Mental Health,
Developmental Disabilities,
and Substance Abuse Services
HEALTH AND HUMAN SERVICES

Request for Application

Child Tiered Case Management Pilot

Applications are due by:

November 14, 2016 by 5:00pm EST

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Introduction

NC Division of MH/DD/SAS is seeking up to two LME/MCO to implement a successful Child Tiered Case Management Pilot. This tiered child case management model connects two at-risk populations of youth and their families to behavioral health services. Youth and families involved in child welfare and juvenile justice have high rates of exposure to trauma and high behavioral health needs. Assessing, treating, and coordinating their behavioral health and life domain needs can assist social services in maintaining and reunifying youth with their families and can assist juvenile justice in keeping youth from moving deeper into the justice system. This tiered case management pilot will focus on youth ages 6-21 years of age in one to two judicial districts. The LME/MCO must also subcontract with a Provider who already has a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile justice

The case management pilot will include the following tiers.

- Tier 1: LME/MCO Liaisons and Family Navigator co-located at juvenile justice and child welfare offices.
- Tier 2: Targeted Case Management for Youth with low to moderate level needs. Access to family and youth peer support.
- Tier 3: Intensive Case Management (High Fidelity Wraparound) with evidence based service planning model and family/youth peer support for youth exiting out-of-home placements--**Primary focus population for the pilot**

In the pilot site, juvenile justice will continue to use the GAIN Short Screener to identify youth with mental health and substance use concerns. The county department of social services agency will use the Project Broadcast trauma screening tool for involved youth. NC Division of Social Services has tested the Project Broadcast tool in 21 counties.

Several critical components for success of the pilot are: 1) access to trauma informed comprehensive clinical assessments. Part of the pilot will be training clinicians in provider agencies in conducting a trauma informed comprehensive clinical assessments based on the model in Partnering for Excellence; 2) tracking outcomes through NC TOPPS; and 3) additional positions at DMHDDSAS and through contractors to provide project management and implementation support. These positions will provide the necessary infrastructure for more responsive program development, consultation, and technical assistance in the pilot sites.

The LME/MCO is expected to help achieve the following definable outcomes:

Child Outcomes

1. Improved clinical outcomes (NC TOPPS)
2. Engaged in school (NC TOPPS)
3. No new legal involvement (NC TOPPS)
4. Living at home/community (NC TOPPS)
5. Reduced use of crisis services (NC TOPPS)
6. Improved caregiver engagement in services (Local Monitoring Across Agencies)

System Outcomes

1. Shorter times from screening to assessment
2. Shorter times from assessment to start of services
3. Shorter time from start of service to first Child and Family Team
4. Improved rates of completion of services
5. Improved connection to community resources

ELIGIBILITY AND INSTRUCTIONS FOR APPLICANTS

Eligible applicants are Local Management Entities-Managed Care Organizations (LME-MCOs). Local Management Entities-Managed Care Organizations are encouraged to review and consider submission of an application for these funds. LME-MCOs must select a judicial district within their catchment area, and LME-MCOS are encouraged to select a judicial district where they already have a foundation of positive relationships with their local department of social services and juvenile justice and where there are providers with a proven record in serving youth involved in these systems.

Instructions to Interested LME-MCOs:

Each LME-MCO may submit up to two applications, each focused on judicial district. No LME-MCO will receive more than one award. Applications should be prepared in accordance with the instructions outlined in this section and elsewhere in this Invitation.

Late applications will not be accepted. The Division of MH/DD/SAS will not be held responsible for the failure of any mail or delivery service to deliver an application prior to the stated due date and time. It is solely the applicant's responsibility to: (1) Ascertain all required and necessary information, documents and attachments are included prior to submitting a response; (2) ensure that the response is received

at the correct location and time. No faxed or emailed responses will be accepted or considered.

Application Format

Applications should be prepared as simply as possible and provide a straightforward, concise description of the applicant's capabilities and partnerships. Formatting should be single-spaced in a minimum of 12-point font.

Questions re: Submission Instructions/DMHDDSAS Contact for Submission of Application

Please submit the application (one (1) original and five (5) hard copies) to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. An email pdf version is a helpful addition but will not be considered as the official submission. For **Regular Mail** attn: Brenda T. Smith at 3004 Mail Service Center Raleigh, NC 27699-3004 or **Express Mail:** attn: Brenda T. Smith at 306 N. Wilmington St., Suite 203, Raleigh, N.C. 27601 **by 5:00 p.m. on November 14, 2016.** Submissions posted after this date and time will not be considered. Please direct all questions concerning this RFA to Brenda Smith at brenda.t.smith@dhhs.nc.gov. Questions will be accepted until 5pm on November 2, 2016. A summary of all questions and answers will be posted at http://www.ncdhhs.gov/about/grant-opportunities/mental-health-developmental-disabilities-substance-abuse-services-grant-opportunities by November 7th 2016.

The LME-MCO's submission should include the following content/headings in the following order:

1. Application Face Sheet (Form available in Attachment A of this document)
2. Name of Provider
3. Description of Capacity of Chosen Provider
4. LME-MCO Organizational Capacity
5. Judicial District
6. Letters of Support

FUNDING AVAILABILITY AND DURATION

The Division of MH/DD/SAS has funding for this pilot through January 30, 2018 with potential for extension. Funding for each year is contingent upon approval by DMH/DD/SAS, as well as continued funding availability. DMH/DD/SAS is interested in developing additional pilot sites in the second year. Funding has been made available from an appropriation to support recommendations from the Governor's Task Force on Mental Health and Substance Use. Sustainability will be based on the development of a service definition for high fidelity wraparound, a model of intensive care coordination combined with structured service and support planning and family and youth peer support.

FUNDING METHODOLOGY

One to two LME-MCOs will be selected to implement this pilot within one judicial district. The allocation per LME-MCO will be $2,371,897.00.

ALLOWABLE COST

Funding may be used for start-up costs and for ongoing operational costs related to direct provision of services. For SFY 17, LMEMCOs and service providers could be expected to earn any portion of the dollars allocated toward service provision through new State Service Definitions and standard UCR claims submission and payment processes if the corresponding policies and procedures are in place.

SCOPE OF WORK

An award based upon successful application for these funds is intended to allow an LME-MCO to develop and implement a tiered child case management model for youth involved with juvenile court and child welfare. The primary target are youth involved in juvenile court and child welfare who are in out of home placement though LME-MCOs will also connect youth involved with those systems living in the community with assessment and services.

Contractor Duties:

The LME-MCO will be expected to carefully choose the judicial district and to limit its selection of Providers for this service to those who are already have a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile justice. The

Provider must be ready to serve the first child in January 2017**. The LME/MCO and its Provider shall adhere to the tier case management structure below and Attachments B-H.**

In the first tier, the LME/MCO will hire (through funding by DMH/DD/SAS) three FTEs per site to serve as liaison (2 FTEs) and a family navigator (1 FTE) for DSS and Juvenile Justice involved youth. LME/MCO DSS/Juvenile Justice Liaisons and Family Navigator will be housed at DSS and Juvenile Justice Offices.

The LME/MCO DSS/Juvenile Justice Liaisons will ensure youth are 1) referred to a provider who can complete a trauma informed clinical assessment and 2) connected with a provider who will address the needs identified in the assessment. The LME/MCO DSS/Juvenile Justice Liaisons are typically only involved to connect the young person with appropriate assessment and behavioral health services but can re-engage any time there are concerns the youth is not getting needed behavioral health services. The LME/MCO DSS/Juvenile Justice Liaison will work with the Family Navigator who helps engage families in the service system. Family Navigators typically stay involved with families for up to sixty days to ensure families are connected to services.

In the second tier, youth involved with juvenile justice or in the custody of social services who meet the requirements for targeted case management will receive this service through EPSDT (Early and Periodic Screening, Diagnostic, and Treatment). The targeted case manager will have access to the family and youth peer support who are part of the high fidelity wraparound team. DMH/DD/SAS will provide funding for the first three months of salary for the targeted case managers embedded at provider.

The third tier is focused on the primary target of this pilot which is youth involved with juvenile justice or in the custody of social services who are in 1) residential treatment or 2) residential placement with significant functional impairment. Youth in the third tier will be served with high fidelity wraparound which combines service planning across multiple agencies with family and youth peer support. Family and youth peer support will engage youth and caregivers who may be hesitant to participate in services. In addition, family and youth peer support help youth and families learn the skills to navigate service systems and connect families to informal supports in communities. DMH/DD/SAS will provide funding (salary, training, mileage, and technology) for three wraparound teams. Each team can serve 50 youth and families. A wraparound team consists of a coach/supervisor, a facilitator, and family and youth peer support. One coach/ supervisor can supervise five facilitators, three family peer support workers, and one youth peer support worker. Each facilitator can work with 10 youth and families so one coach/supervisor can oversee the care of 50 youth. The provider will maintain ratio of one facilitator to 10 youth/families

Additional Responsibilities of Selected LME-MCO(s)

1. Select and subcontract with a Provider for high fidelity wraparound and targeted case management.
2. Submit subcontract to DMH by December 15th, 2016.
3. Ensure provider staff completes high fidelity wraparound training and certification process as well as other training arranged for this pilot by DMH/DD/SAS Project Staff.
4. Hire two LME/MCO DSS/Juvenile Liaisons and one Family Navigator. Ensure these staff have foundational training in high fidelity wraparound and other pilot trainings.
5. Offer training space.
6. Address provider challenges as they arise.
7. Seek to develop or adapt services and supports to address the needs of the target population if they do not exist.
8. Facilitate delivery of timely trauma informed assessments even if young people are in detention or in other out of home placements. This includes training adequate numbers of clinicians in trauma informed clinical assessments and use of funding mechanisms such as assertive engagement to support timely assessments.
9. Provide enhanced rates for trauma informed comprehensive clinical assessments, assessments for youth with problematic sexual behavior, and evidenced based trauma interventions.
10. Meet starting in December 2016 with state and local child welfare and juvenile justice staff and state project manager to develop protocols for referral.
11. Review or collect baseline and on-going data with provider, DSS, and Juvenile Justice on the flow of targeted youth through the service system. This may involve the development of a tracking system if one does not exist to track timely connection to assessment, treatment, and coordination of services. Could use local Juvenile Justice Substance Abuse Mental Health (JJSAMH) Partnership (or similar Partnership) if this Partnership can address this requirement.

12. Participate with provider, DSS, and Juvenile Justice in a continuous quality improvement process (client outcomes and system improvement) for the project.

13. Follow protocols developed in the NC Institute of Medicine and Duke Endowment Project as it relates to this project.

14. Submit monthly invoices and project updates to the state project manager and participate as needed (minimally monthly in the initial six months) in conference calls and meetings with DMHDDSAS.

Responsibilities of Provider:

1. Hire one Targeted Case Management staff and one Wraparound team (coach/supervisor, facilitator, family peer support, and youth peer support) in December 2016 and January 2017 following Wraparound staff requirements. See Attachment G for staff requirements for Wraparound.

2. Hire additional Targeted Case Management staff and two Wraparound teams to serve youth involved in child welfare and juvenile court in out of home placements in February and March 2017. See Attachment C for diagram of staffing.

3. Have staff hired in December 2016 and January 2017report to two weeks of training at the end of January or beginning of February, 2017. See Attachment F for training outline for year one of project. Have staff hired in February and March 2017 attend training in March/April 2017. Have senior leadership attend first day of Wraparound training.

4. Provider must be prepared to receive and serve referrals on by late January, 2017 by having staff on-site and trained.

5. Ensure the Wraparound staff follow the High Fidelity Wraparound training and certification process selected by DMHDDSAS.

6. Complete the NC TOPPS on youth served by the pilot.

7. Meet starting in December 2016 with state and local stakeholders and the state project manager to develop protocols for referral.

8. Meet monthly to make adjustments in the protocol, address challenges as they occur, share progress and outcomes from the pilot, and participate in a continuous quality improvement process for the pilot. Could use Local Juvenile Justice Substance Abuse Mental Health (JJSAMH) Partnership (or similar Partnership) if this group could meet this requirement.

9. Attend local Department of Social Services and Juvenile Court staff meetings in January-March 2017 and as needed after March to explain referral process.

10. Selected LME-MCOs will need to serve youth involved in juvenile justice and child welfare who are privately insured and uninsured.

Responsibilities of DMHDDSAS:

1. Provide funding for two LME/MCO DSS Juvenile Justice Liaison, one Family Navigator, three High Fidelity Wraparound Teams, and first three months of two targeted case managers.

2. Arrange for and fund trainings for the case managers/care coordinators.

3. Hire or contract with a project manager to work with provider, trainers, LME/MCOs, juvenile justice, and Division of Social Services to implement and monitor the project.

4. Support work for the Child Treatment Program to convene expert panel to develop protocol and training plan for clinicians to provide assessments for youth with problematic sexual behavior. Provide funding for LME-MCO to provide this training.

5. Work with Child Treatment Program to convene training and certification process for trauma informed assessments. Provide funding to LME-MCO to contract for this training.

6. Conduct monthly (or as needed) conference calls and meetings with LME-MCO staff, provider, and local department of social services and juvenile justice.

APPLICATION

The Application is to be completed according to the order and descriptions provided in each of the following sections:

1. Name of Provider for High Fidelity Wraparound and Targeted Case Management

2. Description of Capacities of Selected Provider to Meet the Needs of the Target Population

Please describe and provide examples of:

1. How this provider has consistently and innovatively improved the outcomes of youth involved with child welfare and juvenile justice? Please attach relevant outcome summaries and examples of continuous quality improvement processes.
2. This provider's capacity to address the needs of youth with mental health, substance use disorders, and co-occurring intellectual/development disabilities.
3. How this provider would hire and supervise the necessary staff in the required time frames.
4. This provider's past collaborative efforts with your LME/MCO, local department of social services and juvenile justice.
5. Evidenced based or informed practices this provider has successfully implemented. Please note any that required use of fidelity measures and provide examples of their tracking systems.

Does the provider have a statewide or local presence?
Is the provider not for profit?

Provide the name, position, and contact information of the provider management team member who will be directly responsible for implementation of this initiative:

3. LME-MCO Organizational Capacities

Provide the name, title, email address, and phone number of the LME/MCO Management Team member who will be directly responsible for the implementation of this pilot:

Please describe your LME-MCO's:

1. Current array of child/adolescent services including any services targeted for youth involved with child welfare or juvenile justice.
2. Current array of child crisis services.
3. How this tiered case management pilot would support your LME-MCOs efforts to improve child/adolescent outcomes especially for youth involved with child welfare and juvenile justice.
4. Collaborative efforts with the department of social services and juvenile justice office in your selected judicial district resulting in the improved outcomes or processes for youth involved in child welfare or juvenile justice.
5. Efforts to monitor the implementation of child/adolescent evidenced based practices and your LME-MCOS role in fidelity monitoring.

Selected LME-MCOs will need to ensure they can train sufficient numbers of clinicians to conduct trauma informed comprehensive clinical assessments. A description of these trauma informed clinical assessments can be found in Attachment F. Please describe how clinicians will be chosen.

Selected LME-MCOs will need to serve youth involved in juvenile justice and child welfare who are privately insured and uninsured. Please describe how these youth would have access to your system's array of state funded services. Also, describe how the outcomes of privately insured youth will be tracked.

Will the LME-MCO offer an enhanced rate to support these Trauma Informed Clinical Assessments for youth involved with child welfare and juvenile court?

What would your LME-MCO change about the pilot as it is currently described?

4. Judicial District

What Judicial District has been chosen?

Provide the name, position, and contact information of the Chief Court Counselor who will be directly responsible for implementation of this initiative:
Provide the name, position, and contact information of the Department of Social Services staff who will be directly responsible for implementation of this initiative:

Please describe any current or past collaborative efforts that lead to the selection of this judicial district for launching this tiered case management pilot.

5. Letters of Support

LME-MCOs must demonstrate collaboration with their chosen provider as well as the Chief Court Counselor and Department of Social Services Director in the chosen judicial district. Please attach letters from these three collaborators.

EVALUATION CRITERIA – MAXIMUM 100 POINTS

Description of Capacities of Chosen Provider to Meet the Needs of the Target Population up to 40 points

The application demonstrates that the chosen provider has the capacity to address the needs of the target population; track and use outcomes in a continuous quality improvement process; collaborate with LME-MCO, Social Services, Juvenile Justice, and DMH/DD/SAS project team; implement and monitor an evidence based practice; and hire the required qualified staff in order to meet requirements of

the pilot.

LME-MCO Organizational Capacities up to 40 points

The application demonstrates the LME-MCO has a robust child/adolescent service system including crisis services; capacity to support and monitor a provider in implementing evidence based practices; capacity and history of collaborative relationships with social services and juvenile court resulting in improved processes and outcomes; and capacity in developing a network of clinician trained in trauma informed clinical assessments.

Judicial District up to 20 points

The application demonstrates current or past collaborative efforts between the LME-MCO, juvenile Justice, and department of social services

Name of Chosen Provider Pass/Fail

Letters of Support Pass/Fail

SELECTION AND NOTIFICATION PROCEDURES

Applicants must demonstrate capability and capacity to implement their proposal by responding to all sections of this Request for Application. Applications that are incomplete or do not follow the required format may be determined ineligible for review.

Each application that is received prior to the deadline and meets formatting and content requirements will be reviewed by a Selection Committee comprised of various staff from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Social Services, Department of Public Safety/Juvenile Justice, and NC Families United.

Applications will be evaluated and scored as noted above. DMH/DD/SAS may choose to include interviews or site visits with LME-MCO and provider staff as a second step in the evaluation and selection process.

It is the Division's intent to provide funding for one to two separate pilots; however, only those applications that meet scoring and evaluative criteria will be funded. Continuation awards will depend on the availability of funds, progress in meeting project goals and

objectives, timely submission of required data and reports, and compliance with all terms and conditions of the award. Allocation letters for successful applications will be promptly processed and mailed to successful LME-MCO applicants.

ATTACHMENT A: APPLICATION FACE SHEET

Name of LME-MCO: _____

Address: _____

_____

_____

Phone Number: _____

FAX Number: _____

Email Address: _____

LME-MCO Contact Name and Title: _____

Signature of LME-MCO CEO: _____

ATTACHMENT B: Target Population, Functions, and Caseloads for Each Tier

Tiers	Where Position Located	Target Population	Functions	Training Needed	Caseload
Tier 1 LME/MCO DSS/Juvenile Justice Liaisons Family Navigators	DSS and DJJ offices	Youth who are: Not connected to provider and need an assessment Not able to access service/s recommended in clinical assessment	Assist DSS, Juvenile justice, and adult corrections staff connect youth to appropriate assessment and treatment. Troubleshoot with DSS and justice staff on problematic situations. Short term involvement until youth is successfully connected to appropriate services. Feedback to LME/MCO re: service gaps for DSS and justice involved youth as well as any unresolved provider issues. Provides routine information to DSS and justice system partners on service criteria.	Orientation to High Fidelity Wraparound (HFW) and On the Road to Family Driven Care. All other training is standard to LME/MCO care coordinators	No caseload. All levels of need. Family Navigators stay connected for 6 days.
Tier II Targeted	Provider-Services primarily provided in	Youth has: Mental health or substance use diagnosis. Can have co-occurring I/DD.	Case Management Assessment	On the Road to Family Driven Care	1:20

Case Management Access to family and youth peer support from high fidelity wraparound team	the community	**and** Involvement in child protective/ foster care services or juvenile justice. **And** Youth requires coordination between two or more agencies including medical or non-medical providers. **And** Youth is unable to manage his or her symptoms or maintain abstinence (independently or with family/caregiver support), due to at least three unmet needs including safe and adequate housing or food, or legal, educational, vocational, financial, health care, or transportation assistance for necessary services. **OR** Youth is in residential setting and needs coordination to transition to an alternate level of care. **OR** Youth has experienced **two or more** crisis episodes requiring intervention through emergency department, mobile crisis service,	Person Centered Planning across all agencies involved with the family Effective Referral and Linkage Monitoring and Follow-up Addresses transportation needs which could include transporting family members to appointments and assisting in meeting long-term transportation needs.	High Fidelity Wraparound Orientation Information on partner agencies (justice systems, social services, schools). Trauma informed care. Working with dually diagnosed youth with IDD/DD and mental health.

		psychiatric hospitalization or detox within last **three months**.			
Tier III High Fidelity Wraparound Includes facilitator and access to family and youth peer support	Provider-Services primarily provided in the community	Youth has: Mental health or substance use diagnosis. Can have co-occurring I/DD. **and** Involvement in child protective/ foster care services, or juvenile justice. **and** Assessments indicate significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, or community **and one of the following:** Transition from out of home placement will occur with 30-45 days. OR Has experienced 2 psychiatric hospitalizations within last 6 months. OR	The **Wraparound Facilitator** completes the following tasks: 1. Development of an Individual Wraparound Plan: **2.** Facilitation of the CFT meeting 3. Identifies, actively assists the youth and family to obtain, and monitors the delivery of available services including medical, educational, social, therapeutic, or other services; 4. Facilitates reviews of the Wraparound Plan to reflect the changing needs of the youth and family.	All staff (coach, facilitator, family and youth peer support) will be certified or working toward certification in NC High Fidelity Wraparound process. All staff will be trained by certified Wraparound Process Mentors	1:10

3. Three uses of crisis services (emergency department visits or mobile crisis services within last 30 days.

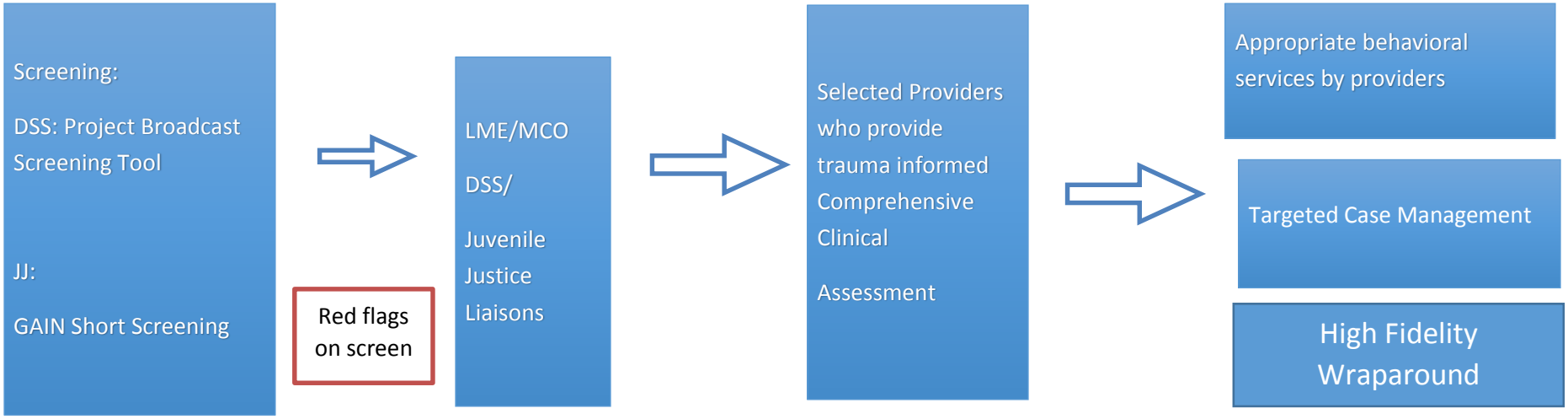
5. Completes NC TOPPs, TOMS, and Transition Asset Tool

6. Addresses transportation needs which could include transporting family members to appointments and assisting in meeting long-term transportation needs.

The **Family and Youth Peer Support** staff complete the following tasks:

Works one-on-one with the youth or parent(s)/caregiver(s) in order to provide information and support throughout the care planning process. The Family and Youth Peer Support educate and empower youth and parents/caregivers about how to effectively navigate the child-serving systems and facilitates the youth and parent's/caregiver's access to information/community resources.

Diagram of Tiered Case Management Model: New Youth Entering Juvenile Justice System or Social Services System (Tier 2)



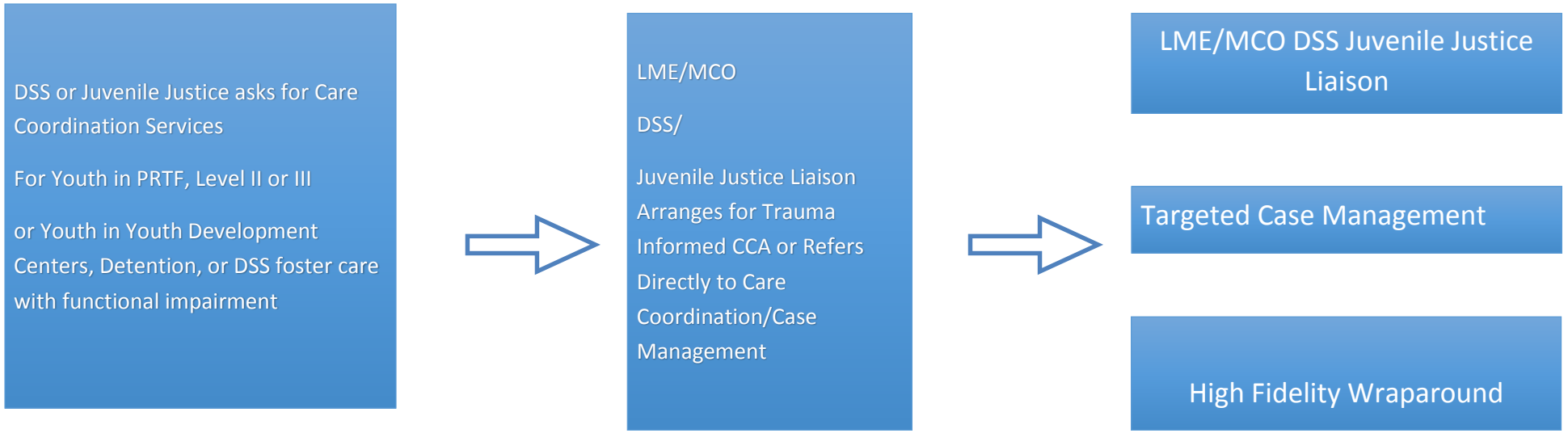
No red flags on screen or no services recommended on assessment: DSS and juvenile justice staff continue to observe for signs of mental health or substance use concerns. Connect youth to resiliency-building community programs.

LME/MCO DSS/Juvenile Justice Liaisons are housed at DSS and DJJ Offices. Liaisons will assist in connecting unconnected youth to a provider for an assessment. Liaisons can troubleshoot anytime a youth is not accessing recommended services. Liaison will provide on-going education to DSS and Juvenile Justice staff on behavioral health services and eligibility. Liaisons would not attend court.

Supports for the Pilot

1. Access to trauma informed assessments
2. Access to IDD Consultants by all levels of care coordination/case management
3. Access to teen court and other Juvenile Crime Prevention Council (JCPC) programs for 16-18 year olds.

Youth Involved with Juvenile Court or in the Custody of Social Services currently at an Out of Home Placement (Tier 3)



ATTACHMENT C: Costs of One Wraparound Team Serving 50 Youth and Families

Component	Calculation	Cost
One Wraparound Coach/Supervisor	$52,000 + 30% benefits	$67,600
Five Facilitators	$42,000 + 30% benefits x 5 facilitators	$273,000
3 Family Peer Support Workers	$40,000 + 30% benefits x 3 FPS	$156,000
1 Youth Peer Support	$32,000 + 30% benefits	$41,600
Mileage	1,350 miles per staff member 10 staff x .54 x 12 months	$87,480
Phones	$65 per phone x 10 staff x 12 months	$7,800
Computers (one time cost)	$835 x 10 staff	$8,350
Administrative cost	3.5% of salary costs (538,200)	$18,837
Total		**$660,667**

Attachment D: Continuous Quality Improvement Process

Individual Child Outcomes:

1. Improved clinical outcomes (NC TOPPS)
2. Engaged in school (NC TOPPS)
3. No new legal involvement (NC TOPPS)
4. Living at home/community (NC TOPPS)
5. Reduced use of crisis services (NC TOPPS)
6. Improved caregiver engagement in services (Local Monitoring Across Agencies)

System Outcomes (Local Monitoring Across Agencies)

1. Shorter times from screening to assessment
2. Shorter times from assessment to start of services
3. Shorter time from start of service to first Child and Family Team
4. Improved rates of completion of services
5. Improved connection to community resources

State level monitoring

State project director will ensure:

1. Provider completes scope of work.
2. Training contracts are in place and trainings are scheduled.
3. Challenges with cross system coordination are addressed.

Attachment E: Training

Training Arranged and/or Contracted by DMH/DD/SAS for Tiers of Case Manages/Care Coordinators

1. High Fidelity Wraparound Training

Component	Cost
4 days of foundational training (4 x $1,500 X 2 trainers)	$24,000
Two rounds of 4 Days of Foundation Training Offered (December 2016 and March 2017	
4 days of coach training (4 x $1,500)	$6,000
Certification and coaching calls (26 calls x $60)	$1,560
Manuals per team (5 x $50)	$250
Mileage/travel for trainer (estimate of $150 per day of on-site training)	$1,200
Airfare for trainer ($450 x 3)	$1,350
Total	**$34,360**

2. Overview of DSS, Juvenile Justice, Adult Corrections Systems, and CCNC

Component	Cost
Training by partner agencies 1 day	---

3. Working with Youth with Dual Diagnoses of MH and I/DD Training

Component	Cost
Overview of Developmental Disabilities: effects on development, range signs/symptoms, frequency of occurrence with mental/behavioral health challenges (1-day x $1,500)	$1,500

1. Intellectual Disabilities

2. Autism Spectrum Disorders
3. Fetal Alcohol Spectrum Disorders
4. Traumatic Brain Injury
5. Cerebral Palsy

Understanding and using evaluations: how to use the evaluations to build a service plan with the young person and family; how the functional behavioral assessment becomes the basis for an individualized behavior plan (1-day x $1,500) $1,500

1. Psychological testing
2. Neuropsychological
3. Functional Behavioral Assessment
4. Adaptive behavior
5. Speech and language evaluations

Effects on Families/Parenting a Dually Diagnosed Child $1,500

Effective Interventions/Adapting Interventions for the Dually Diagnosed

Resources /Technology (1-day x $1,500)

Travel estimate $150 x 3 days $450

Total	**$4,950**

6. Trauma Informed Services

Component	Cost
Trauma Informed Services 1.5 days x $1,500	$2,250
Travel estimate 2 x $150	$300
Total	**$2,550**

7. CANS Training

Component	Cost
1.5 days on in-person training (2,000 x 1.5 days	$3,000
Airfare for 2 trips (450 x 2)	$900
Travel expenses (hotel, rental car, food) (2 x $200)	$400
On-line training for new staff or supervisors	$100
Total	**$4,400**

8. Family Driven Care

Component	Cost
Family driven Care (1 day)	Offered by NC Families United

Training Contracted by LME-MCO for Clinicians Conducting Trauma Informed Assessments and Assessments Youth with Problematic Sexual Behavior

9. Trauma Informed Assessments Training for Clinicians Offering Clinical Assessments for Youth Involved with DSS and Juvenile Court.

Component	Cost
Training in Assessment and Standardized Instruments (3 days x $1,500)	$4,500
Review and feedback of submitted assessments. Each clinician must have three assessments that pass minimum score. After being certified, clinician will submit one out of every 10 assessments for review. (15 clinicians x 5 hours per review x 4 reviews x $150 per hour)	$45,000
Total	**$49,500**

10. Training for Clinicians in Assessments for Problematic Sexual Behavior

Component	Estimated Cost
Training for Clinicians Conducting Assessments for Youth with Problematic Sexual Behaviors	$15,000
Total	**$15,000**

Attachment F:

Essential Program Elements for High Fidelity Wraparound and Targeted Case Management

1. High Fidelity Wraparound Staffing Requirements

One coach/ supervisor can supervise five facilitators, three family peer support workers, and one youth peer support worker. Each facilitator can work with 10 youth and families so one coach/supervisor can oversee the care of 50 youth. Provider will maintain ratio of one facilitator to 10 youth/families.

Targeted Case Management Staffing Requirements: Provider will follow existing targeted case management clinical policy requirements and for this pilot will maintain a caseload under 1:20.

2. Case Management Assessment:

A comprehensive and culturally appropriate case management assessment documents a youth's service needs, strengths, resources, preferences, and goals to develop a Person-Centered Plan (PCP). The case manager gathers information regarding all aspects of the young person's life, including medical, physical and functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational or educational areas. The case management assessment integrates all current assessments including the comprehensive clinical assessment, strengths/needs/culture discovery, and medical assessments, including assessments and information from CCNC and the primary care physician. The case management assessment includes early identification of conditions and needs for prevention and amelioration. The case management assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators to form a complete assessment. Through the assessment process the youth and family identify appropriate members of the Child and Family Team. The case management assessment includes periodic reassessment to determine whether the young person's needs or preferences have changed.

3. Person centered treatment planning

The goal of person centered planning is to assist the young person to obtain the outcomes, skills, and symptom reduction that they desire. This is accomplished through listening to the young person, the family, and treatment providers, and developing action plans that will assist the young person in moving toward achievement of their goals. A PCP is revised as the young person's needs, preferences, and goals change.

Person centered planning is at the center of self-direction and self-management. All good plans are done in partnership with the young person and their family. The case manager, who knows the requirements for a plan and what must be accomplished, works in concert with the content experts who know the detail of what the plan needs to say. The content experts are the young person, their family, friends, and child serving professionals involved with the family who have lengthy experience with the young person. Person centered planning is an ongoing process that drives the development and periodic revision of a plan based on the information collected from the young person, their family, other individual supports, and comprehensive clinical assessments or

reassessments. The information gathered is translated into goals, outcome statements, and the actions necessary to address the medical, behavioral, social, and other service needs of the young person.

The primary reference documents for person-centered planning and Person Centered Plans are the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) Person-Centered Planning Instruction Manual and the Records Management and Documentation Manual. Primary source information on person-centered thinking and person-centered planning are referenced in the Division of Medical Assistance (DMA)/DMH/DD/SAS Implementation Update #73, dated June 3, 2010, located at: http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm. The case manager is required to contact the primary care physician to obtain clinical information pertinent to establishing person-centered goals. For managed care beneficiaries through CCNC, the case manager also contacts CCNC to obtain clinical information pertinent to establishing person-centered goals.

4. Referral and Linkage

Referral and linkage activities connect the young person and their family with medical, behavioral, social and other programs, services, and supports to address identified needs and achieve goals specified in the PCP. Referral and linkage activities include:

1. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcome
2. Facilitating access to and connecting the young person and their family to services and supports identified in the PCP
3. Making referrals to providers for needed services and scheduling appointments with the beneficiary
4. Assisting the young person and their family as they transition through levels of care
5. Facilitating communication and collaboration among all service providers and the young person and their family
6. Assisting the young person in establishing and maintaining a medical home with a CCNC physician or other primary care physician
7. Assisting the pregnant young person in establishing obstetrician and prenatal care as necessary

8. Monitoring and Follow-Up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the PCP is effectively implemented and adequately addresses the needs of the young person and their family. Monitoring activities involve the young person, his or her family, his or her supports, providers, and others involved in care delivery. Monitoring activities helps determine whether:

1. Services are being provided in accordance with the young ’s PCP
2. Services in the PCP are adequate and effective
3. There are changes in the needs or status of the young person
4. The young person is making progress toward his or her goals

High Fidelity Wraparound Facilitator will complete the NC TOPPs as scheduled to track progress and ensures the TOMS and Transition Assets Tool are completed on a set schedule. The targeted case manager will complete NC TOPPs as scheduled.

The duration of services will be based upon medical necessity and the youth and family's willingness to participate in the program.

5. Client Protections

The provider ensures that Wraparound Facilitators and Family and Youth Peer Support complete the state required training program for Wraparound and have successfully completed skill and competency-based training to provide Wraparound Facilitation and Family Peer Support as evidenced by certification in Wraparound Facilitation.

The provider ensures that all Wraparound supervisory staff complete the state required Wraparound training program and have successfully completed skill and competency based training to supervise Wraparound Facilitators and Family Peer Support as evidenced by certification as Wraparound Coach.

Wraparound Facilitator:

1. Must meet requirements as a qualified professional.
2. Must complete Wraparound Facilitation training curriculum and be certified as Wraparound Facilitator (or be in process of completing training and certification)
3. Completes On the Road to Family Driven Care Training.
4. Pass background check, the child and adult abuse registry checks, and motor vehicle screens.
5. Receive ongoing supervision by a master's level mental health professional who is certified as a Wraparound Coach (or in process of being certified a Wraparound Coach).
6. Have received 13 hours of Motivational Interviewing training from a MINT trainer.
7. Juvenile justice, child welfare, and CCNC Basics
8. On the Road to Family Driven Care

<u>Knowledge in:</u>

1. Functional limitations and health problems that may occur in clients with SED, or clients with other disabilities, as well as strategies to reduce limitations and health problems;
2. Safety and crisis planning;
3. Behavioral health service array including PRTF placement criteria; federal, state, and local resources
4. Using assessments (including environmental, psychosocial, health, and functional factors) to develop a Wraparound Plan
5. Family driven and youth guided care including the client's and family/caregiver's right to make decisions about all aspects of their child's care;
6. The principles of human behavior and interpersonal relationships; and
7. General principles of record documentation.

Skills in:

1. Negotiating with clients, family/caregivers, and service providers;
2. Assessing, supporting, observing, recording, and reporting behaviors;
3. Identifying, developing, or providing services to clients with SED, and
4. Identifying services within the established services system and uncovering natural supports to meet the client's needs.

Ability to:

1. Report findings of the assessment or onsite visit, either in writing or an alternative format for clients who have visual impairments;
2. Demonstrate a positive regard for clients and their families;
3. Be persistent and remain objective;
4. Work independently, performing position duties under general supervision
5. Communicate effectively, orally and in writing; and
6. Develop rapport and communicate with persons from diverse cultural backgrounds

Family Peer Support

1. Must have lived experience as a primary caregiver for a child who has/had mental health or substance abuse challenges
2. Experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems
3. Bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate's degree in a human service field from an accredited school and one year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum of two years of experience working with children/adolescents/transition age youth
4. Holds National Certification in Family Peer Support or is actively working on completing certification and is on track to complete Family Peer Support certification within one year of hire date. Family Partner 101 is part of National Certification Trainings for North Carolina. http://www.ffcmh.org/certification
5. Family Peer Support is certified in the role of Family Peer Support in High Fidelity Wraparound or is in process of completing certification process within one year from hire.
6. Criminal Background check presents no health and safety risk to participants.
7. Not listed in the NC Health Care Abuse Registry.
8. Family Peer possesses a current/valid driver's license and an automobile with proof of auto insurance.
9. Juvenile justice, child welfare, and CCNC Basics

Youth Peer Support

1. Must have lived experience as a youth who had mental health or substance abuse challenges.
2. Experience in navigating any of the child and family-serving organizations.
3. Bachelor's degree in a human services field from an accredited university and one year of experience working with the target population.
4. Youth Peer Support is certified in the role of Youth Peer Support in High Fidelity Wraparound or is in process of completing certification process within one year from hire.

5. Criminal Background check presents no health and safety risk to participants.
6. Not listed in the NC Health Care Abuse Registry.
7. Youth Peer possesses a current/valid driver's license and an automobile with proof of auto insurance
8. Juvenile justice, child welfare, and CCNC Basics

Targeted Case Management

Follow service definition requirements plus additional training in:

1. On the Road to Family Driven Care
2. Juvenile justice, child welfare, and CCNC Basics
3. High Fidelity Wraparound Foundation Training
4. **Service Philosophy**

Wraparound planning process is consistent with a System of Care philosophy that results in an individualized and flexible Person Centered Plan for the youth and family. In addition, the planning and resultant plan is:

1. Family driven and youth guided
2. Based on the unique culture, strengths, and assets of the youth and family
3. Coordinated across child serving systems including the medical home
4. Evidence based and trauma informed
5. Culturally competent and community based

Targeted case management services will also be delivered in a family driven and youth guided approach.

Attachment G: How Pilot Addresses Concerns from Child Welfare and Juvenile Justice

1. **Confusion in Connecting Youth and Families to Behavioral Health Services:**

Posting the LME/MCO DSS/Juvenile Justice Liaisons at Social Services and Juvenile Justice allows:

- The Liaisons to attend meetings for high risk youth and/or staff meetings.
- The Liaison to assist in connecting youth to clinical assessments.
- The Liaison to intervene in problematic situations when youth are not getting the care they need. This is true for all levels of intensity of need and whether or not the young person has a provider.
- The LME/MCO to hear directly from a staff member of service gaps or provider challenges experienced by youth involved with child welfare and juvenile justice.

2. **Problems with Providers:**

The LME/MCO in the selected judicial area will agree to proactively troubleshoot provider related challenges.

3. **Problems with the Coordination of Services for Youth with Moderate and High Needs:**

Case management was a top priority in the Governor's Task on Mental Health and Substance Use. Youth with complex needs are often involved with multiple child serving agencies and if their care across agencies and services is not coordinated, these young people often are placed in restrictive levels of care and have high use of crisis services while having poor outcomes. A tiered model of care and case management services will connect youth early to needed services while responding with the right level of intensity to youth with moderate and high needs for coordination.

4. **Inadequate Clinical Assessments:**

Departments of Social Services and Juvenile Justice have voiced concerns that the clinical assessments they are receiving are not of a quality to assist their staff in developing plans to meet the youth and families' needs. Because youth involved in child welfare and juvenile justice have high rates of exposure to traumatic events, this pilot would include additional training to providers who will be conducting clinical assessments for youth involved with social services and juvenile justice. The trauma informed assessments will be modeled on the assessments used in Partnering for Excellence in Rowan County.

5. **Lack of Access for Assessments for Youth with Problematic Sexual Behaviors**

The project manager will work with juvenile justice, the LME/MCO, and the Center for Child and Family Health to develop a protocol for assessing the needs of youth with problematic sexual behavior and developing a training plan to train additional clinicians to complete these assessments. Funds from the project will be used to train clinicians in the pilot area to complete the assessments as outlined in the protocol.

6. Families and Youth Who Are Reluctant to Engage in Mental Health and Substance Use Services

Families involved in child welfare and juvenile justice are often mandated to participate in services. In addition, some families involved with child welfare and juvenile justice have been involved in services previously and may have concerns about the effectiveness of the interventions. This creates a perfect storm where families may be reluctant to engage in mental health and substance use services. The solution is the use of family and youth peer support. Family and youth peer support have lived experience as a parent raising a child with mental health issues or as a young person who experienced mental health or substance use challenges. This lived experience helps family and youth peer support in engaging families into services, in helping teach families and young people to navigate these complex systems, and in connecting families to informal community services**.**

10. Challenges Developing Plans for Youth with both Mental Health and Intellectual Disabilities:

Division of Social Service and DPS/Juvenile Services has reported challenges with connecting youth who have both mental health and intellectual/developmental disabilities to appropriate services. This pilot provides additional training for all tiers of care and case management as well as provides access to specialized consultative services which will allow teams and families to put together plans that address all the issues of these youth with multiple challenges.

11. Challenges Accessing Behavioral Health Services when Young people are in Detention

Juvenile Justice reports that some young people are staying longer than necessary in detention as they await community and residential treatment services to be put in place. In this pilot, juvenile justice staff will have assistance through this tiered case management model for youth in detention. The LME/MCO DSS Juvenile Justice Liaison can arrange assessments and treatment as needed. If the young person in detention is from another LME/MCO; a request will be made for timely assistance from the responsible LME/MCO.

Attachment H: Budget

Description	Allocation to Selected LME/MCO	DMH/DD/SAS Expenses
Personnel		
Salary/Wages/Benefits LME/MCO staff (30% benefits plus Two DSS/JJ Liaisons and One Family Navigator)	207,306.00	
DMH/DD/SAS Project Manager		84,500
DMH/DD/SAS Wraparound Implementation Specialist		84,500
Contracted Salary expenses for Provider (3 Wraparound Teams and start-up for Two Targeted Case Managers plus 3.5 Administrative costs on salary)	1,699,367.00	
IDD Specialized Consultations (15 consultations at rate of $1,200 per 8-hour consultation)	18,000.00	
LME/MCO Administrative Cost on Personnel Expense (3.5%)	66,734.00	
Total Personnel Services	**1,991,407.00**	
Supplies and Materials		
Computer Supplies & Software: eCANS Database and start-up		74,000
Instruments for Trauma Informed Assessments (200 assessments x $25.50)	5,100.00	

Total Supplies and Materials	**5,100.00**

Operational Expenses	**Allocation to Selected LME/MCO**	**DMH/DD/SAS Expenses**
Travel for contracted provider for 3 Wraparound Teams	262,440.00	
Communications (Telephone for Wraparound Teams) 30 phones x $65 x 12 months	23,400.00	
Provider training: Wraparound Training and Certification Process		34,360
Provider training: CANS Training		4,400
Provider Training: Trauma Informed Assessments and Certification for 15 clinicians	49,500.00	
Provider Training: Training in IDD for all levels of Care Coordination/Case Management		4,950
Provider Training: Assessments for Problematic Sexual Behaviors	15,000.00	
Contract for Evaluation (estimate)		100,000
Contract for Implementation Consultation (estimate)		40,000
Total Operational Expenses	**350,340.00**	

Capital Outlay			
Computer Equipment ($835 x 30 Wraparound Staff)	25,050.00		
Total Capital Outlay	**25,050.00**		
Total LME/MCO Allocation	**2,371,897.00**		
Total DMH/DD/SAS Budgeted Expenditures		**286,710**	
Total Budgeted Expenditures for Tiered Case Management Pilot 43 B + 43C			**$2,798,607.00**