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North Sound Mental Health Administration

Section 1500 – CLINICAL: High Intensity Treatment (Wraparound) for Children/Youth

Authorizing Source: MHD & NSMHA Contract
Cancels:
See Also: Approved by: Executive Director Date: 2/14/2008
Responsible Staff: Quality Manager Signature:

POLICY #1568.00

SUBJECT: HIGH INTENSITY TREATMENT – WRAPAROUND

PURPOSE

To define High Intensity Treatment for children/youth and their families utilizing a wraparound model of care including: Eligibility for Admission; Definitions; Referral Process; Service Components; Staffing, Training, and Fiscal Components; and Discontinuation Criteria.

POLICY

The North Sound Mental Health Administration (NSMHA) identifies wraparound as a model for coordinating and delivering formal intensive mental health services in collaboration and partnership with families, other formal agencies, and natural supports. Wraparound is designed to meet the complex needs of families who are receiving services from multiple agencies and not reporting an experience of progress or increased quality of life. Therefore, a multi-disciplinary team approach will be utilized, with the family viewed a key member of the team. No team meetings, facilitation, or staffing will occur without the family present. The long-term goal of wraparound is to improve quality of life by providing maximum community integration for the child/youth and family; ultimately the child and family should discharge from wraparound with an increased level of functioning, strengthened connections to natural supports, and/or a reduced reliance on formal system involvement.

Coordinated crisis services are to be accessible 24 hours a day, seven days a week to meet individualized treatment needs. The provider wraparound team members are the primary program staff responsible to respond to the needs of the family/child/youth and will offer ongoing services. The provider team members will work in coordination with Emergency Services and DMHP's/DCR's as situations arise in which the family/child/youth needs additional resources. See Program/Practice Phase 3.5 below.

NSMHA intends that services and team meetings within wraparound (exclusive of psychiatry and some individual therapy as described in section Program/Practice Phase 3.6) will be delivered in the family home or other non-office based natural setting of the family's choice. Services are based on high-intensity mental health treatment modalities that provide a multi-disciplinary treatment team approach to those individuals who have been assessed to be in greatest need of these services. Team members work together to provide intensive, coordinated and integrated treatment as described in the Wraparound Plan.

NSMHA values a high fidelity approach to wraparound. As community partnerships grow and financial resources become available, NSMHA will take steps to integrate all elements of High Fidelity Wraparound.

Target Population:

Families (biological or other) with children/youth ages 3-17 (18-21 when youth is in foster care and/or when child mental health services are most appropriate); whose functioning is severely impacted due to one or more of the following: severe emotional/behavioral problems, child safety/protection issues, placement disruption (including failing adoption), severe family conflict, discharge from a facility/institution/hospital; **and** the child meets the Eligibility and Risk Factor Criteria below; **and** wraparound is the best approach to meet the child/youth/family's needs.

Eligibility Criteria & Risk Factors:
The child/youth and/or family must meet all eligibility criteria for approval including one or more of the risk factors.

I. Child/youth has a Medicaid Coupon or will have one once services begin.
II. Child/youth meets State Access to Care Standards.
III. Child/youth's most recent CALOCUS level is 4 or higher.
IV. Child/youth will be residing in the NSMHA service area during the episode of care.
V. There is multi-agency involvement in need of collaboration.
VI. The child/youth and his/her family have been informed about wraparound.
VII. Child/youth or family have exhausted other known resources and are seeking additional assistance.
VIII. Child/youth/family voluntarily agrees to wraparound and to participate in services and all team meetings.

Risk Factors
One or more must be met for eligibility. Child/youth is currently experiencing, or is at imminent risk for:

I. - Psychiatric Hospitalization
II. - Children's Administration Placement
III. - Severe Parent/Child Conflict
IV. - Severe Academic Difficulty
V. - Substance Abuse
VI. - Involvement with legal system (delinquency, truancy, JRA, etc).
VII. - Returning from a living situation outside of the home (CLIP, BRS, etc)

Definitions

I. Family
The term "family" is central to the wraparound processes and is utilized throughout this P & P. Therefore, NSMHA will utilize the definition of family according to the State PIHP and SMHC contracts. In the case of children, "family" means: a child's biological parents, adoptive parents, foster parents, guardian, legal custodian authorized pursuant to Title 26 RCW, a relative with whom a child has been placed by the department of social and health services, or a tribe.

II. Wraparound
An innovative and widely practiced service delivery model that focuses on improving the lives of families with complex, multi-system needs. The family is able to get their needs met in unique and flexible ways through a specific process informing **"how"** formal supports (services), and informal supports (friends, family, and community members) partner with the family. The NSMHA has adapted the following **Core Principles of Wraparound** based on the California Wraparound Standards:

A. **Family Voice and Choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in child/youth/ family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
B. **Team-Based**. The wraparound team consists of individuals agreed upon by the child/youth/ family and committed to them through informal, formal, and community support and service relationships.
C. **Natural Supports**. The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The Wraparound Plan reflects activities and interventions that draw on sources of natural support.

D. **Collaboration**. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single Wraparound Plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

E. **Community-Based**. The Wraparound Team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; while safely promoting child and family integration into home and community life.

F. **Culturally Competent**. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth/family and their community.

G. **Individualized & Needs Driven**. Services and supports are individualized, built on strengths, and meet the needs of children and families across the life domains to promote success, safety, and permanency in home, school, and the community. To achieve the goals laid out in the Wraparound Plan, the team develops and implements a customized set of strategies, supports, and services.

H. **Strengths-Based**. The wraparound process and the Wraparound Plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

I. **Persistent**. Despite challenges, the team persists in working toward the goals included in the Wraparound Plan until the team reaches agreement that a formal wraparound process is no longer required.

J. **Outcomes-Based, Cost-Effective, and Accountable**. Services and supports are outcome-based with clear accountability. Plans for children and families have clear outcomes that guide services and supports from Engagement to Transition. The team ties the goals and strategies of the Wraparound Plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Integrated outcome information is used as a tool by families, staff, and policy makers to plan and develop wraparound. "Cost-effective" services and supports blend formal and informal resources that are consistently reviewed to ensure responsible financial utilization.

PROCEDURES

I. Referral Process

The provider will identify a Wraparound Gatekeeper(s) to act as point of contact and to facilitate the wraparound referral process. NSMHA will be made aware of who the Gatekeeper is and how to contact them.

A. **When the child/youth is enrolled with a NSMHA Wraparound provider in outpatient services,** the family may self-refer or, an outpatient clinician may refer the family to wraparound. If the family expresses interest in wraparound, the outpatient clinician, case manager, or agency Parent Partner will contact the provider Wraparound Gatekeeper to identify available slots and to preliminarily review eligibility. The provider will give the family/child/youth a copy of the *Wraparound Handbook for Families* during Referral Process to assist families in understanding this unique program. The provider will notify the NSMHA Care Advocate of all families/youth/children who have begun this process. Notifications may be made by phone or fax and the family/youth/child will be identified.

1) If slots are available, the provider Wraparound Gatekeepers will formally review eligibility and submit the Wraparound Referral Form by fax to the NSMHA Care Advocate. The NSMHA Wraparound Screening Committee will review the Referral Form (Attachment A) and any accompanying documentation (such as assessments, psychiatric evaluations, treatment plans, crisis plans, 180 day treatment plan reviews and/or progress notes) in order to make a decision regarding the family/child/youth's eligibility for approval. Standard Approval decisions will be made within five (5) working days; Expedited Approval decisions

will be made within three (3) working days. Referring staff requesting an Expedited Approval decision need to call NSMHA and inform them of the request for an Expedited Decision. The Approval Referral Form and any accompanying documentation must be FAXED to NSMHA the day of the Expedited request. The NSMHA Care Advocate will contact the provider Gatekeeper with approval determination.

a. If wraparound is approved, the provider Gatekeeper will contact the family, , the Wraparound Facilitator and Parent Partner will be assigned, and the Engagement Process will begin.
b. Approvals will be for 180 days. If at the end of the initial 180 day approval period, wraparound services are still needed, a request for a 180 day extension will be reviewed and considered by the NSMHA Care Advocate. The Gatekeeper will contact the NSMHA Care Advocate as soon as it is known that an extension is needed and to make the request. The Care Advocate may request supporting documentation.

2) If there are no openings or if eligibility is not met, the family will continue to be entitled to ongoing medically necessary outpatient services and the clinician and/or case manager will continue to work with the family/child/youth in a manner that best meets their needs and/or refer to another appropriate service program.
3) Wait lists will not be kept.
4) Families may reapply at any time.

B. **When the child/youth is enrolled in outpatient services with a NSMHA provider that does not have Wraparound**, a transfer to a NSMHA Wraparound provider may occur. The family may self-refer or the outpatient clinician in conjunction with family may refer to Wraparound. The referral steps A-D above will be followed. If the family/child/youth is approved for Wraparound, the episode of care with the original provider will end and a new episode will begin with the Wraparound provider. See Policy 1510.00.
C. **The NSMHA Care Advocates may refer a family/child/youth to Wraparound** or assist them in making a self referral. In this case, the Care Advocate will contact the provider Gatekeeper to start the referral process.
D. **When the child/youth is not enrolled in outpatient services with a NSMHA provider** and not known to the NSMHA Care Advocate, the NSMHA strongly recommends that all less restrictive levels of care be attempted prior to a Wraparound referral. These cases will be decided on a case by case basis with the Wraparound provider and the NSMHA Wraparound Screening Committee.

II. Wraparound Program/Practice Phases (P/P) and High Intensity Treatment Service Components:

NSMHA will use the "California Wraparound Standards" as a guideline to understanding the prescribed phases of Wraparound service provision, planning and implementation. This section contains standards that relate to direct contact with families/children/youth and the program infrastructure that supports the provision of strengths-based, family-centered, needs-driven individualized services. Within this framework, NSMHA expects all services delivered to families/children/youth in wraparound will meet or exceed the core requirements of the WA State Mental Health Division's modality definition for High Intensity Treatment. The provider is responsible for the implementation of the following phases of wraparound:

A. Program/Practice Phase 1: Engagement & Team Preparation:

1) The provider orients a prospective family to wraparound through the *Wraparound Handbook for Families* (Attachment B). If the child/youth/family voluntarily agrees to participate in the model and is approved for wraparound, the Facilitator and Parent Partner are assigned.
2) The family/child/youth's needs are identified through a Strengths, Needs, and Cultural Discovery process (SNCD Example Form, Attachment C*)*. The Facilitator will prepare and review the SNCD with the family prior to the first team meeting. The family will receive a copy.
3) Immediate crisis issues are identified and planned for so that the family and team can give their focus to the Wraparound process and safety needs are met. The family will receive a copy of all crisis plans.
4) Team members are identified engaged, and Releases of Information (ROIs) signed; all team members are provided a copy of the SNCD and crisis plans. Team meeting logistics are addressed.
5) Ground rules for team meetings are established.
6) The provider will ensure that all staff will utilize an engagement process that promotes and supports the use of a non-judgmental, non-blaming, family-centered approach in dealing with families (e.g., staff view children/youth/families as capable, use non-pathologizing language, open all documentation to child/youth/ family review, acknowledge that all children/youth/families have strengths).

B. Program/Practice Phase 2: Initial Plan Development

The Wraparound Plan is created. The written plan should reflect child/youth/family preferences, choice/voice, values and culture. The plan should include the child/youth/family's vision, strengths, needs, strategies, and resources for implementation. A team mission statement is included in the plan. Action steps are assigned to team members and outcomes are to be measured. All members of the team are given a copy of the plan.

C. Program/Practice Phase 3: Implementation

1) Providers will ensure that children/youth/families have access to a flexible individualized array of supports (financial and non-financial), services and material items that provide "whatever it takes" to maintain their families.
2) Team meetings will take place on a regular basis with frequency individually tailored and based on the child/youth/family's needs as identified in the SNCD. The first team meeting will occur no later than 15 working days from the date of approval. Team meetings and "staffings" do not occur without the family/youth/child and Parent Partner present.
3) At each team meeting: a) plans are reviewed, assessed and updated to reflect changing strengths and needs; b) tasks or action steps will be assigned to the family and the team members; c) progress on previous tasks or action steps is tracked; d) success are celebrated.
4) Providers will access and maximize the use of informal family and community supports and resources to meet the needs of the family/child/youth.
5) The Wraparound team will place particular emphasis on crisis planning. All team members (natural and formal) are to be assigned roles in the Wraparound Crisis Plan and will be given a copy at the time of creation or amendment. When a crisis arises, the child/youth/family will follow their Wraparound Crisis Plan which will include instructions on how to contact Wraparound team members, including a provider team member, and the Care Crisis Hotline. To assist with crisis interventions not delivered by the Wraparound Team, the provider will additionally submit a plan to NSMHA describing the process the agency will follow to provide the Care Crisis Hotline and county specific ES/DMHP/DCR

professionals with up to date clinical information about the children/youth/families enrolled in Wraparound

a. During regular business hours, a provider wraparound team member must be available by phone or in person, depending on the child/youth/family's identified need.
b. After regular business hours, Monday through Friday, from 5pm to 10pm, the provider will have at least one team member available for phone coaching and support. During this time period, situations may arise with wraparound families in which the child/youth/family needs additional resources and/or a face to face assessment and intervention. In these instances, the provider wraparound team member will assist the family by phone and coordinate with the Care Crisis Hotline. The provider wraparound team member will remain available by phone to the ES/DMHP/DCR professional during the intervention for continuity of care.
c. After regular business hours, from Friday 10pm through Monday 7am and on all holidays, the existing county specific crisis system will be available to the family when their needs exceed their Wraparound Crisis Plan.

NSMHA will monitor and study the utilization of wraparound crisis interventions through VOA and provider reports. By the 10th of each month, the provider will submit a report for the previous month detailing all wraparound crisis intervention activities including: child/youth name, date of intervention, time of intervention, duration of intervention, type of intervention, outcome of intervention, and who provided the intervention (non-provider team members to be included

6) Wraparound is acutely mindful of the number of services, appointments and meetings family members must attend. Therefore, services (facilitation, family therapy, family support specialist, case management, etc.) and supports are delivered in the communities within which the family/child/youth live, work and play and not in provider offices. ***Exception***: Psychiatric services may be delivered in office. Individual therapy for the youth/child, when needed, may be delivered in the office if: **a)** there is clear documented rationale for an in-office vs. community based service; **b)** there is chart documentation that the family is agreeable to in-office appointments; **c)** the in-office appointment does not create a burden for the family; and **d)** the therapist and the wraparound program are part of the same provider agency. Both psychiatric and therapy services are funded as part of the wraparound capacity payments and are not to be billed separately in the fee for service model.

D. Program/Practice Phase 4: Transition

Transition planning begins at the assessment/engagement phase to support ongoing strategies to meet the enduring needs of the family. This process should support a shift from formal to informal services or, when appropriate, a shift to the adult service system. If a youth will be transitioning into the adult service system, representatives from that system are encouraged to attend team meetings. The Wraparound Plan will have identifiable benchmarks for transitioning the family/child/youth to less restrictive, less intrusive, less formal services. For example, the team may help the family create a phone tree primarily comprised of informal supports/team members to call in the event of a crisis or when the need arises for the team to reconvene. The family/child/youth are taught how to continue the wraparound process, facilitate team meetings, and develop crisis and wraparound plans without the need for a formal provider. The family/child/youth and all team members are provided with a formal discharge plan describing the strengths of the family, the interventions that were successful and those that were not. Included is a transition plan that outlines the next steps the family will follow to continue

meeting their needs and goals. If the youth/child will continue to receive outpatient mental health services, a transition to that provider will be included in the plan and Policy 1540.00 is followed. The wraparound episode may be open for up to six months post-discharge in order for the Parent Partner to stay involved with the family to provide aftercare transitional support. In wraparound, successes are celebrated! Transitional rituals or celebrations are encouraged.

E. Program/Practice Phase 5: Structures

The provider will have policies in place that define how family members are included in the design, development and decision making about the program itself. The provider will create written mechanisms to promote parent-to-parent support. Commitment to persevere with families to self-sufficiency should be documented and evident. The provider will ensure that mechanisms are in place to support the wraparound team as the primary decision-making forum regarding strengths, needs, services, and supports.

F. Service Components of Traditional High Intensity Treatment with Wraparound Cross-Reference

Based on the family/child/youth's service needs, services must minimally include the following **core components**:

High Intensity Treatment Service Components	**Wraparound Term/Process**
a. Assessment	Assessment with Strengths, Needs, Cultural Discovery
b. Treatment Planning	Wraparound Plan
c. Case Management	Facilitation
d. Counseling/Psychotherapy/ Family Counseling	Family Specialists Services and/or Therapy
e. Assessment for and provision of medication and related monitoring & management	Strengths, Needs, Cultural Discovery (SNCD) ; Psychiatric prescriber
f. Service Coordination	Facilitation and/or Parent Partnering
g. Ability to assess for the need for crisis intervention	Strengths, Needs, Cultural Discovery, Wraparound Crisis Plan, Team assessment
h. Symptom Assessment and Management	Continuously addressed by all members of the Team
i. Social/Interpersonal Relationship and Leisure-Time Skill Training	Facilitation, and/or Family Support Services, and/or Team member task

III. <u>Human Resources /Wraparound Staffing Plans</u>

This section emphasizes organizational practices that support staff in adopting new roles with families and with each other across agencies and systems. The California Wraparound Standards were used in part as a guide to the methods and practices that assist staff with such elements as....

A. shifting from a professionally-centered service model to a family-centered service model,
B. shifting from the professional as expert to the family as expert,
C. shifting to a model of professional as facilitator,
D. shifting from prescribers of treatment to facilitators of family decision-making,

E. shifting from service strategies that attempt to fit families into available formal options to service strategies that blend informal and formal service and support options in order to create care plans individualized to specific needs of the family/child/youth

1) Human Resources 1-4: Staff Recruitment

The provider will recruit staff who will reflect diversity and language competency of the children, families, and communities served. Methods must be in place to encourage staff creativity and flexibility in formal and informal supports. Parent advocacy/partnering via an external organization or by provider agency parent partner employee(s) must be present. Job descriptions must set expectations regarding the values and principles of wraparound.

2) Human Resources 5: Staffing Roles/Ratios

NSMHA recognizes the shift in philosophy and staffing roles that wraparound brings to our region. To achieve this shift, NSMHA providers should have in place mechanisms to ensure that staff recruitment, development and supervision is aligned with the vision and principles of the wraparound approach. In wraparound, there are staff roles that must be provided in addition to traditional IOP staff roles. The following grid outlines essential wraparound staff and provides a brief description of their roles and staffing ratios:

Title	Example Functions/Role	Staffing Ratio
Facilitator	Coordinates the development of Wraparound Teams and the implementation of the individualized Wraparound Plans, maximizing the involvement of natural team members and systems workers. This generally entails assuming case management functions, accessing formal resources, providing clinical care, coordinating services, documentation, and Gatekeeping.	1 : 15 children/youth/ families
Family Specialist	Following the Wraparound Plan, provides direct therapeutic services to families, and secures community-based resources. Functions might include: role-modeling, role-play, behavior modification interventions/structures, socialization skills training, supporting development of parenting skills, and behavioral interventions that result in linking the child successfully to the community and enhancing family functioning.	1: 15 families
Parent Partners (PP) *also called* Family Support Person (FSP)	A liaison position involving the support and coordination of services for families entering into the Wraparound process. Mentors and advocates for families. Researches and develops family and community resources. The PP works in concert with the Facilitator to conduct the strength discoveries and co-lead team meetings.	1: 15 families
Service Evaluation	Quality Management function (shared NSMHA responsibility)	No prescribed ratio
Cross-system Collaboration and Teaming	In addition to the teaming functions of the Facilitator; this is an assigned management function wherein agency leaders engage other agency leaders to promote shared values, collaboration and even integration. (shared NSMHA responsibility)	No prescribed ratio

3) **Human Resources 6-7: Performance Appraisals**
NSMHA and the provider will have in place performance appraisal processes that foster:

a. Staff perceived as family-centered;
b. Incorporation of informal supports and community resources;
c. Achievement of parent-family partnerships;
d. Responsiveness to family-identified needs; and
e. Collecting feedback from children/youth/families, outcomes for families, and data regarding cross-system collaboration, facilitation, and teaming.

IV. Training, Education, and Staff Development

This section describes basic structures, practices and implementation of staff training and development as related to Wraparound. Per the California Standards, the provider shall ensure that staff are trained to and informed of all the standards.

A. Training Elements 1-4: Staff Development
The provider will have methods and structures in place for timely coaching or special consultation for team members. Staff are mentored and coached by experienced wraparound managers. If not available within the agency, mentors/coaches may be brought in from outside sources. Training emphasizes the values and principles of wraparound and the implications of the values for practice, programs and systems.

B. Training Elements 5-6: Parent Education
The provider will have an operational plan that includes a parent education program regarding special needs, becoming informed advocates, negotiating the system of care, participating on cross-disciplinary teams, leading program design, and understanding the child's educational rights.

C. Training Element 7: Child/Youth/Parent/Advocate Involvement
NSMHA and the provider will ensure that youth/parents and stakeholders are involved in assessing and selecting training objectives and in their delivery. Names and agencies represented should be on sign-in sheets and minutes.

D. Training Element 8: Cross-System Staff Development
The Children's Policy Executive Team (CPET) will research and explore training on Wraparound Values that may be made available to all staff across all public child-serving systems.

E. Training Element 9: Use of Consumers
Children/youth/parents or parent advocates are utilized in the design and delivery of education, training and staff development. Sign-in sheets would document this.

V. Fiscal/Flexible Funds

This section discusses the fiscal practices, procedures and structures necessary to ensure that the development and implementation of service and support plans are aligned with the vision and values of the wraparound approach, and to maintain accountability. One of the critical fiscal capacities for implementing wraparound includes skills and activities to ensure that flexible funds are used creatively and effectively in the development of plans for family support and services. To this end, NSMHA will make available flexible funds to be accessed by wraparound providers for the benefit of families/children/youth enrolled in Wraparound. (See Fiscal Policy 3046, Flex Funds).

A. Fiscal 1: Community-Based Flexible Funds
NSMHA, through its role on CPET, will explore mechanisms to braid multi-system state, federal and county funds to be available at the program level.

B. Fiscal 2: Access to Flexible Funds
Staff has timely access to flexible funds:

1) Within 2 hours for amounts under $500
2) Within 48 hours for amounts over $500

C. Fiscal 3-5: Tracking Funds and Services

NSMHA and the provider will have mechanisms in place for managing and accounting for the use of flexible funds, tracking formal and informal services delivered and communicating with cross-system partners about the use of flexible funds. Categorical expenditures of flex funds will be tracked. See Policy 3046.

D. Fiscal 6: Cost Savings

NSMHA will develop policies and practices that ensure that any cost savings realized from utilizing wraparound are reinvested to expand or enhance services and resources for children and families.

E. Fiscal 7: Contracts

NSMHA will have mechanisms in place to ensure that providers of contracted or subcontracted services adhere to the Wraparound Standards. This language is within this policy and written into contracts.

VI. Discontinuation of Wraparound Intensive Outpatient Services

The long-term goal of wraparound is to improve quality of life by providing maximum community integration for the child/youth and family. Ultimately, the child and family should discharge from wraparound with an increased level of functioning, strengthened connections to natural supports and/or a reduced reliance on formal system involvement. When formal wraparound ends, it does not necessarily mean that families will be free of all problems. Rather, discontinuation occurs when the family/child/youth has completed all of the Wraparound Phases and no longer meets or needs this level of service intensity. The following are other examples of when discontinuation of wraparound services is warranted:

A. Family/child/youth has successfully reached established goals and objectives in the Wraparound Plan and a lesser level of care is needed and/or informal resources can meet the family/child/youth's needs. For example, family/child/or youth has demonstrated, over time, a return to baseline functioning and/or increased integration into community resources (formal or informal) is evident.
B. When the family/child/youth declines or refuse services and/or requests discharge; despite the team's best efforts to engage the family/child/youth.
C. The family/child/youth moves outside the service area.

For all family/children/youth discharging from wraparound, the provider must notify NSMHA in writing and provide a copy of the formal discharge and transition plan; also given to all Team members (see Program/Practice Phase 4).

RELATED NSMHA POLICIES

1510.00 – Consumer Transfers Between Agencies
1540.00 – Criteria for Closing an Episode of Care/Planned Discharge from Treatment
3046.00 – Flex Funds

ATTACHMENTS

1568.01 – Wraparound Referral Form
1568.02 – Wraparound Handbook for Families
1568.03 – Strengths, Needs, Cultural Discovery