Wraparound with Intensive Services (WISe) Quality Improvement Review Tool (QIRT) Findings Summary & Recommendations

Wraparound with Intensive Services (WISe) is designed for Medicaid-eligible children with complex behavioral health needs. It is a team-based approach that provides services to youth in their homes and communities rather than institutions.

Components of this program include:

- Comprehensive care coordination
- Intensive services provided in the home and in the community
- Mobile crisis intervention and stabilization services

Because of its comprehensive nature, potential for crisis intervention, and the number of professionals and peers partnering in support of the client, all the components must be documented carefully—both to assist the providers in fulfilling program requirements and monitoring client progress, but also to allow a means by which to assess the quality of the WISe program.

Number of Agencies Reviewed:
15

Number of Files Reviewed:
146

Review Period:
January – September 2019

WISe implementation began in Washington in 2014, with a statewide goal establishing WISe treatment throughout the state by 2018. Per the T.R. v. Birch and Strange settlement agreement (https://www.disabilityrightswa.org/cases/tr-v-quigley/) the goals of this review summary are to:

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

As the external quality review organization (EQRO) for Washington, Comagine Health (formerly Qualis Health) was contracted to review behavioral health agencies (BHAs) throughout the state that have implemented the WISe program.

Comagine Health

Comagine Health prepared this report under contract with the Washington State Health Care Authority (Contract No. 1534-28375).

Introduction

The Quality Improvement Review for 2019 consisted of two days of onsite record reviews at each of the 15 behavioral healthcare agency (BHA) offices selected by HCA. These locations reflect a combination of both rural and urban agencies providing WISe services throughout the state of Washington. Record reviews consisted of examining paper records, electronic records or a combination of both against review criteria. The information gleaned from the records was then entered into the online Quality Improvement Review Tool (QIRT). The reviews began in January and concluded in September. Following each agency review, the WISe team presented the state with a summary and recommendations report. Those reports were sent out to the individual agencies in November, after the completion of the final review in September.

The Quality Improvement Review was performed by the Comagine Health WISe clinical review team which consisted of three reviewers with extensive training and years of experience performing External Quality Review (EQR) activities. Additionally, the reviewers:

- Completed a four-day Washington WISe training and are certified in the WISe program
- Participated in the Quality Service Review (QSR) pilot study conducted in previous years and provided feedback on additions and improvements of the QIRT
- Achieved certification on the final QIRT prior to conducting any reviews

A component of the T.R. Settlement Agreement is to develop and refine a review process for future quality assurance. The QIRT is used to assess the quality of care of the WISe program. This review assessed care elements provided by the WISe agency and did not assess other elements such as documentation from other care providers involved in the client's treatment or billing information. Therefore, the scope of the review is likely to underestimate the actual volume of care provided.

Limitations of the QIRT include:

- Limited ability to capture activities such as care coordination completed by the therapist, youth or parent peer because the tool is role defined
- Limited opportunities in the treatment characteristics section as it does not incorporate whether the sessions address the needs identified in the CANS (The Child and Adolescent Needs and Strengths), CFTs, the intake assessment, ISP (individual service plan) or goals and items within the CSCP (Cross System Care Plan)
- Underutilization of the Notes section, which may be a result of limited field space to enter documentation including detailing of activities such as
    - communication between the care coordinator and the therapist and how they can best assist the youth/family
    - documenting difficulties in contacting the youth/family to schedule appointments thereby providing insight as to extended timeframes for services
    - documentation of multiple staff providing the same service at the same time
    - capturing the overall outcome of the youth's success in treatment including what worked well and areas for improvement

As stated in the HCA WISe manual, the Washington State Children's Behavioral Health Principles outlined below guide the implementation of WISe. These principles provide the foundation for the practice model and clinical delivery of intensive services in which the QIRT was used to assess WISe services and assist in identifying needed system changes, educational opportunities for providers and other quality improvement strategies. The Behavioral Health Principles used in reviewing WISe include:

- The use of family and youth voice and choice during all phases of the process, including the first contact with or about the family as well as during the planning, delivery, transition and evaluation of services
- The use of a team-based approach for services and supports to develop and implement a plan to address unmet needs and work toward the youth's and family's vision
- The use of natural supports from the youth's and family members' networks of interpersonal and community relationships
- The use of collaboration and care coordination to respond effectively to the behavioral health needs of multi-system involved youth and their caregivers
- Maintaining or returning youth safely to their own homes or to the least restrictive setting possible
- Providing services that are culturally relevant and provided with respect for the values, preferences, beliefs, culture and identity of the participant/youth and family and their community
- Services, strategies and supports that are individualized and tailored to the unique strengths and needs of the youth and family
- The development of goals and strategies—based on the youth/family's needs and vision—which are tied to observable indicators of success and tracked for use in revising the treatment plan over time
- Working with the family toward their goals until the family indicates that a formal process is no longer required

Key areas of review focused on:

- Care Coordination Elements
- CFT Processes and Transition Planning
- Crisis Prevention and Response
- Treatment Characteristics
- Parent and Youth Support

This report summarizes the trends and results of the QIRT review of the 15 BHAs (146 enrollee records) following the above principles. Each BHA review was performed at one individual provider location and may not reflect the practices throughout the BHAs' office network.

Summary of Findings

Care Coordination Elements

Initial Engagement & Care Planning

Documentation noting inclusion of youth/family in the CANS process is a critical element of WISe and aligns with the principles of the model. To be effective, initial engagement should be a collaborative process and include youth/family voice and choice. To be a collaborative process, the initial full CANS (Child and Adolescent Needs and Strengths) should be reviewed by the caregiver and youth and their feedback solicited and incorporated into the final CANS version. Use of CANS data can inform decision making at many stages during the treatment process.

Per the WISe Program policy and procedure manual, CANS screenings must be offered within 10 business days of receiving a WISe referral and initial full CANS within 30 days of enrollment. Timeliness standards were met for 71% of CANS screening and 55% of initial full CANS. The trend at most BHAs was inconsistency in documentation. For example, documentation on the CANS and what was documented elsewhere in the clinical record were not always consistent. There was not consistent documentation of discussion and review of the

initial full CANS or incorporating youth voice and any suggested changes. The summary results of the reviews indicated this was a collaborative process 22% of the time. We encourage processes and documentation that reflect the voice of the youth and family which support achieving collaborative treatment outcomes.

Overall, there was a lack of consistent documentation of discussions regarding the content of WISe services taking place, literature being provided, or questions elicited and answered. Often, it was unclear how or when collaboration or acceptance of services occurred. Barriers to treatment were not consistently identified nor processes offered to resolve identified barriers. We recommend assisting the family and youth in understanding the WISe objectives, identifying potential barriers and finding solutions to mitigate obstacles to full participation and engagement in WISe services.

The QIRT review criteria states that all needs identified by the initial full CANS are to be addressed in the Cross System Care Plan (CSCP). This includes prioritization of needs and goals by the youth and family, which should be discussed and integrated into the development of the CSCP. The establishment of prioritized needs, goals and the expected outcomes were integrated with input from the youth and family in 17% of the CSCPs. CSCPs did not consistently include or address all the needs and strengths identified on the initial full CANS nor document the decision to defer addressing low priority needs (as allowed in the QIRT criteria). In most records, needs were identified relevant to school and other environments but attempts to contact potential treatment supporters were minimal, and there was not consistent documentation indicating school staff were invited to participate in WISe efforts. We encourage expanded and consistent outreach to treatment supporters when needs are identified in the home, school or community and the inclusion of these supporters in the child and family team meetings. Although 45% of the CSCPs were completed in a timely manner, meaningful strategies to meet the identified needs were not consistently documented in the plans.

If CSCPs did include goals and objectives, the majority were not specific, measurable, attainable, realistic and timely (SMART goals). Moreover, the goals appeared to be written entirely from the perspective of the professional/clinical staff. Goals and objectives captured within the CSCP or Individual Service Plan (ISP) must meet the criteria of being both SMART as well as being written in the youth and family's own words to support actionable, youth-centered work. Additionally, goals need to be specific to the youth and family and include exactly what needs to be accomplished, the timeframe by which the goals need to be completed, and how the team will know when goals are successfully met.

There is an opportunity to incorporate more meaningful discussions of strengths, needs, barriers and culture with family members and integrate these conversations into the formulation of the youth's support needs and strengths in the CSCP. Culture plays an important moral, spiritual and religious role in the youth's life. It is important to include these elements when administering the CANS and collaboratively creating the CSCP as it encourages individuality and respect of other's personal differences and builds an environment of trust and openness in information sharing. The ability of the child and family team to assess and manage family dynamics and behaviors is related to their knowledge, understanding and appreciation of the strengths, needs, barriers and cultural context within which the youth and family function.

Care coordinators play a key role by focusing on early engagement and strategies to expand the child and family team. Documentation indicated the overall average face-to-face time between the care coordinator and caregiver/youth combined was just under an hour a month. Although there is no prescribed duration of time for the care coordinator to meet with the child and family team, a low average of face-to-face time limits the ability to connect with the family. We recommend care coordinators for all BHAs concentrate on early engagement and on outreach to potential treatment supporters and coordination/collaboration with external system stakeholders.

CFT Processes and Transition Planning

The CFT includes the youth, parent/caregiver/ family member, care coordinator, therapist, peer supports, and formal and natural supports. The aim of the CFT meetings is to develop and update the CSCP, address unmet needs and work towards the family's vision and mission. Progress towards meeting goals should be monitored regularly and used to revise the comprehensive care plan. These meetings should take place at least every 30 days once a youth is enrolled in WISe. During the first 90 days in WISe, 52% of the youth had at least one CFT meeting, 14% of youth did not have any meetings occur, while 28% of the youth reviewed had three or more CFT meetings. We recommend that all youth have at least one CFT meeting every 30 days in order to update the CSCPs, address any unmet needs, provide constructive feedback regarding group accountability and continue to work on the family's vison and mission for WISe.

Although discussion of participant roles and the exchange of contact information may be occurring during CFT meetings, the documentation did not reflect that this was regularly occurring. The CFT meetings were attended primarily by family, the care coordinators and therapists. Documentation indicated there were needs in environments other than the home, but did not indicate that these needs were addressed, and potential treatment supporters were contacted and invited to participate in the CFTs.

At the CFT meetings, it was not always clear if the CSCP was collaboratively reviewed. When tasks or action steps were identified in the CSCPs, it was often not evident to whom the items were assigned or when the actions needed to be completed. Documentation did not consistently reflect follow-up with CFT members on previously assigned goals and/or tasks. This step is important as it ensures forward movement towards achieving the treatment goals for successful transition out of WISe.

All team members should receive a copy of the initial CSCP and all updates in order to be an effective CFT member/supporter to the youth and family, however, documentation did not consistently reflect that CFT members received a copy of CSCPs.

Improving engagement of external system partners and natural supports are clear areas for improvement of fidelity to the WISe model. We also recommend documentation reflect partnering with potential treatment supporters and external system stakeholders.

Overall, documentation showed little evidence of any discussions regarding transition goals or discharge criteria. The conversation of transition planning should occur at the very onset of the start of care. We recommend following best practice which includes discussing transition planning and goals as well as discharge goals throughout treatment, beginning with the initial engagement. Additionally, documentation should include outreach to potential treatment supporters or coordination and collaboration with other system supporters.

Crisis Prevention and Response

A critical component of a CSCP is an effective crisis plan that includes:

- Crisis identification and prevention steps
- CFT members' roles in 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
- Re-evaluating the youth's behavioral health status to reflect any progress or changes in the youth/family's expectations
- A post-crisis plan for evaluating the management of the crisis and overall effectiveness of the plan

Although documentation showed that 61% of crisis plans were completed timely, many were completed prior to the youths entering the WISe program and had not been updated to reflect the youth's current risk factors. Crisis plans consistently lacked the above key elements. Additionally, related collaboration with CFT members on roles and interventions occurred in only 13% of records. When a crisis did occur, there was a lack of any follow up by the CFT members for evaluating the management of the crisis and overall effectiveness of the plan. Per the WISe manual, the team 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.

To ensure safety and stability, we encourage incorporating and addressing all elements (including all risk factors identified and addressed in the CANS), creating crisis plans collaboratively with the team and youth, and updating/distributing the crisis plans as outlined in the WISe manual.

Treatment Characteristics

Individual clinical treatment sessions are available to the youth/family in the amount, duration and scope appropriate to address the medically necessary identified needs and are provided by a qualified clinician. Typically, therapists provided two treatment sessions per month, primarily targeted to the youth. A caregiver attended the therapy sessions 44% of the time. There is an opportunity to improve clarity regarding what actions and strategies the therapist used and include any therapeutic treatment interventions. Therapy documentation was not always clear regarding what actions and strategies the therapist used, and sessions lacked evidence of any therapeutic treatment interventions. Progress notes generally included the problem of the day, status updates, youth reported check-ins and updates to the Individual Service Plan (ISP).

Progress note documentation did not always reflect items identified on the CSCP or indicate how the therapeutic intervention benefited the youth's functioning or symptoms, nor did they indicate how the services impacted the youth at home, school or in the community. We recommend clear and consistent documentation describing how the therapy sessions and interventions were beneficial to the youth's functioning or symptoms and how the services impacted the youth at home, school and in the community.

Evidence-Based Practice (EBP) technical language was often used but did not regularly describe what specific strategies of the EBP were put into practice, how they were utilized or the individual's response to the intervention. Therapists would benefit from additional training on how to use consistent session structures focused on skill development and review, success celebration and recruitment of additional practice supporters.

Treatment practice continuity has the potential to significantly improve overall treatment outcomes as it allows the therapist to determine the youth's treatment stage, monitor whether the youth is progressing or regressing and recognize successful practices that could be applied to other goals. Monitoring of progress and success is a means to ensure overall treatment quality. Treatment sessions broadly focused on similar goals. Notes related to reviewing progress or celebrating success were documented 15% and 2% of the time, respectively. The same item or concern was addressed in 52% of consecutive sessions and 42% had a different focus than that of a previous session.

Potential opportunities for improvement include following up on the previous therapy session's focus, reviewing progress towards the overall goals, celebrating successes and using CFT meetings to address the needs and relevant treatment topics discussed in therapy as well as identifying and mitigating barriers to attending treatment sessions.

We recommend clear and focused documentation that describes the youth's progress towards goals, including responses from the family and youth on the effectiveness of the therapeutic intervention, success celebration,

enlistment of added treatment supporters and indication of how the services impacted the youth's overall functioning.

Parent and Youth Support

Offering family and/or youth peer support is a required component of WISe and can be highly effective. Parent and youth partners are formal members of the WISe team whose roles are to partner with the youth/parents and enable them to drive the WISe process through active engagement and informed decision-making.

Parent partners and youth partners both averaged three face-to-face hours per month with the caregiver and youth. Documentation was not consistently clear about what the youth and parent partners' roles were or what tasks/goals the youth, family and partners were focused on completing. For the CFTs that did not have a family or youth peer support, it wasn't clear the peer had been offered to the families as a potential treatment supporter. Our recommendation is to encourage BHAs to increase the use of parent and youth peers for the purpose of promoting the youth/parent's active participation and contributions to the team thereby creating an opportunity for them to drive the WISe process.

Recommendations to the State

Based on the reviews at the 15 BHAs, our top recommendation is to ensure WISe services are clearly and fully documented. In addition, we recommend providing training to all BHAs on the areas/elements listed below to ensure all components are consistent with the goals and principles of the T.R. v. Birch and Strange settlement agreement.

Structured training and guidance should include the following:

- Increased documentation training for providers on how to document and encounter/code for services that are team based or when one or more siblings are simultaneously enrolled in WISe services.
- Developing and implementing individually tailored crisis plans—to include prevention strategies, crisis severity, tiered action steps, crisis response and roles of CFT members
- Establishing a process to ensure crisis plans are created at the onset of treatment, reviewed/updated and properly implemented throughout the course of treatment
- Documenting and communicating what is entailed in various therapeutic interventions (psychoeducation, EBP, etc.) and how the components are linked to the youth's mental health symptoms, needs, goals and objectives as outlined in the ISP or CSCP
- Consistently collaborating with the youth and family on the identification, development and agreement of goals, tasks, preferences and potential treatment supporters
- Establishing documentation standards and the Golden Thread, which ensures the needs identified in the assessment are also identified in the individual service plan and are addressed in each treatment session provided. Each service should indicate medical necessity.
- Ensuring peer supports are offered to all clients and the resulting acceptance/refusal documented
- Clarifying peer roles and responsibilities to reflect the needs of the youth and family
- Defining SMART (specific, measurable, attainable, realistic and timely) goals
- Developing methods to encourage youth and family input in the identification of barriers to service
- Implementing strategies to help youth build skills and apply them outside of the treatment session

One goal of the T.R. v. Birch and Strange settlement agreement is to provide effective care coordination and behavioral health management. When examining the records, the reviewers observed rapid staff turnover often disrupting the continuity of care. Youth would build rapport with one therapist, then have to start over with a new one—delaying therapeutic progress for weeks. We recommend the state work with a consultant to identify barriers and strategies for recruiting the behavioral health workforce as well as adopting ongoing retention strategies to ensure continuity of care.

Services provided should be tied back to a treatment goal on the ISP or CSCP. BHAs were providing services deviating from what was on the ISP or CSCP such as locating funding for the mother to purchase a car, transporting the youth back and forth from school and spending up to four or more hours going to the zoo or YMCA without documenting the connection to the overall goal. Careful documentation allows all treatment providers to see the goals of treatment and the accommodations that have been made to meet them including those non-traditional interventions as stated above.

During the review, we found documentation indicating underutilization of services. Reviewers observed that for many youth, there was an extended length of time between the CANS screening to the initial full CANS until WISe services began. While waiting for services, records did not show documentation that they had received any other intervention such as outpatient, group or inpatient services. For many of the youth, when subsequently enrolled in WISe, either they no longer met the medical necessity criteria (resulting in overutilization of services), or their behavioral conditions had worsened. We recommend the state work with BHAs to make sure certain mitigation strategies are implemented while youth and families are waiting to receive WISe services. Strategies could include:

- Connecting families with another provider
- Providing education to families regarding management of signs/symptoms of behaviors
- Using group interventions where feasible
- Routinely auditing the length of time between the CANS screening to the initial full CANS to determine whether youths awaiting WISe enrollment continue to require services
- Routinely monitor timeframes from referral to enrollment in order to assess network adequacy and utilization of services