WV Wraparound Individual Plan of Care (POC)
Instructions & Desk Guide

The purpose of this document is to assist the Wraparound Facilitator with the development of a person centered comprehensive POC. All fields in this document are required for all Wraparound Services. Some information from this Desk Guide was derived from trainings created by The National Wraparound Implementation Center (NWIC). Examples within the Desk Guide were derived from the "Matthew Vignette" created by NWIC, which can be found on the "Ideas@TheInstitute" training website.

What is a Plan of Care?

The WV Wraparound Individual Plan of Care (POC) is a comprehensive plan that outlines the youth and family's total health and wellness including physical health needs, behavioral health needs, identified supports/resources and the strengths of the youth and their family. The POC is developed in collaboration with the youth, their family/caregivers and their treatment team using a person centered and strength-based approach. All care planning activities are conducted in a culturally sensitive and trauma informed manner with interpreter services, if needed. The POC establishes a road map for the youth's care and outlines the roles and responsibilities for all persons involved in providing supports and services for the individual being assessed or already receiving home and community-based waiver services.

A. Referral Information & Program enrollment information

All information on the POC should be current and up to date to reflect the youth and family's current situation. Updates to the POC may occur at distinct milestones including an initial POC, 30-day, 3-month, 6-month, 9-month, due to a significant life event (SLE), a Transfer of Care or a Discharge in care.

- The Administrative Services Organization (ASO) will conduct the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) for medical eligibility redetermination up to 90 calendar days prior to each youth's anchor date. The **Anchor Date** is assigned by the ASO and is defined as the annual date by which the youth's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the Medical Eligibility Contracted Agent (MECA).
- For CSED Waiver, please put the meeting type beside the meeting date.
- If it is a SLE, please note what happened and attach additional information (such as incident reports) and indicate such is attached

Enrolled Program under WV Wraparound

This field will what program the youth is enrolled in and where the provider should direct their claims for payment. For example, The (Children with Serious Emotional Disorder) CSED Waiver is under (Bureau for Medical Services) BMS, and you would bill Medicaid through the Medicaid Managed Care Plan for payment of services.

B. Demographics

Complete all fields accurately including the name of the youth (preferred and birth name), their date of birth, all insurance information (primary, secondary), the address for the youth and their legal guardian if applicable, the youth's diagnosis that makes them eligible for their wraparound program, the current living situation of the youth, and their academic information (if applicable). **Only** the ICD-10 code should be used to complete the diagnoses field. For more information about the eligibility standards for the CSED Waiver please see Chapter 502 of the Provider Policy Manual.

Please note any academic referrals (such as FAST referrals) and their outcomes under the Other/Misc. section.

C. Team Strengths, Ground Rules, Family Vision, and Team Mission

The Wraparound Facilitator should use this section to identify Team Strengths for each Team Member, Ground Rules, Family Vision, and Team Mission. When identifying team strengths, the Facilitator, family, and team should brainstorm and identify additional natural supports/information resources as well as who will reach out to them (this may be identified in Section D: Putting It All Together).

Team Strengths

- **Team Member** – Identify the Team Member as well as the role they are playing within the team. Make sure that everyone on the team is listed on the table at least once.
- **Strengths** – Identify functional strengths for each team member.

All strengths must be functional strengths and full sentences.

A **strength** is "any interests, talents, and other unique contributions that make things better for the family". Wraparound Facilitators should remember that everyone on the team has unique strengths and that challenges should be reframed into strengths. ***(NWIC)***

Functional Strengths are strengths that individuals and team members are good at that get them through difficult times. These are unique ways in which the individual and/or team member can cope and are resilient and help them "bounce back" after facing a difficult situation or trauma.

As a Wraparound Facilitator, one can identify strengths by using the family story, asking the family what their own strengths, and asking team members to identify strengths of other team members. It may also be helpful to share your own strengths. You may also ask questions of the individual and team, such as:

- How have you dealt with a challenge in the past?

- What hobbies do you have/what do you enjoy doing in your spare time?
- How do you de-stress?

Ground Rules

Ground Rules are established to ensure that the team members know what to do, as well as what not to do. These rules should reflect wraparound principles, mediate conflict and negativity, and address legal and ethical issues (including confidentiality). This should be established with the entire team so that everyone is held accountable. Ensure you are using "family language" when developing these rules.

Family Vision

The Family Vision should be developed by the identified youth and family during engagement (before the initial team meeting). The Family Vision represents the identified youth and caregiver goals, hopes, and dreams for their family. The Family Vision creates meaning and purpose for the identified youth and family and helps professionals understand their sense of themselves beyond the services and systems. While the identified youth's voice is primary and the family's voice is secondary, they are to support each other.. It is more important for the family vision to make sense to the family than make sense to the team. Progress towards the vision should be documented during each team meeting.
Example: To love unconditionally, work hard for the important things, and give back.

Team Mission

The Team Mission is the mission statement the entire team will work on. This statement should be about the entire team (not just the family or youth). Also, the Team Mission should concentrate on the team as a whole, not the team vs. the family. The Team Mission is what the team hopes to accomplish together. This is similar to the "bumper sticker" section in previous versions of POCs. The rating scale should be determined by the team, and progress should be documented during each team meeting.
Example: Work hard, play hard, and never give up!

D. Putting it All Together

This section will examine needs and how they will be addressed. This is the bulk of the plan.

Needs

Needs are defined as the underlying reasons why behaviors happen in a situation. Challenging behaviors are result of unmet needs. Needs are NOT services or goals. A well-written needs statement will modify the context of the family's current situation.

Needs should first be discussed with the identified youth and family during the engagement phase. Together with the family, the Wraparound Facilitator will develop a list of at least ten needs for each family member. (Note: When identifying family needs, consider how the current situation with the identified youth impacts the family, therefore impacting the identified youth). The family will then prioritize their top two to three per family member to bring to the first team meeting. The team will narrow down to two goals; one for the youth and one for the

caregiver/family. In certain circumstances, you may have a third need dedicated to a sibling in the home that the team deems should have a need on the plan because of escalating behavioral issues or for one reason or another the team feels strongly that both caregivers should have a need on the plan.
Example: Matthew needs to know people can be permanent parts of his life.

Rating Scale
The team will create a scale to keep track of the needs being met. This could include a Likert scale, percentages, a smiley face, or anything else that will work for the team.

Rating of Need Being Met
The current rating from the Rating Sale showing how the need is being met.

Outcome Statement(s) and Baseline(s)
Outcome statements should be measurable, targeted to address how the team knows the need is being met, and be tied to the initial reason for the referral. The baseline is where the behavior is starting. Outcomes should relate back to the identified youth.
Example: Increase in positive days at home (baseline: 2 days out of 7); Decrease in office referrals at school (baseline: 3 days out of 5).

Progress Towards Outcome Statement
This section will show any progress that is made toward the outcome statement.
Example: There has been an increase in positive days at home (is now 4 days out of 7).

Life Domain Area of Need
Check any life domains in which the need is affected. You may select more than one area. "Transition to Adulthood" is used if a youth is 15 years of age or older and the goal is related to their transition into adulthood.

Timeline
The time in which the need is going to be addressed. Be sure to include a start date and targeted completion date.

Strength-Based Strategies
These are strategies that are unique to the need and should be brainstormed by the team. These strategies should move the family closer to achievement of their family vision as well as be designed to meet the prioritized needs. In meeting the needs, the Outcome Statement should be affected in a positive manner. Although formal/paid services may be used, natural supports and informal services should be identified and utilized first in regards to tasks.

- **Tasks** are what is going to be done to meet the strategies, as well as the person(s) responsible for completing the tasks. These tasks should be very specific and can be imagined that they are going to be operationally defined.
- **Frequency** is how often the task will occur.
- **Duration** is how long the task will occur in each instance.
- **Start date and projected end date** are when the task will start and how long it is anticipated the task will occur for.

- **Progress** includes any progress that has been met and when these tasks have been accomplished.

E. Crisis Plan

This section is for clinical and non-clinical events that may rise to the level of a safety concern. For example, what to do in the case of youth elopement, suicidal thoughts, self-harm, or violence. The Crisis Plan also must include who to contact during the crisis.

Medications
Include any medications the youth has currently been prescribed. Include dosage and what the medication is being prescribed for.

Brief History
Include a summary of past crisis/safety concerns, what has worked (and what hasn't), and what has happened after the crisis.

Triggers
Include any and all triggers that may result in a crisis. Include any previously used strategies that should be avoided.

Potential Crisis
The reason a crisis needs to be in place. Includes the actions that are putting the youth at risk. Relate back to reason for referral.

Action Steps for All Areas (including back up plans)
This section should include the actions that should be taken when a crisis occurs and includes who is responsible for taking the action steps. Include actions steps for all areas, such as home, community, and school settings. These actions should be from least restrictive to most restrictive and must include both proactive and reactive actions.
Proactive: addresses future behavior concerns. This helps promote stability and accountability by preparing for a potential crisis.
Reactive: results from actions that took place in the past. This can solve a potential crisis before it arises.

Back Up Plan: This portion should start after the initial reactive strategy and will include all back up strategies. A reminder that the back up plan should NOT simply be "Call Mobile Response"

Person's Responsible and Phone Numbers
Include those from the Action Steps above, plus any other contact people that may be part of the crisis plan.

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F. Transition to Adulthood Plan

This section is for the identified youth aged 14 and older. This section should be used to discuss/identify the goals and strategies as they start to transition to adulthood. This may, and should, include strength-based strategies and tasks in Section D: Putting It All Together.

G. Monthly Celebration of Successes and Accomplishments

This is a brief narrative of the time since the last meeting. Successes and accomplishments do not have to be big things; sometimes maintaining is a success.

H. Discharge Plan

The discharge plan is the plan that continues after Wraparound to increase natural supports.

Support Summary
Expresses the positive steps that have been met by the team. The family now knows what steps to take if there is a crisis; they have their own "toolbox." Also note that goals should refer back to the rating scales, such as "Family vision will be at a 5/5"

Further Recommendations
Include any further referrals and/or recommendations that the team has to support the family through the discharge process.

I. Contact List

Include the names, roles, and contact information for each person on the team. This includes paid and natural supports for the identified youth and family.

Signatures

Use this section to collect signatures from each member of the team. This section will also ensure that each member of the team agrees with the initial and/or updated POC.

If the meeting is completed virtually, please note "verbal agreement – virtual meeting" in the signature line.

The Facilitator will note the date that the plan is sent to each team member in the last column.

J. Assessments

Include any assessments that are required or important to note. Also include the Child and Adolescent Needs and Strength (CANS) initial assessment and reassessments in this section.

This section, and the "CSED Waiver Services Needed to Support ME" sections are not to be sent out with the plan to all team members. They may be sent to the family if they so wish. All services will be noted in Section D: Putting It All Together

ASSESSMENT AND CSED WAIVER SPECIFIC PAGES

CAFAS/PECFAS

This information will be sent to the Wraparound Facilitator by the ASO.

BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN, 3RD EDITION (BASC-3)

The MECA makes a final medical eligibility determination within seven calendar days of receipt of the completed IE using the current approved diagnostic tool, which is the CAFAS/ PECFAS, if one of these tools has not been completed within the last 90 days. The Independent Evaluator will also complete the most recent version of the Behavioral Assessment System for Children (BASC) unless the child is currently receiving PRTF services. The MECA notifies the ASO of the medical eligibility determination.

CSED WAIVER SERVICES NEEDED TO SUPPORT ME POC

Once the POC is approved by the family, it is sent to the MCO for review and approval of service units requested. The MCO will send the POC back to the Wraparound Facilitator stating what has been approved/denied. The current rates for each service can be found on the "Rates" section of the CSWED Waiver, managed by BMS.