



Program, policy and procedure manual

The Washington State Wraparound with Intensive Services (WISE) program model is designed to provide comprehensive services and supports to eligible clients. The purpose of this manual is to direct the development of a sustainable service delivery system for providing intensive behavioral health in home and community settings to Medicaid eligible children and youth.



Table of Contents

SECTION	PURPOSE	PAGE NUMBER
SECTION 1:	Purpose and goals	2
SECTION 2:	Agency infrastructure	6
SECTION 3:	WISe access protocol	13
SECTION 4:	WISe service requirements	22
SECTION 5:	Clients rights	36
SECTION 6:	Governance and coordination	42
APPENDIX		
SECTION A:	Background: T.R. settlement agreement	48
SECTION B:	WISe terminology, definitions, and roles	50
SECTION C:	Guidance on team functioning and facilitation of WISe	58
	<ul style="list-style-type: none"> • The approach 	58
	<ul style="list-style-type: none"> • WISe team meeting components and team structure 	58
	<ul style="list-style-type: none"> • Transition 	62
	<ul style="list-style-type: none"> • Principals of evidence in practice 	62
SECTION D:	WISe capacity attestation(s) for managed care entity and tribal behavioral health	63
SECTION E:	Memorandum of understanding	68
SECTION F:	Service array and coding	74
SECTION G:	Washington’s CANS algorithm	75
SECTION H:	WISe cross system care plan	76
SECTION I:	Affinity groups	86
SECTION J:	Quality plan	86
SECTION K:	WISe practitioner training and coaching framework	90
SECTION L:	Behavior rehabilitation services (BRS) and WISe integration	94
SECTION M:	WISe and American Indian and Alaskan Native youth and their family	97
SECTION N:	Working with birth to age 5 in WISe	98
SECTION O:	Working with transitioned aged youth	99
SECTION P:	WISe clients with intellectual disabilities and Autism spectrum disorder	101
	<ul style="list-style-type: none"> • WISe manual update crosswalk 	102



Section 1: Purpose and Goals

Washington State’s Wraparound with Intensive Services (WISe) is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals who are up to 21 years of age, (herein referred to as “youth”) with complex behavioral health needs and their families. 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.

WISe has been implemented in all 39 Washington State counties as of June 30, 2018. The purpose of this manual is to create consistency across Washington State’s service delivery system for those providing intensive in home and community behavioral health services to Medicaid eligible youth.

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

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

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

This version of the manual was updated at a time of multiple transitions. Referenced links, documents, and Washington Administrative Codes (WACs) are still in the process of being updated. Until future versions of the manual are released, any reference to the delivery system within this manual or within referenced material is intended to include any successor.



OBJECTIVE:

This manual will provide guidelines to ensure consistency in the goals, principles, and the delivery of the program - across the state.



We believe implementing this program, utilizing the Washington State Children’s Behavioral Health Principles (previously named the Mental Health Principles) outlined below, will:

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

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

Washington State Children’s Behavioral Health Principles

Washington State’s Health Care Authority (HCA) believes that youth and families should have access to necessary services and supports in the least restrictive, most appropriate, and most effective environment possible. Washington State is committed to operating its Medicaid funded behavioral health system that delivers services to youth, in a manner consistent with these principles:

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



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



Section 2: Agency Infrastructure

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

WISE team members demonstrate a high level of flexibility and accessibility by working at times and locations that ensure meaningful participation of family members, youth and natural supports, including evenings and weekends. WISE also provides access to crisis response 24 hours a day, seven days a week, by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan. The service array includes intensive care coordination, intensive treatment and support services, and mobile crisis outreach services, provided in home and community settings, based on the individual's needs and a plan developed using a wraparound process by a Child and Family Team (CFT). Behavioral health services and supports will be available that are sufficient in intensity and scope, including those based on available evidence of effectiveness, and individualized to each youth and their family's unique needs. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized to the goals identified and prioritized by each youth and family. They often include: increased safety, stabilization, school success, and community integration; and support to ensure that youth and families can live successfully in their homes and communities and make positive and informed decisions regarding their care and lives, with an avoidance of hospitalizations and out-of-home placements.

This section will outline the infrastructure requirements an agency must have in place to be eligible for consideration as a WISE provider.

Federal and State Requirements

The services provided under WISE are Medicaid services, and therefore require agencies to meet all applicable federal standards related to the provision of behavioral health services covered under Medicaid. Agencies interested in becoming a WISE provider must hold a current Behavioral Health Agency License, issued by the Department of Health.



Agencies must also have a contract with a **Managed Care Entity (MCE)**. Additionally, agencies must be certified, or have sub-contracts or Memorandums of Understanding (MOUs) in place, to provide all of the following services:

- Individual treatment services
- Family therapy services
- Case management services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Recovery support—Peer support services

The list above is intended to direct the minimum certification requirements. If an agency provides other services, additional certification standards may apply. The monitoring of these requirements will continue to be completed by Department of Health’s Licensing and Certification staff ([link](#)).

Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated Managed Care Entity (MCE), and DBHR.

WISE-Specific Requirements

Adherence to WISE, outlined below, will be reviewed by the WISE agency, the associated MCE, and DBHR according to the Quality Plan (see Appendix J for link).

Agencies interested in becoming a WISE provider must meet standards related to:

1. Access
2. Practice model
3. Service array
4. Staffing
5. Community oversight and cross-system collaboration
6. Documentation

Access and Practice Model (items one and two) will be discussed in detail in subsequent chapters, beginning on pages 21 and 35. The requirements for items three through six in the list above are as follows.



Service Array

Agencies providing WISE must have capacity to provide a wide array of home and community based services within the agency, or through sub-contracts or an MOU. WISE agencies will provide each participating youth and his or her family 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

The above listed services are to be as described in this document, the Service Encounter Reporting Instructions (SERI) for Behavioral Health Organizations, and as described in the larger Encounter Data Reporting Guide, for Fully Integrated Managed Care Organizations.



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. The CFT has the responsibility to identify needs and develop the most appropriate and normalized strategies to meet these needs, including referral and coordination with other services and systems. Other needed services and supports, 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), which would also be linked to the CSCP and coordinated through the WISE team.

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

Staffing

WISE provider agencies must have sufficient WISE qualified staff to:

- Manage the capacity-level identified by the MCE and DBHR.
- Deliver or coordinate all medically necessary behavioral health services (including intensive services, substance use, and Psychiatric/Medical).
- Provide each youth/family served with:
 - Mental health therapies (i.e., family, individual treatment, etc.).
 - Care coordination.
 - Peer counseling through Family Partner and/or Youth Partner who are certified peer counselors, or qualify for certification.

***Note:** Descriptions and responsibilities for staff that provide each of these services are outlined in Appendix B.*
- Provide clinical supervision and ongoing trainings to WISE-qualified staff (see Appendix K for the framework).
- Have psychiatric consultation available to each team.
- Maintain an average caseload size of 10 or fewer participants, with a maximum of 15 at any given time, for each Care Coordinator.
- Provide 24/7 mobile crisis intervention (see Section 4 for details) to youth and families, preferably through staff that are known to the youth and family.
- Meet timelines for completing WISE CANS screens and CANS Full, as well as entering the information into the Behavioral Health Assessment System (BHAS).



Cross-System Collaboration

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

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

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



Documentation

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

- Quality Plan
- WISE infrastructure monitoring
- Calculation used for caseload management and capacity
- Child and Family Team requirements (Cross System Care Plan {CSCP}, plan reviews, progress, revisions, CFT meeting sign-in sheets, and CFT minutes)
- WISE provider agencies must maintain the following documentation for each WISE-qualified provider's personnel:
 - Skill development and implementation support
 - Training – (Definition: An expert-led educational process designed to create or reinforce a theoretical framework. May occur live or in virtual settings) Certificate of Completion
 - Recertification and competency demonstration
 - Coaching – (Definition: 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. Methods may include individual, group and may occur in live or virtual settings) Coaching plan signed by WISE Coach and staff
 - Supervision – (Definition: A directive process designed to enforce and ensure compliance and facilitate improvement in specific areas of practice) Document signed by WISE Supervisor and staff showing outcomes and how often supervision takes place.

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 client's record:

- Completed CANS Screen, CANS Full within 30 days of WISE enrollment, CANS Full every 90 days, and CANS Full again upon transition to a lower level of care or discharge.
- Discharge from WISE should be based on successful achievement of goals outlined in the CSCP, endorsed and supported by the youth, family, and team.
- Length of stay in WISE is based on medical necessity and allows for transition time into a lower level of care.
- If the youth has been out of WISE services for more than 6 months a new CANS screen must be completed. A CANS Full must be completed within 30 days of a youth's first service regardless of provider.



- Cross System Care Plan (CSCP) (note: see Appendix H for core elements and a sample format), including revisions and updates.
 - The CSCP must address the needs found within the ISP, or could include all required elements of the Individual Service Plan (ISP) within the CSCP.
 - Expected outcomes/transition activities and transition/discharge criteria will be clearly defined in the CSCP or contained in a Transition Plan.
- All necessary Releases of Information
- Crisis/Safety Plan (may also be known at some providers as a Wellness Plan or Support Plan).
- CFT meeting notes:
 - Meeting frequency should be determined by needs intensity. Monthly meetings are a minimum requirement. .
 - Notes should include a list of attendees (the youth and/or family are required to be present for a meeting). Participation of young children will be decided upon by the CFT, as appropriate.
 - A record that notes were shared with all members of the CFT within a week of each meeting that reflects the voice of family and youth.



Section 3 WISE access protocol

This section provides uniform standards on the administrative practices and procedures for providing access to WISE and its services. WISE providers and Managed Care Entities (MCEs) will utilize the protocols of this section to meet the requirements related to:

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

Identification

Child-serving systems, such as Department of Child, Youth & Family Services (DCYF), Department of Social and Health Services (DSHS), Rehabilitation Administration (RA), Developmental Disabilities Administration (DDA), Health Care Authority (HCA), school personnel, county and community providers, and Tribal service providers will be informed to assist in the identification and referral of youth who might benefit from WISE. Consideration for referral begins with youth who are Medicaid eligible, up to age 21, and who have complex behavioral health needs. Other indicators to consider for a WISE referral may include, but are not limited to:

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

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



Referrals

Anyone can make a referral for a WISE screen, including the youth and family. All Medicaid-eligible youth, up to age 21, who might benefit from WISE should be referred for a WISE Screen.

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

1. When a youth is referred to Children's Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS or receiving CLIP services: no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from a psychiatric hospital.
4. When a step-down request has been made from institutional or group care.
5. When a youth receives crisis intervention or stabilization services, and there are past and/or current functional indicators of need for intensive behavioral health services.

If a youth **is currently** receiving Medicaid behavioral health services from a MCE's provider, a referral for a WISE Screen can be completed in the following ways:

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

If a youth **is not currently** receiving Medicaid behavioral health services from a MCE's provider, a referral to WISE can be most easily completed by contacting the WISE referral contacts for each county ([link](#)).

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

WISE Screening

All referrals for a WISE screen to an MCE, any MCE provider or other WISE referral contact should result in a WISE screening, regardless of referral source. A WISE screen must be offered within 10 business days of receiving a referral. WISE screens are available at WISE agencies and clients will be



offered the option to complete the screen over the phone when that option is more convenient for the client.

A referral form can be offered, but must not be required to complete a WISE screen. A mental health intake must not be required to be completed to do the WISE screen. Anyone can request a screen for a youth/family that is Medicaid eligible and under the age of 21.

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

All WISE screens will include:

1. Information gathering that utilizes the information provided by the referent (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 its service delivery.
2. Completion of the Child Adolescent Needs and Strengths (CANS) Screen, which consists of a subset of 26 questions, pulled from the CANS Full. The CANS screen must be completed by a CANS-certified screener ([TCOM Training](#)).

* Note: [Training materials](#), related to how to enter CANS into BHAS are available.

****Note:** For children age 4 and younger, WISE providers will use the CANS 0-4.

3. Entering the CANS Screen into the Behavioral Health Assessment Solution (BHAS) which will apply the CANS algorithm to determine whether the youth would benefit from WISE.

WISE Screens and Behavior Rehabilitation Services (BRS)

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

- When a youth is being considered for or referred to Behavioral Rehabilitation Services (BRS);
- Every six months while a youth is receiving BRS if WISE is not already being provided; and
- At discharge from BRS.

Steps for completing a WISE BRS Screen:

- DCYF or BRS staff are responsible for contacting a WISE agency to request a WISE Screen.



- The list of WISE agencies by county is available on the [HCA website](#) under WISE.
 - **Note:** One exception, is in King County, up **until October 2019**, WISE screens for BRS involved youth will be managed by King County by calling 206-263-9006 or 206-263-8957.
 - After October 1, 2019, WISE screens for BRS involved youth will be completed by WISE agencies.
- WISE agencies are to complete the CANS screen. Screens must be offered to be done by phone as well as in person.
 - The referral may come from the DCYF staff, BRS staff, or any other person on behalf of a Medicaid eligible child under age 21.
 - Note: WISE screens are not considered complete until they are entered into BHAS. WISE staff have ten (ten) business days from the initial contact to complete the screen and enter into BHAS.
- WISE staff are to enter into BHAS, in the comments section, the reason a referral is not made to serve the youth exclusively with WISE if the youth has screened eligible for WISE.
 - WISE staff are to also enter the status of the youth's involvement with BRS: Entering BRS, Six months in BRS, or discharging from BRS.
- WISE agencies are to provide DCYF and/or their contracted BRS staff a copy of the WISE screening results

When a child receives BRS and WISE services, the WISE provider agency and BRS provider shall coordinate and collaborate to provide appropriate WISE and BRS services to the child 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 ten (10) business days;*
 - *There are any systemic barriers preventing completion of a screen.*

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

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



BHAS Data Entry for WISE Staff:

There are two places to enter data. One is the page where it asks the 'assessment reason'. The drop down will force you to choose 'initial', but in the comments you can say something like "BRS 6 month".

Add Assessment for Colin Davis

Assessment Tool * CANS Screen 5+

Assessment Certification * CANS Certification

Assessment Location * Washington, Spokane County Regional, Excelsior Youth Center, Inc., Spokane (

MCO * Coordinated Care Health Options Foster Care

Assessment Reason * Initial BRS six month

Assessment Date * 3/26/2019

Note: Enter date assessment conducted.

Certified Assesor * Paul Davis Paul Davis

Assessment Mode * Rapid Mode

Pre Populate

Then the next screen will require you to choose a referral source. You should indicated from that drop down box if this is an initial, rescreen, or discharge. Also, at the bottom box, you need to indicate that BRS is being preferred by the referring agency.



Intensive Mental Health Services CANS Screen

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


Referral Source Information

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

Then after the diagnosis, you will choose “continue BRS” and give a rationale. The BRS agency or case worker will have information on why BRS is needed rather than having the child be served in the community.



Intensive Mental Health Services CANS Screen

Complete Date * 


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

Algorithm Result

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

Screening Outcome

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

Referral To * 

Please explain reason for override *

WISE Intake

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

1. Establish Medicaid eligibility. WISE is a Medicaid program and can only serve youth who are up to 21 and covered by Medicaid.
2. Establish that the youth meets qualifying medical necessity criteria, based on a covered behavioral health diagnosis, under the MCE's contracted standards, such as Access to Care Standards for Behavioral Health Organizations. All youth who meet the CANS algorithm and the MCE's qualifying criteria 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.

All youth, ages 5 and up to 21, who meet the CANS algorithm and are eligible for behavioral health services through an MCE's qualifying criteria will be offered entry to WISE - For those children under 5 years of age, this decision shall be made based on clinical judgment and in accordance with authorization standards and protocols established in each MCE.



At this point, initial engagement to begin planning, facilitating, and coordinating services will occur. Initial engagement 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 and/or a legal decision-maker for each youth.

Youth who are not enrolled in Medicaid and do not meet intake eligibility requirements will be referred to other community resources, including their health care plan for behavioral health services. All youth receiving or eligible for MCE services, but who do not meet the CANS algorithm, will be referred to and offered other services.

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



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

PREVENTION AND PROMOTION	POINT OF IDENTIFICATION	
	Self and Families • <i>Self referral</i>	
	Health Care Authority	Substance Use Disorder Treatment Providers Mental Health Crisis
	Department of Children, Youth and Families	Child Welfare
	Department of Social and Health Services	Juvenile Rehabilitation Economic Services Developmental Disabilities Administration
	County	Juvenile Justice Other county agency
	Community	Schools Public Health Social Service Organizations
	Tribes	Tribal Mental Health Centers

Referral Process



Intake and Engagement

Data = data points utilizing Child and Adolescent Needs and Strengths (CANS) tools and process



Section 4: WISE service requirements

What is Different about WISE?

Focus on Youth and Family Voice Utilizing a Strength-based Approach

The WISE provider intentionally seeks out youth and family voice, choice and preferences during all phases of the process, including planning, delivery, transition, and evaluation of services. Supports and services are delivered in a way that honors youth-guided and family-driven care. Together, the WISE provider, youth, and family will plan and deliver services and supports in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

Primary setting

WISE services are intended to be provided in the home and in community locations, and at times and locations that ensure meaningful participation of youth, family members, and natural supports. WISE is targeted to 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 creative 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, in spite of having received traditional behavioral health services. This circumstance requires the WISE team to deliver purposeful support without delay, with a "take action" mentality, moving from a 'compliance practice model' to a needs-driven, strengths-based, intensive and flexible approach to providing services and supports.

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

Family Partners and/or Youth Partners who have lived experience must be a part of the team. They must be meaningfully involved in the provision of WISE. The Family Partner and/or Youth Partners are equal team members with the Care Coordinator and Mental Health Clinician. The Family Partner and/or Youth Partner meet with the youth and/or family on a regular basis to provide support in addressing the needs of the youth and family, as defined in the Cross System Care Plan



(CSCP). Youth Partners and Family Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS. A Youth Partner and Family Partner are distinct and separate roles. See Appendix B for more detailed information related to the role of Family Partner and Youth Partner.

Providing Intensive Care Coordination and Services Using a Wraparound Approach

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

Once authorized by the MCE for WISE, youth and families participating will have access to a wide array of services and supports to address their specifically identified needs. Although the intensive care coordination and services available under WISE are funded by Medicaid (see appendix F for links to Reporting Instructions), the program's model is intended to draw in other resources through teaming with both formal (e.g., service providers and representatives of schools and child-serving agencies) and informal (e.g., family, friends, and community members) supports and programs that are offered in a variety of settings (home, community, school, etc.).

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. Through each of the following phases (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 Clinician)*

The key to successful Intensive Care Coordination is also holding central to a key wraparound principle that “**Needs are not Services.**”



Engagement

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

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

Goals/Purpose:

- To **address pressing needs and concerns**, prior to forming a Child and Family Team when necessary, so the youth, family and team can give their attention to the WISE process
- To explore the results of the CANS and the individual’s and family’s strengths, needs, culture, and vision, and develop a youth and family narrative that will serve as the starting point for planning
- To orient the family and youth to the WISE process
- To gain the participation of team members who care about and can aid the youth and family, and to set the stage for their active and collaborative participation on the team
- To ensure that the necessary procedures are undertaken so the team is prepared to begin an effective WISE process

Essential Steps

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



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

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

Assessing

Overview: 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 Practitioner helps the youth and family to understand that their input is central to the WISE process, and that their perspectives and preferences at all phases of care planning and implementation will be prioritized. This includes helping the youth and family understand and incorporate any legal mandates into their plan. The WISE Practitioners also listen to the youth and family perspective for information about the youth's and family's strengths, needs, culture, and natural supports. A WISE Practitioner reviews the CANS results with the youth and family and determines how to present this information to the team.

Goals/Purpose:

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



Essential Steps

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

Teaming

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

Goals/Purpose:

- To identify and engage others who are involved in the youth and family's life in order to align the interests and ensure all involved individuals have a shared mission for the youth and family.
- 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.



- The CFT is expected to meet with sufficient regularity (**every 30 days, at a minimum**), as indicated in the CSCP, to monitor and promote progress on goals as indicated in the CSCP, and maintain clear and coordinated communication.
- The CFT reviews the interventions and action items and adjusts these accordingly, using the outcomes/indicators associated with each priority need, included in the CSCP. A WISE 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.

Service Planning and Implementation

*Overview: During this phase, team trust and mutual respect are built while the team creates an initial Cross System Care Plan using a high-quality planning process that reflects the Washington State Children's Behavioral Health Principles. In particular, youth and family should feel that they are heard, that the needs chosen are ones they want to work on, and that the options, strategies, and interventions chosen capitalize on the strengths of the youth and family and have a reasonable chance of success. The team also reviews and expands the crisis plan to reflect **proactive** and **graduated** strategies to prevent crises, or to respond to them in the most effective and least restrictive manner. The initial CSCP should be completed during one or two meetings that take place within 1-2 weeks. The rapid time frame is intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal, as identified on the CSCP.*

Goals/Purpose:

- To create a CSCP using a facilitated process that elicits multiple perspectives and builds trust and shared vision among team members, with an ever present focus that the youth and family drive the plan.
- To base care planning in relationship to high needs and identified strengths, as indicated on the CANS.



- To establish a Team Mission that guides the planning direction and builds cohesion in the work of the team members and empowers the youth and their family.
- To establish a set of prioritized needs, including the strategies to meet them, and to determine expected outcomes.
- To identify team tasks and roles, and document commitments and timelines
- To establish ground rules to guide team meetings.
- To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan.

Essential Steps:

- The WISE Practitioner(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 CANS assessment.
- The WISE Practitioner(s) convene one or more team meetings to discuss and obtain agreement on the elements of the CSCP.
- In the CFT meeting, the youth and family's vision for their future is presented.
- The CFT discusses and sets ground rules to guide the meetings.
- The CFT reviews and expands the list of strengths for the youth and family.
- The CFT creates a mission that details a collaborative goal describing what needs to happen prior to transition from WISE.
- The CFT reviews the list of needs and agrees which to prioritize in the CSCP, respecting and including the preferences and priorities of the youth and family.
- The CFT determines the intended outcomes that will transpire when the needs are met.
- 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.
- The CFT evaluates the crisis plan and adapts as necessary.
- The work of the team is documented, and distributed among team members.

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

Monitoring and Adapting

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

Goals/Purpose:



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

Essential Steps:

- The CFT continues to meet as necessary to address youth and family needs – at minimum, every 30 days to evaluate progress towards meeting needs and the effectiveness of indicated strategies.
- The CFT collects data to determine the effectiveness of strategies, then adds, subtracts and modifies strategies to create the most effective mix of services and supports.
- The CFT evaluates whether there is progress towards the designated outcomes.
- The CFT adds members, as necessary and appropriate, and strives to create a mix of formal, informal, and natural supports.
- The CFT celebrates successes and adds to strengths as they are identified.
- Full CANS assessments are administered and entered into BHAS every 90 days to help track progress, and to catch emerging needs and make changes to the plan as necessary.
- The WISE Practitioner(s) maintain ongoing communication outside of the team meetings to continue engagement and ensure that all members' perspectives are heard.

Intensive Services Provided in Home and Community Settings:

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

Direct services are delivered according to an Individualized Service Plan, coordinated with the Cross System Care Plan to deliver integrated Wraparound with Intensive Services. The CFT develops goals and objectives for all life domains in which the youth's mental health condition produces impaired functioning (including family life, community life, education, vocation, and independent living) and identifies the specific interventions that will be implemented to meet those goals and objectives. The goals and objectives seek to maximize the youth's ability to live and participate in the community and to function independently by building 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.

Direct services include, but are not limited to:

- Educating the youth's family about how the youth's mental health needs may influence behavior, and how to effectively support the youth.
- In-home functional behavioral assessment.
- Behavior management, including developing and implementing a behavioral plan with positive behavioral supports, modeling for the youth's family and others how to implement behavioral strategies in their home and community.
- Therapeutic services delivered in the youth's home or community including, but not limited to, therapeutic interventions such as individual and/or family therapy and evidence-/research-based practices (e.g., Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy, Family Functional Therapy, etc.). These services are designed to:
 - Improve self-care, by addressing behaviors and social skills deficits that interfere with daily living tasks and to avoid exploitation by others.
 - Improve self-management of symptoms including self-administration of medications.
 - Improve social functioning by addressing social skills deficits and anger management.
 - Reduce negative 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 in the community.
 - Support independent living objectives, by identifying and addressing behaviors that interfere with seeking and maintaining housing and living independently.



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

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

Providers: Non-clinical direct services are typically provided by paraprofessionals under clinical supervision. Peers, including Family Partner and/or Youth Partners, may provide direct services. Clinical treatment services are provided by a qualified clinician, rather than a paraprofessional. Paraprofessionals and Family Partner and/or Youth Partners may provide a follow-on “care extension” role for clinical services (e.g., to provide support to caregivers’ efforts to manage behavior, support to youths’ skill building to develop emotional regulation skills, etc.).

Authorization: The full array of WISE services may be provided, as medically necessary, once WISE is authorized by the MCE.

Crisis Planning and Delivery

Crisis Planning

Effective crisis planning is a critical component of an effective care plan. A Crisis Plan includes the following elements:

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

Services include:

- Crisis planning that, based on youth’s history and needs:
 - Anticipates the types of crises that may occur.
 - Identifies potential precipitating events and methods to reduce or eliminate.
 - Establishes individualized responsive strategies by caregivers and members of the



youth's team to minimize crisis and ensure safety.

- Stabilization of functioning by reducing or eliminating immediate stressors and providing counseling to assist in de-escalating behaviors and interactions.
- Referral and coordination with:
 - Services and supports necessary to continue stabilization or prevent future crises from occurring.
 - Any current providers and team members including a care coordinator, clinicians, youth partner, family partner, family members, primary care practitioners, or school personnel.
- Post-crisis follow-up services (stabilization services) provided periodically to:
 - Ensure continued safety and delivery of services necessary to prevent future crises.
 - Coordinate services between the out-of-home provider (if the youth is placed out of home) and the youth's treatment team to facilitate a plan for rapid return home.
- Tools and resources available to manage potential risks.

Crisis Delivery

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

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

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

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



Transition

Overview

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

Essential Steps:

- The CFT creates 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).

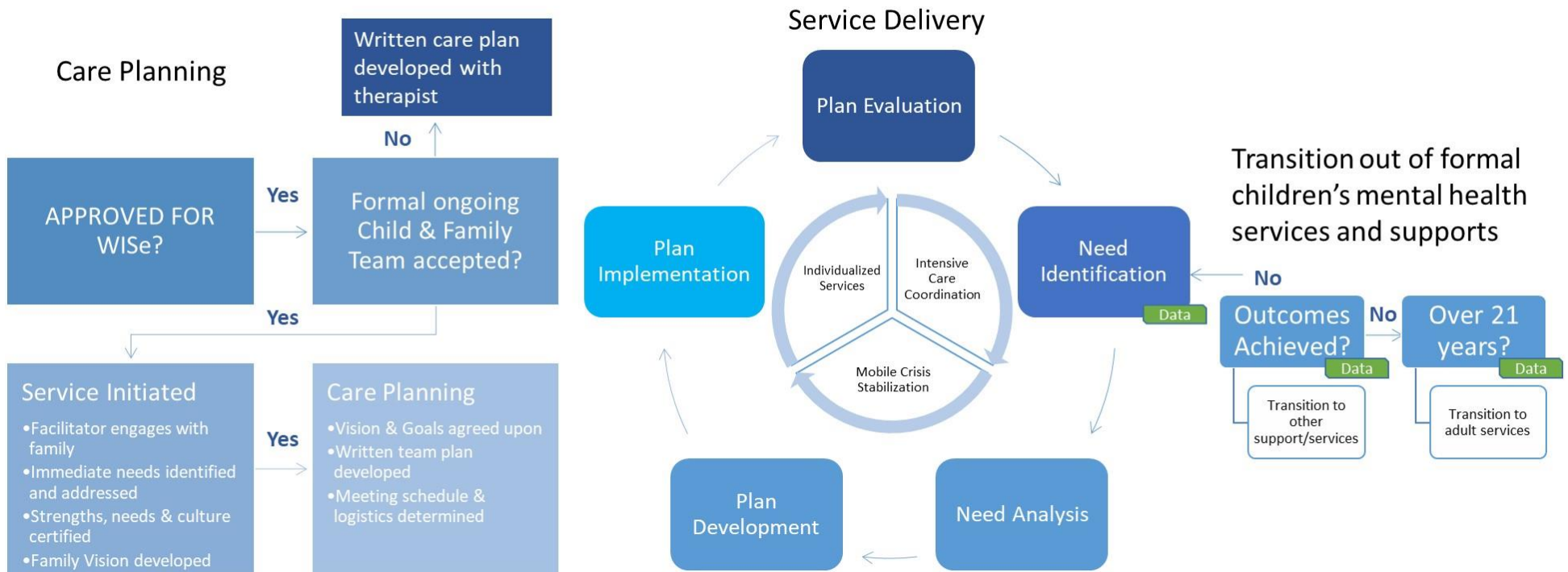
- The CFT is encouraged to create and/or participate in a culturally appropriate “commencement” celebration that is meaningful, to the youth, family, and team, and that recognizes their accomplishments.

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

Note: *When there is sufficient CANS data within BHAS, as well as data from DBHR-sponsored surveys on youth in WISE and their caregivers, DBHR/HCA will examine the development and use of a Reliability Change Index to inform the CFT as to when it may be appropriate for a youth to begin transitioning out of WISE.*



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



Data = data points utilizing Child and Adolescent Needs and Strengths (CANS) tools and process



Section 5: Client Rights

Decisions and Dispute Resolution

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

Reaching Consensus on a CFT

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

CFT members should use the WISE planning model described in Section 4 and the 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 his or her best possible functional level.

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

If the CFT **can reach** agreement on a plan:

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



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

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

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

- Your Name
 - How to reach you
 - A description of the concern or complaint you have
 - What you would like to have happen, if you know
 - Your signature and date of signing
1. When the provider or MCE 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 behavioral health care professional who knows about the youth’s condition will review the grievance.
 3. The provider or MCE will review the grievance and send a letter of their decision as quickly as the youth’s health condition requires and no longer than 90 days from the date the provider or MCE 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 MCE. The MCE 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 MCE and/or provider agency that there is disagreement with treatment plan recommendations found in the Individual Service Plan, made during the care planning process.
- The MCE and/or provider agency denies¹, terminates², reduces³ or suspends⁴ the authorization of services to the youth that are included in the Medicaid mental health service array and recommended by the CFT in the Cross System Care Plan.

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

Types of Appeals.

Appeals must be made to the MCE. There are two types of appeals a youth, parent/caregiver or 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 MCE 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 can ask for either type of appeal.

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

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

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

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

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



- **Expedited (decision within 72 hours):** An expedited appeal is available to a youth or family member, when the MCE or provider determines that the youth’s life, health or ability to function could be seriously harmed by waiting for a standard appeal. An expedited appeal must be decided no later than 72 hours after receipt of the expedited appeal request.
 - If the mental health care provider asks for an expedited appeal, or supports the youth or family in asking for one, and indicates that waiting 30 days could seriously harm the youth’s health, the MCE will automatically grant an expedited appeal.⁵
 - If a youth, parent/caregiver asks for an expedited appeal without support from their mental health care provider, the MCE will decide if the youth’s health requires one. If the MCE does not agree with the request, the plan must decide the appeal within 30 days.
 - The MCE 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 MCE makes an Adverse Benefit Determination involving a youth’s WISE treatment, the youth is entitled to a Notice 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:

1. In an integrated **region**, contact the MCE by phone at the number provided on the notice. In regions where services are coordinated by the BHO, appeals can be filed in person or by phone at the number on the notice. Whoever the appeal is filed with the youth or parent/caregiver must follow-up the appeal in writing and include in your appeal:
 - Your name;
 - Contact number, email or address;
 - Any information about why you disagree with the Adverse Benefit Determination; and,
 - Your signature and date of signing.⁶
2. 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

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

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



- Client's right to a second opinion and how to get one;
- Information about other services available through the Health Care Authority or in the community where the youth lives; and
- Your right to an appeal, an expedited appeal, or administrative (fair) hearing.

3. If the notice of Adverse Benefit Determination is about services a youth is already receiving, the youth can ask for the services to continue until the appeal is decided. If a youth, parent/caregiver want to continue to receive benefits a request must be made as follows:

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

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

How to Request an Administrative (Fair) Hearing:

In order to request an administrative (fair) hearing, you must first receive a Notice of Resolution from the MCE that decides your appeal. You or you representative must request an administrative hearing within 120 calendar days from the date on the Notice of Resolution. If you waited 30 days and did not receive a Notice of Resolution from the MCE, you can go ahead and file for a hearing without waiting for the Notice. To request a hearing, contact the Office of Administrative Hearings by phone, fax or in writing at:

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

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



Continuing Services during the Appeal

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

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

Help for Youth, Families, and Caregivers

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

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



Section 6: governance and coordination

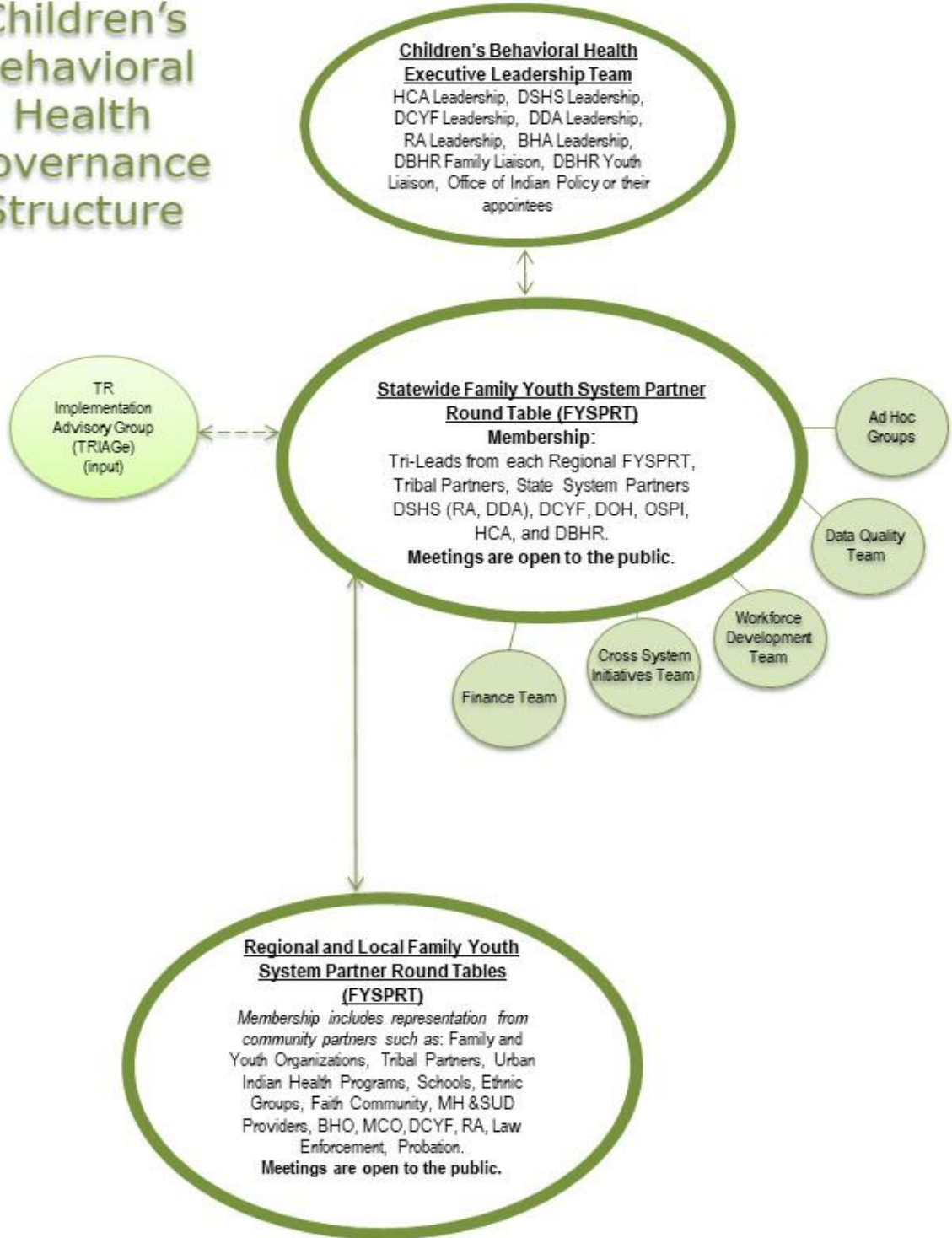
The Settlement Agreement for *T.R. vs. Birch & Strange* (formerly known as *T.R. vs. Quigley & Teeter*) states that Washington State will “maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders,” as a central mechanism for ensuring success of settlement agreement implementation, as well as overseeing implementation of Wraparound with Intensive Services (WISe).

This governance and cross-system collaboration, called the Children’s Behavioral Health Governance Structure is essential in system change efforts to ensure:

- Collaboration and coordination of care for WISe participants
- Participation by local and regional representatives in Child and Family Teams (CFTs) for youth who are enrolled in WISe and served by multiple child-serving systems.
- Coordination of funding sources, to the extent permissible by the state legislature and federal law, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and establish systems to achieve sustainability of WISe.
- The development and provision of cross-system training and technical assistance.
- The development of data-informed quality improvement processes.
- Increased participation of family and youth in all aspects of policy development and decision-making for WISe.

The figure below provides a visual of the various components of the governance structure.


Children's Behavioral Health Governance Structure






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

Children’s Behavioral Health governance structure component descriptions

Regional and Local Family, Youth, System Partner Round Table (FYSPRT)		
Role	Required Members	Of Note:
<p>Looks at the full continuum of care, including WISE implementation, at the local/regional level, and addresses challenges and barriers identified at the local/regional level, and reviews local/regional data, related to meeting the systemic needs and improving the outcomes for youth with behavioral health challenges</p> <p>Identifies local needs and problem-solves as close to the community as possible</p>	<p>Administrative Service Organization (ASO), Behavioral Health Organization (BHO) or Managed Care Organization (MCO) staff, local/regional-level system partners, youth, family members, past/present WISE youth and past/present WISE family members, youth leaders, family leaders, and other community system partners</p> <p>Engagement with tribal governments, to participate in the Regional FYSPRT</p>	<ul style="list-style-type: none"> • Tri-Led by a Youth Leader, Family Leader, and System Partner Leader • Open Meetings – No confidential information shared • Minimum of 51% youth and family membership • Based on how a region defines their community(ies), they may select to have more localized groups (Local FYSPRTs) that feed into their regional structure, to better meet the needs of that region, and address challenges and barriers as close to the community as possible.
		
Statewide FYSPRT		



<p>Role</p> <p>Looks at the full continuum of care, including WISE implementation, at the statewide level</p> <p>Brings forward potential solutions and addresses challenges and barriers identified by Regional FYSPRTs that require policy level decisions/direction, as well as reviews statewide data, related to meeting the systemic needs and improving the outcomes of youth with behavioral health challenges</p> <p>Problem-solves as close to the community as possible</p>	<p>Members</p> <p>Regional FYSPRT Tri-leads, state- level child-serving system partners, tribal government representatives, representatives of the Division of Behavioral Health and Recovery, and community partner representatives</p>	<p>Of Note:</p> <ul style="list-style-type: none"> • Tri-Led by a Youth Leader, Family Leader, and System Partner Leader from the Statewide FYSPRT membership • Open Meetings – No confidential information shared • Workgroups are utilized as a means for completing specific work products, or as a strategy for making systemic changes. Representatives from the Statewide and Regional level will be invited to participate on groups such as: AD-Hoc, Workforce Development, and Data & Quality. • Receives and considers input from the T.R. Implementation Advisory Group (TRIAGe) to improve the coordination and delivery of Title XIX services and WISE
		
<p>Children’s Behavioral Health Executive Leadership Team (CBH ELT)</p>		
<p>Role</p> <p>Receives recommendations, requests input, and makes policy-level decisions related to WISE implementation and meeting the systemic needs of youth with behavioral health challenges and improving outcomes of youth.</p>	<p>Members</p> <p>DSHS Leadership, HCA Leadership, DCYF Leadership, DDA Leadership, RA Leadership, BHA Leadership, DBHR Youth Liaison, DBHR Family Liaison, and Office of Indian Policy or their appointees</p>	<p>Of Note:</p> <ul style="list-style-type: none"> • CBH ELT Representative(s) attend Statewide FYSPRT meetings • CBH ELT Meeting notes posted to website

For more detailed information on the Statewide and Regional FYSPRTs, please refer to [the Regional FYSPRT Manual and Resource Guide](#).



Developing Regional Linkages to the Governance Structure

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

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

Each Managed Care Entity will submit information once to DBHR for approval, as part of transitioning to an integrated region , outlining the processes and mechanisms in which local implementation and oversight of WISE will be achieved and coordinated with the Governance Structure. Any updates or changes in the future to an MCE's processes will also need to be resubmitted for approval.



Appendices



A. Background: T.R. Settlement Agreement

Background

T.R. vs. Birch and Strange (formerly known as Quigley and Teeter), a Medicaid lawsuit regarding intensive children’s mental health services for youth, was filed in November 2009. The lawsuit was based on federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) statutes, requiring states to provide any medically necessary services and treatment to youth, even if the services have not been provided in the past. Washington State reached a settlement agreement with the plaintiffs. With this settlement agreement, Washington has committed to build a mental health system that will bring this law to life for all young Medicaid beneficiaries who need intensive mental health services in order to grow up healthy in their own homes, schools, and communities.

Who is in the Class (and thus eligible for Wraparound with Intensive Services)?

All persons under the age of 21 who now or in the future:

1. Meet or would meet the State of Washington’s Title XIX Medicaid financial eligibility criteria;
2. Have a mental illness or condition;
3. Have a functional impairment related to that mental illness or condition, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and
4. For whom intensive mental health services provided in the home and community based would address or ameliorate a mental illness or condition.

Goals

To have a mental health system that will:

- a) Identify and screen putative (assumed to exist or to have existed) Class members and link eligible youth to the WISE program.
- b) Communicate to families, youth and stakeholders about the nature and purposes of the WISE program and services, who is eligible for the program, and how to gain access to the WISE program and services regardless of the point of entry or referral source.
- c) Provide timely statewide mental health services and supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Class member’s needs consistent with the WISE program model and state and federal Medicaid laws and regulations.



- d) Deliver high quality WISE services and supports facilitated by a system of continuous quality improvement that includes tools and measures to provide and improve quality care, transparency, and accountability to families, youths, and stakeholders.
- e) Afford due process to Class members denied services.
- f) Coordinate delivery of services and supports among child-serving agencies and providers to Class members in order to improve the effectiveness of services and improve outcomes for families and youth. Reduce fragmentation of services for Class members, avoid duplication and waste, and lower costs by improving collaboration among child-serving agencies
- g) Support workforce development and infrastructure necessary for adequate education, training, coaching and mentoring of providers, youth and families.
- h) Maintain a collaborative governance structure that includes child-serving agencies, youth and families, and other stakeholders.
- i) Minimize hospitalizations and out-of-home placements.
- j) Correct or ameliorate mental illness.
- k) Reduce mental disability and restore functioning.
- l) Keep children safe, at home, and in school making progress; avoid delinquency; promote youth development; and maximize Class members' potential to grow into health and independent adults.
- m) Use available approaches that have been effective at achieving these outcomes.



B. WISE Terminology, Definitions, and Roles

Phases

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



Roles

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

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

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

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

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

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



Examples of natural supports include friends, extended family, neighbors, members of the family's faith community, co-workers. The goal is to have more natural and informal supports on the team than formal supports.

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

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

The Mental Health Clinician- 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 clinician. A clinician is a person providing outpatient mental health services (as described in WAC 388-877A; section one) to a WISE enrolled youth. While confidentiality of the details of the clinician-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 practitioners should be trained and supported to use effective treatment elements that connect to the youth and family's strengths and preferences, when therapy or some other



mental health service is included in a Cross System Care plan. The role of the clinician in WISE is expanded upon in [“The Role of the Clinician Employed in a Wraparound Program.”](#)

The Family Partner - a formal member of the WISE team whose role is to serve the family and help them engage and actively participate on the team and make informed decisions that drive the WISE process. They are qualified through their lived, personal experience as the parent of a youth with complex emotional/behavioral needs, hold a peer certification, and have participated in the full WISE training and technical assistance and is involved in ongoing WISE training activities.

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

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

The Family Partner will:

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



- Share resources and information in an individualized manner so that families understand the WISE process and have access to information regarding their child’s care.
- Engage and collaborate with people from diverse backgrounds.
- Maintain a non-judgmental attitude towards youth, families and professionals. Ability to maintain a stance of appreciation and acceptance of parents, including their choices.
- Certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.
- Provide consultation to family members as the family learns new skills to support the youth’s treatment

The role of the Family Partner in WISE care coordination is fully spelled out in [***“How family partners contribute to the phases and activities of the wraparound process.”***](#)

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

The Youth Partner – formal member of the WISE team whose role is to partner with the youth to help support engagement and active participation in making informed decisions to drive the WISE process. The Youth Partner is qualified through lived experience and knowledge of community resources and the wraparound or WISE process. The Youth Partner is a mediator, facilitator, and cultural broker between youth and agencies.

Youth Partners utilize their lived experience and connection to communities and the peer movement to bring resources and informal supports to the CFT. Youth Partners work in collaboration with the other WISE Practitioners. Youth Partners ensure each youth is heard and their individual needs are being addressed and met. The Youth Partner communicates with and educates agency staff on the importance of youth voice and choice, and the power and benefits of peer involvement- particularly in transition age youth. Youth Partners serve as peer advocates to help empower youth in gaining the knowledge and skills necessary to be able to guide and eventually drive their own treatment. Youth Partners should be educated in how to utilize the CANS results to support and educate the youth and family, and are encouraged to be certified in CANS. Youth Partners will:

- Be a person with **lived experience** as a participant in Youth Behavioral Health Services and other involvement in cross systems.
- Be willing to use their own lived experiences to provide hope and peer support to other youth experiencing similar challenges.



- Demonstrate leadership experience and diplomacy in resolving conflicts and integrating divergent perspectives.
- Have knowledge of community resources and supports
- Build relationships with community members and organizations to connect the youth with resources.
- Be able to share resources and information in a developmentally appropriate way to ensure that youth understand the WISE process and have access to information regarding their care.
- Be committed to ensuring that youth have voice and choice in their own care and are active participants in the WISE process.
- Be certified as a Peer Counselor and have training in WISE when serving as WISE Provider Agency staff.
- Provide consultation to the youth and the youth's family members as the family learns new skills to support the youth's treatment

Practice Considerations and Potential Conflict

The National Wraparound Initiative views the Family Partner, Youth Partner, Care Coordinator and Clinician as 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 clinician and care coordinator puts them in the position of having dual roles. This has been known to result in confusion, conflicts and frustration for families, youth and team members.

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

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

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



expand to include formal and natural supports with the long-term goal of replacing formal supports with natural supports.

Family Organization - a family run and family led grass roots, non-profit community organization providing connection, empowerment and education to families and their communities to assure improved outcomes for youth experiencing significant behavioral health challenges and to fulfill a significant role in facilitating family/youth voice in local, state and national policy making.

Managed Care Entity(s) or “MCEs”- A term used to collectively refer to Behavioral Health Organizations (BHOs) and Fully Integrated Managed Care Organizations (MCOs).

Youth Organization - a youth-led non-profit organization dedicated to improving the services and systems that foster and promote positive growth of youth and young adults by using peer support and uniting the voices of individuals who have lived through and experienced obstacles in child-serving systems. Typically focus on activities such as increasing youth participation in service planning, delivery, coordination and evaluation; awareness of challenges young people with cross-systems needs face as adolescents and young adults; and youth involvement in community councils/organizations.

Documents

Child and Adolescent Needs and Strengths (CANS) - a communication tool developed for children’s services to support decision making and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS was developed from a communication perspective to facilitate the linkage between the mental health assessment process and the design of individualized service plans including the application of evidence-based practices. All CANS (screen and full) must be performed by CANS certified staff and entered in the Behavioral Health Assessment System (BHAS).

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

Crisis/Safety Plan/Support Plan - A family friendly, one to two page document that the CFT creates to address potential crises that could occur for the youth and their family and to ensure everyone’s safety. It should include 24/7 response, formal and natural supports/back-up care, details of what leads to crises, successful strategies that have worked in the past, as well as strengths.



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

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

WISE Planning Elements

Youth and Family Vision - A statement constructed, elicited from the family with only the youth and family’s voice and describes how they wish things to be in the future (including long-term goals, hopes and dreams), individually and as a family. Youth and Family Vision is the long-term, overarching goal of the family as identified and described by them.

Team Mission - A statement crafted by the CFT that provides a one to two sentence description of what the team needs to accomplish while they are together and to know when the WISE program has been completed. Mission statements are written in the present tense as if they are true today. 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 family members and others to successfully navigate life situations; thus, a goal for the WISE process is to promote these strengths and to use them to accomplish the goals in the team’s plan of care.

Needs - Anything that is necessary, but lacking. A need is a condition requiring relief and something required or wanted. Needs are not considered services. Needs are essential requirements of life that, when left unmet, can create a gap or void that causes behavior to occur.

Outcomes - Youth, family and/or team goals stated in a way that can be observed and measured as indicators of progress related to addressing an identified need.

Strategies - Ideas, plans and/or methods for achieving the desired outcome. When coming up with strategies in the WISE process, a brainstorming process is applied.

Action Steps - Statements in a Cross System Care plan that describe specific activities that will be undertaken, including who will do them and within what time frame.



Services and Supports

Formal supports - Services and supports provided by individuals who are “paid to care” under a structure of requirements for which there is oversight by state or federal agencies or national professional associations, or.

Informal supports - Supports provided by individuals or organizations through citizenship and work on a volunteer basis under a structure of certain qualifications, training and oversight.

Natural Supports - Individuals or organizations in the family’s own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers and neighbors who are not “paid to help.”

Peer Support – [State certified peer counselors](#) who work with their peers, mental health consumers and the parents of children with serious emotional disturbances. They assist consumers and families with identifying goals and taking specific steps to achieve them such as building up social support networks, managing internal and external stress, and navigating service delivery systems.

WISE Training and Coaching Framework

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

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

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

C. Guidance on Team Functioning and Facilitation of WISE

The Approach

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



WISe Team Meeting Facilitation Components and Team Structure

Each team meeting must include the following facilitation components:

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

Facilitate Introductions and Review Agenda:

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

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

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

Review the Youth and Family Vision Statement(s):

- The WISe Practitioners should talk with the youth and family about their vision(s) before the first team meeting and help them express this vision(s) to the rest of the team.
 - Generally, there should be one collective vision for the youth and family. However, there are times that the youth may have a separate vision than the family.
- The language used by the youth and family should be preserved in the final vision statement.
- The family vision is created and owned by the family, is an expression of their voice and choice, and is used as a touchstone to ensure team activities align with the family’s preferred future. Team members may, however, need clarification as to the implications.
- All team members should be given a written copy of the final vision statement and should be reviewed by the team regularly.



Construct a Team Mission Statement and Review Team Mission:

- The team should formulate a mission statement that is focused on what they need to accomplish during their time together and how they will know when they are done.
- All team members should add to the mission statement.
- Consider recording major themes and edit final statement as an independent activity.
- All team members should be given a written copy of the final mission statement and it shall be reviewed by the team regularly.

Develop a List of Strengths and Review Strengths:

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

Develop a List of Needs and Review Current Needs:

- The WISE practitioners should talk with the youth and family about their needs, as indicated on the CANS, and help them list these at the first team meeting.
- Team members should state all concerns or identified problems in needs language: "I need..., we need..., they need..., etc."
- Needs are not services. Team members should be redirected to state the real need(s).
- Avoid going back-and-forth between strengths and needs. Complete strengths before identifying needs.
- During the brainstorming of needs, avoid organizing the list of needs by person.

Prioritize Needs:

- Facilitate a discussion with the team about which needs should be prioritized (including those domains with 2's or 3's on the CANS) to work on over the next 30/60/90 days.



- Typically, teams work better with less than 5 needs prioritized at one time.
- Avoid a numeric ranking of each need by importance.

Develop Outcome Statements for Prioritized Needs:

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

Brainstorm Strategies:

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

Assign Action Steps:

- Each selected strategy includes specific action steps and should be assigned to a specific team member(s) keeping the individuals strengths and abilities in mind. When appropriate, all team members are given action steps for the strategy that will help achieve the outcome statement and meet the need.

Summarize and Agree on the Plan:

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

SMART GOALS

When developing outcome statements for prioritized needs, remember the SMART test.

Specific

Linked to a rate, number, percentage, or frequency

Measurable

Has a reliable process to measure progress toward the achievement of the goal, objective, or outcome

Achievable

It can be done with a reasonable amount of effort

Relevant

The objective is consistent with the overall goal

Time-Bound

Has a start/finish date clearly stated and defined



Schedule the next Team Meeting:

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

Transition

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

Principles Evidenced in Practice

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



D. WISe Capacity Attestation(s) for Managed Care Entity 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 Entity or from a Tribal Behavioral Health Agency. On the following pages are the form templates: 1) for MCEs and 2) for Tribal Behavioral Health Agencies.



WISe Attestation for a Managed Care Entity (MCE)

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



WISE staff certified in CANS on each team? • If yes, please note on staff list	<input type="checkbox"/>	<input type="checkbox"/>	
Established protocols for responding to crisis, in line with Section 4	<input type="checkbox"/>	<input type="checkbox"/>	
Established process(es) in which local implementation and oversight of WISE will be achieved and coordinated? • If yes, please submit process(es) • If no, please attach a written plan to establish this structure with a completion date.	<input type="checkbox"/>	<input type="checkbox"/>	
Tribal relationship established? • If yes, please list tribe(s) • If no, please indicate plan to engage	<input type="checkbox"/>	<input type="checkbox"/>	
Documentation of a Provider Quality Committee (PQC) group consistent with the WISE Quality Plan, section II-C-ii (pp 11-12). • If yes, please submit documentation. • If no, please attach a written plan to establish a PQC group with a completion date.	<input type="checkbox"/>	<input type="checkbox"/>	
Discussion with DBHR to determine approved number of WISE participants? • If yes, please indicate the approved number of participant in comments.	<input type="checkbox"/>	<input type="checkbox"/>	Requested capacity number: DBHR Approved number:

Additional Comments:

Signatures

Managed Care Entity:

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

Approval

DBHR:

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

Agency capacity and qualifications forwarded to Provider One	Date _____	Initials _____
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Submit completed WISE Attestation form to WISupport@hca.wa.gov



WISe Capacity Attestation for Tribal Behavioral Health

Tribal Agency Name:		Agency NPI:	
Agency Address(es)			
Key WISe contact person:		Phone number and email:	
Background			
The WISe Capacity Attestation must be completed by the Tribal Behavioral Health agency upon the initiation and any expansion of WISe within their area.			
WISe Key Elements			
	Yes	No	Comments
Contacted DBHR regarding any questions on the WISe Program, Policy and Procedure Manual.	<input type="checkbox"/>	<input type="checkbox"/>	
Tribal BH Agency is licensed by DOH by either (attestation, deeming or licensure).	<input type="checkbox"/>	<input type="checkbox"/>	
Agency provides all of the following services:	<input type="checkbox"/>	<input type="checkbox"/>	
• Individual treatment services	<input type="checkbox"/>	<input type="checkbox"/>	
• Family therapy services	<input type="checkbox"/>	<input type="checkbox"/>	
• Case management services	<input type="checkbox"/>	<input type="checkbox"/>	
• Psychiatric medication services	<input type="checkbox"/>	<input type="checkbox"/>	
• Crisis mental health services—Outreach services	<input type="checkbox"/>	<input type="checkbox"/>	
• Recovery support—Wraparound facilitation services.	<input type="checkbox"/>	<input type="checkbox"/>	
• Recovery support—Peer support services	<input type="checkbox"/>	<input type="checkbox"/>	
Have WISe program staff attended WISe training?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please list staff, role and training date in comments section.			
• If no, please indicate training plan			
Are family partners are peer certified (or qualify for certification)?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list.			
• If no, please indicate plan to certify on staff list.			
Are youth partners peer certified (or qualify for certification)?	<input type="checkbox"/>	<input type="checkbox"/>	
• If yes, please note on staff list.			
• If no, please indicate proposed certification plan and staff list.			



Are WISE staff certified in CANS on each team? • If yes, please note on staff list.	<input type="checkbox"/>	<input type="checkbox"/>	
Established protocols for crisis intervention and stabilization response, in line with Section 4 of the WISE Manual	<input type="checkbox"/>	<input type="checkbox"/>	
Established process(es) in which local implementation and oversight of WISE will be achieved and coordinated? • If yes, please submit process(es). • If no, please attach a written plan to establish this process with a completion date.	<input type="checkbox"/>	<input type="checkbox"/>	
Discussion with DBHR to determine number of WISE participants to receive WISE? • If yes, please indicate the approved number of participant in comments.	<input type="checkbox"/>	<input type="checkbox"/>	Requested capacity number: DBHR Approved number:

Signatures

Tribal Representative

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

Approval

DBHR:

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

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

Agency capacity and qualifications forwarded to Provider One	Date _____	Initials _____
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E. MEMORANDUM OF UNDERSTANDING

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

MEMORANDUM OF UNDERSTANDING

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

AMONG

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

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

WASHINGTON HEALTH CARE AUTHORITY (HCA)

A. Background

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

B. Purpose

This MOU describes the mutually supportive working partnerships between DSHS, DCYF, and HCA as they relate to the community-based mental health needs and service delivery systems for



children and youth with significant emotional and behavioral health needs, and their families, who are typically served by more than one state agency. Consistent with the Settlement Agreement, this MOU will support the agencies developing cross-system protocols to coordinate services for these youth and their families.

C. Agreements:

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

- **Family and Youth Voice and Choice:** Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based:** Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the youth’s and family’s vision.
- **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn from the youth’s and family members’ networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multisystem involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based:** Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.



- **Strength Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome Based:** Based on the youth and family’s needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional:** A youth and family team’s commitment to achieving its goals persists regardless of the youth’s behavior, placement setting, family’s circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

These principles provide a framework for the success of cross-system work on behalf of children, youth and families served through the Medicaid funded behavioral health system and in compliance with the T.R. vs Quigley & Teeter Settlement Agreement.

D. The parties mutually agree that:

1. Working together cooperatively and collaboratively develops the best possible foundation to achieve shared, successful outcomes.
2. Planning will strive to balance mandates, interests and resources of participating agencies.
3. An integrated system of effective services and supports for treating children and youth with significant emotional or behavioral health needs must:
 - a. Be based in organizations that are accountable for costs and outcomes.
 - b. Be delivered by teams that coordinate medical, behavioral, and long-term services.
 - c. Be provided by networks capable of addressing the full range of needs.
 - d. Emphasize primary care and home and community-based service approaches while reducing the need for institutional levels of care.
 - e. Provide information regarding available services, supports and client rights.
 - f. Provide access to qualified providers.
 - g. Respect and prioritize consumer preferences in the services and supports they receive.



h. Align financial incentives to support integration of care.

4. Specific activities for collaboration are:

a. To set up practices and procedures consistent with the WA Children’s Mental Health Principles and Wraparound with Intensive Services (WISE) Program Model established under this MOU to guide inter- and intra-agency efforts to collaborate and coordinate delivery of care in order to improve the effectiveness of services and outcomes for children, youth and their families that are served by or may need services from more than one agency.

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

c. To align and support efforts to secure funding sources, within funding restrictions, to strengthen inter- and intra-agency collaboration, support improved long-term outcomes, and sustain funding for WISE.

d. To develop cross system training and technical assistance for the parties’ respective staff and relevant stakeholders and government partners, including Washington Tribes, to address information sharing, the coordination of programs and services, enhancement of working relationships and increase the use of evidence and research- based practices across disciplines. Specifically, this may include training and assistance on the implementation of Evidence and Research Based Practices, the Child Adolescent Needs and Strengths (CANS) tool, and the WISE access protocol, practice model, and service array.

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

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

E. Governance Structure

The interagency governance structure that is part of the Settlement Agreement is intended to improve the coordination of access to intensive community-based mental health services and thereby improve both effectiveness of services and outcomes for youths and their families. Governance informs decision-making at a policy level that has legitimacy, authority, and accountability.



The structure of the Children’s Mental Health Governance will consist of chief operating bodies with clear roles and reporting guidelines:

1. Executive Team - The role of the Executive Team is to provide leadership, problem solving and decision making regarding progress in implementing system-wide practice improvements, fiscal accountability and quality oversight. Each agency will identify an executive leader to participate in the Executive Team meetings.

2. Regional Family, Youth, System Partner Round Tables (FYSPRTs) identify local needs and develop a plan to bring those needs forward to the Statewide FYSPRT, with recommendations about how to meet those needs. Representatives from the agencies that are parties to this MOU will attend the Statewide FYSPRT.

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

a. Cross Systems Initiatives Team - Policy and Practice - Works on behalf of the Governance structure to addresses cross system issues and initiatives through the facilitation and development of policies and procedures based on WA Children’s Mental Health Principles.

b. Children’s Behavioral Health Data and Quality (DQ) Team - The mission of the Team is to provide a forum for developing and refining data collection and management strategies related to screening, assessment, performance measurement and quality improvement relevant to children’s behavioral health in Washington State. Reporting, outcomes evaluation, and other types of accountability activities are another aspect of the Team purpose. Working in an inclusive and transparent fashion the Team will assure integration of data activities across systems involving children, youth, and families

c. Children’s Mental Health Cross Administration Finance Team – A cross-system team to address the need of aligning funding sources, costs of expanding service capacity and improving cost effectiveness.

d. Workforce Development – Develops and strengthens a workforce that operationalizes the WA Children’s Mental Health Principles and WISE Program Model



F. Period of Performance

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

Signatories (in process)

- DSHS
- DCYF
- HCA

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



F. Service Array and Coding

The Service Encounter Reporting Instructions (SERI) provide Apple Health Managed Care Organizations (MCO) and the Behavioral Health Administrative Services Organizations (BH-ASO) in integrated care regions, Behavior Health Organizations (BHOs) in non-integrated regions 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 [Service Encounter Reporting Instructions SERI v2019.1 \(Effective July 1, 2019\)](#). The Service Encounter Reporting Instructions (SERI) can be found online.



G. Washington’s CANS Algorithm

7/24/14

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

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



H. WISE Cross System Care Plan

(Example template from the WISE Workforce Collaborative)

Date:

Name:

ID:

Care Coordinator:

Ground Rules Generated by the Team *(What will help us be most productive as a team?):*

- 1.
- 2.
- 3.
- 4.
- 5.

Vision Statement of Family and Youth *(What does better look like for my family?):*

Mission Statement of the Team *(What do we need to accomplish while we're together?):*



--

Team Member	Role	Contact Information
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Strengths & Needs Summary

STRENGTHS

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

Strengths List from the CANS:	
0	1
0	1
0	1
0	1
Strengths List from the Team	
Strengths to Build from the CANS:	
2	3
2	3
2	3
2	3



NEEDS

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

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

INDIVIDUALIZED PLAN

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

Priority #1:	Life Domain: _____ <input type="checkbox"/> CANS Generated Score: 0 1 2 3	Status <i>(ongoing if unchecked)</i> <input type="checkbox"/> Dropped <input type="checkbox"/> Met
Context:	<i>(Can include team concerns, observable behavior, background CANS items, system requirements - e.g., being on probation, etc. - and any other information relevant to plan development.)</i>	
Needs Statement and CANS Target:	<i>(CANS Target Item and Underlying need statement developed by the team and from the youth and family perspective)</i>	
SMART GOO Statement #1.1:	<i>(The SMART indicator of the desired end result. May be called a Goal, Objective, or Outcome)</i>	



Options:	<i>(Potential strategies brainstormed by the team at the meeting)</i>		
Strengths:	<i>(May include CANS items and team generated strengths that can be used as part of the plan)</i>		
Selected Strategies:	<i>(Preferred strategies selected by the youth and family from the list of Options brainstormed by the team)</i>		
Action Steps <small>(team member assigned action steps to achieve the GOO and meet the need):</small>	Person Responsible	Time Frame	Status
1			<input type="checkbox"/> Active <input type="checkbox"/> Complete
2			<input type="checkbox"/> Active <input type="checkbox"/> Complete
3			<input type="checkbox"/> Active <input type="checkbox"/> Complete
4			<input type="checkbox"/> Active <input type="checkbox"/> Complete
[Optional] Anticipated Outcomes (Across Life Domains): <i>CANS items expected to change as a result of addressing the prioritized need.</i>			
	3		
	4		



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

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



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



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



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



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



SUMMARY AND SIGNATURES

Plan Summary and Notes:

Wraparound Care Coordinator Signature Date

Wraparound Supervisor/Coach Signature Date

Wraparound Team Member Signatures:



I. Affinity Groups

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

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



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

- **Specific elements to be included are:**
- Identifying youth that may benefit from WISE, and when a referral is mandatory.
- How to refer; who to contact/what information is needed.
- Individual roles and responsibilities of cross-system partners.
- What to expect in the WISE model and how to participate including how to utilize and contribute to a single Cross System Care Plan.



J. Quality Plan

I. Introduction

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 the Wraparound with Intensive Services (WISE) program.

A. Background

The original WISE Quality Management Plan (QMP), adopted in December 2014, was developed pursuant to the Commitments set forth in the *T.R. v. Birch and Strange1* Settlement Agreement dated December 19, 2013 (DKT 119-1, paragraphs 18 – 64). The name has been simplified to “Quality Plan” to reflect the focus on the future, rather than the past, and to better describe the full scope and intent of Washington’s quality planning and activities. As with this Quality Plan, future iterations will continue to be informed and guided by the foundational T.R. principles and goals.

B. Components

The WISE practice model is built around collaborative goal-setting, individualized, strengths-based, intensive treatment, provided in the community. This Quality Plan provides a foundation for 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. Specifically, the access protocol outlines the process whereby children and youth who may need intensive mental health supports are identified, screened and routed to effective care. The on-demand reporting system provides CANS data at every level of the WISE behavioral health system so that variations in effectiveness can be tracked, studied, and lessons learned disseminated. Finally, cross-system care coordination, information dissemination, and decision-making structures allow for consistent and tailored responses to children and youth with complex support needs.

C. Future development

The principles and goals that guide this Plan are derived from and informed by the goals set forth in paragraph 17 of the T.R. Settlement Agreement, as well as quality management principles and practices, and the real-world knowledge and experience of stakeholders, clinicians, and WISE program managers. As such, they are not cast in stone, but are intended to evolve as our understanding of needs, treatments, management techniques, and healthcare delivery systems



evolve. What is not expected to change is the overarching purpose of the system: to ensure that all eligible children and youth are provided timely, effective, high quality, individualized care, appropriate in scope, intensity, and duration to correct or ameliorate behavioral health conditions, reduce disability, and restore functioning.

D. Quality Infrastructure

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

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

A copy of the Quality Plan can be [found online](#).



K. WISE Practitioner Training and Coaching Framework

Overview

In July 2018, DBHR expanded training and coaching opportunities for WISE practitioners at the provider level. The commitment to providing enhanced training and coaching to our valued WISE practitioners not only develops increased skill sets to better support youth and their families participating in WISE, it increases the quality of the model and offers additional supports to all WISE practitioners. An additional benefit is to highlight and support the roles of each WISE practitioner which also offers an element of networking and promotes individual self-care for all WISE practitioner roles. This on-going coaching supports staff working in a highly intense service structure with the goal of retaining WISE practitioners to provide continuity of care for youth and families.

Additionally, this enhancement aligns with the intent of the WISE Implementation Plan which provides more authority and accountability at the provider level for onboarding new staff. The WISE training and coaching framework now requires role specific trainings and coaching sessions. The framework is also linked to TCOM processes and outcomes identified in the Quality Plan. The work to improve training and coaching will be informed by all levels of the system.

Training and Coaching Framework

System Level: Technical assistance for WISE is provided at each level of the system. DBHR supports Managed Care Entities (MCEs), WISE agency staff and allied Child and Family Serving Systems through the work of the DBHR WISE System Coach. The function of this position is to communicate system level needs and initiatives in a timely manner with the MCE and WISE agency leads and other identified system partners as identified. This teaming structure, at the various levels of the system, is to assist with timely responsive practice changes.

Requirements: WISE leads from the MCEs and leads from their contracted WISE providers participate in a monthly DBHR/HCA WISE System Coaching Call. This call is facilitated by the WISE System Coach with partnership from content experts.

Topics for WISE System Coaching calls are selected based on outcomes identified from a variety of reports and resources, which include: annual WISE Youth and Family Survey; quarterly BHAS reports; quarterly WISE Data Dashboards; WISE Service Characteristics reports; quarterly Due Process reports; feedback from the statewide FYSPRT; outcomes from Quality Improvement Reviews; new statewide initiatives such as the BRS/WISE; and from feedback from those who participate on the monthly calls.



Practitioner Training and Coaching

The WISE Workforce Collaborative (the Collaborative) is the training and coaching hub for WISE practitioners across the state. The Collaborative provides WISE training for new practitioners as well as additional training and coaching.

[Link to the WISE WF Collaborative](#)

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

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

Enhanced training sessions include:

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

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

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



As of July 2018, all WISE agencies are required to have lead staff participate in WISE coaching sessions. Regions will partner with the WISE Workforce Collaborative, which will serve – under the direction of DBHR – as their primary resource for ongoing technical assistance related to training and coaching for WISE practitioners.

Regions will:

- Work with the WISE Workforce Collaborative to develop a training and coaching plan for providers in their region.
- Participate in monthly coaching calls with the DBHR Systems Coach.

WISE agencies will:

- Be accountable to the training and coaching plan developed by their regional representatives.
- Participate in monthly coaching calls, as needed, with the DBHR WISE Systems Coach and their regional representatives.
- Participate in coaching calls offered by the WISE Workforce Collaborative.

Regional and Agency Training and Coaching Plans

Regions and agencies are encouraged to design an onboarding system to prepare their staff with sufficient knowledge and skills for their work with youth and families. Regions (MCO staff) and/or 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 WISE Workforce Collaborative on completing a regional and 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 at least annually to assure that the training is aligned with the state approved curriculum.

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



Orientation:

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

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

DBHR will offer “train the trainer sessions” to regions and agencies interested in managing the WISE orientation and onboarding of new staff. MCOs 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 WISESupport@hca.wa.gov

Coaching: Starting in summer of 2018, Supervisors of Care Coordinators, Supervisors of Certified Peer Counselors and Supervisors of WISE Mental Health Therapists will receive state sponsored coaching through the WISE Workforce Collaborative. Participation in the regional coaching plans will be a contractual requirement.

Regional coaching plans will be developed by MCE and WISE leads with facilitation provided by the WISE Workforce Collaborative. Various WISE surveys and reports will be considered as part of drafting the coaching plans, examples include: Youth and Family Survey, WISE Quarterly reports, QIRT outcomes, PDSA, staff surveys, and local WISE surveys from youth and family participants.

WISE supervisors and coaches will continue to provide on-going support to WISE practitioners. Coaching that is already happening at the regional and/or agency should link to the WISE Coaching requirement to assist with further support of the WISE supervisors and practitioners.



The statewide goal is for WISE practitioners to receive ongoing, competency-based coaching to facilitate skill development relevant to their role.

To support this work:

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

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

Definitions

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

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

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

L. Behavior Rehabilitation Services (BRS) and WISE Integration

Behavior Rehabilitation Services (BRS) and WISE Delivered Concurrently

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

Both BRS and WISE services are intended to:



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

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

To identify a process for how BRS and WISE teams can efficiently work together and provide a highly intense service package for BRS involved youth, four integration sites started in October 2018. Site locations include: King County, Pierce County, Spokane County and Yakima County. The expertise of the sites leadership and staff - *at Catholic Community Services, Center for Human Services, Comprehensive Life Resources, Excelsior, Ryther, and Yakima Valley Farmworkers* – will help inform the DCYF and HCA **BRS WISE Integration Guidance Document**. This document is due out in September 2019.

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

- **In July 2019**, on a voluntary basis, agencies who have a contract for both BRS and WISE may begin simultaneously providing both services to DCYF dependent children and youth who are being served in BRS and have screened eligible for WISE.
 - Agencies must inform DCYF and HCA/DBHR of their interest prior to starting combined services to assure that training and coordination has been established.
 - Agencies, who have contracts for both BRS and WISE, and are interested in early integration must send an email to the DCYF HQ Intensive Resource Manager.
- **In August 2019**, DCYF dependent children and youth who are currently being served in WISE AND who may need to enter BRS services – can be jointly served (WISE services can stay open).
- **In October 1, 2019**, all children and youth who screen eligible for WISE and are entering BRS may receive both services delivered at the same time.
- **In January 2020**, children and youth who are receiving BRS and screen eligible for WISE at the time of their six month WISE screening may be referred to WISE and may receive both services.

In preparation for this work HCA and DCYF, along with the WISE Workforce Collaborative, provided BRS contracted staff a WISE overview training; these trainings started in October 2018 and



completed in April 2019. The state will also offer more detailed BRS and WISe implementation trainings starting in July 2019 with a kickoff workshop at the annual WISe Symposium. WISe staff will also receive training on BRS starting in August 2019.

On-going technical assistance and support will be provided during the phasing in of BRS and WISe by HCA/DBHR and DCYF and Coordinated Care of Washington.



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

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

HCA/DBHR is hopeful Tribal Behavioral Health agencies will consider the updated training curriculum and WISE as a service delivery model to include in the array of services they provide. Anticipated completion date for the updated training curriculum is March 2020.

HCA/DBHR is also working to identify additional resource materials to include on this page to assist non-native WISE practitioners when working with American Indian and Alaska Native Youth and their Family. Links to these resources will be included in the next WISE Manual update.



N. Working with birth to age 5 in WISE

CANS 0-4 will be updated to become CANS 0-5 in partnership with WISE providers and other child serving practitioners as well as with Dr. Lyons from Praed Foundation. This work is scheduled for July 2019 through June 2020. This section will be updated when the work is completed.



O. Working with Transition Aged Youth in WISE

HCA/DBHR is working with Community Youth Services, a WISE agency specializing in WISE and TAY, and the WISE Workforce Collaborative to provide additional guidance for consideration when working with transition aged youth. Information will be provided in the next annual WISE Manual update.



P. WISe clients with Intellectual Disabilities and Autism Spectrum Disorder

HCA is convening a stakeholder group, to include representatives from WISe agencies, DDA, DCYF, and MCOs, to identify a WISe “Best Practice” when working with clients with Intellectual Disabilities and Autism Spectrum Disorder. This work will begin in August 2019 and run through May 2020. Information will be included in the annual WISe Manual update in July 2020.



WISE Manual Update Crosswalk for Version 1.9

Table of Contents	New & Revised Page Numbers	Page 1
<i>WISE Screening</i> (Section 3)	Revision	Page 14
<i>WISE Screens and BRS*</i> (Section 3)	New	Page 15
Client Rights (Section 5)	Revision	Page 36
Governance and Coordination (Section 6)	Revision	Page 42
Appendix D WISE Capacity Attestation for Managed Care Entity and Tribal Behavioral Health	MCE Revision Tribal New	Page 63
Appendix E Memorandum of Understanding	Under Revision	Page 68
Appendix H Cross System Care Plan	Updated Templates	Page 76
Appendix J Quality Plan	Revision	Page 86
Appendix L BRS* and WISE Integration	New	Page 94
Appendix M WISE and AI/AN* Youth and Family	Next Update	Page 97
Appendix N Working with Birth to Age 5 in WISE	Next Update	Page 98
Appendix O Working with Transition Aged Youth	Next Update	Page 99
Appendix P WISE Clients with Intellectual Disabilities and Autism Spectrum Disorder	Next Update	Page 101

*BRS – Behavioral Rehabilitation Services

*AI/AN - American Indian/Alaskan Native