Washington State Health Care Authority

WISe
Wraparound with Intensive Services

Service Delivery, Policy, Procedure, and Resource Manual

Washington State Wraparound with Intensive Services (WISe) is a range of services designed to provide behavioral health services and support to individuals twenty years of age or younger, and the individual's family. WISe provides intensive behavioral health in home and community settings to youth who are Apple Health eligible under WAC 182-505-0210 and meet medical necessity criteria for WISe.

Introduction to the WISe service delivery, policy, procedure, and resource manual

The WISe service delivery, policy, procedure, and resource manual, commonly referred to as "The WISe Manual" is arranged in three sections:

- Foundational requirements
- Specialty teams and guidance
- Background and additional information.

The first section, Foundational requirements, covers general information and requirements needed for WISe agencies to provide WISe. It also includes information on the WISe practice model, service requirements, training, and other foundational information such as client rights and the quality plan.

The second section, Specialty teams and guidance, provides information to WISe teams who are partnering with youth and families where the WISe model may need slight adjustments to have the best opportunity for youth and family success. While WISe is already individualized, there are times when specific approaches can be used from the start of services to help with outreach, increase engagement and improve outcomes for youth and families.

Finally, the third section is background and additional information. Here you can find historical information on the T.R. Settlement Agreement, sample forms, the CANS algorithm, and information on encountering WISe services.

Section 1: Foundational requirements

Washington State's Wraparound with Intensive Services (WISe) is based on System of Care (SOC) values and is a range of services designed to provide behavioral health services and support to individuals twenty years of age or younger, (herein referred to as "youth") and the individual's family. WISe is for youth who are experiencing behavioral health symptoms that disrupt or interfere with their functioning in family, school, vocation, with peers or in their community. 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. In order for family/youth voice and choice and a team-based approach, a hierarchal model does not work in WISe. Every role on the WISe team has equal value and peers are essential to this process every step of the way.

The purpose of this manual* is to create consistency across Washington State's service delivery system for those providing intensive in-home and community-based behavioral health services to eligible youth. The WISe service delivery model is intended to ensure that all child and family team members roles are equitable and for the model 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 provision of WISe. It is intended to provide an understanding of the required infrastructure, expectations, and the Practice Model of WISe.

*This manual is a living document and will be reviewed annually. The most current version of the manual will be posted on our HCA WISe webpage.

Objective

The WISe service delivery model:

- Promotes recovery by leveraging and increasing strengths, to reduce the impact of behavioral health symptoms on youth and families.
- Keeps youth safe, at home, in the community, and make successful progress in school.
- Promotes youth development, maximizing their potential to grow into healthy and independent adults.

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 voices, choices, 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 plan for the delivery 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 is 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 (in Section 3, Part C, Service Array and Coding). 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 Specialists) is essential

Family partners and/or youth partners who have lived experience must be a part of the team and are an essential part of the child and family team meetings to assist in enhancing youth and family voice and choice in the child and family team (CFT) meeting. They must be meaningfully involved in the provision of WISe. The family partner and/or youth partner 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 Child Adolescent Needs and Strengths (CANS) results to support, give voice, and further inform the youth and family. Peers are encouraged to be certified in CANS. If peers are not involved in the completion of CANS, it is less likely that youth and family will have an adequate voice in this process of identifying needs and strengths. 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.

Roles and Definitions

Care Coordinator: a formal member of the WISe team who is specially trained to be the central point of contact for scheduling, coordinating and facilitating the WISe process throughout the phases and activities of WISe. In order to effectively provide care coordination, it is critical that the care coordinator knows local and state resources including, but not limited to, child welfare, developmental disabilities, education, and juvenile justice. Care coordination is more involved than simply giving the youth and family a list of emails and phone contacts. It can be actively working with the youth and family to help them understand and access appropriate services.

The functions of a care coordinator include but are not limited to:

- Being familiar with local resources and how those can benefit the youth and family.
- Discern what parts of the system and resources are relevant to the youth/family's strengths and needs
- Nurture positive connections with various system partners and integrate them into the WISe team per youth and family voice
- Establish a strong connection with the youth's MCO to ensure access to appropriate Medicaid state plan services
- Work in partnership with other WISe team members to integrate their areas of expertise into the WISe planning process

Family partner (Certified Peer Specialist): a formal member of the WISe team whose primary responsibility is to ensure that the voice and choice of the parent or guardian of the WISe client is articulated and honored. Many parents/guardians may view themselves as inadequate or underqualified to assertively describe their perspectives on the strengths and needs of the child in treatment and their own ability to contribute to making things work. The family partner will work with the parent/guardian to make sure that those hopes and concerns are captured in a respectful way in the cross-system care plan (CSCP) and the Child and Adolescent Needs and Strengths (CANS) tool.

Youth partner (Certified Peer Specialist): a formal member of the WISe team whose primarily responsibility is to ensure that the voice and choice of the WISe participant (youth) is articulated and honored. WISe participants may be reluctant to share their perspective, hopes, and concerns, especially if they have been marginalized in previous system of care experiences. The youth partner will make sure that the youth's perspective is reflected in an honorable and clear manner in the CSCP and CANS.

Clinician/Mental Health Therapist: a formal member of the WISe team who is qualified under Service Encounter Reporting Instructions (SERI) to provide individual, group, and or family therapy for WISe participants as well as create the mental health individual service plan (ISP) and related progress notes. The clinician is also responsible for ensuring that Individual Service Plan (ISP) goals and objectives are captured and prioritized in the Cross System Care Plan in a way that the youth and family want. It is also critical that the ISP goals and objectives work in concert with other system plans goals and objectives including IEP, ABA, juvenile justice, and child welfare plans.

Agency infrastructure

WISe utilizes a range of outpatient behavioral health service components in a way that is individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based.

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. This can be provided by the WISe team or through an MOU or subcontract with an external agency.

The WISe service array includes intensive care coordination, intensive treatment and support services, and behavioral health outpatient crisis 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).

WISe was designed to be comprehensive and may change through the course of treatment, based on the needs of the youth and family. **On average, a WISe participant should be getting more than 10 hours of service per month. Participants and families need to agree that this level of service intensity meets their needs in order to be in WISe. If the youth and family indicate that they don't want that level of service, the WISe team needs to refer them to an appropriate level of service.** It is expected that while the youth and families' strengths increase and goals are met, their needs will decrease, and this level of intensive service will no longer meet the needs of the youth/family. This is when transition planning can be initiated. However, it is common to discover needs early in the WISe engagement, so needs may increase in the first portion of the WISe episode of care. 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 hospitalization and out-of-home placements whenever possible

Federal and State requirements

This section outlines the infrastructure requirements an agency must have in place to be eligible for consideration as a WISe provider. Most of the services provided under WISe are Medicaid state plan funded services and therefore require agencies to meet all applicable federal standards related to the provision of behavioral health services covered under the Medicaid state plan. 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 a Managed Care Organization (MCO) or a Fee for Service (FFS) contract with HCA. Ideally, approved WISe agencies will 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 services listed under the following Washington Administrative Code (WAC):

- WAC **246-341-0737** Outpatient intervention, assessment, and treatment
- WAC **246-341-0700** Behavioral Health Support
- WAC **246-341-0901** Behavioral Health Outpatient Crisis Observation and Intervention

Which includes such services as:

- Individual treatment services
- Family therapy services
- Case management services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Peer support services (for example peer counseling)

The list above is intended to direct the **minimum** certification requirements. Agencies need to follow all WACs and certification requirements for the services they provide. If an agency provides other services, additional certification standards may apply. The monitoring of these requirements will continue to be completed by the Department of Health's Licensing and Certification staff. More information can be found on the Department of Health website.

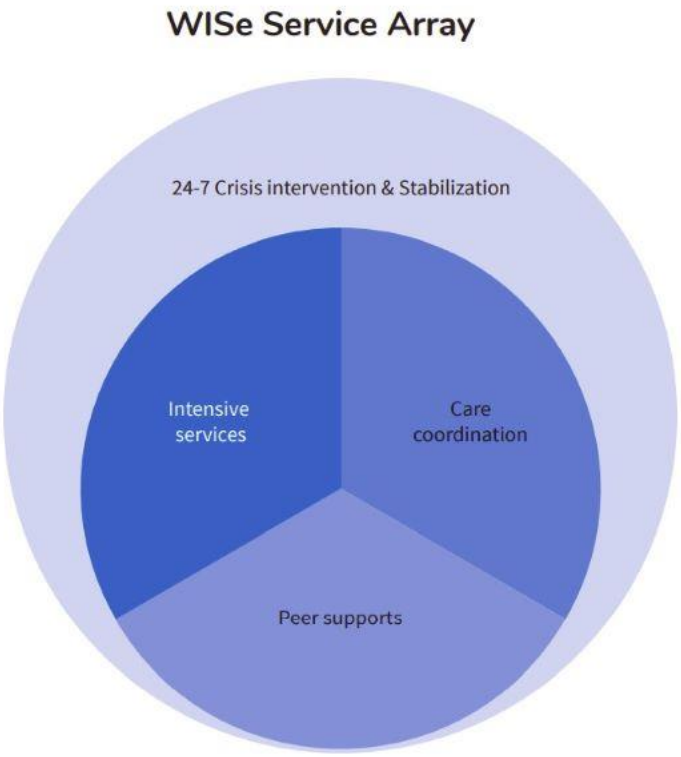
WISe-specific requirements

Adherence to WISe, outlined below, will be reviewed by the WISe agency, the associated MCO, and DBHR according to the WISe Quality Plan. In accordance with WAC 182-501-0215, HCA, MCOs and WISe provider agencies must comply with 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 linked sections. The requirements for items three through six in the list above are as follows.

Service array



Agencies providing WISe must have the capacity to provide and coordinate 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 WISe service array must be provided and encountered as described in the most recent versions of the Integrated Managed Care or IMC Service Encounter Reporting Instructions (SERI), and for WISe Fee for Service, Part 2 of the Mental Health Service Billing Guide or the Tribal Health Billing Guide or the Tribal Billing Guide within the subsections of the Provider billing guides and fee schedules.

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 applicable sections of WAC 246-341. 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 MCO and

obtain MCO 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 agency monthly caseload target identified by the MCO
- For WISe FFS manage agency monthly caseload target 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 support through family partner and/or youth partner who are certified peer specialists.

> Note: Descriptions and responsibilities for staff that provide each of these services are outlined in Section 1 Guidance on Team Functioning and Facilitation of WISe.

- Provide clinical supervision and support in participation for ongoing training and coaching with the WISe- Workforce Collaborative (see Section 3 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 behavioral health outpatient crisis services to youth and families, preferably through staff that are known to youth and family.
- Meet timelines for completing WISe CANS (Child and Adolescent Needs and Strengths)

Highlighted staffing requirements

- All staff on the WISe team must be an Agency Affiliated Counselor (AAC) unless they have another appropriately designated license with DOH (LICSW, LMHC, LMFT, etc.)
    - Applications for AAC must be submitted to DOH within 30 days of hire
- To become a certified peer support specialist the following steps are required when not already certified
    - Complete the online Certified Peer Support Specialist prerequisite modules

- Submit certificate of completion of online modules and application to DBHR
- Only approved applicants will be invited to a state Certified Peer Support Specialist training
- Individuals will be required to pass an exam at the end of the training
- For more details on this process visit the HCA Peer support website
- Integrated managed care guidance on Medicaid reimbursable peer services, July 2021

CANS

The CANS is a way to organize, capture, and communicate needs and strengths of an individual, and family. It is also a communication tool that is used by all the systems involved with the youth and family to help the teams communicate, set priorities, and identify strategies based on the youth and families direction.

A CANS information sheet is available online to help youth and families become more familiar with CANS and how it is used in WISe.

In WISe, the Full CANS tool is used for care planning, and outcome measurement. The Full CANS assessments that are completed during the individual's time in WISe, are *not* used for continued eligibility determination or as a factor for determining payment. Full CANS should be completed in a timely manner, though WISe youth and families often have complicating factors that may make meeting timelines challenging.

Timelines for WISe CANS:

- CANS screen completed and entered into BHAS **within 14 days of referral,** to determine if WISe would be a good fit for the individual
- Initial Full CANS within approximately 30 days of WISe enrollment, **considered late after 45 days** and
- Re-occurring Full CANS approximately every 90 to 105 days while the youth is enrolled in WISe, **considered late if completed after 105 days**

Note, the first re-occurring Full CANS is completed 90 to 105 days after the Initial Full CANS is completed.

- ALL CANS screens and Full CANS include entering the information into the Behavioral Health Assessment Solution (BHAS, the online CANS data repository).
- A discharge Full CANS when WISe services end. If it is not possible to complete a separate Full CANS for discharge, the last Full CANS may be converted to a discharge CANS **BHAS1015634.pptx**

CANS and BHAS (Behavioral Health Assessment Solution)

All CANS Screens and Full CANS must be entered into BHAS. Reports are available in BHAS to assist MCOs and WISe agencies in monitoring timeliness of CANS. Additional information on using BHAS to monitor CANS timeliness will be available as it is developed on the provider page of the WISe website, BHAS™ User Manual.

Community oversight and Cross-system collaboration

WISe provider agencies are required to collaborate and include other child serving system partners such as child welfare, juvenile justice, education system, developmental disabilities support, (hereafter referred to as system partners) on the development of the cross-system care plan and CFTs, and as indicated by youth and family choice. 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. 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 MCOs will work within their local communities to invite diverse representation and establish appropriate communication channels for engaging family, youth, and local community representatives in the Regional Family, Youth, System Partner Round Tables (FYSPRTs) to inform local policy-making and program planning. Section 1, part I describes the requirements to identify regional processes on how MCOs coordinate and participate in the governance structure.

Documentation

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

- Quality Plan
- Monitoring to ensure WISe teams meet monthly caseload benchmark
- Monitoring to ensure WISe agency is meeting monthly service intensity benchmark
- 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:
    - Required WISe trainings
    - Coaching
    - Supervision
    - Agency Affiliated Counselor registration or another 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:

- A copy of all CANS screens and assessments completed.
- Reason for discharge from WISe, which should be based on successful achievement of goals outlined in the CSCP, youth and family choice to discharge from services, or other documented reason.
    - Length of treatment in WISe is not a set time period. It is based on medical necessity and allows for up to six months of transition time into a lower level of care.
- If the youth has been out of WISe for more than 6 months a new CANS screen must be completed. If it has been less than 6 months since the youth discharged from WISe, no new CANS screen is needed. A Full CANS should be completed within 30 to 45 days of a youth's first WISe service regardless of provider to assist with care planning.
- Cross System Care Plan (CSCP) (note: see the WISe Manual Resources section of the HCA website for core elements and a sample format), including revisions and updates.
    - 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 and documentation of consent to treatment

    - It is required that when a client moves from one WISe agency to another, the receiving agency will work with the client to get a ROI to coordinate service transition, including access to CANS in BHAS, from the previous agency
- Crisis/Safety Plan (may also be known at some providers as a Wellness Plan or Support Plan.)
- CFT meeting notes:
    - CFT meetings should occur as frequently as needed, based on the needs of the youth and family. Meetings should be held monthly **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 the CFT, as appropriate.
    - A record that notes 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

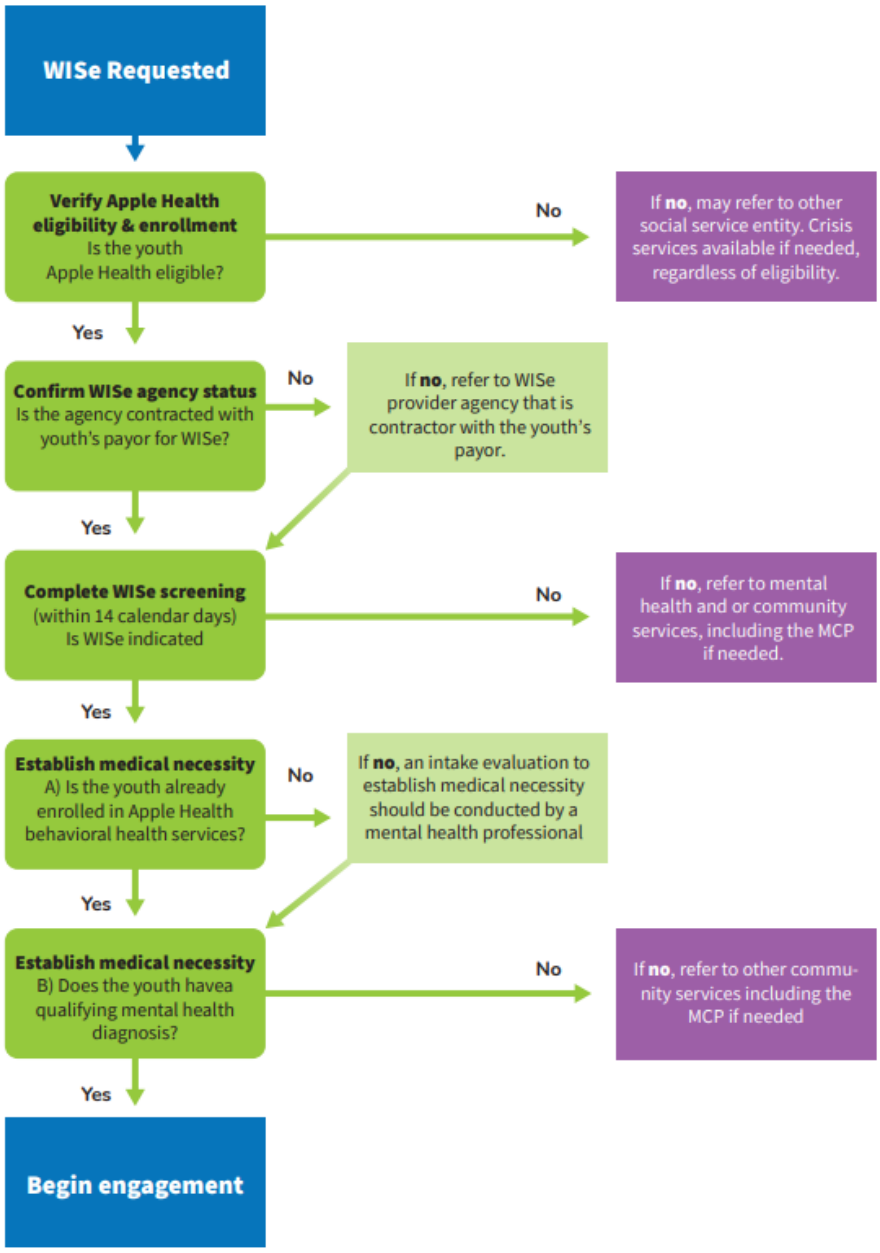
The following information should be included on the website for each WISe agency:

- General information about WISe
- Information regarding eligibility for WISe
- Direction on how to make a referral for WISe Helpful, but optional, to have a link to the HCA WISe website.

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 Organizations (MCOs) 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 Children, Youth & Families (DCYF), Department of Social and Health Services (DSHS), Health Care Authority (HCA), school personnel, county and community providers, Tribal service providers, mobile crisis teams (including youth mobile rapid response crisis teams) and MCO's assist in the identification and referral of youth who might benefit from WISe. Consideration for referral begins with youth who are Apple Health eligible for coverage under WAC 182-505-0210, 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.

Referrals

Anyone can make a referral for a WISe screen, including the youth and family. All Apple Health youth who are eligible for coverage under WAC 182-505-0210, 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 youth who are eligible for Apple Health coverage under WAC 182-505-0210 in the following circumstances:

1. When a youth is referred to Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS services only (not BRS and WISe concurrently): no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from CLIP.
    a. *Managed Care Organization staff are responsible for making the referral for their enrollee to a WISe agency at least 30 days prior to discharge*
4. Prior to a youth discharging from a psychiatric hospital.
5. When a step-down request has been made from institutional or group care.
6. When a youth receives crisis intervention or stabilization services, there are past and/or current functional indicators of need for intensive behavioral health services.

If a youth **is currently** receiving Apple Health behavioral health services, a referral for a WISe Screen can be completed in the following ways:

- The current outpatient provider can complete the CANS screen, if they are also an approved WISe provider or
- The current provider that is not an approved WISe agency, can make a referral to an approved WISe 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. Note that for children under the age of 6, there is no algorithm, and the decision is made on clinical judgment.

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 Managed Care Organization (MCO) 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 MCO or any contracted WISe provider.

WISe CANS 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." A WISe screen is not considered to be complete until entered into BHAS.** WISe screens are available at WISe agencies and can be easily completed over the phone. The option to complete the screen in person will be offered when that option is more convenient for the youth/family.

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 that is eligible for Apple Health coverage under WAC 182-505-0210 and is age 20 or younger.

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 CANS-certified see Transformational Collaborative Outcomes Management Training (TCOM Training).

Note: Training materials, related to how to enter CANS into BHAS are available **here**. For children age 5 and younger, WISe providers will use the CANS Birth - 5.

3. Entering the CANS Screen into the Behavioral Health Assessment Solution (BHAS) which will apply the CANS algorithm (for individuals over the age of 5) to determine whether the youth would benefit from WISe.
    - The CANS Screen should be entered into BHAS prior to MCO notification. Make sure to follow MCO timeframes around notifications of WISe eligibility status.
4. **If a youth does not meet the CANS algorithm**, clinical judgment may be used to continue with a referral to WISe. Note that for children under the age of 6, there is no algorithm, and the decision is made on clinical judgment.

Note: There are differences in screening requirements and BHAS entry steps for youth being referred to, enrolled or discharging from BRS services. Please see Section 2 Specialty teams and guidance for more detailed information.

Interest List Monitoring

The BHAS "Closed Pending Enrollment" status is currently in place to demonstrate that a youth is eligible for WISe and is not yet enrolled.

MCOs and Providers need to ensure this list is timely, up to date, and accurate to track to understand capacity needs and how long it takes people to get into WISe. It is critical that screens are entered into BHAS on time and that the screens are accurately categorized as 'closed pending' when the youth is on the interest list.

BHAS "Closed Pending" lists are required to be reviewed regularly by MCO's and Providers. Instruction on the process are included on the WISe Interest List Quality Improvement and Monitoring information sheet.

Note: Per existing requirements, MCOs 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.

Children and youth are considered to be on the interest list as soon as the CANS screen shows WISe is recommended or it is determined the CANS screen outcome will be overridden regardless of mental health intake completion and the screen is placed in "closed pending" status.

This **is not** considered a waitlist and **children and youth must be offered Medicaid state plan services.** Waitlists are not allowed by Medicaid.

If a screen is placed in "closed pending" by a different agency than the agency that the individual is enrolling in WISe, the agency that will enroll the individual should NOT complete a new screen unless it has been more than six months since the screen was completed. The original screen should be used. To be compliant with RCW 18.225.105 and RCW 18.19.180, a release of information (ROI) should be completed at the time of the screen so that the results can be shared with the WISe agency that will enroll the individual. A template for this ROI is available from HCA.

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 mental health state plan services and can only serve youth age 20 and younger and eligible for Apple Health coverage under WAC 182-505-0210.

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. There is no algorithm for individuals under the age of 6, so clinical judgment is used for those instances. Indicate in BHAS comment section the reason youth is being offered entry into WISe.

*Note: See access protocol updates for non-MCO beneficiaries (i.e. AI/AN beneficiaries receiving FFS WISe)

For youth who are determined eligible for WISe, this is when 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, 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 with information for both providers and parents and family members.

Youth who are not eligible for Apple Health coverage under WAC 182-505-0210 or 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 and enrolled in a Managed Care Plan, but who do not meet the CANS algorithm or receive a clinical override, will be notified of their rights of grievances and appeals by the MCO. Youth and families will also be referred to other services, which could include relevant behavioral health community services and/or care coordination through the individual's MCO. In addition, agencies must follow MCO notification timelines when youth are determined not eligible for WISe.

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.

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 includes facilitating and coordinating all services and supports identified in the Cross System Care Plan. 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.

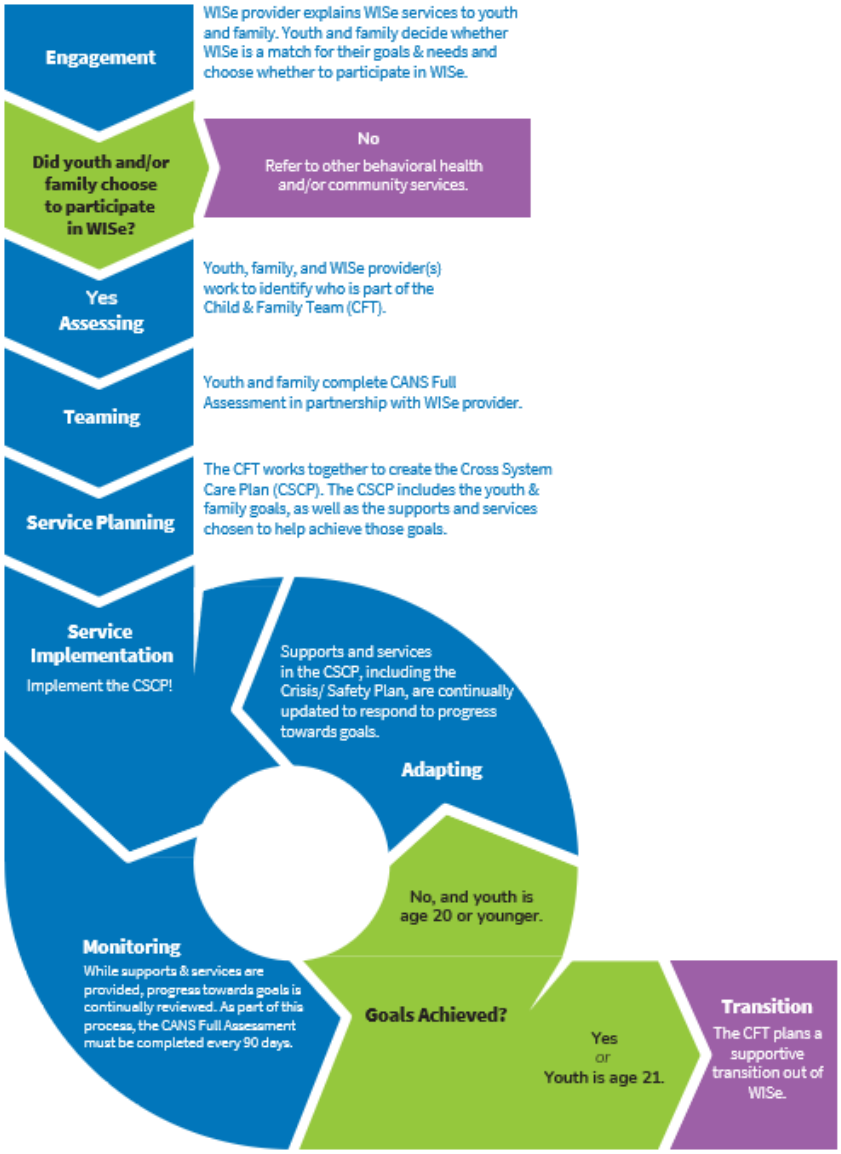
*WISe Practitioners– a term used to describe the collection of WISe-certified staff roles, required for each team (the Care Coordinator, the family partner and/or youth partner, and the Mental Health Therapist)

Phases of WISe (Practice model)

There are six phases in WISe:

1. Engagement
2. Assessing
3. Teaming
4. Service Planning and Service Implementation
5. Monitoring and Adapting
6. Transition

This section will expand more on the goals and tasks of each phase. Below you will see a visual representation of a WISe episode as it moves through each phase.



1. Engagement

In the engagement 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, SUD residential or a juvenile justice facility), this phase is especially important, to begin before the youth discharges the program or placement, to assist in successfully transitioning youth back into the community. H0023, Behavioral Health Care Coordination and Community Integration (formerly called Rehabilitation Case Management) can be used prior to an intake and can be offered to a youth who is nearing completion of a CLIP stay. The WISe provider will need to consult with the MCO to determine if a U8 modifier should be used in these cases as we expect this to be used only when there are more than 10 hours of service being provided.

> Note: Contact the youth's MCO to develop a plan for contacting the youth prior to discharge from a program or placement. MCO's must prioritize access to WISe services for all youth qualified to receive WISe services that the MCO has been notified are discharging from CLIP and Juvenile Rehabilitation Facilities.

Goals/purpose

- To lay the groundwork for trust and shared vision among the youth, family and WISe team.
- To establish rapport and build commitment to the WISe process through warmth, optimism, humor, and identification of strengths.
- 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

- 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.

2. 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's 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 Full CANS (to be completed within 30 to 45 days of enrollment into WISe) 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 list 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.
- CANS information can be gathered and compiled by a WISe Practitioner certified in completing the CANS based on meetings and conversations that have occurred as part of the Engagement/Assessment process. The CANS does not need to be completed in one sitting with the youth and family, and information obtained throughout the process may be included.

Documentation Considerations

- Document that the initial Full CANS is completed and entered into BHAS within 30 to 45 days of WISe enrollment.

> Note: For data entry and as referred to in the Service Encounter Reporting Instructions (SERI), using a U8 modifier indicates the youth is enrolled and receiving WISe. The date of WISe enrollment is the first use of U8 modifier. The first U8 modifier entered should be the first encounterable/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.

- 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 youth's needs and strengths.
- Does the Full CANS indicate need for psychiatric consultation? If yes, document conversation around this need with the youth and/or family and the outcome.

3. 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 and creation of the Cross System Care Plan (CSCP). See service planning and implementation for more details on the CSCP.

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 **(monthly, 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. However, the youth and family may determine that specific CFT meetings should only include relevant members and not the full team. In order to be considered a CFT meeting, the youth and/or parent and a WISe team member need to be in attendance. SERI page 86-87
- It is acceptable to have existing cross system meetings serve as the CFT as long as the requirements are met for being considered a CFT. For instance, if there is an IEP/504 meeting at the school, this can serve as the CFT for the month if that meeting serves the needs of the youth and family.

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 and considers the safety of all the team members.
- **Considerations** WISe participants are likely to have multiple existing plans and the role of the CSCP is to ensure that these plans are working to support the youth and family by having all plans coordinated and working in a collaborative effort while avoiding conflicts in these multiple plans.
- 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.
- The CSCP should be concise enough for the youth and family as well as other CFT members to easily understand what goals are being addressed by which cross system formal and natural supports.

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.

4. Service Planning and Implementation

Cross System Care Plan

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. Youth and families 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 are going to 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

- Distills the youth/families multiple care plans from independent sources and align the youth and families needs and goals into one plan/document
- Prioritize needs and includes the strengths to address the needs as indicated on the CANS
- Informs the teams mission and guides team meetings through the process of identifying barriers and potential crises and supports creating effective crisis prevention and response plan
- Detailed enough to clarify roles and responsibilities to effectively support the youth/family but does not include sensitive information that is not needed for the entire team to see.

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, which is completed and shared with the youth and family.
- 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 F.

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. It is important that the CFT creates a plan where the goals and objectives complement each other and do not create conflicting priorities. (e.g. if the ABA plan suggests ignoring a specific behavior and the school IEP prioritizes confronting that same behavior)
- 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 a new Full CANS is completed.
- The role of each team member is clear.
- Tasks are clearly assigned and updated at each CFT.

5. 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 concurrence 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 month 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 to 105 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.

Service Implementation/Service Array

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. 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 in accordance with the youth and family's Individualized Service Plan (ISP), and coordinated with the Cross System Care Plan, which will contain the appropriate levels of details, 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.
- 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 strategies or core elements from 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.

- Coordination of other services such as:
  - Personal care or respite hours
  - Applied Behavior Analysis (ABA) Therapy
  - Speech and Occupational Therapy
  - Medical/Dental services
  - Other needed supports as identified by the WISe team

Settings: Direct services will be provided in any setting where the youth is 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: Certified peer specialists, which include a family partner and/or a youth partner, 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 youth's skill building to develop emotional regulation skills, etc.).

Notification: The full array of WISe services may be provided, as medically necessary, once the MCO is notified by a provider of WISe enrollment. Make sure to follow the MCO process and procedures for notification.

Crisis Planning and Delivery

All Community Behavioral Health Agencies have general requirements around crisis response and suicide prevention, and all WISe agencies must maintain appropriate crisis certification by DOH. In addition to these required expectations, there are additional expectations specific to the WISe process.

If you are not familiar with, or want to review some of the general BHA agency crisis de-escalation and suicide prevention training requirements, those can be found at:

- RCW 49.19.020 Workplace violence plan
- RCW 49.19.030 Violence prevention training
- Marty Smith Trainings
- RCW 43.70.442

The rest of this section will focus specifically on requirements for WISe crisis planning and delivery. Effective crisis planning is a critical component of an effective care plan. Steps in WISe crisis planning include:

- Help youth and family define what crisis means to them
- Help youth and family identify what leads to crisis
- Help youth and family understand the crisis cycle
- Help youth and family understand when they would reach out for additional support, i.e. call 911 if youth reports an overdose or medical emergency

A Crisis Prevention and Response Plan (A Crisis Plan) should include the following elements:

- Types of crisis
- Crisis identification and prevention steps, including CFT members' roles related to proactive interventions to minimize the occurrence and severity of crises.
- Crisis response actions to address severity of crisis situation
- Legal mandates and community safety
- Clear behavioral benchmarks that change over time to reflect progress, and changes in the youth/family's expectations.
- A post crisis process for evaluating the crisis plan for what worked and what part or parts of the crisis plan could be updated after a crisis occurs. WISe requires:
    - Follow up with the family within three days to schedule a team meeting
    - The team meeting can involve members of the team that family and youth deem necessary in a mode that meets the current needs of the youth and family
    - Refer to Crisis training provided by WISe workforce collaborative (En route)
    - Planning relies on support people who will not escalate a crisis.
    - Coordination of services between out-of-home provider and the CFT.
    - Crisis plans/safety plans are modified as needed based on the changing situation of the family and youth and understanding of when outside supports such as calling 911 or accessing an emergency department may be needed to assist with crisis response. This should be an identified step on the WISe crisis plan to address an imminent safety need. There may be times where supports are beyond the scope of the WISe team and natural supports.
- Information related to assessed safety risks and a plan to manage risks identified (i.e. restricting access to medications, sharps or other objects of concern, limiting access to upper floors, increasing supervision).

Crisis Response Actions

- Offer 24/7 response
- Identify formal and natural supports
- Implement respite/back up care as determined by the cross-system care plan. Respite is not a state plan service, but may be available through natural supports or other programs.

- Identify potential precipitating events and methods
- Identify successful strategies that have worked in the past
- Provide Strengths-based strategies that ensure safety

Crisis Services include

- Crisis planning that, based on the youth's history and needs:
    - Anticipates the types of crises that may occur.
    - Identifies potential precipitating events and methods to reduce or eliminate.
    - Includes coordination with tribal crisis plan when appropriate
    - Establishes individualized responsive strategies by caregivers and members of the youth's team, including natural supports, to minimize crisis and ensure safety.
- Stabilization of crisis 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.
    - Any current providers and team members including a care coordinator, mental health therapist, youth partner, family partner, family members, primary care practitioners, tribal agencies or school personnel or others working with the youth and family
- Crisis follow-up services (stabilization services) provided periodically to:
    - Ensure continued safety and delivery of services necessary to prevent future crises.
    - Coordinate services between the out-of-home provider (if the youth is placed out of home) and the youth's treatment team to facilitate a plan for rapid return home.
- Tools and resources available to manage potential risks.
- Crisis Awareness and Communications in Peer Support (CACPS) training is not required for peers that respond to WISe crisis if they are not the sole responders.

Documentation Considerations

- All WISe services including Crisis need to be encountered as indicated in the most current version of SERI. For WISe, use the HCPS code H2011 with the U8 modifier.
- A crisis prevention and response plan is completed and available to all appropriate 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 included in the CSCP with details as appropriate.
- The Crisis Prevention and Response plan is updated regularly.
- The Crisis Plan actively addresses early intervention and identification and has tiered action steps that match 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 plan and update as needed.

Crisis Delivery

Crisis services are provided to support the youth and family and may include crisis planning and prevention services, telephone support, as well as face-to-face interventions.

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 behavioral health outpatient crisis 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 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.

Note: At the time of this update, Washington State is undergoing a system wide change in how crisis and stabilization services are provided for everyone in the state. These changes will not alter the 24/7 WISe crisis and stabilization requirements. A communication pathway will need to be established between WISe providers and crisis teams to ensure a clear understanding of the roles of each and how they will refer or partner when individuals enrolled in WISe are in crisis.

Individuals enrolled in WISe who are experiencing a crisis may be contacted initially by a Mobile Rapid Response Crisis Team (MRRCT) including a Mobile Response and Stabilization Team (MRSS). The MRRCT and MRSS team should be made aware the youth is enrolled in WISe with the goal of a warm handoff to the WISe team for continued support.

6. Transition phase

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.

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

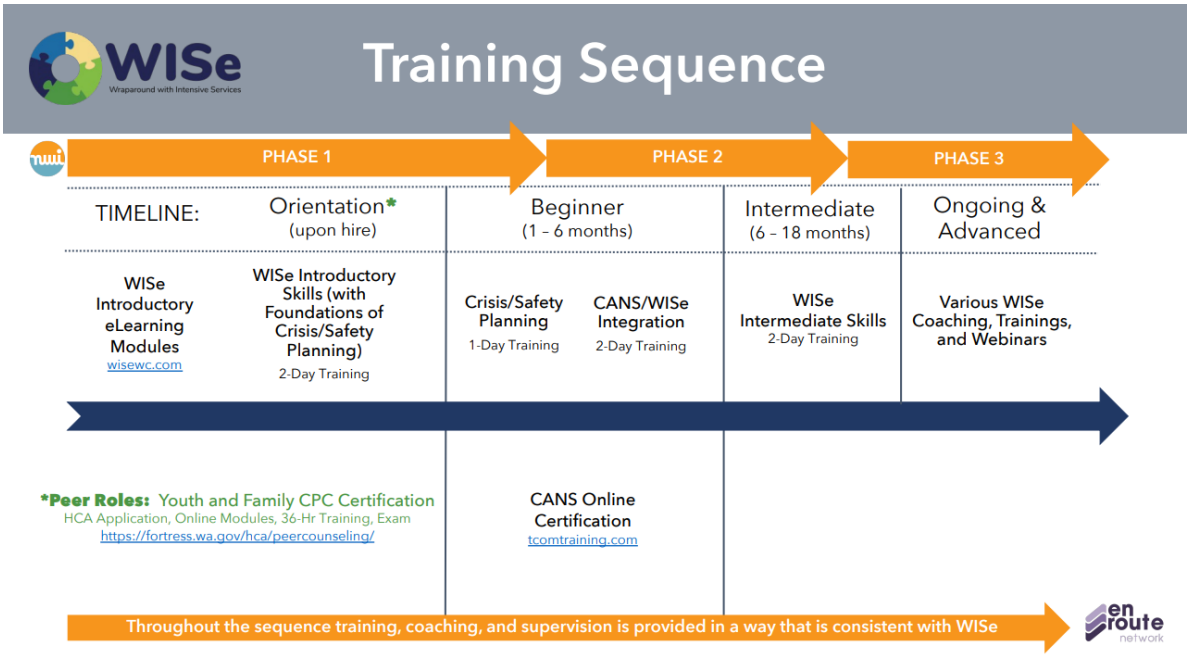
CFTs use the CANS to monitor for an increase of strengths and a reduction of needs. the CFT (including the family) and all WISe Team members (Clinician, Peers and Care Coordinator) work together to determine the timeline for transitions, once the transition date is identified, the maximum time in this phase is six months

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. Coaching and training and materials are available through the WISe Workforce Collaborative.

WISe training and coaching framework



WISe practitioner training and coaching framework

WISe training and coaching is an ongoing **contractual requirement.** The WISe case rate includes cost reimbursement for participation in training and coaching. The case rate is based on the expectation that newly hired WISe staff will engage in 100 hours of training and coaching during their first year. The case rate supports 80 hours of training and coaching for each WISe practitioner each year after completion of their first year in WISe.

The WISe Workforce Collaborative (Enroute) 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

Requirements: Representatives from all MCOs 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 offered virtually and facilitated by the WISe Workforce Collaborative contractor, En Route.

Practitioner training and coaching

The WISe Workforce Collaborative (En Route) is the training and coaching hub for WISe practitioners across the state. En Route 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 (Enroute) are a requirement of WISe agency staff. When onboarding new WISe practitioners, agencies must document completion of the following set of trainings:

- WISe Introductory eLearning modules
- WISe Introductory Skills with Foundations of Crisis/Safety Planning, (2 days)
    - Note: If a region or a WISe agency has an approved training plan, see additional information under the section, Regional/Agency training plan.
- Crisis and Safety Planning, (1 day)
- Certified Peer Specialist (CPS) training (Hybrid with 40 hours in person (5 days) and 40 hours virtual (10 half days) • Fully virtual (20 half days)) for those hired in peer support roles.
    - Note: See section 2 of the WISe manual for additional information.
- CANS online certification
- CANS/WISe Integration (2 days)
- WISe Intermediate Training – Care Coordinators, youth partners, family partners, and Clinicians (2 days)

Enhanced training sessions offered include:

- Bridging the Gap to Culturally Specific Practices in WISe, led by BIPOC trainers (2 days)
- WISe and Indian Health Care Providers Training, led by American Indian or Alaska Native Trainers (2 days)
- WISe Supervisors-(4 half-day trainings)
- WISe Data to Practice trainings (times vary)

WISe coaching virtual sessions may include:

- Mental Health Therapists
- Supervisors, Managers, Leads, Directors
- Youth Peers
- Family Peers
- Care Coordinators

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)
• 32 hours of live training + 14 hours of eLearning content for **all new WISe staff** 36 hours of training + avg 6 hours of eLearning for **Youth and Family Peers** – if not certified at time of hire	12-18 hours required training **per role** on the WISe team, annually.	• 8-16 hours of coaching calls annually, based on coaching plan
Onboarding and Orientation for all new staff includes: • WISe Introductory eLearning Modules & Exam (avg 6 hours) • CANS eLearning Modules and Certification (avg 8 hours) • WISe Introductory Skills & Crisis/Safety Planning (2-days) • CANS/WISe Integration training (2-days) • Crisis/Safety Planning (1-day)*	**Required Intermediate Trainings for all WISe team members** • Intermediate Practice Skills (2-days) ○ 12-18 hours	**On-going coaching calls** Topics and staff to attend are based on the region or agency coaching plan. Call: 1-2 hours a month, up to 8 calls annually, based on need.
Certified Peer Specialist Training - for WISe Youth and Family Peers Certified Peer Specialist eLearning modules and live training for those hired in peer support roles.	**Supervisors/Coaches/Leads:** WISe Supervisors training (2-day)- Crisis/Safety Planning (1-day) 16 hours	**Coaching for Supervisors/Leads/Coaches:** Based on the agency's coaching plan and Quality Review outcomes. *Who attends the particular coaching depends on topic, coaching needs, and coaching plan.*

WISe agencies are required to have lead staff participate in WISe coaching sessions. Agencies will partner with the WISe Workforce Collaborative (En Route), 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 (En Route).

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 MCO) 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.

Orientation

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

- Staff must be provided with their own copy of the WISe manual. Staff entering CANS data must also review the Behavioral Health Assessment System (BHAS) manual.
- Staff must have access to the Regional Family, Youth, System Partner Round Table (FYSPRT) manual. When appropriate, WISe participants should be invited to attend regional FYSPRT meetings.
- Staff must review the WISe Due Process brochure.
- Staff must review the Quality Plan
- Staff must complete the WISe Introductory eLearning modules and the self-test through their Bridge/WISe training account
    - 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. MCO's 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 MCO to submit a training plan. To receive a WISe Onboarding Training Approval form please send a request to WISe Support.

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 agencies may work with the WISe Workforce Collaborative (En Route) to develop a coaching plan. 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 (En Route)-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).

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. **This section of this manual does not alter any Medicaid or due process rights contained in state or federal law.** A WISe information sheet with information on client rights can be found at the HCA website.

Reaching consensus on a CFT

Youth participating in WISe are entitled to any services on the Medicaid behavioral 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 and the Washington State Children's Behavioral Health Principles when developing the Cross System Care Plan to reach consensus on the services and supports necessary to reach the youth's best possible functional level. The team should also adhere to the needs and strengths identified with the CANS and utilize the preferred strategies expressed by the youth and family. Although the CANS assessment is not the sole measure of youth functioning, the CANS assessment will be utilized to evaluate the progress of the youth in reaching their 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.

When the CFT reaches agreement on a plan

- The CFT should meet again within the agreed specified timeframe.
- 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.

When the CFT cannot reach agreement on a plan

If the CFT **cannot reach** an 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 their MCO 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[1]. A grievance may be filed with the client's MCO over the phone, or in writing. Youth or families 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 are not sure what you would like to happen you can still file grievance
- Your signature and date of signing

1. When the MCO 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 MCO who is familiar with the youth's condition will review the grievance.
3. The MCO will review the grievance and send a letter of their decision as quickly as the youth's health condition requires and no longer than 45 days from the date the MCO 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 MCO. The MCO 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 MCO and/or provider agency that there is disagreement with treatment plan recommendations found in the Individual Service Plan, made during the care planning process.

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[1] **"Adverse benefit determination"** means one or more of the following:
(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(b) The reduction, suspension, or termination of a previously authorized service;
(c) The denial, in whole or in part, of payment for a service;
(d) The failure to provide services in a timely manner, as defined by the state;
(e) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. Sec. 438.408 (a), (b)(1) and (2) for standard resolution of grievances and appeals; or
(f) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52 (b)(2)(ii)

- The MCO denies[2], terminates[3], reduces[4] or suspends[5] 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
- Client's 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 MCOs.

Types of appeals

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

- **Expedited:** An expedited appeal is available to a youth or family member, when the MCO 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 for a standard appeal could seriously harm the youth's health, the MCO will automatically grant an expedited appeal.[6]

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[2] 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.

[3] 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.

[4] 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.

[5] 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.

[6] 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

- If a youth, parent/caregiver asks for an expedited appeal without support from their mental health care provider, the MCO will decide if the youth's health requires one. If the MCO does not agree with the request, the plan must decide the appeal within standard appeal timeframes.
- The MCO 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 MCO 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 MCO by phone at the number provided on the notice, or in writing. The appeal must include:
  - Client name
  - Contact number, email or address
  - ProviderOne ID
  - The service or treatment being appealed
  - Information about why the client disagrees with the Adverse Benefit

Determination

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:

- 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.

Note: The client may have to pay for the continued services if the appeal is upheld.

How to request an administrative (fair) hearing

In order to request an administrative (fair) hearing, the individual must first receive a Notice of Resolution from the MCO that decided the appeal. The individual or their 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

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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.

Fax: (360) 664-8721
(**No email correspondence is accepted**)

An Administrative Law judge will look at the evidence provided and decide on whether to grant the appeal. The judge has 90 days from the date the request was filed to decide. If the judge agrees with the appeal, the MCO must follow the decision by the judge and authorize or provide the services as fast as the individual's health condition requires. An administrative hearing may not be filed regarding a grievance decision unless the MCO fails to decide on the grievance within the required time frame. Learn more about the administrative hearing process.

Continuing services during the appeal

If a youth is currently receiving services, their 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

Governance and coordination

Washington State will maintain a collaborative governance structure that includes families, youth, community, and youth-serving system partners, as a mechanism for improving behavioral health services and supports as well as informing the quality of Wraparound with Intensive Services (WISe). This includes the Regional (and Local) FYSPRTs, the Statewide FYSPRT and legislative groups such as the Youth and Young Adult Continuum of Care and the Children and Youth Behavioral Health Work Group. This collaborative governance structure includes youth, family and youth serving system partner (juvenile rehabilitation, child welfare, education, etc.)

voice in all parts of the structure, coming together to ensure coordination, and identify and address recurring system gaps and barriers to improve outcomes for youth and families.

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

- Collaboration and coordination across child and youth serving systems with youth, family, and community partners.
- Working to address recurring system gaps and barriers as close to the community as possible.
- Connection to legislative groups to ensure recurring system gaps and barriers elevated by family and youth are addressed.
- Participation by local system partner representatives (child welfare, juvenile rehabilitation, education, etc.) in Child and Family Teams (CFTs) when invited by youth and families who are enrolled in WISe and served by multiple youth and child-serving systems including tribal program partners when appropriate.
- 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 youth and family in all aspects of policy development and decision-making for WISe and behavioral health services that are designed for youth and families.

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

Child, Youth and Family Behavioral Health Governance Structure Component Descriptions

Regional and local family, youth, system partner round table (FYSPRT)

Role	Required members	Of note
Looks at the full continuum of care, including WISe quality and service delivery in the region. Brings families, youth and youth serving systems and community together to	Families and youth with lived experience (including past/present WISe youth and family participants), Tribal and Urban Indian Health Partners, Behavioral Health - Administrative Service Organization (BH-	**Of Note:** • Tri-Led by family and youth partners with lived experience (does not need to be a Certified Peer), and

address regional challenges and barriers as identified by the Regional FYSPRT. Reviews local/regional WISe data to celebrate success and identify recurring needs or gaps to address to improve outcomes for children and youth experiencing behavioral health challenges. If not able to resolve or address a recurring system gap or barrier at the regional FYSPRT, the Regional FYSPRT can bring the challenge forward to the Statewide FYSPRT with recommendations for how to address the need.	ASO), Managed Care Plan (MCO) staff, local/regional system partners (for example juvenile justice, education, etc.), and other interested community partners.	System Partner from the membership • Open Meetings – No confidential or Protected Health Information (PHI) shared. The Regional FYSPRT is intended to identify recurring needs, gaps or barriers in the child and family behavioral health system and provide recommendations to the Statewide FYSPRT • Minimum of 51% youth and family membership. • Includes tribal, underrepresented and underserved populations • Based on how a region defines their community(ies), they may select to have more localized groups (local FYSPRTs) that connect to their regional structure, to better meet the needs of that region, and address challenges and barriers as close to the community as possible • When part of an individual's Cross System Care Plan it is possible for a WISe practitioner to attend a FYSPRT meeting with the individual and/or family and count it toward service intensity when attendance at FYSPRT is part of the youths individual service plan.

Statewide FYSPRT

Role	Members	Of note
Looks at the full continuum of care, including WISe quality and service delivery, across Washington state. Brings together Regional FYSPRT Tri-leads and state level youth serving	Regional FYSPRT Tri-leads, state-level system partners from child and youth serving systems, tribal and urban Indian health partners, family and youth organization representatives, FYSPRT Tri-leads from the	• Tri-Led by Youth, Family, and System Partner leaders from the Statewide FYSPRT membership • Open Meetings – No confidential or Protected

system representatives (child welfare, juvenile rehabilitation, education, etc.) to support the work of the Regional FYSPRTs. Works together to address recurring system gaps or barriers identified by regional FYSPRTs that may require policy decisions/direction, as well as reviews statewide data, to improve outcomes for children, youth and families experiencing behavioral health challenges	Division of Behavioral Health and Recovery, and community partners	Health Information (PHI) shared. The Statewide FYSPRT is intended to identify recurring system gaps and barriers, share solutions and provide recommendations to a youth and young adult behavioral health focused legislative work group. • Statewide FYSPRT workgroups are utilized as a means for completing specific work products, or as a strategy for making systemic changes. Representatives from the Statewide and/or Regional FYSPRTs will be invited to participate. • Statewide FYSPRT meeting notes are posted to **HCA's FYSPRT webpage**.

Youth and Young Adult Continuum of Care subgroup of the

Children and Youth Behavioral Health Work Group

Role	Members	Of note
A legislative work group that receives recommendations from the Statewide FYSPRT, requests input, and makes recommendations to the Children and Youth Behavioral Health Work Group related to behavioral health services and WISe quality and service delivery and to improve outcomes for children and youth experiencing behavioral health challenges.	State child and youth serving agencies, legislators, health care providers, youth and parents of children/youth who have received services, tribes, a FYSPRT representative, and community partners and organizations	• Quad-led by legislators, a family leader and a youth leader • A Youth and Young Adult Continuum of Care Subgroup member(s) attend Statewide FYSPRT meetings • Youth and Young Adult Continuum of Care Subgroup meeting notes are posted HCA's Children and Youth Behavioral Health Work Group website • Meetings are open to the public

Children and Youth Behavioral Health Work Group (CYBHWG)

Role	Members	Of note
A legislative work group that receives recommendations from the Youth and Young Adult Continuum	State child and youth serving agencies, legislators, health care providers, tribes, a FYSPRT representative, youth and parents	• Children and Youth Behavioral Health Work

of Care subgroup, requests input, and makes policy-level decisions and recommendations to the Governor's office, legislature and child, youth, and family serving agencies. Recommendations could be related to behavioral health services and WISe quality and service delivery to improve outcomes for children and youth experiencing behavioral health challenges	who have received services and community partners and organizations	Group meeting notes are posted to website • Meetings are open to the public

For more detailed information on the Statewide and Regional FYSPRTs, please refer to the Regional FYSPRT Manual .

Developing regional linkages to the governance structure

MCOs 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 recurring and thematic system gaps and barriers expressed by a CFT or CFTs. Reviewing WISe data at a more local level for continuous quality improvement to problem solve or identify systemic barriers.

Center of Parent Excellence

The Center of Parent Excellence (COPE) project was developed as a support to enhance the System of Care framework. The project is intended to provide a pathway for Washington State parents who are accessing and navigating the children and youth behavioral health system. The COPE project is staffed by lead parent support specialists, hired for their lived experience as a parent/caregiver.

Supports provided by COPE are available to CFTs or families. COPE project staff will assist the family and CFTs when needed to address concerns and barriers identified by the family, youth or CFT. COPE project will track recurring system gaps and barriers expressed by a CFT and advance to the local and/or Regional FYSPRT by proposing the recurring system gap as an agenda item at a future meeting to share and brainstorm solutions.

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. The WISe quality plan must be used by HCA, MCO's and WISe agencies per WAC 182-501-0215.

HCA is currently reviewing and updating the Quality Plan, including assessing the QIRT and associated requirements. During the Quality Plan update process, use of the QIRT is not required. This section will be updated once the update is complete. View the Quality Plan timeline.

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.

WISe Fee for Service

Overview of Apple Health for individuals not in Managed Care (Enrolled in Fee for Services (FFS))

Federal law requires state Medicaid programs to enable American Indian/Alaska Native (AI/AN) individuals to opt into or out of managed care plans. This is to ensure AI/AN persons can access culturally appropriate care from their Indian Health Care provider. As a result, approximately 60% of AI/AN individuals in Medicaid are enrolled in Apple Health without a managed care organization (also known as the Apple Health fee-for-service (FFS) program). WISe is available to all individuals in Apple Health FFS who need the service and does not require prior authorization from either HCA or a managed care organization. There are a limited number of other youth who are not AI/AN who are also enrolled in FFS. The WISe provider can use Provider One to look up a client's current MCO. If the client shows active Medicaid coverage, but no MCO is shown, this means the client has Fee for Service. This is shown in the FFS billing guide. You should NOT assume that this means the client is American Indian since some other groups also have FFS.

Participation as a WISe Fee for Service (FFS) provider

HCA encourages all WISe providers to participate in the FFS program to ensure adequate access to WISe for the estimated 22,500 AI/AN and other youth not enrolled in an Apple Health managed care plan.

WISe payments in the Apple Health FFS program (WISe FFS) allow for services to be unbundled and paid for separately. WISe FFS also involves a case rate each month for each youth receiving WISe - in addition to reimbursement for all services provided. WISe FFS providers are required to follow all expectations in the WISe manual.

To provide WISe FFS, an agency must have a Core Provider Agreement (CPA) with HCA, be an approved WISe agency, and register through the Provider Entry Portal for Behavioral Health Agencies. HCA staff are available to provide guidance on the necessary steps to become a WISe FFS agency. The CPA's terms and conditions incorporate federal laws, rules and regulations, state laws, rules and regulations, and agency program policies, provider notices, and provider guides, including the ProviderOne Billing and Resource Guide, and the mental health services billing guide.

WISe innovations when serving individuals not in Managed Care (FFS program)

In an effort to support rural WISe FFS providers (or single county WISe FFS providers servicing rural communities), it may be beneficial to identify additional approaches to ensure success of the youth and family enrolled in the WISe program. Suggested considerations for WISe FFS providers include:

- Create an innovative Cross System Care Plan. Youth receiving WISe FFS can receive services concurrently from other Apple Health FFS providers. A WISe Care Coordinator can assist in coordination of these services and invite other Apple Health FFS staff to participate in Child and Family Teams (CFTs).
- WISe FFS providers are encouraged to be as flexible as possible, particularly in rural counties. For example, include peers from the youth's community and actively engage individuals in the CFT already known to the youth.
- In rural and frontier counties, consider supporting the expansion of WISe business agreements to allow youth to remain with counselors or peers in their local community who would become an integral part of the CFT. This would reduce instances of transfer of counselors (which can be a stressor for the child and family) and reduce travel time for the service provider.
- Expand support for local training of peers and employment of local peers through business agreements or other means. Tribes may have Certified Peer Specialists on staff or in the community who would be a better fit for an AI/AN youth enrolled in WISe.
- Develop working relationships to utilize tribal peers or family supports whenever possible. Peers employed by the WISe provider who are not part of the tribal community, or the rural community, will likely struggle to develop trust and be effective.

WISe FFS referral list

For WISe FFS referrals, see the WISe FFS provider list.

If interested in becoming an Apple Health FFS provider that offers WISe, please contact, WISe Support.

Section 2: Specialty teams and guidance

These sections provide an overview and best practices and understands that each agency has their own resources and connections with community partners in their region.

A. 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. Washington State Health Care Authority and Department of Children, Youth, and Families created this joint document to provide guidance on how to coordinate services concurrently when a youth is involved with BRS and screens eligible for WISe. We will update this document as needed.

Both BRS and WISe 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.

WISe Screens and Behavior Rehabilitation Services

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 if the youth is not enrolled in WISe at that time.

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 into 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 youth who is Apple Health eligible for coverage under WAC 182-505-0210 aged 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's screen is eligible for WISe, but the youth does not plan to enter WISe, WISe staff are to document the reason a referral is not made to serve the youth concurrently in WISe and BRS into the comments section of BHAS.

- 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 "ELIGBLE" screen but is not offered entry into WISe, they should receive a Notice of Adverse Benefit Determination (NOABD).

When a child receives BRS and WISe, 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 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

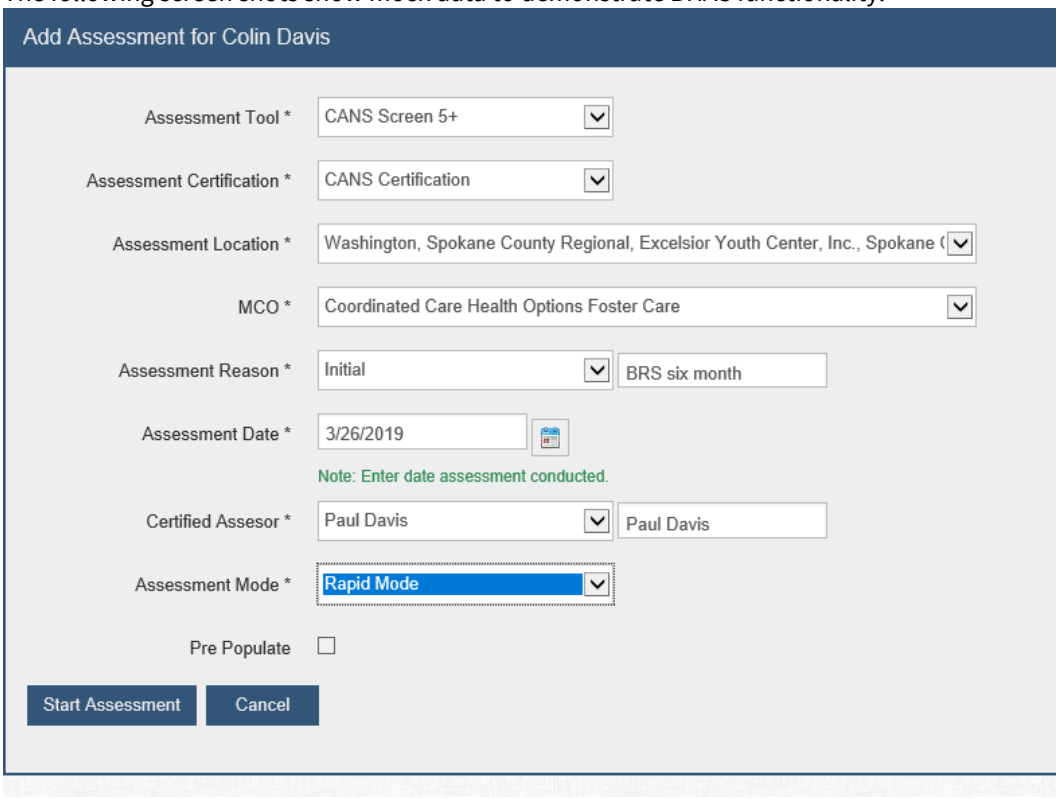
There are two unique areas to attend to when entering WISe screens for youth enrolled in BRS:

- Assessment reason
- Referral source

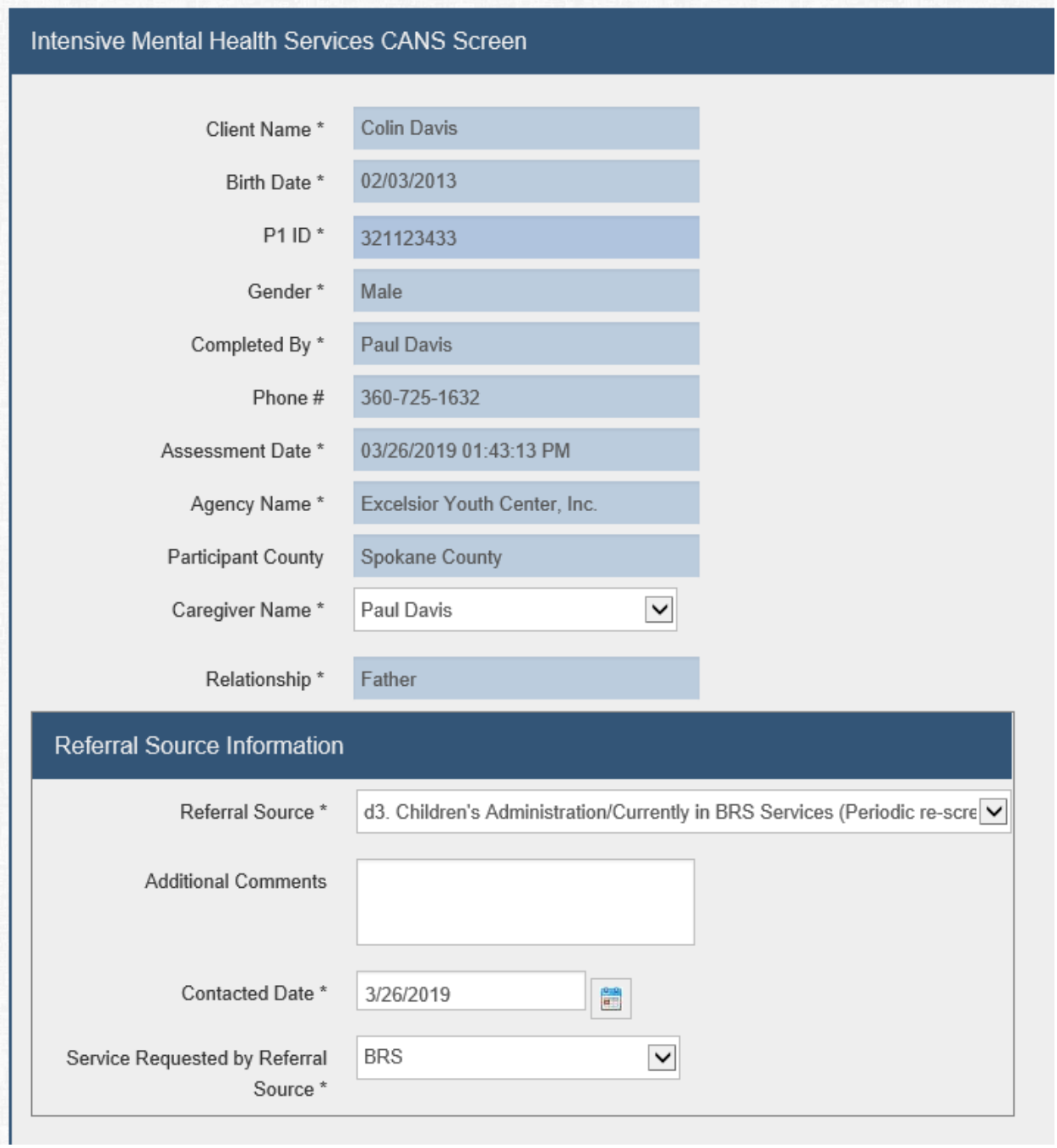
The following screen shots provide an overview of the steps for entering this information:

- The first page is where it asks for the "assessment reason".
- The drop down menu will force you to choose "initial".
- Use the comments to further clarify the reason for the assessment, i.e. "BRS 6 month."

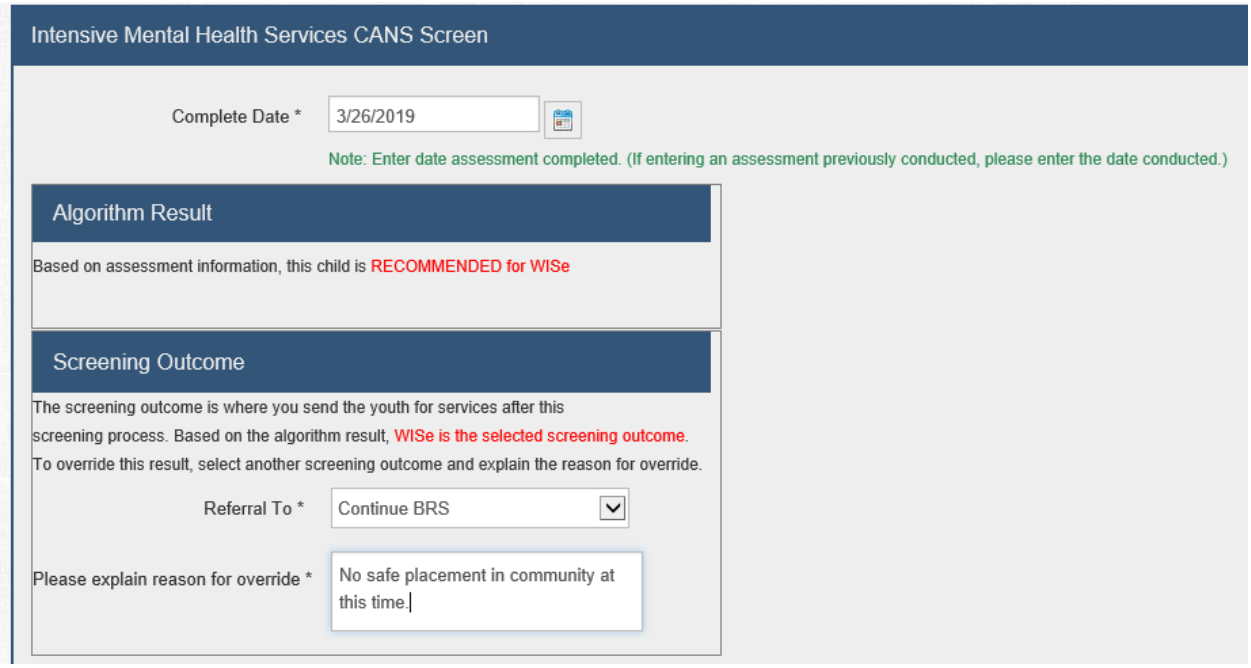
The following screen shots show mock data to demonstrate BHAS functionality.



The next screen will require you to choose a referral source. Use the drop-down menu to indicate whether this is an initial, rescreen, or discharge.



Then after the diagnosis is input into BHAS, 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.



On-going technical assistance and support is being provided during the phasing in of BRS and WISe by HCA/DBHR, DCYF, and Coordinated Care of Washington (CCW).

WISe provider expectations

- WISe practitioners will 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 will collaborate with BRS teams to provide highly coordinated and intensive services for youth enrolled in BRS. This may include having the same meeting for a CFT and required BRS care coordination meetings. As long as a WISe team member and a parent or youth attend that meeting, it can count as a CFT.
- WISe teams will participate in provided technical assistance sessions, such as the BRS and WISe webinars
- Monthly, WISe agencies will report the number of youth receiving WISe and BRS concurrently to the contracted MCO.

B. 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.

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 below 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 IndianTribe 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 Heath 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 Training and Technical Assistance (TTA) Center offers training and technical assistance 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 American Indian and Alaska Native youth and 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

The Office of 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 American Indian and Alaska Native youth 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.

C. Partnering with Transition Age Youth in WISe

HCA/DBHR worked 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 15 and 26 years old. For WISe specifically, TAY refers to youth from the ages of 15 – 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.

WISe and TAY pilot

DBHR worked 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 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.

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. The HCA Youth Liaison will guide this work and updates to this section will be made in future versions.

TAY consultation

SPARK Peer Learning Center 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 in Washington State.

SPARK reviewed the WISe manual for this update and offered the following feedback regarding Youth Peer Specialists and WISe TAY programs:

- Teams should keep in mind some youth may have had negative experiences with therapy and/or other systems prior to the referral to WISe
- Youth Partner can be an integral part of crisis prevention and response
- TAY teams often find it is helpful when the Youth Partner has a prominent role in initial engagement and through each phase of WISe
- Designated WISe teams that partner specifically with transition age youth
- Find ways from the start of services to empower the youth to create their team and who they want on it. This includes honoring the youth's definition of who is their family. Team members continue adding natural and informal supports as directed by the youth.
- Consider having Youth Peer being a liaison with SUD agencies for referral and engagement
- 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 if the youth's parents are not a part of the care team.
- **Not pushing agency or system agenda on youth.** Youth should feel empowered from the start to create their team, service plan and goals

Role of Youth Peer on TAY WISe teams

- Prominent in providing outreach and engagement. It is beneficial for Youth Peer to be 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.
- Youth Peer is a model of how to maintain and how to handle challenges to recovery.
- Groups with Youth Peers in lead roles such as groups teaching "real life," "adulting 101" skills can be helpful, 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
- Continue to offer professional development opportunities for youth peer specialists to expand the YPs toolbox

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.

> "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

D. WISe Birth through Five (B-5)

Children birth through age 5 (B-5) with qualifying mental health conditions are eligible to receive infant-early childhood mental health services, including through WISe. Because providing infant-early childhood mental health services can often look and feel different than for older children and youth, additional information about Infant-Early Childhood Mental Health and WISe B-5 is included below.

Infant-Early Childhood Mental Health

What is infant-early childhood mental health (I-ECMH)? Infant and early childhood mental health includes the capacities for developing enjoyable, trusting relationships with others; experiencing, communicating, and managing a range of emotions; and playing and learning. Nurturing relationships with loving, capable, consistent caregivers provide the context for developing these abilities, which create the foundation for continued growth and success across childhood and beyond (Cohen & Andujar, 2022).

Can infants and young children have mental health conditions? While positive early childhood experiences promote strong emotional health, negative experiences can adversely impact brain development. Approximately 20% of young children have emotional, relational, or behavioral conditions (**Vasileva et al., 2021**). However, when mental health concerns are identified early, there are services that can redirect the course and place children on a pathway for healthy development. Research demonstrates that treatment at this age has a strong return on investment, and may be more cost-effective than waiting to treat emotional difficulties after they become more serious (Oppenheim & Bartlett, 2022).

How are mental health conditions diagnosed in infants and young children? Mental health conditions in children birth through age five should be diagnosed using the DC:0-5, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. The DC:0-5 uses developmentally specific diagnostic criteria and reflects mental health disorders that are typically diagnosed in infancy and early childhood. This makes it a more developmentally appropriate diagnostic manual than the DSM.

Both CMS and SAMHSA recommend that I-ECMH clinicians use the DC:0-5 for the assessment and diagnosis of children younger than age 6.

Apple Health mental health professionals are required to use the DC:0-5 for mental health assessment and diagnosis of children younger than six. Providers can learn more about using the DC:0-5 on HCA's webpage and can also find free DC:0-5 training from the IECMH Workforce Collaborative.

What does I-ECMH treatment for a mental health condition look like? Infant early childhood mental health treatment is designed to alleviate the distress and suffering of the infant or young child's mental health problems and support the return to healthy development and behavior, specifically by empowering parents to build strong caregiver-child relationships. Infant-early childhood mental health treatment is often *dyadic*, which means it focuses on the relationship between the child and the caregiver(s). Providers can learn more about IECMH treatment on HCA's webpage.

WISe B-5

While WISe B-5 is similar to WISe for older children in many ways, there are a few key considerations for this specialty area. Several webinars on providing WISe services to children birth through age five are also available through the WISe Workforce Collaborative via The Bridge, and individualized coaching for agencies on this topic is available through the WISe Workforce Collaborative.

CANS screening & assessment: When working with children birth through age 5, practitioners should use the CANS B-5, as it addresses the unique developmental considerations of this age range. Currently, there is no WISe eligibility algorithm for the CANS B-5, so WISe eligibility for the B-5 population is based on clinical judgment.

Cross-system partners: Key cross-system partners for the B-5 population may be different than for older children and youth. While children younger than 5 may be enrolled in preschool, they may also attend other early childhood education or childcare programs, such as Head Start or ECEAP. Other specialized programs for children birth through five, such as home visiting, early intervention (ESIT), and Early Childhood Intervention and Prevention Services (ECLIPSE), may also be key partners. Primary care providers (PCPs) play a key role in the lives of many families of infants and young children, as there are at least twelve recommended well child visits from birth through five years of age. Lastly, programs and services that serve parents/caregivers may be particularly important partners for working with families of young children; these services could include mental health or substance abuse disorder treatment, domestic violence or housing insecurity services, or other economic support systems like TANF, SNAP, WIC, or SSI.

Based on individual need, these potential cross system partners should be considered for participation on a Child and Family Team (CFT) or at the least coordinated with for care planning. 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.

The "identified client": One of the defining features of I-ECMH is its focus on relationships; it is common in the I-ECMH field to hear that "the relationship is the client." For Medicaid billing purposes, however, a client is defined as an individual, and for WISe, the client is defined as the child. While much of the work of I-ECMH treatment may be done with family members, it is important to remember to structure documentation with Golden Thread principles in mind, such that the "identified client" is the child. For example, interventions that involve work with family members should be tied back to the child's diagnosis and child-level outcomes in the child's Individual Service Plan (ISP).

Knowledge of developmental milestones: Developmentally appropriate services are important for everyone, but birth through age 5 is a time of particularly great change and development for children; the brain forms more than a million neural connections each second in the first years of life (Center for the Developing Child, 2007). It is important for WISe practitioners working with the B – 5 population to be familiar with the developmental milestones of young children, and to understand 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.

E. Intellectual or Developmental Disabilities Including Autism Spectrum Disorder (ASD/IDD) and WISe

Providing WISe to an individual with ASD/IDD may be similar to working with a very young child if the individual has limited speech skills. Much of the work can be done with parents, family members and caregivers to create a support structure that is conducive to the increased functioning of the individual.

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 Mangers
    - 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.

F. Partnering with Youth and Families experiencing homelessness

DBHR in partnership with other state agencies such as Office of Homeless Youth (OHY), Department of Children, Youth & Families (DCYF) and the Developmental Disabilities Administration (DDA) are working to develop best practice and resource information for WISe teams in partnering with youth and families who are experiencing homelessness. WISe are still applicable to youth who are experiencing homelessness who meet WISe eligibility criteria. Services may look different for them. It is essential to communicate with the Care coordinators, McKinney Vento Liaison, any assigned case managers with DCYF, OHY or DDA and youth peers, that are vital in this process. The WISe team should also partner with Wellpoint for Foundational Community Supports when applicable. Additional Resources can be found on the HCA website.

From HCA

Safe and supportive transition to stable housing for youth ages 16 - 25

Apple Health (Medicaid) Application for Unaccompanied Youth age 18 and under

Foundational Community Supports (FCS) is a program offering benefits for supportive housing and supported employment for Apple Health-eligible beneficiaries **ages 16+ with complex needs.** For questions or for more information, email FCSTPA@wellpoint.com or call 844-451-2828, or fax inquiries to 844-470-8859. FCS Referral Form | FCS Transition Assistance Program (FCS-TAP)

Post-Inpatient Behavioral Health Facility (IBHTF) Transitional Housing Program
also known as "The Bridge Housing", is a step-down housing program from inpatient and/or residential behavioral health programs, into a voluntary transitional housing facility program. The Program is available to persons **ages 18 through 24** who: (1) are exiting inpatient behavioral health treatment or have exited behavioral health treatment and are engaged in a recovery plan; and (2) have not secured long-term housing. The current Eastern Cascade provider is **Excelsior Wellness 509-559-3100**. HCA is still in the process of identifying a Western Cascade provider.

Tools Helpful for 18+
The Discharge Planners Toolkit, can be utilized to identify housing other housing programs with behavioral health components. As well as the Pathways to Housing website.

From the Washington Office of Superintendent of Public Instruction (OSPI)

McKinney-Vento provides federal funding to states for the purpose of supporting district programs that serve homeless students. A list of McKinney-Vento Liaisons can be found here.

From the Department of Children, Youth & Families (DCYF)

Family Reconciliation Services (FRS) is a voluntary program that serves youth and families who are in conflict, which may lead to a youth running away, not following house rules, substance abuse or other concerns within the family. Request FRS services by calling DCYF central intake at 1-866-363-4276.

Youth & Young Adult Housing Response Team (YYAHRT) is a cross-agency response team for any youth or young adult ages 12 through 24 years old, exiting a publicly funded system of care who is experiencing or at risk of homelessness. For questions or to complete a referral email the YYAHRT team. Every Wednesday from 1 to 2pm, two core members of YYAHRT attend office hours via Microsoft Teams will be available to meet with youth, young adults, public employees, service providers, families, and community members.

From the Office of Homeless youth

Unaccompanied minor services

HOPE Centers Serve youth for up to 90 days who are living on the street or another unsafe location. Youth must voluntarily self-refer and be assisted by family, friends, schools, law enforcement, tribes, social workers, or other community-based organizations.

Crisis Residential Centers (CRC) Serve youth for up to 15 days who have run away, are experiencing family conflict, or whose health and safety may be at risk. Youth may voluntarily refer to self-refer, be referred by law enforcement due to circumstances which constitute a danger to the youth's safety or be referred to by DCYF or the court when an out-of-home placement has been approved.

Secure Crisis Residential Centers (SCRC) Provide CRC services for no longer than 5 days and are located within juvenile detention centers. Youth must be referred by law enforcement due to circumstances which constitute a danger to the youth's safety or be court ordered for contempt in at-risk youth proceedings.

Transitional Living Programs (TLP) Long-term housing for non-state dependent youth ages 16-17 who lack a fixed, regular, and adequate nighttime residence. Programs provide housing transition planning within 6 months of turning 18. TLPs may be operated within licensed facilities and/or host homes.

Youth Shelter programs Some counties in Washington State have low-barrier, 24-hour emergency shelters for young people ages 13-18. These shelters offer a temporary place for young people to sleep during the evenings. Many programs require young people to leave during the day, but policies and procedures may vary depending on the area.

The list of OHY Provider list can be found on their website. For general information contact the Office of Homeless Youth.

Young Adult (18 through 24) services

Young Adult Shelter programs Emergency, temporary shelter, assessment, referrals, and permanency planning services for young adults ages 18 through 24. A list of providers can be found on the OHY website.

Young Adult Housing Programs (YAHP) Serves young adults who are currently or at-risk of becoming homeless. Provides transitional housing, rental assistance and case management to help individuals move towards independence and self-sufficiency. Serves young adults ages 18 through 24 who meet low-income limits.

Independent Youth Housing Programs Serves young adults who were dependent of Washington State or federally recognized tribal foster care prior to age 18, or who are enrolled in Extended Foster Care. More information can be found here. 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.

Coordinated Entry, within some counties youth & young adults are required to complete the CE process in the county in which they are homeless. CE acts as the front door to the homeless crisis response systems by completing an initial assessment and completing referrals to housing programs. It is important to contact the local CE Provider to determine whether young people must complete this process.

The Youth Diversion Infrastructure Project (YDIP) & Homeless Prevention & Diversion Fund (HPDF)Flexible funding programs utilized to identify and obtain safe & stable housing. Some examples of what this funding can be used for including: security deposits, rental assistance, utility assistance etc. More information.

The list of OHY providers for these programs can be found on their website. For general program information contact the Office of Homeless Youth.

Other resources

Other DDA Services such as short-term stabilization services and out-of-home services can be found on their website. A guide to eligibility and support services can also be found here.

Legal Counsel for Youth & Children, Young people ages 12-24 who are experiencing, or at risk of, homelessness are eligible for free civil legal services from LCYC.

ORCA: Many Counties also offer free bus fare for young people 18 & under. Find more information here.

Homeless Youth Handbook

Section 3: Background and additional information

A. WISe Terminology, Definitions, and Roles

Definitions

- **WISe Interest List:** A list of children and youth who have expressed interest in WISe, who have completed a CANS screen with a result of "WISe recommended" or clinical override into WISe but are not actively enrolled in WISe. Children and youth should be placed on the interest list as soon as the CANS screen shows WISe is recommended or it is determined the CANS screen outcome will be overridden, regardless of mental health intake completion. This is not to be considered a wait list, these children and youth should be offered and receive state plan services timely. Wait lists are not allowable by Medicaid.

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 - 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 partner s 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, and include family partners in the scheduling of team meetings. Ensure all newly enrolled families have the opportunity to have support from 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:

- Commit to ensuring that parents and caregivers have a voice in the youth's care and are active participants in the WISe process
- 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.
- 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 Specialist and have training in WISe when serving as WISe Provider Agency staff.
- Provide support 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 to youth and young adults in community-based settings to help young people gain control over their lives. 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 committed to ensuring that youth have voice and choice in their own care and are active participants in the WISe process
- 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 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.

Practice Considerations and Potential Conflict

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 WISe practitioners and who fully understands WISe policies, procedures and mandates. Equally important, a WISe supervisor should have experience in the role in

which they are 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). CANS info is available online.

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, 1-2 page document that at least one WISe team member and the youth/family 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 training and coaching

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.

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.

Peer Support – 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.

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."

B. 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

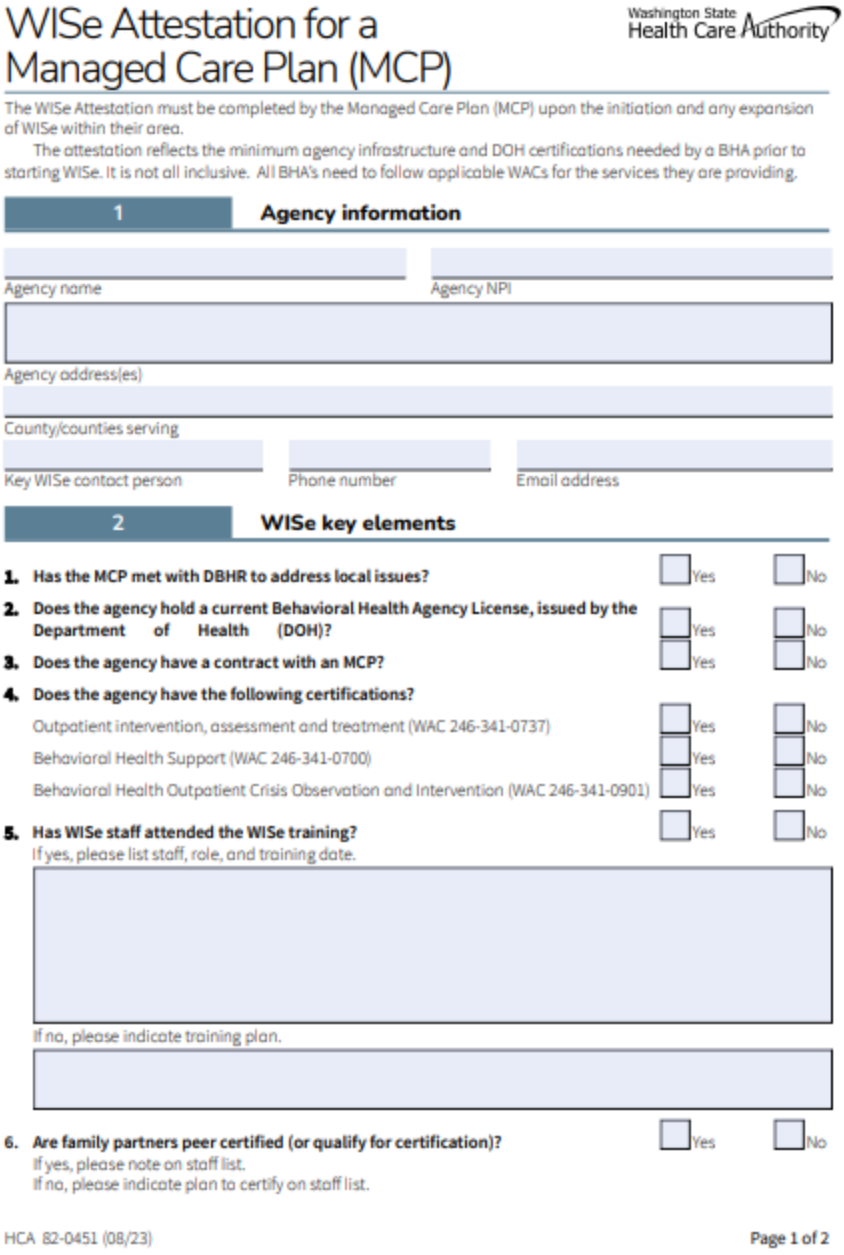
Reporting Guide. The Encounter Data Reporting Guide (EDGR) can be found online.

Updated policies and procedures on the use of telemedicine can be found online in the Telemedicine policy and billing guide (wa.gov).

C. WISe Attestation(s) for Managed Care Organizations 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 Organization or from a Tribal Behavioral Health Agency. On the following pages are example form templates: 1) for MCO and 2) for Tribal Behavioral Health Agencies. These forms are available for download online.

WISe Attestation for a Managed Care Plan (MCP)



WISe Attestation for a Managed Care Plan (MCP)

Washington State Health Care Authority

The WISe Attestation must be completed by the Managed Care Plan (MCP) upon the initiation and any expansion of WISe within their area.

The attestation reflects the minimum agency infrastructure and DOH certifications needed by a BHA prior to starting WISe. It is not all inclusive. All BHA's need to follow applicable WACs for the services they are providing.

1 Agency information

Agency name

Agency NPI

Agency address(es)

County/counties serving

Key WISe contact person

Phone number

Email address

2 WISe key elements

1. **Has the MCP met with DBHR to address local issues?** ☐ Yes ☐ No
2. **Does the agency hold a current Behavioral Health Agency License, issued by the Department of Health (DOH)?** ☐ Yes ☐ No
3. **Does the agency have a contract with an MCP?** ☐ Yes ☐ No
4. **Does the agency have the following certifications?**
   - Outpatient intervention, assessment and treatment (WAC 246-341-0737) ☐ Yes ☐ No
   - Behavioral Health Support (WAC 246-341-0700) ☐ Yes ☐ No
   - Behavioral Health Outpatient Crisis Observation and Intervention (WAC 246-341-0901) ☐ Yes ☐ No
5. **Has WISe staff attended the WISe training?** ☐ Yes ☐ No
   If yes, please list staff, role, and training date.

   If no, please indicate training plan.
6. **Are family partners peer certified (or qualify for certification)?** ☐ Yes ☐ No
   If yes, please note on staff list.
   If no, please indicate plan to certify on staff list.

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WISe Attestation for Tribal Behavioral Health

WISe Attestation for a Tribal Behavorial Health

Washington State Health Care Authority

The WISe Attestation must be completed by the Tribal Behavioral Health Agency upon the initiation and any expansion of WISe within their area.

1 Agency information

Tribal Agency name

Agency NPI

Agency address(es)

Key WISe contact person

Phone number

Email address

2 WISe key elements

1. **Has the agency contacted DBHR regarding any questions on the WISe program, Policy and Procedure Manuel?** ☐ Yes ☐ No
2. **Is the Tribal Behavioral Health Agency licensed by the Department of Health (DOH) by either attestation, deeming, or licensure?** ☐ Yes ☐ No
3. **Does the agency have the following certifications?**
   - Outpatient intervention, assessment and treatment (WAC 246-341-0737) ☐ Yes ☐ No
   - Behavioral Health Support (WAC 246-341-0700) ☐ Yes ☐ No
   - Behavioral Health Outpatient Crisis Observation and Intervention (WAC 246-341-0901) ☐ Yes ☐ No
4. **Has WISe staff attended the WISe training?** ☐ Yes ☐ No
   If yes, please list staff, role, and training date.

   If no, please indicate training plan.
5. **Are family partners peer certified (or qualify for certification)?** ☐ Yes ☐ No
   If yes, please note on staff list.
   If no, please indicate plan to certify on staff list.
6. **Are youth partners peer certified (or qualify for certification)?** ☐ Yes ☐ No
   If yes, please note on staff list.
   If no, please indicate plan to certify on staff list.

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D. Washington's CANS algorithm

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
Note: Behavioral/emotional needs items we plan to include in our screener: Psychosis; Attention/Impulse; Mood
Disturbance; Anxiety; Disruptive Behavior; Adjustment to Trauma; Emotional Control
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
Note: Risk factors included: Suicide Risk; Non-Suicidal Self-Injury; Danger to Others; Runaway;
Criterion 3. Serious Functional Impairment
3a. 2or 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"

E. WISe example template

A Crisis Plan Template example has been adapted from a template provided by En Route with input from the WISe Training Advisory Group. The template is presented as an example of what a WISe Cross System Care Plan that includes all the required elements might look. However, it is not required that agencies use this format.

An example Cross System Care Plan template can be found on the WISe provider resource page.

WISe Manual Update for version (2025)

The WISe manual is a living document designed to support users with clear, up-to-date guidance. To ensure transparency and ease of use, we provide a detailed log of all updates made to the manual.