



## Comagine Health

### **Wraparound with Intensive Services (WISe)**

### **July 2021- June 2022 Findings Summary & Recommendations**

**WISe Services Delivery Period: January 2021 – June 2021**

**QIRT Record Review Dates: August 15, 2021 – April 16, 2022**

**Number of Records Reviewed: 177**

**Number of Agencies Included in Sample Reviewed: 23**

This report was prepared under a subcontract with Comagine Health under contract K3866 with the Washington State Health Care Authority to conduct External Quality Review and Quality Improvement Activities.

## Introduction

### Objectives

The state of Washington Health Care Authority (HCA) chose to conduct a state-wide study on quality with focus on the WISe service delivery model in 2021. As the External Quality Review Organization for Washington, Comagine Health is contracted to review agencies throughout the state that have implemented the WISe service delivery model. Comagine Health contracted with MetaStar, Inc. to conduct the WISe record reviews. WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. According to the *T.R. v. Birch and Strange* settlement agreement,<sup>1</sup> the goals of this review summary are to:

- Assess WISe performance at both the individual child and system level
- Gauge fidelity to the WISe program
- Present program data and identify weaknesses/opportunities for improvement
- Develop and refine a review process for future quality assurance use
- Identify practices associated with high-quality, effective care coordination and behavioral health treatment

### Overview

WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs within the Washington Apple Health Integrated Foster Care (AH-IFC), Washington Apple Health-Integrated Managed Care (AH-IMC) and Behavioral Health Services Only (BHSO) programs.<sup>2</sup> It is a team-based approach that provides services to youth and their families in home and community settings rather than at a Behavioral Health Agency (BHA) and is intended as a treatment model to defer from and limit the need for institutional care.

## Review Methodology and Scope of Review

### Technical Methods of Data Collection

The reviews consisted of clinical record reviews chosen from a statewide sample provided by HCA. These records reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington. The review criteria are identified in the Washington Quality Improvement Review Tool (QIRT)<sup>3</sup>. The information obtained in the QIRT informs the understanding of the practices used by different practitioners at each critical decision point in care, and how those practices impact child, youth and family outcomes. The QIRT is specifically designed to help identify practices associated with high-quality, effective care coordination and behavioral health treatment.

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<sup>1</sup> Disability Rights Washington. *T.R. v. Birch and Strange*. Available at: <https://www.hca.wa.gov/about-hca/behavioral-health-recovery/childrens-mental-health-lawsuit-and-agreement>.

<sup>2</sup> WISe Policy and Procedure Manual. Available at: <https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf>

<sup>3</sup> WISe QIRT Manual. Available at: <https://www.hca.wa.gov/assets/program/qirt-manual-v1.6.pdf>

The key areas evaluated during the review include:

- Care Coordination
- Child and Family Team (CFT) Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Peer Support

## Description of Data Obtained

HCA provided Comagine Health with a list of randomly selected charts from a list of randomly selected agencies. The initial review process included 180 charts; however, three (3) of the reviewed charts were excluded from the analysis and dashboard due to technical limitations of the data cleaning process. The review included examining pdf records of the clinical charts covering services provided during the period from January 2021 through June 2021.

## Data Aggregation and Analysis

Review data was collected and recorded into the Research Electronic Data Capture (REDCap) system. REDCap is a secure web-based data collection application supported by the Center for Clinical and Translational Science at the University of Kentucky. Aggregate level results are provided in a dashboard pulled from REDCap and included in this report.

This summary review is based on what was documented within the records. In addition, each chart review was performed on documentation from individual WISe provider agencies and may not reflect care provided outside the reviewed agencies, if not coordinated and documented by the agencies reviewed. Once the reviews of all charts were completed, HCA provided an state-wide aggregate dashboard of the data generated from the QIRT reviews<sup>4</sup>. WISe agencies can/should use this report and its accompanying dashboard as a source of comparison data for their internal QIRT reviews.

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<sup>4</sup> WISe Quality Improvement Review Tool reports. Available at <https://www.hca.wa.gov/about-hca/behavioral-health-recovery/wraparound-intensive-services-wise-0>

## Summary of Findings

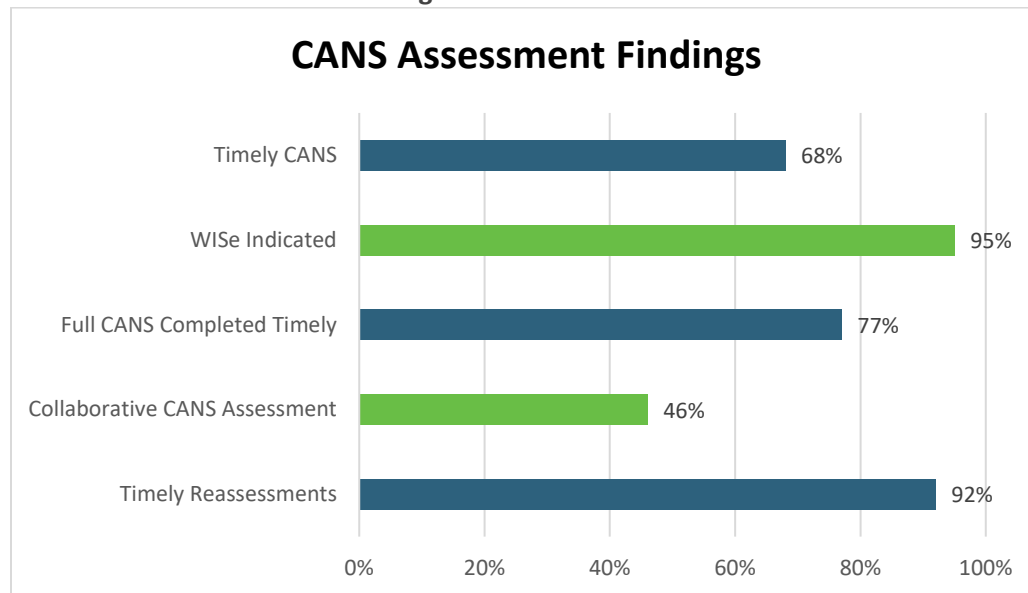
### Care Coordination Elements

#### Initial Engagement & Assessment

A Child and Adolescent Needs and Strengths (CANS) screening is required to be offered within 10 business days of a WISe referral and an initial full CANS assessment completed within the first 30 days of enrollment. Documentation should include evidence of youth and family inclusion in the CANS process.

Of the 177 charts in this review, four (4) received the 0-4 version while 173 received the 5+ version of the CANS, respectively. Please note that due to the low number of records in the sample that utilized the 0-4 CANS version, the results of the review are not representative of the population utilizing this assessment.

**Chart 1: CANS Assessment Findings**



Note, there is not an algorithm for the 0-4 version of the CANS screening; therefore, these cases were not included in the calculation of WISe indicated youth.

#### CFT Processes and Transition Planning

Each youth has a Child and Family Team (CFT) that develops and implements the youth and family's plan, addresses unmet needs and works toward the family's vision and monitors progress regularly. CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria.

- During the first 30 days, the average contact between CFT members and youth/family was 7.1 hours.

- Almost a quarter of the youth in the sample had fewer than 2 CFTs during the first 90 days of enrollment.

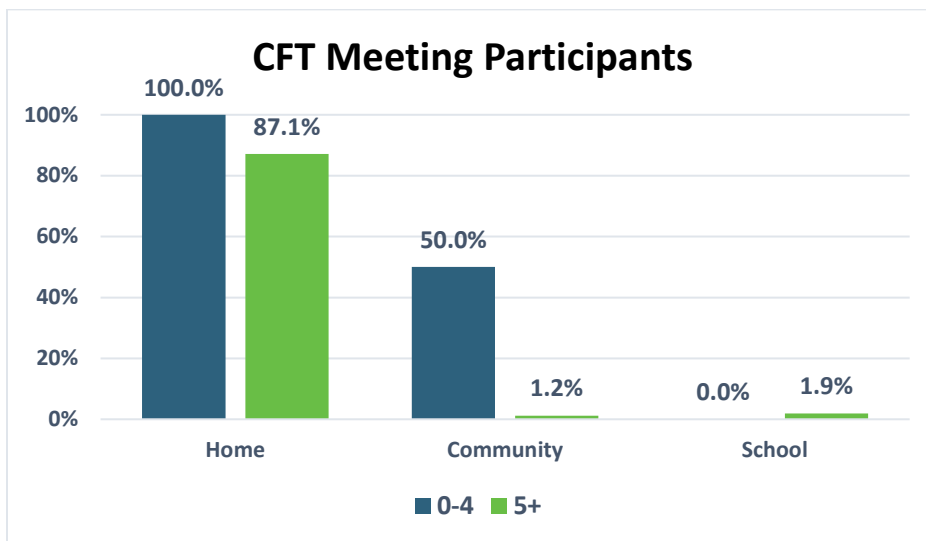
During the first 90 days of enrollment:

- 23.2% of youth had zero (0) to one (1) CFT meetings
- 76.8% of youth had two (2) or more CFT meetings

### Participation

The chart below identifies the percentage of attendees by category who participated in CFT processes.

**Chart 2. WISe Care Coordination Elements: CFT Processes and Transition Planning – CFT Meetings**



During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 0-4 version included:

- 100% of sessions attended by a home representative
- 50% of sessions attended by community representative
- 0% of sessions attended by a school representative

During the first 90 days of enrollment, CFT Meeting Participation for youth receiving the 5+ version included:

- 87.1% of sessions attended by a home representative
- 1.2% of sessions attended by community representative
- 1.9% of sessions attended by a school representative

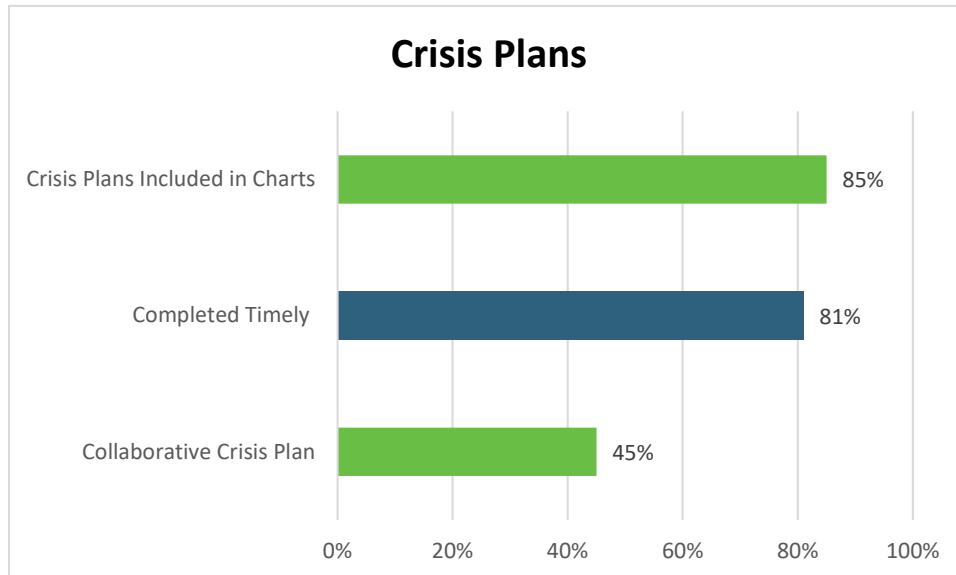
### Crisis Prevention and Response

Each Cross-System Care Plan (CSCP) must include a crisis plan that addresses potential crises that could occur for the youth and family to ensure safety. An effective crisis plan includes:

- Crisis identification and prevention steps, with CFT members’ roles

- Crisis response actions based on the severity level of a crisis
- Post-crisis evaluation of the youth's behavioral health status and the effectiveness of the crisis plan

Chart 3. Crisis Plans



Of 177 charts reviewed, 85% contained crisis plans. Of the 150 charts containing crisis plans, 81% were completed timely within 45 days of enrollment. For the 150 charts that contained crisis plans reviewed they were created collaboratively 45% of the time.

## Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs. Documentation should reflect needs identified in the CSCP, indicate how the therapeutic intervention benefitted the youth's functioning or symptoms, and the impact of the services for the youth at home, school and/or in the community.

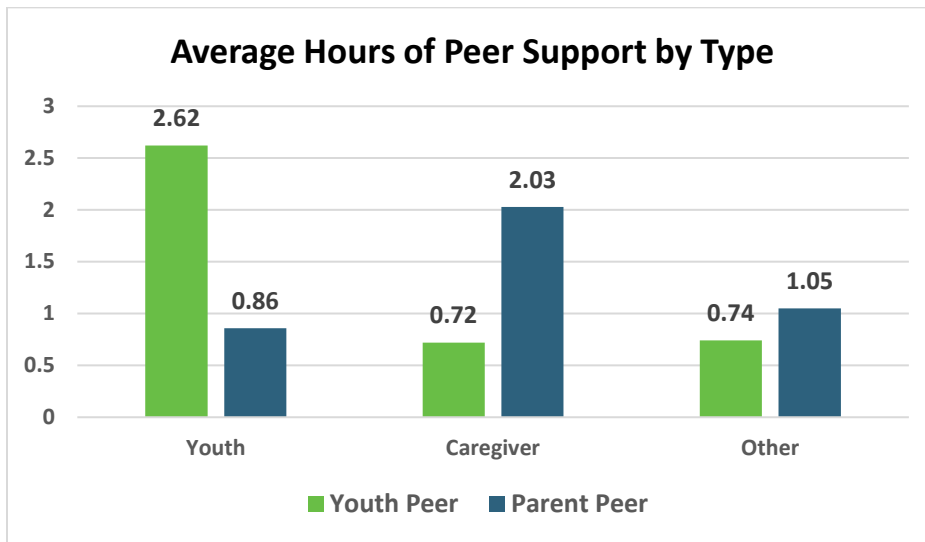
- Therapist involvement in the WISe service model was evidenced by participation in 74.5% of all CFT meetings and an average of 3.3 treatment sessions monthly
- The review indicated 51% of treatment sessions were attended by the youth alone
- The youth and caregiver participated in 33% of sessions
- Only the caregiver attended 16% of the treatment sessions

Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 95% of the sessions. Most frequently treatment content documented were Skill Development and Enlisting Treatment Support at 18.6% and 9.5%, respectively. Documentation of progress reviewed was identified in 7% of records, while 3% of records included celebrating success.

## Parent & Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent support partner. These partners are formal members of the CFT who support the parent/youth in the WISe process through active engagement and informed decision making.

**Chart 4. Parent and Youth Peer Support Elements: Average Hours of Peer Support by Type\*.**



\*Since children under age 5 are not eligible for youth peers, these cases are not included in Youth Peer metrics of any kind.

## Conclusions

### Strengths

The agencies reviewed exhibited strengths in the following areas of the WISe service delivery model:

- The initial full CANS assessment was completed timely in the required timeframe, 77% of the time
- A home representative attended CFT sessions 100% of the time for the 0-4 age and 87.1% of the time for the 5+ age group
- Crisis plans were evidenced in the chart 85.3% of records reviewed
- Crisis plans were completed in a timely manner 81% of the time
- Persistence in problem-solving remained the same focus from session to session in 95% of the records
- Reassessment documentation was identified in 92% of records reviewed

### Weaknesses/Opportunities for Improvement

As a result of this review, the following opportunities for improvement were identified to support improvements in the quality of care and services provided to youth enrolled in the WISe service delivery

model.

- Collaboration when completing the initial full CANS assessment was evident in 46% of the records
- During the first 90 days of enrollment, 8% of youth had no (0) CFT meetings, 15% of youth had one (1) CFT meeting
- Crisis plans were created collaboratively 45% of the time
- Documentation of progress reviewed was identified in 7% of records

## Recommendations

We recommend agencies conduct a root cause analysis to identify the barriers to success in meeting WISe requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention.

Recommended focus areas for improvement include:

- Conduct collaborative initial full CANS assessments. The CANS assessments indicate collaboration when:
  - Areas of the youth and caregiver feedback are addressed
  - Documentation reflects the changes that are incorporated
  - Consensus is clearly identified
  - Both strengths and culture are discussed
- Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need
- Ensure CFT meetings are conducted with youth included 100% of the time
- Ensure all youth in WISe have an active crisis plan
- Ensure collaboration in the development of crisis plans. Documentation of collaboration may include:
  - Specific action steps
  - Post-crisis follow-up activities
  - Identification of all CFT members' roles in crisis response
- Ensure documentation is identified in all records including therapy notes that clearly reflect the following:
  - Interventions used in therapy sessions
  - Youth and/or caregiver responses to the intervention
  - Progress reviewed and successes celebrated
  - Document the specific content of treatment sessions such as psychoeducation, skill development or evidence-based practice components