordinate and participate in the governance structure.

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

Documentation

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

- Quality Plan
- 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 file:
 - Skill development and implementation support
 - Training
 - Recertification and competency demonstration

- Coaching
- Supervision
- [Agency Affiliated Counselor registration](#) or other individual professional licensure (LMHC, LICSW, LMFT, etc.) in accordance with Department of Health rules and/or [Certified Peer Counselor as outlined by HCA/DBHR](#)

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

- Completed CANS Screen, Full CANS within 30 days of WISE enrollment, Full CANS every 90 days, and Full CANS again upon transition to a lower level of care or discharge.
- Discharge from WISE should be based on successful achievement of goals outlined in the CSCP, endorsed and supported by the youth, family, and team.
- Length of treatment in WISE is not a set time period. It is based on medical necessity and allows for transition time into a lower level of care.
- If the youth has been out of WISE services for more than 6 months a new CANS screen must be completed. A Full CANS must be completed within 30 days of a youth's first service regardless of provider.
- Cross System Care Plan (CSCP) (note: see Appendix H for core elements and a sample format), including revisions and updates.
 - The CSCP must address the needs found within the Individual Service Plan (ISP), or could include all required elements of the ISP within the CSCP.
 - Expected outcomes/transition activities and transition/discharge criteria will be clearly defined in the CSCP or contained in a Transition Plan.
- All necessary Releases of Information
- Crisis/Safety Plan (may also be known at some providers as a Wellness Plan or Support Plan.)
- CFT meeting notes:
 - Meeting frequency should be determined by needs intensity, and every 30 days at a minimum, or more often if youth and family needs indicate.
 - Notes should include a list of attendees (the youth and/or family are required to be present for a meeting to be considered a CFT). Participation of young children will be decided upon by the CFT, as appropriate.
 - A record that notes were shared with all members of the CFT, with a signed release of information, within a week of each meeting that reflects the voice of family and youth.



WISE Agency Website

The following information should be included on the website for each WISE agency:

- General information about WISE services
- Information regarding eligibility for WISE services
- Direction on how to make a referral for WISE services
Note: Agencies must not require an intake or application be completed in order to have a WISE screen. Also, the ability to complete the CANS screen over the phone must be an option
- Helpful, but optional, to have a Link to the [HCA WISE website](#).



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, WISE providers approved for Fee For Service (FFS) and Managed Care Plans (MCPs) will utilize the protocols of this section to meet the requirements related to:

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

Identification

Child-serving systems, such as Department of Child, Youth & Family Services (DCYF), Department of Social and Health Services (DSHS), Health Care Authority (HCA), school personnel, county and community providers, and Tribal service providers assist in the identification and referral of youth who might benefit from WISE. Consideration for referral begins with youth who are Medicaid eligible, age 20 or younger, and who have complex behavioral health needs. Other indicators to consider for a WISE referral may include, but are not limited to:

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

Information sheets with more detailed factors to consider, specific to identified affinity groups, have been developed. A link to these materials is included in Appendix I.



Referrals

Anyone can make a referral for a WISE screen, including the youth and family. All Medicaid-eligible youth, age 20 or younger, who might benefit from WISE should be referred for a WISE Screen.

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

1. When a youth is referred to Children's Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS services only (not BRS and WISE concurrently), or receiving CLIP services: no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from a psychiatric hospital.
4. When a step-down request has been made from institutional or group care.
5. When a youth receives crisis intervention or stabilization services, and there are past and/or current functional indicators of need for intensive behavioral health services.

If a youth **is currently** receiving Medicaid behavioral health services a referral for a WISE Screen can be completed in the following ways:

- The current provider can complete the CANS screen, if they are certified in the CANS, or
- The current provider can make a referral to a WISE-contracted provider agency that will complete the CANS Screening. If a youth does not meet the CANS algorithm, clinical judgment may be used to continue with a referral to WISE.

If a youth **is not currently** receiving Medicaid behavioral health services, a referral to WISE can be most easily completed by contacting the WISE referral contacts for each [MCP contracted WISE provider or county Fee For Service providers](#).

In addition, requests for assistance with referrals for a WISE screen may be made directly to an MCP or any contracted WISE provider.

WISE Screening

Anyone can make a referral for a WISE screen and all referrals should result in a WISE screening, regardless of referral source. A WISE screen must be completed and entered into BHAS within 14 calendar days of receiving a referral for the screen to be considered "on time." WISE screens are available at WISE agencies and the option to complete the screen over the phone will be offered when that option is more convenient.



A referral form can be offered, but must not be required to complete a WISE screen. A mental health intake must not be required to be completed to do the WISE screen. Anyone can request a screen for a youth/family that is Medicaid eligible and age 20 or younger.

Screens must be completed and entered into BHAS no later than 14 calendar days after initial contact. A WISE screen is not considered to be complete until entered into BHAS.

All WISE screens will include:

1. Information gathering that utilizes the information provided by the referral source (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or other service providers working with the youth and family.
2. Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled from the Full CANS. The CANS screen must be completed by a CANS-certified screener. For more information on how to become a CANS-certified trainer see Transformational Collaborative Outcomes Management Training ([TCOM Training](#)).

Note: Training materials, related to how to enter CANS into BHAS are available.

Note: For children age 5 and younger, WISE providers will use the CANS 0-5.

3. Entering the CANS Screen into the Behavioral Health Assessment Solution (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISE.
 - The CANS Screen should be entered into BHAS prior to MCP notification. Make sure to follow MCP timeframes around notifications.

WISE Screens and Behavior Rehabilitation Services (BRS)

A referral for a WISE screen must be made for youth in the following circumstances:

- When a youth is being considered for or referred to Behavioral Rehabilitation Services (BRS);
- Every six months while a youth is receiving BRS only. For youth receiving WISE and BRS concurrently CANS are completed per WISE timelines ; and
- At discharge from BRS.

Steps for completing a WISE BRS Screen:

- DCYF or BRS staff are responsible for contacting a WISE agency to request a WISE Screen.
 - The list of WISE agencies by county is available on the [HCA website](#) under WISE.



- WISE agencies are to complete the CANS screen and enter it in to BHAS. Screens must be offered to be done by phone as well as in person.
 - The referral may come from the DCYF staff, BRS staff, or any other person on behalf of a Medicaid eligible child age 20 or younger.
 - Note: WISE screens are not considered complete until they are entered into BHAS. WISE staff have 14 calendar days from the initial contact to complete the screen and enter into BHAS.
- If the youth screens eligible for WISE, but a WISE referral is not made, WISE staff are to enter into BHAS in the comments section, the reason a referral is not made to serve the youth with WISE and BRS concurrently.
- WISE agencies are to provide DCYF and/or their contracted BRS staff a copy of the WISE screening results.
- If the BRS screen is “NOT ELIGIBLE,” or a youth in BRS has an “ELIGIBLE” screen but is not offered entry into WISE, they should receive an NOABD.

When a child receives BRS and WISE services, the WISE provider agency and BRS provider shall coordinate and collaborate to provide appropriate WISE and BRS services to the youth and family or caregiver.

For DCYF and BRS staff: WISE Screening Solution Communication

If there are complications or delays in receiving a WISE screen from a WISE agency, DCYF and BRS staff are to follow the steps below:

- 1) *Contact Coordinated Care of Washington at 1-844-354-9876, if:*
 - *The screen is not completed after fourteen (14) calendar days;*
 - *There are any systemic barriers preventing completion of a screen.*

If after 72 hours of contacting Coordinated Care of Washington, challenges persist, please do the following:

- 2) *[Submit an email to HCA Managed Care Programs](#) with the subject header line “URGENT - WISE Screening issue” and identify the situation, whether you need an urgent screen or it is a systemic issue and provide your contact information for follow-up.*



BRS Data Entry into BHAS for WISE Staff


For WISE screens for BRS involved youth there are two areas unique to BRS to attend to when entering data. The two areas are:

- Assessment reason
- Referral source

The following screen shots provide a walkthrough of the steps for entering this information. First is the page where it asks the 'assessment reason'. The drop down will force you to choose 'initial.'

Use the comments to further clarify the reason for the assessment, i.e. "BRS 6 month." The following screen shots show mock data to demonstrate BHAS functionality.

Add Assessment for Colin Davis

Assessment Tool *	CANS Screen 5+	▼
Assessment Certification *	CANS Certification	▼
Assessment Location *	Washington, Spokane County Regional, Excelsior Youth Center, Inc., Spokane (▼)	
MCO *	Coordinated Care Health Options Foster Care (▼)	
Assessment Reason *	Initial (▼)	BRS six month
Assessment Date *	3/26/2019	
Note: Enter date assessment conducted.		
Certified Assessor *	Paul Davis (▼)	Paul Davis
Assessment Mode *	Rapid Mode (▼)	
Pre Populate	<input type="checkbox"/>	
<div>Start Assessment</div> <div>Cancel</div>		

The next screen will require you to choose a referral source. Indicate from that drop-down box if this is an initial, rescreen, or discharge.



Intensive Mental Health Services CANS Screen	
Client Name *	Colin Davis
Birth Date *	02/03/2013
P1 ID *	321123433
Gender *	Male
Completed By *	Paul Davis
Phone #	360-725-1632
Assessment Date *	03/26/2019 01:43:13 PM
Agency Name *	Excelsior Youth Center, Inc.
Participant County	Spokane County
Caregiver Name *	Paul Davis <input type="button" value="v"/>
Relationship *	Father


Referral Source Information	
Referral Source *	d3. Children's Administration/Currently in BRS Services (Periodic re-scre <input type="button" value="v"/>
Additional Comments	<input type="text"/>
Contacted Date *	3/26/2019 <input type="button" value="Calendar"/>
Service Requested by Referral Source *	BRS <input type="button" value="v"/>

Then after the diagnosis, you will choose “BRS and WISE.” A rationale must be given if a youth in BRS screens eligible for WISE but will not be offered entry into WISE and BRS services concurrently. A Notice of Adverse Benefit Determination (NOABD) must also



be issued to youth who screen eligible but are not offered entry into WISE. In addition, youth whose screen results in “not eligible” should receive an NOABD

Intensive Mental Health Services CANS Screen

Complete Date * 3/26/2019 


Note: Enter date assessment completed. (If entering an assessment previously conducted, please enter the date conducted.)

Algorithm Result

Based on assessment information, this child is **RECOMMENDED for WISE**

Screening Outcome

The screening outcome is where you send the youth for services after this screening process. Based on the algorithm result, **WISE is the selected screening outcome.**
To override this result, select another screening outcome and explain the reason for override.

Referral To * Continue BRS 

Please explain reason for override *
No safe placement in community at this time.

WISE Intake

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

1. Establish Medicaid eligibility. The WISE service delivery model is a collection of Medicaid state plan services and can only serve youth who are up to 21 and covered by Medicaid.
2. Establish that the youth meets qualifying medical necessity criteria. All youth who meet the CANS algorithm and have a mental health diagnosis will be determined to meet WISE level of care. If a youth does not meet the CANS algorithm, clinical judgment may be used to continue with a referral to WISE if indicated. Indicate in BHAS comment section the reason youth is being offered entry into WISE.

All youth, ages 5 through 20, who meet the CANS algorithm and are eligible for behavioral health services through Medicaid qualifying criteria noted above will be offered entry to WISE. For those children under 5 years of age, this decision shall be made based on information from the CANS Screen and clinical judgment.

**Note: See access protocol updates for non-MCE beneficiaries (i.e. AI/AN beneficiaries getting FFS WISE*



At this point, initial engagement to begin planning, facilitating, and coordinating services will occur. Initial engagement can be done by any WISE Practitioner and is typically done by a Care Coordinator and Youth Partner and/or Family Partner (depending on the youth and family's preference). WISE may be accepted or declined by any youth who has achieved the age of consent, 13 years and older. If a youth is reluctant to engage in WISE services, a parent may work with their WISE provider to request Family Initiated Treatment as a time limited opportunity to engage the WISE team with a youth who meets medical necessity and their family. More information on FIT services can be found online at the [HCA FIT website](#).

Youth who are not enrolled in Medicaid and do not meet intake eligibility requirements will be referred to other community resources, including their health care plan for behavioral health services. All youth receiving or eligible for Medicaid behavioral health services, but who do not meet the CANS algorithm, will be referred to and offered other services. In addition, agencies must follow MCP notification timelines when youth are determined not eligible for WISE.

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

Access Model for Wraparound with Intensive Services (WISE)

Point of Identification

Self and families

- Self Referral

Department of Children, Youth and Families

- Child welfare
- Juvenile Rehabilitation

County

- Juvenile Justice
- Other county agency

Tribes

- Tribal mental health centers
- Managed Care Plan Enrolled or Fee For Service Enrolled

Education

- Schools

Behavioral Health Providers

- Outpatient behavioral health
- Inpatient behavioral health facilities
- Substance Use Treatment facilities

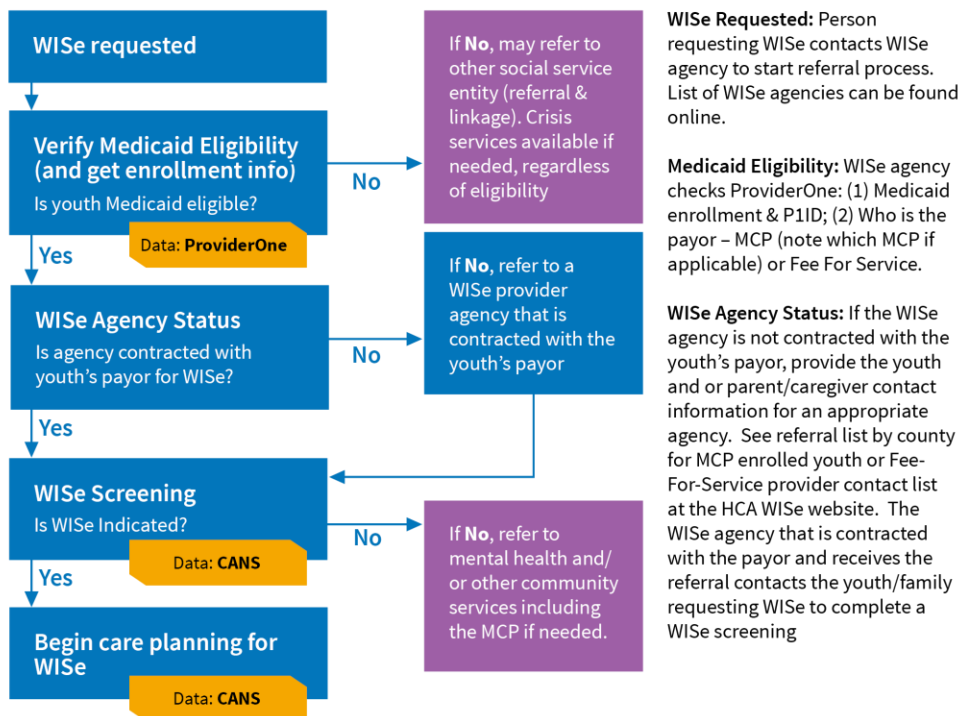
Department of Social and Health Services

- Developmental Disabilities Administration

Community

- Public health
- Social service organizations
- Hospital/Emergency Department
- Crisis services
- Programs and supports for youth experiencing homelessness (shelters etc)

Referral Process





Section 4: WISE service requirements

Culturally and Linguistically Appropriate Services (CLAS)

Agencies are required to promote access to and delivery of culturally and linguistically appropriate services to all youth and families. More information about the CLAS standards can be found on the [U.S. Department of Health and Human Services website](#).

Providing Intensive Care Coordination and Services Using a Wraparound Approach

WISE is intended to operationalize the system of care (SOC) values in service delivery to eligible, youth, and their families with complex behavioral health needs. WISE will be implemented through the support of a statewide system of care to the fullest extent feasible. It is delivered using a wraparound approach, to improve collaboration among child-serving agencies. It focuses on the individual strengths and needs of each participating youth and family.

Once screened eligible for WISE, youth and families participating will have access to a wide array of services and supports to address their specifically identified needs. Although the intensive care coordination and services available under WISE are funded by Medicaid (see appendix F for links to Reporting Instructions), the WISE service model is intended to draw in other resources through teaming with formal, informal and natural supports and programs that are offered in a variety of settings (home, community, school, etc.). For more information and a definition of formal, informal and natural supports, see Appendix B: WISE Terminology, Definitions and Roles.

Intensive Care Coordination

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

While WISE is a team-based approach, it is typically the role of a Care Coordinator to facilitate and coordinate services and supports. This intensive coordination continues through each of the phases of WISE as described on the following pages (adapted from the nationally recognized Wraparound phases). Other WISE Practitioners* should be partnering to most effectively meet the needs of the youth and family.

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

WISE Documentation Considerations

WISE is a collaborative process. When considering how to document services provided, it is important to note not only what the WISE practitioners are doing, but also the youth/family/team response to the action. In the following section about the phases of WISE, general documentation considerations are listed for each phase. However, WISE phases are not always clear and distinct



and are often not linear. Documentation considerations listed for one phase may also be relevant to other phases as well. Clear and descriptive documentation is also important for the Quality Improvement Review Tool (QIRT), see page 86 in the WISE Manual for information on the QIRT and the Quality Plan. The complete [WISE Quality Plan](#) can be found at the HCA website online.

Engagement

During this phase, the groundwork for trust and shared vision among the youth, family, and WISE team members is established, so people are prepared to come to meetings and collaborate. The tone is set for teamwork and team interactions that are consistent with the Washington State Children's Behavioral Health Principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase begins to shift the youth and family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. Initial engagement should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as soon as possible. However, elements of the engagement phase will be implemented in conjunction with other phases.

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

Goals/Purpose:

- To **address pressing needs and concerns**, prior to forming a Child and Family Team when necessary, so the youth, family and team can give their attention to the WISE process.
- To explore the results of the CANS and the individual's and family's strengths, needs, culture, and vision, and develop a youth and family narrative that will serve as the starting point for planning.
- To orient the youth and family to the WISE process.
- To gain the participation of team members who care about and can aid the youth and family,
- 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

- To lay the groundwork for trust and shared vision among the youth, family and WISE team.
- To establish rapport and build commitment to WISE process through warmth, optimism, humor, and identification of strengths.
- The WISE Practitioner(s) meet with the youth and family to explain the WISE process, and how it differs from traditional care.
- The WISE Practitioner(s) obtains consent for services.
- The WISE Practitioner(s) discuss with the youth and family the events, circumstances, and moments that brought the youth and family to WISE.
- The WISE Practitioner(s) obtain the youth and family perspective on where they have been), where they are presently (including listening for both their expressed needs and strengths), and where they would like to go in the future.
- The WISE Practitioner(s) discuss the youth's and family's view of crises, and develops a written plan to stabilize dangerous or harmful situations immediately.
- The WISE Practitioner(s) ensure the youth and family understand any system mandates (if applicable) and ethical issues.

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

Documentation Considerations

- Capture the outcome of efforts made to create a genuine understanding of WISE services, their content, duration and intended outcome, and the roles of key persons involved in WISE.
- Describe the process to identify barriers to participate in WISE services and how these barriers were addressed.
- Clearly indicate the intensity of contact between the WISE practitioners and the youth and family in the first 30 days.

Assessing

In this continuation of the engagement phase, the WISE Practitioners expand the discussion with the youth and family to add context to their involvement in WISE. The WISE Practitioners (Care Coordinator, Family Peer, Youth Peer and Mental Health Therapist) help the youth and family to understand that their input is central to the WISE process, and that their perspectives and preferences at all phases of care planning and implementation will be prioritized. This includes helping the youth and family understand and incorporate any legal mandates into their plan. The WISE Practitioners also listen to the youth and family perspective for information about the youth's and family's strengths, needs, culture, and natural supports. A WISE Practitioner completes and reviews the results of the CANS



Full (to be completed within 30 days of enrollment into WISE services) with the youth and family and determines how to present this information to the team.

Goals/Purpose:

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

Essential Steps

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

Documentation Considerations

- Document that the initial Full CANS is completed and entered into BHAS within 30 days of WISE enrollment
 - Note: The date of WISE enrollment is the first use of U8 modifier, for the youth in WISE. That first U8 entered should be the first billable WISE service provided for the youth and/or family in order to maintain a consistent timeframe for tracking the 'full CANS timeliness'. That date needs to be entered into BHAS to track this time.
- The results of the Full CANS have been reviewed with the youth/family and their feedback is solicited and changes incorporated into the final written version before the Full CANS is entered into BHAS.
- Clear indication in BHAS or individual's record that a meaningful discussion of strengths and culture across family members and integration of that discussion into the formulation of the youths needs and strengths.
- Does the Full CANS indicate need for psychiatric consultation?



Teaming

In this continuation of engagement and building on the assessing phase, the WISE Practitioners help the youth and family identify, and reach out to persons who should be part of the WISE Child and Family Team (CFT). The team is essential to successful planning and intervention.

Goals/Purpose:

- To identify who the youth and family want as part of their team. Periodic check-ins should occur to continue to identify and engage supports as the child and family team evolves.
- To engage others who are involved in the youth and family's life to collaboratively support the youth and family and ensure all involved individuals are aware of the youth and family's mission and vision.
- To explain the team process to potential team members and elicit commitment to the process from team members.
- To make necessary meeting arrangements.

Essential Steps:

- The WISE Practitioner(s) explain WISE to potential team members, eliciting their perspectives, and working to get their commitment to participate in the team process.
- The WISE Practitioner(s) invite potential team members to join the team process.
- The WISE Practitioner(s) partner and orient team members to the WISE process and team meeting structure.
- The CFT members help to create the team meeting agenda, provide input about the meeting logistics and provide comfort for youth and family.
- The CFT will include the youth, parents/caregivers (see definitions in Appendix B), relevant family members, and natural and community supports. For further guidance on teaming with transition age youth, see Appendix O, Partnering with Transition Age Youth in WISE
- The CFT is expected to meet with sufficient regularity **(every 30 days, at a minimum)**, as indicated in the CSCP, to monitor and promote progress on goals as indicated in the CSCP, and maintain clear and coordinated communication.

The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP.



- Practitioner guides the team in evaluating whether selected strategies are promoting improved health and wellness for the youth and successfully assisting in meeting the youth and family's identified needs.
- The CFT works together to resolve differences regarding service recommendations, with particular attention to the preferences of the youth and family.
- The CFT has a process to resolve disputes and arrive at a mutually agreed upon approach for moving forward with services.
- The WISE Practitioner(s) are expected to check in with team members on progress made on assigned tasks between meetings.
- The WISE Practitioner(s) set a time, date and location for the team meeting that is convenient to the youth and family.

Documentation Considerations

- To ensure a comprehensive CSCP, representatives from all domains where there is an identified need are contacted and their input solicited for the CSCP where there is an identified need in the CANS. For example, for an identified need in the school setting, input from a representative from the school should be included in the CSCP. Or for a need regarding housing stability a representative from that area should be contacted for possible input into the CSCP.
Note: Input for the CFT can be obtained in multiple ways. A specific representative does not need to be physically present at a CFT meeting to incorporate their input into the plan.
- Be mindful of identifying any legal mandates or systems which need to be included in the CSCP planning process.

Service Planning and Implementation

*During this phase, team trust and mutual respect are built while the team creates an initial Cross System Care Plan using a high-quality planning process that reflects the Washington State Children's Behavioral Health Principles. In particular, youth and family should feel that they are heard, that the needs chosen are ones they want to work on, and that the options, strategies, and interventions chosen capitalize on the strengths of the youth and family. The team also reviews and expands the crisis plan to reflect **proactive** and **graduated** strategies to prevent crisis, or to respond to them in the most effective and least restrictive manner. The initial CSCP 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, as identified on the CSCP.*



Goals/Purpose:

- To create a CSCP using a facilitated process that elicits multiple perspectives and builds trust and shared vision among team members, with an ever-present focus that the youth and family drive the plan.
- To base care planning on needs and identified strengths, as indicated on the CANS.
- To establish a Team Mission that guides the planning direction and builds cohesion in the work of the team members and empowers the youth and their family.
- To establish a set of prioritized needs, including the strategies to meet them, and to determine expected outcomes.
- To identify team tasks and roles, and document commitments and timelines.
- To establish ground rules to guide team meetings.
- To identify potential barriers and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan.

Essential Steps:

- The WISE Practitioner(s) meet with the youth and family and develops a list of possible needs of the family prior to the team meeting, based on the results of the Full CANS assessment.
- The WISE Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family's vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISE.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT brainstorms an array of strategies to meet these needs, and then prioritizes strategies for each need, including the use of natural supports and intensive services.
- CFT members agree upon assignments, or action steps, around implementing the strategies including follow up on action items/assignments.
- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.
- The CFT monitors youth and family goals and objectives to highlight when progress is being made and when youth and family are ready to transition out of WISE.

Note: See the Cross System Care Plan example in Appendix H



Documentation Considerations

- The CSCP reflects the youth and family's priorities, as well as including needs and strengths identified in the initial Full CANS, and any decisions to defer addressing lower priority needs.
 - For example, there are 10 needs rated 2 or 3 on the Full CANS. In the CFT meeting together the youth, family and the team identify the top 3 to address now. The CSCP indicates which needs were chosen for action and which have been deferred to be addressed in the future.
- The CSCP contains a manageable number of SMART (Specific, Measurable, Achievable, Relevant, Time bound) goals.
- At least one of the CSCP goals involves a strength area to develop, or the use of an already identified strength to enhance.
- CSCP is updated when new Full CANS is completed.
- The role of each team member is clear.
- Tasks are clearly assigned and updated each CFT.

Monitoring and Adapting

During this phase, the CSCP is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented; all the while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved.

Goals/Purpose:

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

Essential Steps:

- The CFT continues to meet as necessary to address youth and family needs – at minimum, every 30 days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The CFT collects data to determine the effectiveness of strategies, then adds, subtracts and modifies strategies to create the most effective mix of services and supports.
- The CFT evaluates whether there is progress towards the designated outcomes.
- The CFT adds members, as necessary and appropriate, and strives to create a mix of formal, informal, and natural supports.
- The CFT celebrates successes and adds to strengths as they are identified.



- Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
- The WISE Practitioner(s) maintain ongoing communication outside of the team meetings to continue engagement and ensure that all members' perspectives are heard.
- As needs are met, continue to prioritize other needs that may have been deferred earlier in the planning process.

Documentation Considerations

- For each new Full CANS completed, make sure relevant changes or updates have been made to the CSCP and prioritized.
- Review and incorporate youth and family feedback prior to entering each new Full CANS into BHAS.
- Document completion of CSCP tasks and update CSCP as needed.
- Continue to discuss all strengths and needs with family and team and prioritize based on youth and family preferences in the CSCP.
- Continue to clearly document participation of and feedback from relevant formal, informal and system partners.

Intensive Services Provided in Home and Community Settings:

Intensive services ("direct services") are individualized, strength based services and supports provided in home and community-based settings. These services are designed to improve mental health symptoms that interfere with a youth's functioning, or provided in order to maintain or restore functioning. Interventions are aimed at promoting health and wellness and helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community.

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health symptoms produce 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 strengths including social, communication, behavioral, and basic living skills. WISE Practitioners should engage the youth in home and community activities where the youth has an opportunity to work towards identified goals and objectives in a natural setting. Phone contact and consultation may be provided as part of the service. For the most up to date information on telehealth services see the [HCA website](#).



Direct services include, but are not limited to:

- Educating the youth's family about how the youth's behavioral health needs may influence behavior, and how to effectively support the youth.
- In-home functional behavioral assessment.
- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies in their home and community.
- Therapeutic services delivered in the youth's home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Multi-Systemic Therapy (MST), Dialectical Behavioral Therapy (DBT), etc.).

These services are designed to:

- Improve self-care, by addressing behaviors that interfere with daily living tasks.
- Improve self-management of symptoms including self-administration of medications.
- Improve social functioning by developing behavioral health interventions that address social skills needs and anger management.
- Reduce negative effects of past trauma, using evidence-/research- based approaches.
- Reduce negative impact of mental health disorders, such as depression and anxiety, through use of evidence-/research- based approaches.
- Support the development and maintenance of social support networks and the use of community resources.
- Support employment objectives by identifying and addressing behaviors that interfere with seeking and maintaining a job.
- Support educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program.
- Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.

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

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

Providers: Non-clinical direct services are typically provided by paraprofessionals under clinical supervision. Peers, including Family Partner and/or Youth Partners, may provide direct services. Clinical treatment services are provided by a qualified mental health therapist, rather than a



paraprofessional. Paraprofessionals and Family Partner and/or Youth Partners may provide a follow-on “care extension” role for clinical services (e.g., to provide support to caregivers’ efforts to manage behavior, support to youths’ skill building to develop emotional regulation skills, etc.).

Notification: The full array of WISE services may be provided, as medically necessary, once the MCP is notified by a provider of WISE enrollment.

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

Services include:

- Crisis planning that, based on youth’s history and needs:
 - Anticipates the types of crises that may occur.
 - Identifies potential precipitating events and methods to reduce or eliminate.
 - Establishes individualized responsive strategies by caregivers and members of the youth’s team to minimize crisis and ensure safety.
- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions.
- Referral and coordination with:
 - Services and supports necessary to continue stabilization or prevent future crises from occurring.
 - Any current providers and team members including a care coordinator, mental health therapist, youth partner, family partner, family members, primary care practitioners, or school personnel.



- Post-crisis follow-up services (stabilization services) provided periodically to:
 - Ensure continued safety and delivery of services necessary to prevent future crises.
 - Coordinate services between the out-of-home provider (if the youth is placed out of home) and the youth's treatment team to facilitate a plan for rapid return home.
- Tools and resources available to manage potential risks.

Documentation Considerations

- A crisis prevention and response plan is completed and available to all CFT members and crisis-specific supports.
- All items in the Risk Behavior Domain rated 3 in the initial Full CANS are addressed in the Crisis Plan and CSCP.
- The Crisis Prevention and Response plan is updated regularly.
- The Crisis Plan actively addresses early intervention and identification and has tiered action steps with clearly identified roles before, during and after a crisis.
- The crisis plan indicates the CFT team will meet within 14 days of crisis resolution to review the crisis support plan and update as needed.

Crisis Delivery

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

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

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

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

Transition

Transition to a lower level of care occurs after the CSCP has been implemented and modified over time, and the right set of interventions have been successfully delivered to produce desired outcomes and the team's mission has been achieved. The goal of this phase is to identify an "end date" which supports rather than abandons the family, and assists them with moving into a life free from system interference.



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 transition out of WISE is conducted in a way that celebrates successes and frames transition proactively and positively.
- To ensure that the family is continuing to experience success after WISE and to provide support if necessary.

Essential Steps:

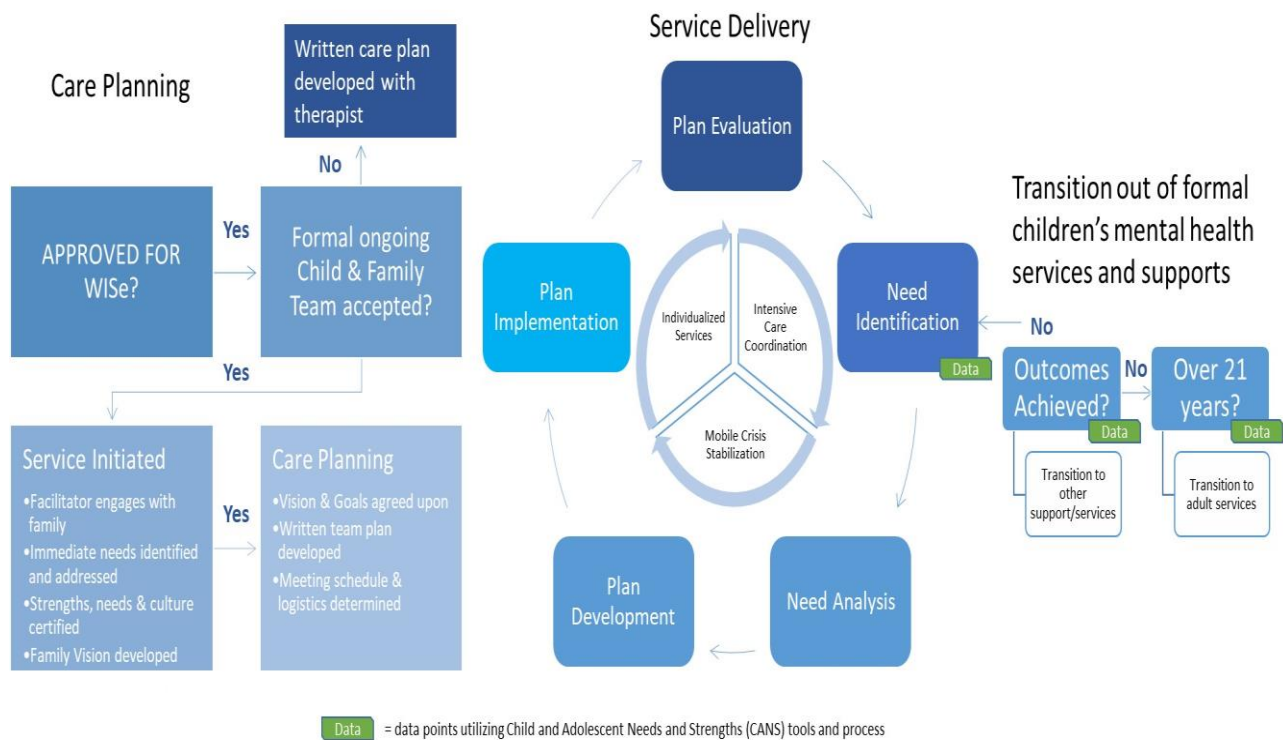
- The CFT creates strategies within the CSCP for a purposeful exit out of WISE to a mix of possible formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). At the same time, it is important to note that focus on transition is continual during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

Documentation Considerations:

- Formal transition plan developed when the team agrees that is appropriate
- Evidence of transition planning is found in CFT meeting notes,
- Transition plan includes input from formal providers, natural supports, family and youth

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

Access Model to Wraparound with Intensive Services (WISE) WA State Children's Behavioral Health Principles





Section 5: Client Rights

Decisions and Dispute Resolution

This section is intended to explain the decision-making and appeal procedures for youth, parent/caregiver (for youth under 13) seeking or receiving WISE services. **This section of this manual does not alter any Medicaid or due process rights contained in state or federal law.**

Reaching Consensus on a CFT

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

CFT members should use the WISE planning model described in Section 4 and the Washington State Children's Behavioral Health Principles (pg. 5) when developing the Cross System Care Plan to reach consensus on the services and supports necessary to reach the youth's best possible functional level. The team should also adhere to the needs and strengths identified with the CANS and utilize the preferred strategies expressed by the youth and family. Although the CANS assessment is not the sole measure of youth functioning, the CANS assessment will be utilized to evaluate the progress of the youth in reaching his or her best possible functional level.

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

If the CFT can reach agreement on a plan:

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

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



- Care Coordinator should ensure the youth and family is aware of how to use the grievance process to notify the MCP of any disagreements they have with specific mental health treatment recommendations made during the care planning process.
- The team will invite agency administrative or supervisory staff to the next CFT meeting to assist in finding resolution to the dispute. This process may escalate up the chain of authority until consensus is reached on the matter. All attempts at finding a solution to a grievance should be made at the lowest level possible.

How Do I File a Grievance? A youth, parent/caregiver (for youth under 13) or their representative can file a complaint on any matter with which they are dissatisfied. This is called a “grievance.” A grievance is used by a youth, parent/caregiver (for youth under 13) or their representative to express dissatisfaction about any matter other than a notice of adverse benefit determination. A grievance may be filed in person, over the phone, or by writing. When filing a grievance with an MCP this may be done by phone or in writing. You may also contact the [Ombuds](#) for assistance. If you file a written grievance, you should include:

- Your Name
 - How to reach you
 - A description of the concern or complaint you have
 - What you would like to have happen, if you know
 - Your signature and date of signing
1. When the MCP receives a grievance, they will notify the youth, parent/caregiver (for youth under 13) or representative to let them know in writing within five (5) business days that a grievance has been received.
 2. The grievance will be reviewed by staff who have not been involved before with the issue(s). If the grievance is about behavioral health treatment, a health care professional at the MCP who is familiar with the youth’s condition will review the grievance.
 3. The MCP will review the grievance and send a letter of their decision as quickly as the youth’s health condition requires and no longer than 90 days from the date the provider or MCP receives the grievance.

Right to Appeal a Denial, Termination, Reduction, or Suspension of Services

WISE enrollees have a right to a specific and detailed written notice and to file an appeal when they disagree with decisions made by their provider or MCP. The MCP must provide the youth or parent/caregiver (for youth under 13) with a written Notice of Adverse Benefit Determination, advising them of their right to request an appeal and to obtain an administrative fair hearing when:

- A youth is screened for WISE and determined not to need or qualify for that service, for any reason.



- A youth or parent/caregiver (for youth under 13) participating in WISE indicates to the MCP and/or provider agency that there is disagreement with treatment plan recommendations found in the Individual Service Plan, made during the care planning process.
- The MCP and/or provider agency denies¹, terminates², reduces³ or suspends⁴ the authorization of services to the youth that are included in the Medicaid mental health service array and recommended by the CFT in the Cross System Care Plan.

An Adverse Benefit Determination is a denial, reduction, termination or suspension of services. The notice to the youth, parent/caregiver (for youth under 13) and provider must contain:

- An explanation of why the letter was sent
- The reason for the Adverse Benefit Determination
- Client's right to a second opinion and how to get one; and
- Your right to an appeal, an expedited appeal, or administrative (fair) hearing.

These rights are further explained in the [Washington Medicaid Behavioral Health Benefits Booklet](#), for MCPs.

Types of Appeals

Appeals must be made to the MCP. There are two types of appeals a youth, parent/caregiver or designated representative can file to challenge a denial, termination, reduction or suspension of services: a *standard* or *expedited* appeal. An appeal must be filed within 60 calendar days from the date on the Notice of Adverse Benefit Determination. An MCP must assist a youth, family/caregiver in filing an appeal, including providing any interpreter services or other aids they may need. A youth, parent/caregiver or mental health care provider or other authorized representative acting on the youth parent/caregiver's behalf and with written consent can ask for either type of appeal.

- **Standard (decision within 30 calendar days):** For a standard appeal with no continued services requested, a decision must be issued by the MCP within 14 days from the day the MCP received the appeal. The MCP may extend this time up to 14 days based on a request for an extension by the enrollee (youth or family).

¹ A "denial" is the decision not to offer an intake or a decision by the Managed Care Plan (MCP), or their formal designee, not to authorize covered medically necessary Medicaid mental health services.

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

³ A "reduction" of services is the decision by an MCP or their formal designee, to decrease the amount duration or scope of previously authorized covered Medicaid mental health services. The decision by a provider to decrease or change a covered service (in the Individualized Service Plan) solely based on his/her clinical judgment is not a reduction.

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



- **Expedited (decision within 72 hours):** An expedited appeal is available to a youth or family member, when the MCP determines or provider indicates that the youth's life, health or ability to function could be seriously harmed by waiting for a standard appeal. An expedited appeal must be decided no later than 72 hours after receipt of the expedited appeal request.
 - If the mental health care provider asks for an expedited appeal, or supports the youth or family in asking for one, and indicates that waiting 30 days could seriously harm the youth's health, the MCP will automatically grant an expedited appeal.⁵
 - If a youth, parent/caregiver asks for an expedited appeal without support from their mental health care provider, the MCP will decide if the youth's health requires one. If the MCP does not agree with the request, the plan must decide the appeal within 30 days.
 - The MCP may extend this time up to 14 days based on a request by the enrollee (youth or parent/caregiver) for an extension.

How do I file an Appeal? If the MCP makes an Adverse Benefit Determination involving a youth's WISe treatment, or the youth is not considered eligible for WISe from a CANS Screen, the youth is entitled to a Notice of Adverse Benefit Determination about the decision and the youth's rights. If the youth, parent/caregiver disagree with the decision, the youth has a right to file an appeal. To appeal, the youth or parent/caregiver would:

- Contact the MCP by phone at the number provided on the notice. A written request for appeal must also be completed, and the MCO will mail you the form to complete and mail back. The appeal process cannot move forward without the written and signed appeal form. Your appeal must include:
 - Your name;
 - Contact number, email or address;
 - ProviderOne ID
 - The service or treatment you are appealing
 - Any information about why you disagree with the Adverse Benefit Determination; and,
 - Your signature and date of signing.⁶
1. If the notice of Adverse Benefit Determination is about services a youth is already receiving, the youth or parent/caregiver can ask for the services to continue until the appeal is decided. If a youth or parent/caregiver want to continue to receive benefits a request must be made as follows:

⁵ **438.410 Expedited resolution of appeals.** (a) *General rule.* Each P, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the P, PIHP, or PAHP determines (a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

⁶ CFR requires appeal requests to be signed and dated by the client. The client can request the appeal, and this request is followed up with a member appeal consent form being sent from the MCP to the client for the signature and date, and then when the signed form is received by the MCP the appeal process can begin.



- File the appeal and request benefits continue within 10 calendar days from the date on the Adverse Benefit Determination or before the termination, reduction or suspension of services occurs (if longer than 10 days from the notice or a notice was not provided as required).

Note: You may have to pay for the continued services if your relief is denied.

How to Request an Administrative (Fair) Hearing:

In order to request an administrative (fair) hearing, you must first receive a Notice of Resolution from the MCP that decides your appeal. You or you representative must request an administrative hearing within 120 calendar days from the date on the Notice of Resolution. To request a hearing, contact the Office of Administrative Hearings by phone, fax or in writing at:

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 98504
Phone: 1-800-583-8271
Fax: (360) 664-8721
(No email correspondence is accepted)

An Administrative Law Judge will look at the evidence provided and make a decision on whether or not to grant your appeal. The judge has 90 days from the date that you filed your request for a hearing to make a decision in your case. If the judge agrees with your appeal, the MCP must follow the decision by the judge and authorize or provide the services as fast as your health condition requires. You may not file an administrative hearing regarding a grievance decision unless the MCP fails to make a decision on the grievance within the required time frame. To read all about the administrative hearing process [follow this link](#).

Continuing Services during the Appeal

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

- The appeal or state administrative hearing request is filed within 10 calendar days from the date the notification of the resolution was written;
- The appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services; and
- The youth or family asks for continuing services.



Help for Youth, Families, and Caregivers

If youth, families, or caregivers request help with filing a grievance or appeal, they should be referred to the Regional Ombudsman.

Below is a list of additional legal or mental health advocates where the youth and family may be referred:

TeamChild
1225 South Weller St, Suite 420
Seattle, WA 98144
Phone: (206) 322-2444
Fax: (206) 381-1742
Email: questions@teamchild.org

Northwest Justice Project
1-888-201-1014

Disability Rights Washington
315 5th Avenue S, Suite 850
Seattle, WA 98104
1-800-562-2702 (ask for a "Technical Assistance" appointment)
Fax (206) 957-0729



Section 6: Governance and Coordination

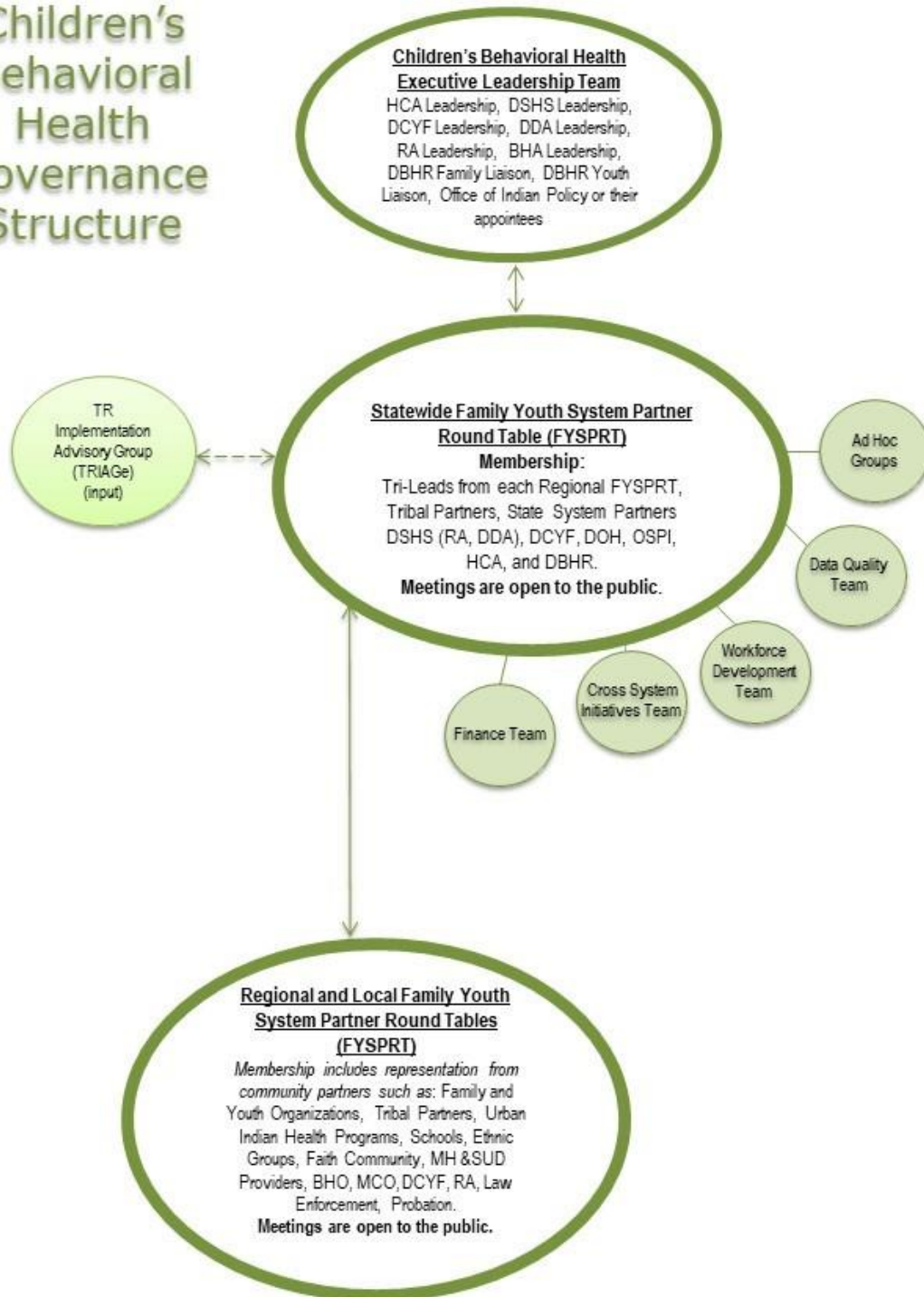
The Settlement Agreement for *T.R. vs. Birch & Strange* (formerly known as *T.R. vs Quigley & Teeter*) states that Washington State will “maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders,” as a mechanism for ensuring success of settlement agreement implementation and maintenance, as well as informing quality of Wraparound with Intensive Services (WISE). A collaborative governance structure includes youth, family and system partner voice coming together to ensure coordination and improve outcomes for youth and families.

This governance and cross-system collaboration, called the Children, Youth and Family Behavioral Health Governance Structure (the Governance Structure) is essential in system change efforts to ensure:

- Collaboration across systems and coordination of care with WISE participants.
- Participation by local and regional representatives in Child and Family Teams (CFTs) with youth and families who are enrolled in WISE and served by multiple youth and 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.
- Information sharing about FYSPRT and the governance structure to support cross system learning.
- The development of data-informed quality improvement processes.
- Increased participation of family and youth in all aspects of policy development and decision-making for WISE.


The figure below provides a visual of the various components of the Governance Structure.



Children's Behavioral Health Governance Structure



The following table provides a brief description of the role and function for each component.

Children, Youth and Family Behavioral Health Governance Structure Component Descriptions

Regional and Local Family, Youth, System Partner Round Table (FYSPRT)		
Role	Required Members	Of Note:
<p>Looks at the full continuum of care, including WISE quality and service delivery in the region, addresses regional challenges and barriers identified, and reviews local/regional data, related to meeting the systemic needs and improving the outcomes for youth with behavioral health challenges</p> <p>Identifies regional and local needs and problem-solves as close to the community as possible</p> <p>If not able to resolve or address a challenge at the regional FYSPRT, the Regional FYSPRT can bring the challenge forward to the Statewide FYSPRT with recommendations for how to address the need.</p>	<p>Families and youth with lived experience (including past/present WISE youth and family participants), Administrative Service Organization (ASO), or Managed Care Plan (MCP) staff, local/regional system partners, and other community system partners</p> <p>Engagement with tribal governments to participate in the Regional FYSPRT</p>	<ul style="list-style-type: none"> • Tri-Led by family and youth partners with lived experience (does not need to be a Certified Peer), and System Partner from the membership • Open Meetings – No confidential or specific case information shared. The Regional FYSPRT is intended to identify themes around challenges or solutions around process • Minimum of 51% youth and family membership • Based on how a region defines their community(ies), they may select to have more localized groups (local FYSPRTs) that feed into their regional structure, to better meet the needs of that region, and address challenges and barriers as close to the community as possible
		

Statewide FYSPRT		
<p>Role</p> <p>Looks at the full continuum of care, including WISE quality and service delivery, across Washington state</p> <p>Shares potential solutions identified by regional FYSPRTs and addresses challenges and barriers identified by regional FYSPRTs that may require policy decisions/direction, as well as reviews statewide data, related to meeting the systemic needs and improving the outcomes of youth with behavioral health challenges</p> <p>Problem-solves as close to the community as possible</p>	<p>Members</p> <p>Regional FYSPRT Tri-leads, state-representatives from child and youth serving systems, tribal partners, representatives of the Division of Behavioral Health and Recovery, and community partner representatives</p>	<p>Of Note:</p> <ul style="list-style-type: none"> • Tri-Led by Youth, Family, and System Partner leaders from the Statewide FYSPRT membership • Open Meetings – No confidential or specific case information shared. The Statewide FYSPRT is intended to identify themes, challenges or solutions around process • Workgroups are utilized as a means for completing specific work products, or as a strategy for making systemic changes. Representatives from the Statewide and Regional FYSPRTs will be invited to participate on groups such as: AD-Hoc, Workforce Development, and Data & Quality. • Receives and considers input from the T.R. Implementation Advisory Group (TRIAGe) to improve the coordination and delivery of Title XIX services and WISE
		
Youth and Young Adult Continuum of Care Subgroup of the Children and Youth Behavioral Health Work Group		
<p>Role</p> <p>Receives recommendations from the Statewide FYSPRT, requests input, and makes recommendations to the Children and Youth Behavioral Health Work Group related to WISE quality and service delivery and meeting the systemic needs of youth experiencing behavioral health challenges and improving outcomes of youth.</p>	<p>Members</p> <p>State child and youth serving agencies, legislators, health care providers, tribal governments, and other organizations, a FYSPRT representative, youth and parents of children/youth who have received services</p>	<p>Of Note:</p> <ul style="list-style-type: none"> • Youth and Young Adult Continuum of Care Subgroup members attend Statewide FYSPRT meetings • Youth and Young Adult Continuum of Care Subgroup meeting notes posted to website • Meetings are open to the public
		



Children and Youth Behavioral Health Work Group		
<p>Role</p> <p>Receives recommendations from the Youth and Young Adult Continuum of Care subgroup, requests input, and makes policy-level decisions and recommendations to the legislature and child youth and family serving agencies. Recommendations could be related to WISE quality and service delivery and meeting the systemic needs of youth with behavioral health challenges and improving outcomes of youth and families</p>	<p>Members</p> <p>State child and youth serving agencies, legislators, health care providers, tribal governments, and other organizations, a FYSPT representative, youth and parents of children/youth who have received services</p>	<p>Of Note:</p> <ul style="list-style-type: none"> • Children and Youth Behavioral Health Work Group meeting notes posted to website • Meetings are open to the public

For more detailed information on the Statewide and Regional FYSPTs, please refer to [the Regional FYSPT Manual](#).



Developing Regional Linkages to the Governance Structure

Managed Care Plans, or MCPs will work within their local communities to define processes in which local implementation and oversight of WISE will be achieved and coordinated with the regional and local FYSPRT efforts, and the governance structure. These processes will differ from the work of Regional and Local FYSPRTs in that they could include confidential information. The identified processes would describe efforts to:

- Provide collaboration and coordination of care for youth that are eligible for WISE or are participating in WISE.
- Address concerns and barriers expressed by a CFT or CFTs. Barriers unresolved through the identified regional processes should be advanced to the local and/or regional FYSPRT within the Governance Structure.
- Reviewing WISE data at a more local level for continuous quality improvement to problem solve or identify systemic barriers. This includes areas such as local referents' understanding of referral procedures and enrollment criteria, gaining access to WISE in a timely fashion, the array of services and supports is adequately accessible and of high quality, WISE service utilization (e.g., patterns, attention to outliers, use of home and community versus restrictive services, patterns by child-serving system and locality), and 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 MCP function, those groups identified in the regional processes should also have access to information and use it to solve problems and help improve the local WISE implementation, as is appropriate per their respective group's responsibilities.*



Appendices

A. Background: T.R. Settlement Agreement

Background

T.R. vs. Birch and Strange (formerly known as 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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) statutes, requiring states to provide any medically necessary services and treatment to youth, even if the services have not been provided in the past. Washington State reached a settlement agreement 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 related to that mental illness or condition, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and
4. For whom intensive mental health services provided in the home and community based would address or ameliorate a mental illness or condition.



Goals

To have a mental health system that will:

- a) Identify and screen putative (assumed to exist or to have existed) Class members and link eligible youth to the WISE program.
- b) Communicate to families, youth and stakeholders about the nature and purposes of the WISE program and services, who is eligible for the program, and how to gain access to the WISE program and services regardless of the point of entry or referral source.
- c) Provide timely statewide mental health services and supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Class member's needs consistent with the WISE program model and state and federal Medicaid laws and regulations.
- d) Deliver high quality WISE services and supports facilitated by a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to families, youths, and stakeholders.
- e) Afford due process to Class members denied services.
- f) Coordinate delivery of services and supports among child-serving agencies and providers to Class members in order to improve the effectiveness of services and improve outcomes for families and youth. Reduce fragmentation of services for Class members, avoid duplication and waste, and lower costs by improving collaboration among child-serving agencies
- g) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families.
- h) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders.
- i) Minimize hospitalizations and out-of-home placements.
- j) Correct or ameliorate mental illness.
- k) Reduce mental disability and restore functioning.
- l) Keep children safe, at home, and in school making progress; avoid delinquency; promote youth development; and maximize Class members' potential to grow into health and independent adults.
- m) Use available approaches that have been effective at achieving these outcomes.



B. WISE Terminology, Definitions, and Roles

Phases

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



Roles

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

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

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

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

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

- Facilitate CFT meetings.
- Guide the team process.
- Be the central point of communication.
- Encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems.
- Utilize consensus-building techniques to meet the needs of the youth and family.
- Establish and sustain an effective team culture by inviting CFT members to propose, discuss, and accept ground rules for working together.
- Engage all CFT members and identify their needs for meeting agency mandates. The Care Coordinator identifies the strengths and needs of the youth and family, provides CFT members with an overview of CFT practice, and clarifies their role and responsibilities as a team member in this process.
- Increase the “natural supports” in CFT membership and the youth/family’s integration into their community. This is accomplished by getting to know the family history, culture, and resources, and by helping the youth and family to identify and engage potential supports. Examples of natural supports include friends, extended family, neighbors, members of the family’s faith community, co-workers. The goal is to have more natural and informal supports on the team than formal supports.



- Work with the Youth Partner and/or Family Partner to identify family support, peer support or other “system” and community resources that can assist the youth and family with exercising their voice in the CFT process, if needed.
- Prepare for meetings:
 - Develop a meeting agenda with the youth, family, and other CFT members.
 - Schedule meetings at a place/time that is accommodating (comfortable and convenient) to the youth and family and available to all CFT members.
 - Prepare visual aids or tools to facilitate the meeting process.
 - Inform all CFT members of the date, time and location of each meeting.
- Contact CFT members who are unable to attend a meeting, in advance, to elicit their input.
- Ensure all CFT members receive an updated copy of the CSCP, documentation of progress, CFT meeting activities, discussions and task assignments within 7 days after the CFT meeting.
- Maintain team focus on scope of work for the WISE team and progress/movement toward transition.
- Be sensitive to the needs of team members when working in rural areas where getting members together physically may be challenging. The Care Coordinator is creative in establishing a team that may meet via phone or through teleconferencing.
- Ensure respect for the input and needs of the youth when forming the team.
- Inform the youth and family of their rights (including Due Process) and obtaining all necessary consents and releases of information.
- Acknowledge and celebrate successes and transitions.

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

The Mental Health Therapist- is a provider and resource for the WISE team. The majority of WISE-enrolled youth will have clinical needs that may be met at least in part through the efforts of a skilled mental health therapist. A mental health therapist is a person providing outpatient mental health services (as described in WAC 246-341) to a WISE enrolled youth. While confidentiality of the details of the therapist-client (i.e., family and/or youth) relationship should be protected, the clinical professionals on the team also must have clearly defined roles in terms of meeting needs in the plan of care. WISE therapists will provide effective treatment interventions that build on the youth and family’s strengths, when therapy or some other mental health treatment is outlined in the Cross System Care Plan. WISE therapists should be encouraged, trained and supported to learn and use Evidence Based Practices (EBP). More information on reporting EBPs, including the most recent EBP reporting guide can be found online at the [HCA website](#). The role of the therapist in WISE is expanded upon in “[The Role of the Clinician Employed in a Wraparound Program](#)” which can be found online at the [National Wraparound Initiative](#) website.



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

Family Partners should be encouraged and supported to establish and maintain strong connections within the community. These strong community connections are vital to the Parent Partner role. One way to make sure the Family Partners maintain strong community connections is through participation in community groups and functions such as Statewide Family Network events; local, state, and national conferences; and Washington State Community Connectors. There may also be local parent or advocacy groups not mentioned here which would be a helpful connection for Family Partners.

The Family Partner has a collaborative relationship with the Care Coordinator, Therapist, and Youth Partner. Together they establish mechanisms to keep each other informed, make sure the family partner knows when new families are enrolled in WISE, as well as when and where team meetings will occur, ensure all newly enrolled families have the opportunity to have support from a newly enrolled families have the opportunity to have support from a Family Partner, if they choose. The Family Partner and Youth Partner roles are unique and not interchangeable. In the absence of a Youth Partner, the Family Partner will not fulfill that role. The Family Partner collaborates with the Care Coordinator to establish the trust and mutual respect necessary for the team (including the family) to function well. Family Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS



The Family Partner will:

- Be a biological/adoptive/step/foster parent, kin, or other “forever” person in the parent role – who has been the primary caregiver of a youth with emotional or behavioral challenges.
- Be willing to use their own lived experiences to provide hope and peer support to other families experiencing similar challenges.
- Commit to ensuring that other parents have a voice in the youth’s care and are active participants in the WISE process.
- 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.
- Engage and collaborate with people from diverse backgrounds.
- 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.
- Provide consultation to family members as the family learns new skills to support the youth’s treatment

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.”*](#)

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

The Youth Partner – a peer with lived experience as a youth who is an equal member of the WISE team. The role of the Youth Partner is to partner with youth to help support their engagement and active participation in making informed decisions to drive the WISE process. The Youth Partner is a mediator, facilitator, and cultural broker between youth and agencies. A Youth Partner has lived experience in mental health, substance abuse/recovery, incarceration/juvenile justice, foster care, education, homelessness or identify as LGBTQ+. They provide support services to youth and young adults in community based settings. They deliver a wide range of services to help young people gain control over their lives and create change in their communities. Youth Partners are role models for competency in recovery (in mental health, addictions etc.) and ongoing coping skills.

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



peer involvement- particularly in transition age youth. Youth Partners serve as peer advocates to help empower youth in gaining the knowledge and skills necessary to be able to guide and eventually drive their own treatment. Youth Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS. Youth Partners will:

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

Youth Partners should participate in activities with the youth that pertain to the youth's goals and treatment. Some examples include:

- Providing self-esteem building activities
- Taking the youth to a music or art studio. Engaging in the activity with the youth is important.
- Asking the youth what they like to do and taking interest in activities that are of interest to the youth
- Linking youth to leadership trainings, Family, Youth, System Partner Round Tables (FYSPRTS) committees and councils.
- Connecting the youth to education, housing and other prosocial activities.

***Note: Additional information for Youth Peers can be found online in the [Youth Peer Toolkit](#)**



The National Wraparound Initiative views the Family Partner, Youth Partner, Care Coordinator and Mental Health Therapists four distinct, full-time roles. Placing these roles together may result in none of them being done well. There is also a distinct difference in the role of coordination/facilitation, support and a specific therapeutic treatment modality. A person acting as both mental health therapist and care coordinator puts them in the position of having dual roles. This has been known to result in confusion, conflicts and frustration for families, youth and team members.

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

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

Child and Family Team (CFT) - A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's plan, address unmet needs, and work toward the family's vision and team mission, monitoring progress regularly and using this information to revise and refine the comprehensive care plan. The CFT must include the youth (or caregiver of a young child) and parent/caregiver/family member. A youth over the age of consent must be invited to attend CFT meetings and agree to the membership of that team. As the team matures, membership should expand to include formal and natural supports with the long-term goal of replacing formal supports with natural supports.

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.

Managed Care Plan (MCP) – encompasses managed care organizations (MCO's) and Behavioral Health services only (BHASO) contracted through the Apple Health managed care delivery system.

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 (CANS) - a communication tool developed for children's services to support decision making 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 to facilitate the linkage between the mental health assessment process and the design of individualized service plans including the application of evidence-based practices. All CANS (screen and full) must be performed by CANS certified staff and entered in the Behavioral Health Assessment System (BHAS).

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

Crisis/Safety Plan/Support 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/back-up care, details of what leads to crises, successful strategies that have worked in the past, as well as strengths.

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

Individual Service Plan - A document that outlines the progression and planning of an individual's treatment.

WISE Planning Elements

Youth and Family Vision - A statement constructed, elicited from the family 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. Youth and Family Vision is the long-term, overarching goal of the family as identified and described by them.

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 WISE services have been completed.

The Team Mission describes the pre-determined end point of WISE as described by the family and members of the CFT. Mission statements are written in the present tense, as if they were 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 youth, family members and others to successfully navigate life situations; thus, a goal for the WISE process is to identify and 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. Needs are essential requirements of life that, when left unmet, can create a gap or void that causes behavior to occur.

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.

WISE Training and Coaching Framework

Training - An expert-led educational experience designed to introduce or reinforce a theoretical framework. May occur live or in virtual settings.

Coaching - An intentional process designed to help staff apply information learned in training in real world settings. It is a future-oriented intervention that leverages staff knowledge and



experience to enhance critical thinking and build generalizable skills. Coaching is collaborative; goals are grounded in competencies associated with desirable practice standards.

Supervision - A directive process designed to enforce agency policy and procedures, monitor and ensure compliance and facilitate improvement in specific areas of practice.

C. Guidance on Team Functioning and Facilitation of WISE

The Approach

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

WISE Team Meeting Facilitation Components and Team Structure

Each team meeting must include the following facilitation components:

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

Facilitate Introductions and Review Agenda:

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

Set Ground Rules (sometimes referred to as Comfort Agreement) or Review Ground Rules:

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

Review the Youth and Family Vision Statement(s):

- The WISE Practitioners should talk with the youth and family about their vision(s) before the first team meeting and help them express this vision(s) to the rest of the team.
 - Generally, there should be one collective vision for the youth and family. However, there are times that the youth may have a separate vision than the family.



- The language used by the youth and family should be preserved in the final vision statement.
- The family vision is created and owned by the family, is an expression of their voice and choice, and is used as a touchstone to ensure team activities align with the family's preferred future. Team members may, however, need clarification as to the implications.
- All team members should be given a written copy of the final vision statement and should be reviewed by the team regularly.

Construct a Team Mission Statement and Review Team Mission:

- The team should formulate a mission statement, stated as if it is true today, 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 as an independent activity.
- All team members should be given a written copy of the final mission statement and it shall be reviewed by the team regularly.

Develop a List of Strengths and Review Strengths:

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

Develop a List of Needs and Review Current Needs:

- The WISE practitioners should talk with the youth and family about their needs, as indicated on the CANS, and help them list these at the first team meeting.
- Team members should state all concerns or identified problems in needs language: "I need..., we need..., they need..., etc."
- Needs are not services*. Team members should be redirected to state the real need(s).



- Avoid going back-and-forth between strengths and needs. Complete strengths before identifying needs.
- During the brainstorming of needs, avoid organizing the list of needs by person.

**Note: See further information about needs vs services on pg. 72*

Prioritize Needs:

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

Develop Outcome Statements for Prioritized Needs:

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

Brainstorm Strategies:

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

Assign Action Steps:

- Each selected strategy includes specific action steps and should be assigned to a specific team member(s) keeping the individual's strengths and abilities in mind. When

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

Relevant

The objective is consistent with the overall goal

Time-Bound

Has a start/finish date clearly stated and defined *SMART goal criteria developed by George T. Doran*



appropriate, all team members are given action steps for the strategy that will help achieve the outcome statement and meet the need.

Summarize and Agree on the Plan:

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

Schedule the next Team Meeting:

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

Transition

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



A note regarding “needs are not services” from EnRoute, the WISE Workforce Collaborative:

It is very common for people to say “he needs therapy” or “she needs residential treatment.” When we do this, we fail to articulate what the real underlying need is. A common way to untangle this is to ask what the actual need(s) the person we are referencing has that they were hoping the stated service was going to address.

For example:

Service: Therapy

Possible Needs: Someone to talk to, understand my behavior, and learn strategies to control my anger etc....

Service: Residential Treatment

Possible Needs: Safety, structure, stability etc....

Services are the chosen intervention or strategy to address a need. Not the need itself. When we don’t distinguish the two, we interrupt the creative, individualized planning and focus on the one stated intervention. If we focus on the need, there are possible multiple ways to meet the need that include formal, informal or natural supports. Also, getting a service doesn’t mean your need is met.

In order to get a true needs statement, take the service that has been suggested and plug it into any or all of the following questions.

What is it you hope to get out of ____?

How will ____ help you?

What type of concerns do you want ____ to address

What does the child/youth/family need help with that ____ will address?



Principals Evidenced in Practice

The 10 Washington State Children’s Behavioral Health Principals are the guide to practice-level decision-making (pg.3&4)

D. WISE Attestation(s) for Managed Care Plans and Tribal Behavioral Health

To become an approved WISE agency, a completed attestation form must be submitted to HCA for review and approval. Forms are submitted by a Managed Care Plan or from a Tribal Behavioral Health Agency. On the following pages are the form templates: 1) for MCP and 2) for Tribal Behavioral Health Agencies.



WISE Attestation for a Managed Care Plan (MCP)

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



Established protocols for responding to crisis, in line with Section 4	<input type="checkbox"/>	<input type="checkbox"/>	
Established process(es) in which local implementation and oversight of WISE will be achieved and coordinated? <ul style="list-style-type: none"> • If yes, please submit process(es) • If no, please attach a written plan to establish this structure with a completion date. 	<input type="checkbox"/>	<input type="checkbox"/>	
Tribal relationship established? <ul style="list-style-type: none"> • If yes, please list tribe(s) • If no, please indicate plan to engage 	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of a Provider Quality Committee (PQC) group consistent with the WISE Quality Plan, section II-C-ii (pp 11-12). <ul style="list-style-type: none"> • If yes, please submit documentation. • If no, please attach a written plan to establish a PQC group with a completion date. 	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments:

Signatures

Managed Care Entity:

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

Approval

DBHR:

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

Submit completed WISE Attestation form to WISupport@hca.wa.gov



WISE Attestation for Tribal Behavioral Health

Tribal Agency Name:		Agency NPI:	
Agency Address(es)			
Key WISE contact person:		Phone number and email:	
Background			
The WISE Attestation must be completed by the Tribal Behavioral Health agency upon the initiation and any expansion of WISE within their area.			
WISE Key Elements			
	Yes	No	Comments
Contacted DBHR regarding any questions on the WISE Program, Policy and Procedure Manual.	<input type="checkbox"/>	<input type="checkbox"/>	
Tribal BH Agency is licensed by DOH by either (attestation, deeming or licensure).	<input type="checkbox"/>	<input type="checkbox"/>	
Agency provides 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"/>	
Have WISE staff attended WISE training?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please list staff, role and training date in comments section.			
• If no, please indicate training plan			
Are family partners 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.			
Are youth partners peer certified (or qualify for certification)?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list.			
• If no, please indicate proposed certification plan and staff list.			
Are WISE staff certified in CANS on each team?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list.			



Established protocols for crisis intervention and stabilization response, in line with Section 4 of the WISE Manual	<input type="checkbox"/>	<input type="checkbox"/>	
Established process(es) in which local implementation and oversight of WISE will be achieved and coordinated? <ul style="list-style-type: none"> • If yes, please submit process(es). • If no, please attach a written plan to establish this process with a completion date. 	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Signatures

Tribal Representative

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

Approval

DBHR:

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

For questions regarding this form or to submit a completed WISE Attestation, contact Tina Burrell, HCA, Children's Behavioral Health Administrator at tina.burrell@hca.wa.gov



E. Memorandum of Understanding

Note: The below Memorandum of Understanding is being routed for signature at the time of publishing the annual WISE Manual update; a signed copy will be included in a future manual update.

MEMORANDUM OF UNDERSTANDING

in connection with T.R. vs Birch & Strange formerly known as: Quigley & Teeter Litigation

AMONG

WASHINGTON'S DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS): Behavioral Health Administration (BHA), Developmental Disabilities Administration (DDA), Aging and Long-Term Support Administration (AL TSA), and

WASHINGTON'S DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF) and

WASHINGTON HEALTH CARE AUTHORITY (HCA)

A. Background

In 2009, a class of children and youth in Washington State with serious emotional disturbances sued the State in federal court in the T.R. vs. Dreyfus & Porter case, now known as T.R. vs Strange & Birch. The class of plaintiffs argued that they had insufficient access to intensive services provided in home and community settings in violation of federal Medicaid requirements. On December 19, 2013, U.S. District Court Judge Thomas Zilly approved a Settlement Agreement to that lawsuit. The Settlement Agreement committed DSHS to infrastructure development for a 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, in the family home or community. The Settlement Agreement also contemplated that the State would develop an interagency Memorandum of Understanding (MOU) to coordinate certain services performed by the agencies pursuant to the Settlement Agreement.

B. Purpose

This MOU describes the mutually supportive working partnerships between DSHS, DCYF, 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 typically served by more than one state agency. Consistent with the Settlement Agreement, this MOU will support the agencies developing cross-system protocols to coordinate services for these youth and their families.

C. Agreements:



The above-named agencies hereby agree to promote the WA Children's Behavioral Health Principles:

- **Family and Youth Voice and Choice:** Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth's and family's vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from the youth's and family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multisystem 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.
- **Strength Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome Based:** Based on the youth and family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as



to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.

- **Unconditional:** A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

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 Quigley & Teeter Settlement Agreement.

D. The parties mutually agree that:

1. Working together cooperatively and collaboratively develops the best possible foundation to achieve shared, successful outcomes.

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 Wraparound with Intensive Services (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 children, youth and their families that are served by or may need services from more than one agency.

b. To require relevant state, local and regional representatives of the above-named collaborating child-serving agencies to be invited and to participate and engage in Child and Family Teams (or care planning teams) for children and youth enrolled in WISE as well as governance structure meetings.

c. To align and support efforts to secure 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 and government partners, including Washington Tribes, to address information sharing, the coordination of programs and services, enhancement of working relationships and increase the use of evidence and research-based practices across disciplines. Specifically, this may include training and assistance on the implementation of Evidence and Research Based Practices, the Child Adolescent Needs and Strengths (CANS) tool, and the WISE access protocol, practice model, and service array.

e. To develop and implement data-informed quality improvement processes (utilizing the Measures of Statewide Performance) in order to strengthen and sustain the System of Care over time.

f. To increase youth and family participation in all aspects of policy development and decision-making that will lead to increased system transparency.

E. Governance Structure

The interagency governance structure that is part of the Settlement Agreement 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. Each agency will identify an executive leader to participate in the Executive Team meetings.



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. Representatives from the agencies that are parties to this MOU will attend the Statewide FYSPRT.

3. Work Groups comprised of but not limited to representatives from DSHS, DCYF, HCA, Office of the Superintendent of Public Instruction (OSPI), Department of Health (DOH), Washington Tribes, youth and families, Managed Care Plans (MCPs), Administrative Service Organizations (ASOs) and service providers will be developed as needed.

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

F. Period of Performance

This MOU takes effect on July 30, 2019 and ends on July 29, 2022.

Signatories (in process)

- DSHS
- DCYF
- HCA

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



F. Service Array and Coding

The Service Encounter Reporting Instructions (SERI) provide Apple Health Managed Care Plans (MCP) and the Behavioral Health Administrative Services Organizations (BH-ASO), and all BH providers in licensed community mental health clinics/licensed behavior health agencies assistance for reporting behavior health service encounters. These instructions describe the requirements and timelines for reporting service encounters, program information and assignment of standardized nomenclature, which accurately describes data routinely used in the management of the public behavior health system.

For service array and coding, follow the most recent [Service Encounter Reporting Instructions](#). The Service Encounter Reporting Instructions (SERI) can be found online.

For technical specifications related to encounter submission, follow the most recent Encounter **Data Reporting Guide**. The [Encounter Data Reporting Guide \(EDGR\)](#) can be found online.

A note about COVID – 19

HCA provides guidance to providers regarding behavioral health services and COVID – 19. More information and guidance from HCA and other relevant state agencies can be found online at

<https://www.hca.wa.gov/information-about-novel-coronavirus-covid-19>



G. Washington's CANS Algorithm

7/24/14

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

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



H. WISE Example Templates

Example Cross System Care Plan template from the WISE Workforce Collaborative

Date:

Name:

ID:

Care Coordinator:

Ground Rules Generated by the Team <i>(What will help us be most productive as a team?):</i>	
1.	
2.	
3.	
4.	
5.	

Vision Statement of Family and Youth <i>(What does better look like for my family?):</i>

Mission Statement of the Team <i>(What do we need to accomplish while we're together?):</i>

Team Member	Role	Contact Information
1		
2		
3		
4		
5		

6			
7			
8			
9			
10			

Strengths & Needs Summary

STRENGTHS

Strengths are generated from the family, youth, and all team members as well as the CANS

Strengths List from the CANS:	
o	1
o	1
o	1
o	1
Strengths List from the Team	
Strengths to Build from the CANS:	
2	3
2	3
2	3
2	3

NEEDS

Needs are generated from the family, youth, and all team members as well as the CANS

Needs List from the CANS:	Target?		Target?
3		2	
3		2	
3		2	
3		2	
3		2	

3		2	
Needs List from the Team			

INDIVIDUALIZED PLAN

At the WISE team meeting on _____ the youth, family and the team reviewed the latest CANS data and also brainstormed a list of needs. The team collectively prioritized the following needs.

Priority #1:	Life Domain: Score: 0 1 2 3	<input type="checkbox"/> CANS Generated	Status (ongoing if unchecked) <input type="checkbox"/> Dropped <input type="checkbox"/> Met
Context:	(Can include team concerns, observable behavior, background CANS items, system requirements - e.g., being on probation, etc. - and any other information relevant to plan development.)		
Needs Statement and CANS Target:	(CANS Target Item and Underlying need statement developed by the team and from the youth and family perspective)		
SMART GOO Statement #1.1:	(The SMART indicator of the desired end result. May be called a Goal, Objective, or Outcome)		
Options:	(Potential strategies brainstormed by the team at the meeting)		
Strengths:	(May include CANS items and team generated strengths that can be used as part of the plan)		
Selected Strategies:	(Preferred strategies selected by the youth and family from the list of Options brainstormed by the team)		
Action Steps (team member assigned action steps to achieve the GOO and meet the need):		Person Responsible	Time Frame
1			<input type="checkbox"/> Active <input type="checkbox"/> Complete
2			<input type="checkbox"/> Active <input type="checkbox"/> Complete
3			<input type="checkbox"/> Active <input type="checkbox"/> Complete
4			<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains): CANS items expected to change as a result of addressing the prioritized need.			
	3		
	4		



There may or may not be more than one GOO for an identified need.

SMART GOO Statement #1.2:				
Options:				
Strengths:				
Selected Strategies				
Action Steps:		Person Responsible	Time Frame	Status
1				<input type="checkbox"/> Active <input type="checkbox"/> Complete
2				<input type="checkbox"/> Active <input type="checkbox"/> Complete
3				<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains):				
	3			
	4			

Priority #2:	Life Domain: <input type="checkbox"/> CANS Generated Score: 0 1 2 3		Status <i>(ongoing if unchecked)</i> <input type="checkbox"/> Dropped <input type="checkbox"/> Met	
Context:				
Needs Statement and CANS Target:				
SMART GOO Statement #2.1:				
Options:				
Strengths:				
Selected Strategies:				
Action Steps:		Person Responsible	Time Frame	Status
1				<input type="checkbox"/> Active <input type="checkbox"/> Complete
2				<input type="checkbox"/> Active <input type="checkbox"/> Complete
3				<input type="checkbox"/> Active <input type="checkbox"/> Complete
4				<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains):				
	3			
	4			



SMART GOO Statement #2.2:				
Options:				
Strengths:				
Selected Strategies				
Action Steps:		Person Responsible	Time Frame	Status
1				<input type="checkbox"/> Active <input type="checkbox"/> Complete
2				<input type="checkbox"/> Active <input type="checkbox"/> Complete
3				<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains):				
	3			
	4			

Priority #3:	Life Domain: <input type="checkbox"/> CANS Generated Score: 0 1 2 3		Status <i>(ongoing if unchecked)</i> <input type="checkbox"/> Dropped <input type="checkbox"/> Met	
Context:				
Needs Statement and CANS Target:				
SMART GOO Statement #3.1:				
Options:				
Strengths:				
Selected Strategies:				
Action Steps:		Person Responsible	Time Frame	Status
1				<input type="checkbox"/> Active <input type="checkbox"/> Complete
2				<input type="checkbox"/> Active <input type="checkbox"/> Complete
3				<input type="checkbox"/> Active <input type="checkbox"/> Complete
4				<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains):				
	3			
	4			

SMART GOO Statement #3.2:				
Options:				
Strengths:				
Selected Strategies				
Action Steps:	Person Responsible	Time Frame	Status	
1			<input type="checkbox"/> Active <input type="checkbox"/> Complete	
2			<input type="checkbox"/> Active <input type="checkbox"/> Complete	
3			<input type="checkbox"/> Active <input type="checkbox"/> Complete	
[Optional] Anticipated Outcomes (Across Life Domains):				
	3			
	4			

Summary and Signatures

Plan Summary and Notes:



Wraparound Care Coordinator Signature

Date

Wraparound Supervisor/Coach Signature

Date

Wraparound Team Member Signatures:

<hr/>	<hr/>
<hr/>	<hr/>
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<hr/>	<hr/>
<hr/>	<hr/>



Example Crisis Plan Template from the WISE Workforce Collaborative

WISE Crisis Plan

Youth and Family: _____

Record Number: _____

Crisis Plan	
Scores from the CANS: ____ RF01. Suicide Risk ____ RF02. Non-suicidal self-injury ____ RF01/2a. Other self-harm ____ RF03. Danger to others ____ RF04. Runaway ____ RF05. Decision making ____ RF07. Intended misbehavior ____ CG03. Safety	Narrative Summary (Strengths and Needs):
History and Background Information 	
Medical Information	
Diagnosis:	
Medication:	
Primary Care Provider:	



Psychiatric Provider:
Allergies:
Other Medical Information:

Youth and Family Definition of a Crisis
Warning Signs and Triggers
Home:
School:
Community:
Anticipated Crisis
Home:
School:
Community:
Detailed Proactive/Prevention Plan
Home:
School:



Community:

Detailed Reactive / Intervention Plan
Home:
School:
Community:
Recommendations. What has been successful in the past?
Things to Avoid. What has not been successful in the past?
Youth and Family Preferences (Preferred Treatment, Services, Hospitals, Advanced Directives, etc.)

Family and Friends Contact List			
Name	Relationship	Address/Email	Phone



Wraparound with Intensive Services

Team Member Contact List			
Name	Agency	Email	Phone
Planned Respite Provider			
Name/Agency	Address	Email	Phone
Crisis Respite Provider			
Name/Agency	Address	Email	Phone

Family Member: _____

Date: _____

Family Member: _____

Date: _____

Youth: _____

Date: _____

Care Coordinator: _____

Date: _____

F/Y Partner: _____

Date: _____



Team Member: _____

Date: _____

Team Member: _____

Date: _____



I. Affinity Groups

Materials have been developed to support each of the following affinity groups:

[Child Psychiatrists and ARNPs](#)
[Department of Child, Youth and Family Social Service Specialists](#)
[Children's Long Term Inpatient Program Staff](#)
[Developmental Disabilities Administration](#)
[Designated Crisis Responder and Crisis Teams](#)
[Families/Family Organizations](#)
[Individuals Providing Mental Health Services](#)
[Juvenile Court, Detention, and Probation Personnel](#)
[Juvenile Rehabilitation Personnel](#)
[K-12 Educators and Professionals](#)
[Pediatricians, Family Practitioners, Physicians Assistants and ARNPs](#)
[Substance Use Disorders \(SUD\) Providers](#)
[Youth/Youth Organizations](#)

These materials can be found at [the following website](#).



J. Quality Plan

The Quality Plan describes the goals, objectives, tools, resources, and processes used by Washington to assess, manage, and improve the quality of home and community-based intensive mental health services provided through Wraparound with Intensive Services (WISE). A copy of the WISE Quality Plan can be [found on the HCA website](#).

A. Background

The original WISE Quality Management Plan (QMP), adopted in December 2014, was developed pursuant to the Commitments set forth in the *T.R. v. Birch and Strange* Settlement Agreement dated December 19, 2013 (DKT 119-1, paragraphs 18 – 64). The name has been simplified to “Quality Plan” to reflect the focus on the future, rather than the past, and to better describe the full scope and intent of Washington’s quality planning and activities. The Quality Plan is periodically reviewed and updated. Future iterations will continue to be informed and guided by the foundational T.R. principles and goals.

B. Components

The WISE practice model is built around collaborative goal-setting, individualized, strengths-based, intensive treatment, provided in the community. The Quality Plan is a key part of efficiently delivering high quality, effective care to Washington’s children and youth with complex behavioral health needs and their families.

The components of the Quality Plan facilitate both performance benchmarking and adaptation to better meet the needs of children and youth. Cross-system care coordination, information dissemination, and decision-making structures allow for consistent and tailored responses to children and youth with complex support needs.

C. Quality Infrastructure

WISE provider agencies are key partners in assessing, managing, and improving the quality of care. Each WISE provider agency must participate in a Provider Quality Committee (PQC), as described in the WISE Quality Plan, section II-C-ii (pp 11-12). PQCs can be internal to a WISE provider agency, or a collaborative group comprising representatives from multiple WISE provider agencies.

Provider Quality Committees must effectively communicate with “frontline” WISE staff, including care coordinators, family and youth partners, and mental health therapists. Communicating and collaborating with staff is a key strategy for identifying not only needed improvements, but also effective quality improvement strategies and innovative practices. PQCs are required to formally describe their processes for reviewing and using WISE data, in order to demonstrate that they can meet the quality performance functions required of them in the WISE quality plan. A PQC “charter document” should lay out expected mechanisms by which the PQC will document, communicate,



and accomplish their quality improvement activities. PQC documentation is required as part of the WISE attestation process. Each year your WISE provider agency should check to make sure your PQC documentation is still up to date. If your charter has been amended or updated please submit the updated copy to WISupport@hca.wa.gov and follow any submission requirements directed by the MCPs with which your agency is contracted.

D. Quality Improvement Review Tool (QIRT)

The QIRT uses a file review process to assess and provide feedback about the delivery of WISE services. It has a modular format and it is designed to be flexible so WISE provider agencies can use it as part of their regular WISE quality assurance activities. For example, a WISE supervisor might use the transition planning submodule of the QIRT Care Coordination section to inform quality improvement activities focused on improving transitions from WISE to a less intensive level of care. The QIRT also includes an interview module that is used to gather feedback from youth and families who have participated in WISE. Additionally, HCA uses the QIRT to conduct external review of WISE and WISE services.

The QIRT was specifically developed for WISE and many of the QIRT items focus not only on what the WISE practitioners do, but also the responses of youth and family. This reflects the collaborative nature of WISE. Because the QIRT is based on a file review process, complete and accurate documentation of the WISE process is essential.

The two requirements for becoming approved to use the QIRT are 1) completing the QIRT training and 2) successfully meeting the interrater reliability standard. HCA periodically offers the QIRT training. Please contact wisesupport@hca.wa.gov if you are interested in more information on the QIRT.



K. WISE Practitioner Training and Coaching Framework

Overview

In July 2018, DBHR expanded training and coaching opportunities for WISE practitioners at the provider level. The commitment to providing enhanced training and coaching to our valued WISE practitioners not only develops increased skill sets to better support youth and their families participating in WISE, it increases the quality of the model and offers additional supports to all WISE practitioners. An additional benefit is to highlight and support the roles of each WISE practitioner which also offers an element of networking and promotes individual self-care for all WISE practitioner roles. This on-going coaching supports staff working in a highly intense service structure with the goal of retaining WISE practitioners to provide continuity of care for youth and families. The training framework also provides authority and accountability at the provider level for onboarding new staff for interested WISE providers. The WISE training and coaching framework requires role specific trainings and coaching sessions. The framework is also linked to TCOM processes and outcomes identified in the Quality Plan. The work to improve training and coaching will be informed by all levels of the system.

WISE training and coaching is facilitated by the WISE Workforce Collaborative and informed by the annual WISE Youth and Parent/Caregiver Survey; Quality Improvement Reviews, quarterly BHAS reports; WISE Data Dashboards; Ise Service Characteristics reports; feedback from the statewide FYSPRT; feedback from WISE practitioners.

The WISE Workforce Collaborative wants to hear from providers about [training and coaching needs](#) to continue expanding and improving WISE training and coaching content, curriculum and offerings.

Training and Coaching Framework

System Level: Technical assistance for WISE is available at each level of the system. DBHR works in partnership with Managed Care Plan (MCP) staff and allied Child and Family Serving Systems through the work of the WISE Workforce Collaborative. Convening WISE community trainings and webinars for system initiatives is a function of the Workforce Collaborative. MCP staff also collect feedback from their contracted WISE provider network. An example of this work is the BRS and WISE webinar series.

Requirements: Representatives from all MCPs participate in the WISE Training Advisory Group to assist in providing input and guidance for the annual training schedule and review of updating curriculum. WISE leads are encouraged to participate in the on-going provider coaching calls. These sessions may be offered in person or virtually and facilitated by the WISE Workforce Collaborative contractor.



Practitioner Training and Coaching

[The WISE Workforce Collaborative](#) is the training and coaching hub for WISE practitioners across the state. The Collaborative provides WISE training for new practitioners as well as additional on-going training and coaching.

Requirements: Participation in the state sponsored trainings and coaching sessions offered through the WISE Workforce Collaborative are a requirement of WISE agency staff. When onboarding new WISE practitioners, agencies must document completion of the following set of trainings:

- WISE Introductory Skills (2 days in-person or HCA approved virtual course)
 - Note: If a region or a WISE agency has an approved training plan, see additional information under the section, Regional/Agency training plan.
- Certified Peer Counselor (CPC) training (5 days in person or HCA approved virtual course) for those hired in peer support roles.
 - Note: See section 2 of the WISE manual for additional information.
- [CANS online certification](#)
- Use of CANS for care coordination and treatment planning (2 days) for all new staff.
 - Note: If a region or a WISE agency has an approved training plan, see additional information under the section, Regional/Agency training plan (**see next page**).

Enhanced training sessions offered include:

- Care Coordinator Intermediate Practice Skills (2-days)
- Advancing WISE Practice—Supervision and Managing to Quality (2-days)
- Intermediate Practice Skills training for peers (2-days)
- Advancing Supervision and Managing to Quality-advanced training for WISE peer support supervisors (2-days)
- WISE Mental Health Therapists (1 day)

WISE Coaching will offer onsite sessions and virtual sessions and include:

- CANS - virtual coaching
- Mental Health Therapists – virtual coaching
- Supervisors of Youth and Family Peers – onsite coaching
- Youth and Family Peers- virtual coaching
- Supervisors of Care Coordinators – onsite coaching
- Care Coordinators – virtual coaching

Representatives from the WISE providers participate in the WISE Training Advisory Group to assist in providing input and guidance for annual training and review for updating curriculum.

WISE Training and Coaching Framework

New Staff – Orientation and Onboarding (one-time trainings)	Intermediate Trainings (one-time trainings and on-going)	Coaching (on-going)
<ul style="list-style-type: none"> ✓ 32 hours of training for all new WISE staff ✓ 36 hour of training for Youth and Family Peers – if not certified at time of hire 	<ul style="list-style-type: none"> ✓ 6-12 hours required training per role on the WISE team, annually. 	<ul style="list-style-type: none"> ✓ 8-16 hours of coaching calls annually, based regional coaching plan ✓ 3-16 hours of onsite coaching annually, based on regional coaching plan <p><i>Who attends the particular coaching depends on topic, coaching needs and determined coaching plan.</i></p>
<p>Onboarding and Orientation for all new staff includes:</p> <ul style="list-style-type: none"> • WISE Introductory Skills (2- days) • CANS training (2- days) <p>Total: 32 hours all new staff</p>	<p>Intermediate Trainings for WISE Team</p> <p>Care Coordinators: Intermediate Practice Skills (2-days)</p> <ul style="list-style-type: none"> • 12 hours annually <p>Peer Counselor: Intermediate Practice Skills (2-days)</p> <ul style="list-style-type: none"> • 12 hours annually <p>Mental Health Therapists: WISE Mental Health Therapists (1 day)</p> <ul style="list-style-type: none"> • 6 hours annually <p><i>If WISE Practitioners have attended the Intermediate training, in subsequent years, they may attend other DBHR WISE sponsored trainings or activities such as: QIRT training, WISE Crisis & Safety Planning, and the WISE Symposium.</i></p>	<p>On-going coaching calls</p> <p>Topics and staff to attend are based on the region or agency coaching plan.</p> <ul style="list-style-type: none"> • Call: 1-2 hours a month, up to 8 calls annually, based on need.
<p>Certified Peer Counselor (CPC) Training - for WISE Youth and Family Peers</p> <ul style="list-style-type: none"> • Certified Peer Counselor (CPC) training and testing for those hired in peer support roles. <p>Total: 36 hours</p>	<p>Supervisors: Advancing WISE Practice—Supervision and Managing to Quality (includes information on supervising peers) (2- days)</p> <ul style="list-style-type: none"> • 12 hours annually <p><i>If WISE Supervisors have attended the Supervisor training, in subsequent years, they may attend other DBHR WISE sponsored trainings or activities such as: QIRT training, WISE Crisis & Safety Planning, and the WISE Symposium.</i></p>	<p>On-site coaching:</p> <p>Up to 4 sessions a year per region based on needs of the region/agency, the coaching plan and Quality Review outcomes.</p>



WISE agencies are required to have lead staff participate in WISE coaching sessions. Agencies will partner with the WISE Workforce Collaborative, which serves under the direction of DBHR as their primary resource for ongoing technical assistance related to training and coaching for WISE practitioners. WISE agencies will:

- Develop annual coaching plans
- Be accountable to the training and coaching plans
- Participate in coaching calls offered by the WISE Workforce Collaborative.

Training and Coaching Plans

Agencies are encouraged to design an onboarding system to prepare their staff with sufficient knowledge and skills for their work with youth and families. WISE agencies (approved by an MCP) qualify once they have attended a WISE “Train the Trainer” session and have a training plan approved by DBHR and the WISE Workforce Collaborative. Technical assistance from the WISE Workforce Collaborative on completing a regional agency WISE onboarding plan is available. Regions and/or agencies must provide documentation of their individualized onboarding processes to the WISE Workforce Collaborative as a part of their overall training and coaching plans.

Once approved and to maintain qualifications as a regional or agency WISE onboarding training site, DBHR staff and the WISE Workforce Collaborative will observe one training annually to assure that the training is aligned with the state approved curriculum.

The following activities are required to orient WISE practitioners in all roles. Agencies must document completion of these activities as indicated below:

Orientation:

- Staff must be provided with their own copy of the WISE manual. (Staff must also review the [Behavioral Health Assessment System \(BHAS\) manual](#).)
- Staff must review the Regional Family, Youth, System Partner Round Table [\(FYSPRT\) manual](#).
- Staff must review the WISE Due Process brochure.
- Staff must review the [Quality Plan](#)
- Staff must complete the WISE Overview Modules 1-6 and the self-test
 - Completion of items above must be noted on a WISE orientation checklist.

Training: WISE practitioners must participate in the required trainings in the “Practitioner Training and Coaching” section noted above unless a region or an agency has an approved training plan.



DBHR will offer “train the trainer sessions” to agencies interested in managing the WISE orientation and onboarding of new staff. MCPs or WISE agencies may also develop a regional training plan to provide the WISE Introductory Skills Training and a portion of the required two day CANS training.

Regional or Agency Training Plans are reviewed and approved by the DBHR WISE lead and the WISE Workforce Collaborative. WISE agencies must have approval from an MCP to submit a training plan. To receive a WISE Onboarding Training Approval form please send a request to WISESupport@hca.wa.gov

WISE supervisors and coaches will continue to provide on-going support to WISE practitioners. Coaching that is already happening at the regional level and/or agency should link to the WISE Coaching requirement to assist with further support of the WISE supervisors and practitioners. The statewide goal is for WISE practitioners to receive ongoing, competency-based coaching to facilitate skill development relevant to their role.

To support this work:

- WISE agencies should identify one or more seasoned staff who can provide mentoring to newly hired staff. Trainees should have the opportunity to see good practice performed, either live or via video, in real or simulated situations.
- WISE practitioners should have regular, ongoing coaching with their supervisor or coach.
- WISE supervisors and coaches will participate in WISE Collaborative-facilitated coaching calls.

Supervision: WISE practitioners must receive regular, ongoing supervision by qualified agency staff as required by their licensing body. (**Documentation requirements determined by provider**).

Definitions:

Training: An expert-led educational experience designed to introduce or reinforce a theoretical framework. May occur live or in virtual settings.

Coaching: An intentional process designed to help staff apply information learned in training in real world settings. It is a future-oriented intervention that leverages staff knowledge and experience to enhance critical thinking and build generalizable skills. Coaching is collaborative; goals are grounded in competencies associated with desirable practice standards.

Supervision: A directive process designed to enforce agency policy and procedures, monitor and ensure compliance and facilitate improvement in specific areas of practice.



L. Behavior Rehabilitation Services (BRS) and WISE

Behavior Rehabilitation Services (BRS) and WISE Delivered Concurrently

Washington State Department of Children, Youth and Families (DCYF) contracts for Behavior Rehabilitation Services (BRS) which is a temporary intensive support and treatment program for children and youth with high-level complex service needs who are in the care authority of DCYF. BRS is intended to stabilize children and youth and assist them in achieving their permanent plan.

Both BRS and WISE services are intended to:

- Keep children and youth in their own homes with supports to the family.
- Reunify or achieve alternative permanency more quickly.
- Meet the needs of children and youth in family-based care to prevent the need for placement into a more restrictive setting.
- Reduce length of service by transitioning children and youth to a permanent home or less intensive service.

The intent of BRS directly aligns with WISE and the state is committed to providing both services together in a highly coordinated effort by BRS and WISE staff.

To identify a process for how BRS and WISE teams can efficiently work together and provide a highly intense service package for BRS involved youth, four integration sites started in October 2018. Site locations include: King County, Pierce County, Spokane County and Yakima County. The expertise of the sites leadership and staff - *at Catholic Community Services, Center for Human Services, Comprehensive Life Resources, Excelsior, Ryther, and Yakima Valley Farmworkers* – helped inform the DCYF and HCA on steps needed for the statewide implementation process.

With the State's commitment to this effort and its commitments under the *T.R. Settlement Agreement* lawsuit, HCA and DCYF began **phasing-in access** to both WISE and BRS for children and youth across the state through the following steps:

- **In October 1, 2019**, all children and youth who screen eligible for WISE and are entering BRS may receive both services delivered at the same time.
- **In January 2020**, children and youth who are receiving BRS and screen eligible for WISE at the time of their six month WISE screening may be referred to WISE and may receive both services.

In October 2019, HCA and DCYF disseminated [the BRS WISE Integration Guidance Document](#). The BRS and WISE Guidance Document provides an overview of providing these two services concurrently.

On-going technical assistance and support is being provided during the phasing in of BRS and WISE by HCA/DBHR and DCYF and Coordinated Care of Washington. In January 2020, quarterly WISE and BRS webinars began and will continue as needed.



Highlighted WISE Provider Expectations:

- WISE practitioners review the BRS and WISE Guidance Document
- BRS providers can contact any WISE agency to request a screen and one will be provided
- WISE providers who have contracts for both BRS and WISE will provide services to other BRS providers when requested. Screens must be completed and entered into BHAS within 14 calendar days to be considered complete
- WISE teams work with BRS teams to provide highly coordinated and intensive services for BRS involved youth
- WISE teams will participate in provided technical assistance sessions such as the BRS and WISE webinars
- WISE agencies will report to the contracted MCP on a monthly basis the number of youth receiving WISE and BRS concurrently

M. WISE and American Indian and Alaska Native Youth and their Family

HCA/DBHR is pleased to share WISE staff have partnered with Tribal representatives to update the WISE training curriculum to better support working with American Indian and Alaska Native youth and their families.

HCA/DBHR is hopeful Tribal Behavioral Health agencies will consider the updated training curriculum and WISE as a service delivery model to include in the array of services they provide. Anticipated completion date for the updated training curriculum is early 2021.

HCA/DBHR has identified the following resource materials to assist non-native WISE practitioners when working with American Indian and Alaska Native Youth and their Family. This resource list will continue to be updated in future WISE Manual editions as new resources are identified.

General Information and Map

Washington State is home to 29 federally-recognized Indian Tribes. Tribal governments are improving people's lives, Indian and non-Indian alike, in all communities from Neah Bay to Usk. More information on Washington State Indian Tribes can be found on the [Washington Tribes website](#). More information on Indian Tribes in Washington State can be found at the following pages:

- [Confederated Tribes of the Chehalis Reservation](#), Oakville
- [Confederated Tribes of the Colville Reservation](#), Nespelem, Inchelium, Keller, Omak, and several other locations
- [Confederated Tribes and Bands of the Yakama Nation](#), Toppenish



- [Cowlitz Indian Tribe](#), Longview
- [Hoh Indian Tribe](#), Forks
- [Jamestown S'Klallam Tribe](#), Sequim
- [Kalispel Indian Community of the Kalispel Reservation](#), Usk
- [Lower Elwha Klallam Tribe](#), Port Angeles
- [Lummi Tribe of the Lummi Reservation](#), west of Bellingham
- [Makah Indian Tribe of the Makah Indian Reservation](#), Neah Bay
- [Muckleshoot Indian Tribe](#), Auburn
- [Nisqually Indian Tribe](#), Olympia
- [Nooksack Indian Tribe of Washington](#), Deming
- [Port Gamble S'Klallam Tribe](#), Kingston
- [Puyallup Tribe of the Puyallup Reservation](#), Tacoma
- [Quileute Tribe of the Quileute Reservation](#), LaPush
- [Quinault Indian Nation](#), Taholah
- [Samish Indian Nation](#), Anacortes
- [Sauk-Suiattle Indian Tribe of Washington](#), Darrington
- [Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian Reservation](#), Tokeland
- [Skokomish Indian Tribe](#), Skokomish
- [Snoqualmie Indian Tribe](#), Snoqualmie
- [Spokane Tribe of the Spokane Reservation](#), Wellpinit
- [Squaxin Island Tribe of the Squaxin Island Reservation](#), Shelton
- [Stillaguamish Tribe of Indians of Washington](#), Arlington
- [Suquamish Indian Tribe of the Port Madison Reservation](#), Suquamish
- [Swinomish Indian Tribal Community](#), LaConner
- [Tulalip Tribes of Washington](#), Tulalip
- [Upper Skagit Indian Tribe of Washington](#), Sedro Woolley

Pulling Together for Wellness Framework

The American Indian Health Commission for Washington State (AIHC) has the [Pulling Together for Wellness Framework on their website](#). AIHC is a tribally-driven non-profit organization with a mission of improving health outcomes for American Indians and Alaska Natives (AI/AN) through a health policy focus at the Washington State level. AIHC works on behalf of the 29 federally-recognized Indian Tribes and two Urban Indian Health Organizations (UIHOs) in the state. [The AIHC website](#).

The Substance Abuse and Mental Health Services Administration (SAMHSA)

The Tribal TTA Center offers training and technical assistance (TTA) on mental and substance use disorders, suicide prevention, and mental health promotion using the Strategic Cultural Framework.

- [Link to the site](#)
- [TTA Resources](#)
- [TTA Webinars](#)



Department of Children, Youth, and Families

Services are provided to Indian children, consistent with the federal Indian Child Welfare Act (ICWA) and Washington State Indian Child Welfare Act, in the areas of child protective services, foster care, dependency guardianship, termination of parental rights, and adoption proceedings. Additional information can be found online

- [DCYF Tribal Relations](#)

Health Care Authority

[Tribal Affairs](#) provides support and communication with tribes and tribal-related organizations for [American Indian/Alaskan Native \(AI/AN\) health care](#).

Department of Health

[The Department of Health \(DOH\)](#) collaborates with Indian Tribes, urban Indian health programs and recognized American Indian Organizations in the development of policies, agreements, and program implementation that directly affects Native Americans/Alaskan Natives. DOH maintains a government to government relationship with tribes, resulting in partnerships which promotes effective public health services for Indian people.



N. WISE and birth to age 5 in WISE

CANS 0-4 has been updated to become CANS 0-5 in partnership with WISE providers and other child serving practitioners as well as the Praed Foundation (see note below for more information on the Praed foundation). This work was scheduled for July 2019 through June 2020. This work was impacted by COVID-19 and will continue to be developed. Initial information and resources continue to be developed and will be provided as completed.

Considerations:

- Much of the work with infant mental health is care coordination, parent training, and parent support advocacy.
- Much of the work may be done with parents or caregivers, but it is important to remember the “identified patient” is still the child and the golden thread needs to be maintained. Interventions that involve work with the parents and/or caregiver should be tied back to the child’s ISP.
- It is important that WISE practitioners working with the 0 – 5 population are familiar with developmental milestones of young children. Knowing the difference between what may be developmentally appropriate, even if it may still be troubling to the caregiver, and what is out of expectation with developmental milestones and may need intervention.

This section will continue to be updated over time and informed by parents/caregivers, families and agencies who have participated in WISE 0-5.

Note: The Praed Foundation is the developer of the Child and Adolescent Strengths and Needs (CANS) tool used by numerous state and local child welfare and behavioral health organizations as a way to quantify and communicate strengths and needs of a child and family. Washington State uses CANS for WISE with the permission of Praed Foundation. CANS is copyrighted by Praed to ensure that it remains free to use. For permission to use CANS in other projects, [contact the Praed Foundation](#).



O. Partnering with Transition Age Youth in WISE

HCA/DBHR is working with Community Youth Services and Compass Health, WISE agencies specializing in WISE and Transition Age Youth (TAY), and the WISE Workforce Collaborative to provide additional guidance for consideration when engaging transition age youth. HCA has also consulted with Students Providing and Receiving Knowledge (SPARK) to further inform this guidance. Initial information and resources are included in this WISE Manual update and will continue to be updated as needed.

In the larger context of services for youth in Washington State, Transition Age Youth (TAY) are considered to be between 16 and 26 years old. For WISE services specifically, TAY refers to youth from the ages of 16 – 20 years old. There is a special focus on building resources for this age range in our overall system of care for multiple reasons. During this time services for young children are no longer appropriate, but “adult” services don’t quite meet the needs of transition age youth either. Considerations in this section and future updates will focus on the needs of transition age youth, resources and considerations related to how WISE may look different with the TAY population. To inform this work, DBHR has initiated two WISE and TAY pilot sites and references national guidance “Wraparound for Older Youth and Young Adults: Providers’ Views On Whether and How to Adapt Wraparound, which can be found [online](#) .

WISE and TAY pilot

DBHR has been working with Community Youth Services (Mason County and Thurston County), Compass Health (Whatcom County) and Portland State University to identify strategies focused on reaching and engaging transition age youth. This pilot focuses on WISE services to transition age youth to determine the supports, guidance and resources that may be needed to support this population.

Each agency has identified one specific WISE TAY team to participate. All core components of WISE outlined in the manual are required with the agreed upon flexibility of the timing of Team Meetings (not referred to as Child and Family Team meetings). These teams will work with youth 18 – 20 years old.

HCA will work with the two sites and review WISE outcomes and processes to learn about the following areas:

- Service characteristics
- Team meeting frequency
- Team member roles
- How natural supports and families are defined when working with TAY



For this pilot a required Team meeting in the first 30 days has been waived. Based on feedback from 18-20 years who received WISE, this requirement is too prescriptive.

“Just like other young people in their late teens and early twenties, older youth and young adults involved in Wraparound expect themselves—and are expected by others—to take more responsibility for running their own lives. As they do this, they move toward greater self-reliance and independence from the protection and authority of parents and other caregivers. Young people over the age of 18 are considered the drivers of their Wraparound process, and they are expected to make decisions about who will be on the team and what goals to pursue.”
- Wraparound for Older Youth and Young Adults

This work is intended to identify additional guidance on how to best offer WISE for this age group that is underserved in WISE.

Note: The WISE and TAY pilot has been extended another year due to COVID interruptions.

TAY Consultation

SPARK is a career exploration class for youth who are interested in becoming a Certified Peer Counselor in the State of Washington. They also explore a career path to higher education in social services. The SPARK program is housed at New Horizons High School in Pasco, WA. Youth also receive interpersonal tools to use such as social and emotional skills that can be applied to all relationships, personal and professional. SPARK has partnered with HCA (Washington Health Care Authority) to help build the workforce development of youth per counselors with an emphasis on WISE services in Washington State.

SPARK consulted with HCA on various strategies for WISE and TAY and offered the following:

Engagement

- Youth Partner is an integral part of crisis prevention and response
- Youth Partner has a prominent role in initial engagement and through each phase of WISE
- Designated WISE teams for transition age youth
- Ensure teams provide consistent outreach and engagement to reach youth outside of formal systems:
 - in places youth might be such as homeless shelters, teen centers or libraries
 - to build rapport with youth
 - to provide tools and resources to youth when needed
- Be mindful of shelter rules around length of stay for youth under 18 years old. In some cases, youth are only allowed to stay for 72 hours and then must be out of the shelter for 24 hours. Also, once a youth turn 18, they are no longer allowed to stay at teen shelters
- Being familiar with laws related to TAY and homelessness
- Mindful of activities that can't be done without parent approval and how that impacts care planning



- **Not pushing agency or system agenda on youth**

Role of Youth Peer

- Being available regularly in places where transition age youth are likely to be, and to share information and resources about WISE
- Education about recovery, it doesn't happen overnight and it looks different between people and cultures.
- Model of how to maintain and how to handle challenges to recovery.
- Consider groups teaching "real life," "adulting 101" skills, such as
 - how to start and maintain a checking account
 - budgeting and credit scores
 - how to find a place to live
 - buying a house vs. renting a house
 - how to use the health care system
 - how to buy a car
 - how to ride the bus
 - resume writing
- Assistance with navigating the housing system, if needed, and other services the youth may qualify for
- Consider being a liaison with SUD agencies for referral and engagement

Identified family (not always bio family)

Transition age youth may identify others in their lives that they consider family who they want to participate on their team, even if they are not biologically related to them. The WISE team may also work to bridge the relationship between the youth and biological family members who may be estranged upon the youth's request.

For additional information about SPARK, where youth empower youth, go to spark.ignite2019@gmail.com or call (509)567-0304

"We want them to build their natural supports but then we also want to teach them independence and how to handle these things."- Wraparound for Older Youth and Young Adults



P. Intellectual or Developmental Disabilities Including Autism Spectrum Disorder and WISE

HCA convened an ongoing stakeholder group, to include representatives from Northwest Autism Center, WISE agencies, DDA, DCYF, MCPs, and families to identify additional guidance and considerations for WISE when working with individuals who have Intellectual or Developmental Disabilities including Autism Spectrum Disorder (ASD/IDD). This work began in August 2019 and will continue as needed. Information and resources will be added and updated in future WISE manual versions as they develop.

Each Child and Family Team (CFT) will be made of relevant partner members who contribute to the overall plan of care for each youth and family. Not all formal supports will be able to attend CFT's, but the Care Coordinator should make every effort to include input from them into care planning. A list is provided below of potential partners to consider including on a child and family team, but this is not a complete or required list of potential participants.

Potential Partners to include in the CFT and Cross System Care Plan:

- Developmental Disabilities Administration (DDA) staff/Case Managers
 - More information on how to apply for DDA services can be found online at the [Developmental Disabilities Administration website](#).
- Applied Behavioral Analysis (ABA) therapy provider
 - For access and more information on ABA therapy go to ABA therapy go to the [HCA website](#)
- Primary Care Provider
- School system and Special Education staff
- Speech Language Pathologist
- Occupational Therapists
- Physical Therapist

Trauma Considerations

People with Intellectual and Developmental Disabilities including Autism Spectrum Disorder experience trauma at a higher rate than people without disabilities. Children with disabilities are three times more likely to be victims of physical and/or sexual abuse and 2-3 times more likely to be bullied than children without disabilities (Crime against People with Disabilities, 2009-2015 - Statistical Tables, 2020). In addition, people with disabilities have frequent experiences such as people trying to “fix” them, being called names, multiple medical procedures, and being frequently invalidated by others which can add up over a lifetime.

When completing the CANS, make a special effort to determine what kind of trauma the youth may have encountered which may be driving behavior. Use plain language to get at these concerns like



asking “what kind of unpleasant or traumatic experiences has the youth experienced, such as bullying, separation from family, medical trauma, etc.”

Communication

Communication happens in multiple ways, not always exclusively with words. Even youth who are non-verbal, or have limited verbal ability to speak, communicate. It is important to spend time to learn about and make sure everyone on the team understands the individual and how they express themselves. Spending this time is crucial to getting accurate assessments and determining the impact of any interventions. WISE teams may need to come up with creative solutions to ensure they are communicating with the youth in a way that makes sense for the situation.

Other Considerations

Care coordination will likely be a large focus for teams when working with youth who have an Intellectual or Developmental Disability including Autism Spectrum Disorder. Families who have not yet accessed auxiliary services may need assistance in seeking out and learning how to navigate complex systems. Families who are already accessing these services may need assistance in coordinating the multiple systems and rules they encounter. WISE teams will need to consider the amount of advocacy skills each family already has, and if needed, assist them in learning how to increase family’s skills in advocating for themselves and their youth.



Q. Partnering with Youth and Families Experiencing Homelessness

DBHR in partnership with the Office of Homeless Youth, is working to develop best practice and resource information for WISE teams in partnering with youth and families who are experiencing homelessness. This work continues at the time of this manual update.

The following information is to help assist WISE agencies in supporting a youth who is experiencing homelessness. WISE services are still applicable to youth who are experiencing homelessness who meet WISE eligibility criteria. Services may look different for them. Care coordinators and youth peers are vital in this process. Below is information from the Office of Homeless youth.

Crisis Residential Centers

Temporary residence, assessment, referrals, and permanency planning services provided in semi-secure and secure facilities for youth ages 12 through 17 who are in conflict with their family, have run away from home, or whose health and safety is at risk.

HOPE Centers

Temporary residence, assessment, referrals, and permanency planning services for street youth under the age of 18.

Independent Youth Housing Program

Rental assistance and case management for eligible youth who have aged out of the state foster care system. Participants must be between 18 and 23 years old, have been a dependent of the state at any time during the four-month period preceding his or her 18th birthday, and meet income eligibility. Priority is given to young adults who were dependents of the state for at least one year.

Street Youth Services

Street Youth Services (SYS) connect youth under the age of 18 to services and resources through street and community-based outreach. Services can include either directly or through referral drug/alcohol abuse intervention, crisis intervention, counseling, access to emergency shelter or housing, prevention and education activities, employment skill building, advocacy, family-focused services, and follow-up support.

Young Adult Shelter

Emergency, temporary shelter, assessment, referrals, and permanency planning services for young adults ages 18 through 24.



Young Adult Housing Program

Resources for rent assistance, transitional housing, and case management for young adults ages 18 through 24.

- [MAP](#)
- Please see their [website](#) for more resources and information

WISE Manual Update Crosswalk for Version 2.0

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*BRS – Behavioral Rehabilitation Services

*AI/AN - American Indian/Alaskan Native