



Comagine Health

Wraparound with Intensive Services (WISE)

Quarter One 2021 Findings Summary & Recommendations

Quarter One Review Period: 6/5/18 – 11/20/20

Quarter One Review Dates: 1/19/21 – 4/15/21

Number of Records Reviewed: 57

Number of Agencies Reviewed: 7

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

Introduction

As the external quality review organization (EQRO) for Washington, Comagine Health is contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe service delivery model. Comagine Health contracted with MetaStar, Inc. to conduct the WISe record reviews. WISe is a service delivery model that offers intensive services to Medicaid-eligible youth with complex behavioral health needs. It is a team-based approach that provides services to youth and their families in home and community settings rather than institutions.

Review Methodology and Scope of Review

This review evaluated seven BHAs in the Greater Columbia, King and Thurston-Mason regions to ensure quality behavioral health care provided to enrolled youth focusing on the components of the WISe service delivery model. The agencies reviewed include:

The review criteria are identified in the Washington Quality Improvement Review Tool (QIRT). The key areas evaluated during the review include:

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

The review team is provided a randomly selected list of names by HCA identifying records for review for each provider. Six records, at a minimum, are reviewed per BHA with results entered into the QIRT database. Seven (7) of the 57 records reviewed were for children under the age of five (5).

The review is based on what was documented within the records. In addition, each review was performed for one individual provider agency and may not reflect care provided outside the reviewed providers, if not coordinated and documented by the providers reviewed. The review period included the early days of the COVID-19 public health emergency, including the *Stay Home, Stay Healthy* orders. The requirements of the *Stay Home, Stay Healthy* orders may be a contributing factor in the agency's results.

Agency results varied, with strengths and opportunities for improvement noted in each agency's individual report. This report includes aggregated results for seven WISe reviews conducted during calendar year 2021, including overall identified strengths and opportunities for improvement.

Summary of Findings

Care Coordination Elements

Initial Engagement & Assessment

A Child and Adolescent Needs and Strengths (CANS) screening is required to be offered within 10 business days of a WISe referral and an initial full CANS assessment completed within the first 30 days of enrollment. Documentation should include evidence of youth and family inclusion in the CANS process. Timely CANS screenings were identified in 68% of the records reviewed. Out of the 57 cases in these reviews, seven (7) received the 0-4 version of the CANS. There is not an algorithm for the 0-4 version of the CANS screening; therefore, these cases were not included in the calculation of WISe indicated youth. Of the remaining 50 records that received the CANS 5+ screening, 95% met the criteria for WISe indicated. The initial full CANS assessment was completed collaboratively in 35% of the records and within the required timeframe in 42% of the records. The documentation identified 49% of reassessments occurred as required.

Care Planning

All needs identified by the initial full CANS are to be included in the youth's Cross System Care Plan (CSCP). Needs may be "deferred" on the CSCP if not currently being addressed. A comprehensive CSCP includes all needs and strengths identified in the CANS and includes prioritized needs, goals and expected outcomes. Aggregately, 26% of CSCPs were completed within the required timeframe and 44% showed a collaborative review with youth and families. WISe team face-to-face contacts within the first 30 days of enrollment averaged 5.72 hours across all agencies. In addition, the care coordinators averaged 0.19 hours non-CFT face-to-face contact per month with caregivers, 0.15 hours with youth, and 0.14 hours with other treatment partners.

CFT Processes and Transition Planning

Each youth has a CFT that develops and implements the youth and family's plan, addresses unmet needs, works toward the family's vision and monitors progress regularly. CFT meetings should take place every 30 days, with documentation reflecting ongoing discussions for transition planning and discharge criteria. During the first 90 days of enrollment, 18% of youth had no CFT meetings, while 21% of youth had at least one (1) CFT. Two (2) CFT meetings occurred for 25% of youth and 37% had three (3) or more CFTs. Caregivers attended all CFTs for the 0-4 age group and 65% of CFTs for the 5+ age group. Community resource partners participated in 50% of CFTs for youth in the 0-4 age group and none in the 5+ age group. School partners attended none of the CFTs for the 0-4 age group and 10% in the 5+ age group. Needs were identified in both domains across both age groups.

Crisis Prevention and Response

Each CSCP must include a crisis plan that addresses potential crises that could occur for the youth and family to ensure safety. An effective crisis plan includes:

- Crisis identification and prevention steps, with CFT members' roles
- Crisis response actions based on the severity level of a crisis
- Post-crisis evaluation of the youth's behavioral health status and the effectiveness of the crisis plan

Forty-one (41) of the 57 youth records reviewed included crisis plans. Of the crisis plans available, 63% were timely, defined as completed within 45 days of enrollment. The crisis plans reviewed were created collaboratively 29% of the time.

Treatment Characteristics

Qualified clinicians provide individual clinical treatment sessions to the youth/family in the amount, duration and scope appropriate to address the identified medically necessary needs. Documentation should reflect needs identified in the CSCP, indicate how the therapeutic intervention benefitted the youth's functioning or symptoms, and the impact of the services for the youth at home, school and/or in the community. Therapists participated in 66% of all CFT meetings and averaged of 2.77 treatment sessions monthly. The reviews indicated 49% of treatment sessions were attended by the youth alone. The youth and caregiver participated in 34% of sessions and only the caregiver attended 17% of treatment sessions. Persistence in problem-solving was evidenced by documentation of the same treatment focus from session to session in 89% of the sessions.

Specific treatment content was not consistently documented. Enlisting treatment support and skill development were the most frequently documented content at 14% and 11%, respectively. However, the youth and/or caregiver's response to the treatment content was not consistently documented. Documentation of progress reviewed was identified in 14% of records, while 3% of records included celebrating success.

Parent & Youth Peer Support Elements

Each youth and family must be offered a youth peer or parent support partner. These partners are formal members of the CFT who support the parent/youth in the WISe process through active engagement and informed decision making. Out of the 57 youth records reviewed, seven (7) received the 0-4 version of the CANS. Since children under age five are not eligible for youth peers, these cases were not included in the Youth Peer metrics. Youth Peer Partners averaged 1.24 hours of non-CFT face-to-face contact per month with youth, 0.9 hours with caregivers and 0.72 hours with others. Parent Peer Partners averaged 1.39 hours per month non-CFT face-to-face with caregivers, 1.09 hours with youth and 0.58 hours with others.

Conclusions

Strengths

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

- Two (2) agencies completed timely CANS screenings in at least 88% of the records reviewed

- WISe team members for two (2) agencies averaged more than nine (9) hours of contact with youth and families in the first 30 days of enrollment
- Documentation indicated Two (2) agencies conducted three (3) or more CFTs during the first 90 days of WISe enrollment in over 85% of the records reviewed
- Caregivers in the 0-4 age group attended 100% of CFTs
- Therapists for two (2) agencies attended more than 80% of CFTs
- Aggregately, persistence in problem solving was evidenced in 89% of therapy sessions; five (5) agencies demonstrated persistence in problem-solving in more than 75% of therapy sessions

Opportunities for Improvement

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

Each organization should review their response to the COVID-19 public health emergency (PHE) to address gaps in the emergency or disaster plans to:

- Identify alternate methods for providing services and supports in the event of a PHE
- Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services.

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

Recommended focus areas for improvement include:

- Conduct CFT meetings at least every 30 days, ensuring each CFT includes educators and/or community partners when identified as areas of need
- Conduct timely and collaborative initial full CANS assessments. The CANS assessments indicate collaboration when:
 - Areas of the youth and caregiver feedback are addressed
 - Documentation reflects the changes that are incorporated
 - Consensus is clearly identified
 - Both strengths and culture are discussed
- Complete timely and collaborative CSCPs. Documentation that reflects collaboration may include:
 - Attendees and their titles
 - CFT members' contact information
 - Youth or family agreement with the CSCP
 - Documenting a copy of the CSCP was provided to all CFT participants
- Complete timely and collaborative crisis plans. Documentation of collaboration may include:
 - Specific action steps

- Post-crisis follow-up activities
- Identification of all CFT members' roles in crisis response
- Ensure therapy notes clearly reflect the following:
 - Interventions used in therapy sessions
 - Youth and/or caregiver responses to the intervention
 - Progress reviewed and successes celebrated
 - Document the specific content of treatment sessions such as psychoeducation, skill development or evidence-based practice components