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REQUEST FOR APPLICATIONS

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Tiered Care Coordination: Governor's Task Force

NC DEPARTMENT OF HUMAN AND HEALTH SERVICES

**North Carolina  
Department of Health and Human Services**

**Division of Mental Health, Developmental Disabilities and Substance Abuse Services  
REQUEST FOR APPLICATION No.**

**January 1, 2021 – June 30, 2021  
Governor’s Task Force Funding**

Application Deadline	October 30, 2020		
Funding Title	Tiered Care Coordination Project		
Funding Agency	Division of Mental Health, Developmental Disabilities and Substance Abuse Services		
Estimated Funding available	\$513,408 January 1, 2010 – June 30, 2021 \$600,000 July 1, 2021 – June 30, 2022		
Catalogue of Federal Domestic Assistance CFDA No.			
RFA issuing Agency	DMH/DD/SAS		
RFA Posted			
Period of Performance	01/01/2021 – 06/30/2021		
E-mail Applications and Questions to	Tammie Houck	Email	tammie.b.houck@dhhs.nc.gov

**The Request for Application (RFA)** announces the availability of funding based on the Notice of Award, Legislation and the budget. The RFA includes all the pertinent information and requirements for an applicant to assess their eligibility, competency, and interest in the funding opportunity.

Direct all inquiries to:

NC Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services  
Tammie Houck  
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## 1. Purpose of Funding Opportunity

NC Division of MH/DD/SAS is seeking one LME/MCO to implement a successful Child Tiered Care Coordination Pilot. This child tiered care coordination 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 pilot will focus on youth ages 6-21 years of age in two to three 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/or juvenile justice. Additionally, it is important that the work be family driven and youth guided.

The care coordination 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: Includes DSS/JJ Liaisons and Family Navigator, co-located at juvenile justice and child welfare offices. Applicants can offer additional ideas on how to meet other Care/Coordination/care coordination needs of their child welfare and juvenile justice population in this tier.
- Tier 3: High-Fidelity Wraparound (Intensive Care Coordination), an evidence-based planning model with family/ youth support team members for youth entering, currently placed and 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 possible mental health and substance use concerns. The county's department of social services agency will use a screening protocol and tool/s that are approved by their leadership.

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; 2) tracking outcomes and providing data to the university partner and referring interested and eligible families to the evaluation; and 3) additional positions at DMHDD/SAS and through contractors to provide project Coordination and implementation support. These positions will provide the necessary infrastructure for more responsive program development, consultation, and technical assistance in the pilot sites.

## 2. Background

The Child Tiered Care Coordination pilot was developed from the Governor's Task Force on Mental Health. The High-Fidelity Wraparound 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 care coordination pilot will focus on youth ages 6-21 years of age in multiple judicial districts. The LME/MCO must also subcontract with a Provider to provide High-Fidelity Wraparound, who already has a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile justice. Additionally, it is important that the work be family driven and youth guided.

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

#### **Child Outcomes**

1. Improved clinical outcomes
2. Engaged in school
3. No new legal involvement
4. Living at home/community
5. Reduced use of crisis services
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

### **3. Scope of Work**

An award based upon successful application for these funds is intended to allow an LME/MCO to develop and implement a child tiered case management model for youth involved with juvenile justice and child welfare. The primary targets are youth involved in juvenile justice and/or child welfare who are entering out- of-home placement, in out-of-home placement or are exiting out of home placement and returning to a community-based setting. The 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/s 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 and a willingness to include the culture of the Family workforce. **The LME/MCO and its Provider shall adhere to the Tiered Care Coordination structure below and in Attachments B-I**

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

The LME/MCO DSS/Juvenile Justice Liaisons will ensure youth are:

- a. referred to a provider who can complete a clinical assessment or a trauma-informed clinical assessment, and
- b. connected with a provider who will address the needs identified in the assessment. The LME/MCO DSS/JJ 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/JJ Liaisons 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 and provided support from a family driven perspective.

In the second tier, youth involved with JJ 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). Targeted Case Management will be explored until

the youth is connected to an enhanced service in which case management is embedded. Access to the LME/MCO DSS/JJ Liaisons and Family Navigator is included. DMH/DD/SAS will provide funding for the first three months of salary for the targeted case managers embedded at the provider. In this tier the applicant can also outline other strategies to address the case management/care coordination of youth involved with child welfare and juvenile court who have moderate needs.

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 exiting or at risk of entering

- a. residential treatment or
- b. residential placement with significant functional impairment.

All youth in the third tier will be offered 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 one wraparound team. Each team can serve up to 48 youth and families. A wraparound team consists of a coach/supervisor, up to four facilitators, up to two family support partners and a youth peer support. One coach/ supervisor can supervise four facilitators, two family peer support workers, and one youth peer support worker. Each facilitator can work with 10-12 youth and families so one coach/supervisor can oversee the service planning of 40-48 youth while maintaining a caseload of 2 youth and families. The provider will maintain ratio of one facilitator to 10-12 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. Ensure provider HFW staff completes High-Fidelity Wraparound training and credentialing process as outlined in the NC High-Fidelity Wraparound Training and Credentialing Requirements through the NC High-Fidelity Wraparound Training Program as well as other training arranged for this pilot by DMH/DD/SAS Project Staff.
3. Ensure provider meets training timeline for HFW credentialing process for each team member within 9-12 months.
4. Hire one (each) LME/MCO DSS/Juvenile Liaisons and one Family Navigator. Ensure these staff have foundational training in High-Fidelity wraparound, recommended 5 trainings and two electives for Family Partners who navigate by the state family organization and other pilot trainings. Family Navigator should also be a Certified Parent Support Provider (CPSP) or become certified within one year from hire date. Additionally, these staff will be responsible for much of the data collection for the project that will be inputted into the LME/MCO system.
5. Involve a local family partner/member from a Family Organization (defined as a non-profit organization that has 51% family and youth board members and an administrator that is a family member), a Certified Parent Support Provider (CPSP), or access support from statewide family organization NC Families United, in interview/selection process for Family Navigator and Family and Youth Peer Support positions.
6. Use Cross systems approach in working with residential partners to prepare, develop and build capacity for implementation of using of HFW model with youth while in placement.

7. Provide training space for all project related trainings.
8. Address provider challenges as they arise.
9. Seek to develop or adapt services and supports to address the needs of the target population if they do not exist.
10. 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.
11. Provide enhanced rates for trauma informed comprehensive clinical assessments, assessments for youth with problematic sexual behavior, and evidenced based trauma interventions and develop a scope of work to ensure these services, if new, have capacity as a billable service.
12. Meet at least monthly with state and local child welfare and juvenile justice staff and state project manager to develop protocols for referral and problem solve local barriers.
13. Review or collect baseline and on-going data with provider, DSS, and JJ on the flow of targeted youth through the service system from referral from DSS and Juvenile Justice and for three months after treatment discharge. 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. Use of the local Juvenile Justice Substance Abuse Mental Health Partnership's (JJSAMHP) or similar Partnership tracking system can address this requirement.
14. Collect program performance data (service counts, costs, outcomes) relating to youth, family, and treatment and ancillary services provided to youth as determined by DMHDDSAS and coordinate data sharing with the university partner. This includes providing a staff member at the LME/MCO who will be responsible for working with the university partner on data collection and data sharing protocols.
15. Work in partnership with data collectors, through the University, support completion of youth behavior and family functioning reporting measures at case initiation, at designated (typically 3 or 6-month intervals) progress points, at case closure, and at 3-months after case closure.
16. Enter (or determine who enters) designated youth and case data (as determined by DMHDDSAS) into an electronic reporting system for aggregation by the LME/MCO for evaluation by the university partner
17. Participate with provider, DSS, and JJ in a continuous quality improvement process (client outcomes and system improvement) for the project.
18. Share data with DMH/DD/SAS and its evaluation contractor in support of all aspects of the TCC evaluation, including but not limited to JJSAMH spreadsheets from pilot and comparison counties and service billing data for youth served. Data shared directly with the evaluation contractor shall be subject to data sharing agreements negotiated in good faith between the LME/MCO, DMH/DD/SAS, and the evaluation contractor
19. Be responsible for referring new HFW/TCC youth and families to the UNCG evaluation team within agreed upon timeframe of determination and assist in promoting the evaluation data collection

20. Be responsible for directing providers/staff/care coordinators and others involved in service provision and coordination of care to assist UNCG evaluation team in interviews, focus groups, and other program-level data collection as well as data on cost and administrative work estimates for return on investment analyses
21. Submit weekly census updates, monthly reports and invoices, and quarterly 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 or the state project manager.
22. Ensure the selected provider receives all HFW training, credentialing, and fidelity monitoring through the North Carolina High-Fidelity Wraparound Training Program (HFW TP).

Responsibilities of Provider:

1. Hire one Assessor/targeted case manager and up to one High-Fidelity Wraparound teams (team coach/supervisor, 4 facilitators, 2 family peer support, and 1 youth peer support) following Wraparound staff requirements. See Attachment F for staff requirements for Wraparound.
2. Involve family representative from a local Family Organization, Nationally Certified Parent Support Provider (CPSP), or access support from statewide family organization NC Families United, in interview/selection process for Family Navigator and HFW Family and Youth Peer Support positions.
3. Develop training plan and work closely with High-Fidelity Wraparound Implementation Specialist to engage in credentialing process for team members and ongoing coaching with Coaches/Supervisors. See Attachment H for Training and Credentialing processes.
4. Meet training timeline for HFW certification process: 9 months for new teams; 6 months for existing teams.
5. Ensure Family Peer Support team member meets the National Certification for Parent Support Provider (CPSP) within one year of employment as HFW Team member.
6. Ensure Youth Peer Support team member attends Peer2Peer training within one year of employment as HFW Team member.
7. Train High-Fidelity Wraparound staff following the NC High-Fidelity Wraparound Training and Certification requirements through the NC High-Fidelity Wraparound Training Program. Have senior leadership attend first day of Wraparound training.
8. Complete the chosen outcome tools on youth and families served by the pilot at the expected collection points.
9. Collect program performance data (service counts, case outcomes) relating to youth, family, and treatment and ancillary services provided to youth as determined by DMHDDSAS and provide data LME/MCO or designee.
10. Complete WFI-EZ according to collection timeframes on HFW Team Planning process. According to the Wraparound Evaluation and Research Team website, "the Wraparound Fidelity Index, Short Version (WFI-EZ) is a brief, self-administered survey that measures adherence to the Wraparound principles. Respondents (caregivers, youth, facilitators, and team members) answer questions in three categories: Experiences in Wraparound (25 items), Satisfaction (4 items), and Outcomes (9 items).

Data result in quantitative summaries of Total Fidelity, Key Element Fidelity Scores (Effective Teamwork, Needs-Based, Natural & Community Supports, Strength and Family Driven, and Outcomes-Based), Satisfaction, and Outcomes.”

(<https://depts.washington.edu/wrapeval/content/quality-assurance-and-fidelity-monitoring>)

The WFI-EZ surveys will be entered in to the national WrapTrack data base and evaluated by North Carolina’s Tiered Case Management evaluator, UNC Greensboro.

11. Meet with state and local stakeholders and the state project manager to develop protocols for referral from both DSS and Juvenile Justice. Supporting documentation should indicate support for this development from both DSS and JJ.
12. 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 (JJSAMHP), or similar Partnership, if this group could meet this requirement. If using JJSAMHP, supporting documentation should indicate that DSS is willing to be engaged with this process with modifications based on DSS definitions.
13. Attend local Department of Social Services and Juvenile Court staff meetings as needed to explain pilot program activities (referral, services, discharge).
14. Agree to serve youth involved in juvenile justice and child welfare who are privately insured and uninsured.

#### Responsibilities of DMHDDSAS:

1. Provide funding for one LME/MCO DSS Juvenile Justice Liaisons, one Family Navigator, one High-Fidelity Wraparound Team, and first three months of one targeted case manager or other configuration of staffing for tier 2.
2. Arrange for and fund trainings for the case managers/care coordinators.
3. 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. Work with The NC Child Treatment Program to convene training and certification process for trauma informed assessments. Conduct monthly (or as needed) conference calls and meetings with LME/MCO staff, provider, and local department of social services and juvenile justice.

#### **4. Eligibility**

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/s within their catchment area, and LME/MCO’s 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.

#### **5. Federal Award Information**

- N/A

## **6. Federal Funding Accountability and Transparency Act (FFATA)**

As an applicant of federal funds, each selected applicant will be required to provide certain information required by the Federal Funding Accountability and Transparency Act (FFATA), including the organization's Data Universal Numbering System (DUNS) number. Please see <https://fedgov.dnb.com/webform> for free registration. Additional information about FFATA is available at <https://www.fsrc.gov/>.

## **7. Funding Availability and Duration**

The Division of MH/DD/SAS has funding for this pilot for the first year from January 1, 2021 through June 30, 2021. This pilot will be funded for 18 months, with potential for extension. Funding for each year is contingent upon approval by DMH/DD/SAS, as well as continued funding availability. 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 facilitated service and support planning and family and youth support. Successful applicants will either have already submitted an in lieu of service definition for High-Fidelity Wraparound to NC Medicaid or applicants agree to submit one within six months of award of these funds.

## **Section B-- Application and Submission Specifications**

### **1. How to Apply**

The RFA and instructions can be obtained by going to <http://www.ncdhhs.gov>. Applications must be typed and presented with the same topic headings and in the same order as set forth in Section C of this RFA. All applications must include a cover page. The cover page shall include:

- A. The applicant's name and address
- B. Title of the Project
- C. Title and the number of the RFA
- D. Name and contact information of the authorized official of the agency
- E. The website of the agency (if any)

Applications must be received no later than 5:00 p.m. October 30, 2020. Applications received after 5:00 p.m. will be classified as late and will not be considered for funding. Please send your application via email to: [tammie.b.houck@dhhs.nc.gov](mailto:tammie.b.houck@dhhs.nc.gov).

### **2. Number of copies required**

One (1) complete original application plus three (4) copies of the application, including all attachments. The original application must contain the original signature of an authorized official of the applicant's agency.

### **3. Written Questions**

All inquiries regarding the funding opportunity must be submitted via email to [tammie.b.houck@dhhs.nc.gov](mailto:tammie.b.houck@dhhs.nc.gov) by October 15, 2020.

### **4. Application Selection and Scoring**

An evaluation/selection committee will review and score all applications received by 5:00 p.m. on October 30, 2020. This committee will be comprised of:

- a. Tammie Houck – (Contract Specialist)
- b. Christopher Drew – (Contract Specialist)
- c. Petra Mozzetti (Child Behavioral Health)
- d. Stacy Justiss (North Carolina Families United)
- e. Sonja Frison (University of North Carolina at Greensboro)
- f. Terri Grant (Child Behavioral Health: State System of Care Coordinator)

Scoring chart is provided below:

A. Proposal Summary	10 POINTS
B. Organization Background and Qualifications	10 POINTS
C. Need/s Assessment (Problem Statement)	10 POINTS
D. Applicants approach to the problem	20 POINTS
E. Project Narrative	20 POINTS
F. Budget and Narrative	20 POINTS
G. Supporting Documentation	10 POINTS
<b>TOTAL</b>	<b>100 POINTS</b>

## 5. Required Documentation

Upon approval of the application, the following documents will be required:

- A. Proof of non-profit status
- B. Conflict of Interest Policy
- C. Signed State and /or Federal Certifications
- D. Proof of no overdue taxes

## 8. Division of Mental Health, Developmental Disabilities and Substance Abuse Services reserves the right to:

- A. Modify the application and budget after consulting with the applicant. Items that may be modified include, but are not limited to goals, costs, performance and reporting requirements.
- B. Allow or disallow budget amendments during the performance period of the project.
- C. Monitor the program based on the Division's Subrecipient Monitoring plan.
- D. Implement any change or requirement mandated by State or Federal government during the life of the project.

## 8. Applicant Financial Capacity

Applicants must have the financial capacity to operate without reimbursement for at least 90 days of the project period. Applicant funded through this grant must submit all requests for payment and expenditure reports by the 10<sup>th</sup> of each month following the month of service.

## 9. Match Requirement

N/A

## 10. Period of Performance

Initial allocation period is: 01/01/2021 through 06/30/2021.

## 11. Costs

Allowable and appropriate costs must be reasonable and necessary to provide the services. Funding may be used for start-up costs and for ongoing operational costs related to direct provision of services. For SFY 21, LME/MCOs 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.

## 12. Contractual Services

Contractual services are allowed in order to achieve the goals of the project. Contractual service under a subaward is used to procure services and goods. The budget narrative should include justification for the contractual services. 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 already have a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile. The LME/MCO and its Provider shall adhere to the tiered care coordination structure below and Attachments B-I

### Section C -- Programmatic Requirements

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 already have a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile.

The LME/MCO will:

- Share data with DMHDDSAS and its evaluation contractor in support of all aspects of the TCC evaluation, including but not limited to JJSAMH spreadsheets from pilot and comparison counties and service billing data for youth served. Data shared directly with the evaluation contractor shall be subject to data sharing agreements negotiated in good faith between the LME/MCO, DMHDDSAS, and the evaluation contractor
- Be responsible for referring new HFW/TCC youth and families to the UNCG evaluation team within agreed upon timeframe of determination and assist in promoting the evaluation data collection
- Be responsible for directing providers/staff/care coordinators/and others involved in service provision and coordination of care to assist UNCG evaluation team in interviews, focus groups, and other program-level data collection as well as data on cost and administrative work estimates for return on investment analyses

The LME/MCO and its Provider shall adhere to the tiered care coordination structure below.

The LME/MCO will fund (through funding by DMH/DD/SAS) 4 FTE's to serve as: liaisons for DSS and Juvenile Justice involved (2 FTEs); a family navigator (1 FTE); a LME/MCO Project Manager (0.5 FTE) and a LME/MCO Data Manager (0.5 FTE). The expectation is that the LME/MCO DSS/Juvenile Justice Liaisons and Family Navigator will be embedded at DSS and Juvenile Justice.

In the first tier, The LME/MCO DSS/Juvenile Justice Liaisons will ensure youth are: 1) referred to a provider who can complete a clinical assessment or a trauma-informed clinical assessment, and 2)

connected with a provider who will address the needs identified in the assessment 2) and to coordinate the tracking of above actions/information with the data manager for the tracking spreadsheet. Additionally, Family Navigator support should be family driven and the Family Navigator, DSS and Juvenile Justice will develop protocols to support family driven access. 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 Liaisons will work with the Family Navigator who supports engaging 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 entrance requirements are also eligible for Targeted Case Management through EPSDT (Early and Periodic Screening, Diagnostic, and Treatment). The targeted case manager will have access to the supports of the LME/MCO DSS/JJ Liaisons and Family Navigator. DMH/DD/SAS will provide funding for the first three months of salary for the targeted case manager embedded at provider. In this tier the applicant can also outline other strategies to address the case management/care coordination of youth involved with child welfare and juvenile court who have moderate needs.

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 1) entering residential, 2) within 60 days exiting residential or release from a Youth Development Center and 3) youth at risk of entering residential placement and who also have significant functional impairment. Youth in the third tier will be offered High-Fidelity wraparound which combines service planning across multiple agencies with family and youth support. High-Fidelity Wraparound (HFW) is an evidence-based practice driven by the National Wraparound Initiative (NWI). This structured, team-based process uses a nationally recognized model to partner with families using their vision, strengths, and priorities to develop a family-driven planning process that promotes self-advocacy and independence. HFW assures family voice and decision-making drives an integrated, holistic planning process that focuses on helping families achieve their unique, individualized vision and gain the skills and confidence to identify, plan for, and sustain action steps for meeting their future needs. HFW Teams serve youth 6 through 21 years with serious emotional disturbances (SED).

In addition, HFW emphasizes that Family and Youth Support Partners will engage youth and caregivers who may be hesitant to participate in services. Family and Youth Support Partners 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 two wraparound teams. Each team can serve 32-38 youth and families. A wraparound team consists of a coach/supervisor, facilitators, family and youth support partner. One coach/ supervisor can supervise four Facilitators, two Family Support Partners, and one Youth Support Partner. Each Facilitator can work with 10-12 youth and families so one coach/supervisor can oversee the service planning of 40-48 youth while maintaining a caseload of 2 youth and families. The provider will maintain ratio of one facilitator to 10-12 youth/families.

#### Additional Responsibilities of Selected LME/MCO(s)

1. Select and subcontract with a Provider for High-Fidelity Wraparound and Targeted Care Coordination.

2. Conduct Readiness Assessment with Stakeholders prior to implementation of grant and provide to Implementation Specialist for review and discussion to improve upon any priority areas for HFW implementation.
3. Ensure provider staff completes High-Fidelity wraparound training and certification process as outlined in the NC High-Fidelity Wraparound Training and Certification Requirements as well as other training arranged for this pilot by DMH/DD/SAS Project Staff.
4. Ensure provider meets training timeline for HFW certification process as outlined by NC HFW Training program: 9 months for new teams; 6 months for existing teams.
5. Ensures HFW teams are trained, coached, and monitored by the NC HFW Training program.
6. Hire one LME/MCO DSS/Juvenile Liaisons and one Family Navigator and appoint a project manager and a data manager. Ensure these staff attend HFW Foundations training and additional recommended trainings. Family Navigator should also be or become a Certified Parent Support Provider (CPSP) or become certified within one year from hire date.
7. Involve a local family partner/member from a Family Organization (defined as a non-profit organization that has 51% family and youth board members and an administrator that is a family member), a Certified Parent Support Provider (CPSP), or access support from statewide family organization, NC Families United, in interview/selection process for Family Navigator.
8. Provide or arrange for training space for all project related trainings.
9. Address provider challenges as they arise.
10. Use cross systems approach while engaging and educating partners around High-Fidelity Wraparound principles to include services that are family driven and youth guided, collaborative, use of natural supports, community based, culturally competent, culturally competent and strengths based.
11. Engage and educate residential providers and the LME-MCO's child Care Coordinators about working with the HFW teams while youth are in placement to focus on reducing length of stays and engaging families while the youth is in placement.
12. Seek to develop or adapt services and supports to address the needs of the target population if they do not exist.
13. 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.
14. Provide enhanced rates for trauma informed comprehensive clinical assessments, assessments for youth with problematic sexual behavior, and evidenced based trauma interventions.
15. 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 Partnership (JJSAMHP), or similar Partnership, if this group could meet this requirement. Partnerships with local DSS, JJ, and/or other community stakeholders is strongly encouraged.
16. Meet with state and local child welfare and juvenile justice staff and state project manager to develop protocols for referral.

17. Review or collect baseline and on-going data with provider, DSS, and Juvenile Justice on the flow of targeted youth through the service system from referral from DSS and Juvenile Justice and for three months after treatment discharge. This may involve the development of a tracking system if one does not exist to track timely connection to assessment, Family Navigator or HFW Teams, treatment, and coordination of services. Use of the local Juvenile Justice Substance Abuse Mental Health Partnership (JJSAMHP), or similar Partnership, tracking system can address this requirement.
18. Collect program performance data (service counts, costs, outcomes) relating to youth, family, and treatment and ancillary services provided to youth as determined by DMHDDSAS and coordinate data sharing with the university partner. This includes providing a staff member at the LME/MCO who will be responsible for working with the university partner on data collection and data sharing protocols.
19. Work in partnership with data collectors, through UNC- Greensboro, and support completion of youth behavior and family functioning reporting measures at case initiation, at designated (typically 3 or 6-month intervals) progress points, at case closure, and at 3-months after closure.
20. Enter (or determine who enters) designated youth and case data (as determined by DMHDDSAS) into an electronic reporting system for aggregation by the LME/MCO for evaluation by UNC-Greensboro per data sharing agreement.
21. Participate with provider, DSS, and Juvenile Justice in a continuous quality improvement process (client outcomes and system improvement) for the project.
22. Follow protocol recommendations for partnerships between DSS and LME/MCO's as developed by the NC Institute of Medicine and Duke Endowment Project as it relates to this project: (<http://nciom.org/bridging-local-systems-strategies-for-behavioral-health-and-social-services-collaboration-2/>)
23. Attend local Department of Social Services and Juvenile Court staff meetings as needed to explain pilot program activities (referral, services, discharge).
24. Submit weekly census reports, monthly invoices, monthly project updates, and quarterly reports to the state project manager and participate as needed (minimally monthly in the initial six months) in conference calls and meetings with DMHDDSAS or the state project manager. Reports should include updates on census trends, trainings and attendees, HFW certification progress, learning collaboratives (Trauma Assessments) plans to address and resolve local barriers.
25. At minimum of six months prior to the ending of grant funding, determine a process for sustainability with representation from partners and stakeholders and the State.
26. MCO will facilitate a contract with their provider and the contract will ensure ongoing training and fidelity monitoring for sustainability with NC HFWTP and NC Families United (NCFU).

#### Responsibilities of Provider:

1. Hire one Assessor/targeted Care manager and one Wraparound team if referrals support needs (team= Coach/supervisor, 4 Facilitators, 2 Family Support Partner, and 1 Youth Support Partner) following Wraparound staff requirements per NC High-Fidelity Wraparound Training Program (NC HFWTP). See Attachment F for staff requirements for Wraparound.
2. Involve family representative from a local Family Organization, Nationally Certified Parent Support Provider (CPSP), or access support from statewide family organization NCFU,

- in interview/selection process for High-Fidelity Wraparound Family and Youth Support Partner positions.
3. Work closely with NC HFWTP Implementation Specialist to engage in training and certification process for team members and ongoing coaching with Coaches/Supervisors. See Attachment H for Training Certification processes.
  4. Meet best practice timeline for HFW certification process: 9 months for new teams; 6 months for existing teams.
  5. Ensure Family Support Partner team member meets the National Certification for Parent Support Provider (CPSP) within one year of employment as HFW Team member.
  6. Ensure Youth Support Partner team member attends 2 trainings within one year of employment as HFW Team member.
  7. Send TCC team members to state level meetings on implementation and fidelity.
  8. Have senior leadership attend a one-day Wraparound training.
  9. Complete the chosen outcome tools on youth and families served by the pilot.
  10. Collect program performance data (service counts, Care outcomes) relating to youth, family, and treatment and ancillary services provided to youth as determined by DMHDDSAS and provide data LME/MCO or designee.
  11. Complete WFI-EZ according to collection timeframes as noted in the NC HFWTP protocol titled *Continuous Quality Improvement Using the Wraparound Fidelity Index – Short Form (WFI-EZ)*. According to the Wraparound Evaluation and Research Team website, “the Wraparound Fidelity Index, Short Version (WFI-EZ) is a brief, self-administered survey that measures adherence to the Wraparound principles. Respondents (caregivers, youth, facilitators, and team members) answer questions in three categories: Experiences in Wraparound (25 items), Satisfaction (4 items), and Outcomes (9 items). Data result in quantitative summaries of Total Fidelity, Key Element Fidelity Scores (Effective Teamwork, Needs-Based, Natural & Community Supports, Strength and Family Driven, and Outcomes-Based), Satisfaction, and Outcomes.”  
<https://depts.washington.edu/wrapeval/content/quality-assurance-and-fidelity-monitoring>  
 The WFI-EZ surveys will be entered in to the national WrapTrack data base and evaluated by North Carolina’s Tiered Care Coordination evaluator, UNC Greensboro. NC HFWTP Implementation Specialists will also use WFI-EZ data to support and inform HFW Coach and Team member skill development plans.
  12. Meet with state and local stakeholders and the state project manager to develop protocols for referral from both DSS and Juvenile Justice. Supporting documentation should indicate support for this development from both DSS and Juvenile Justice.
  13. Attend local Department of Social Services and Juvenile Court staff meetings as needed to explain HFW and targeted case management (referral, services, discharge).
  14. Agree to serve youth involved in juvenile justice and child welfare who are privately insured and uninsured.

## Section D – Application Contents and Instructions

Provide guidance to the applicant about the required content of the application. List the items requires for the applicant to submit.

## **1. Proposal Summary (2 page limit)**

The summary encompasses all the key points necessary to communicate the objectives of the project. It is the cornerstone of the proposal, and the initial impression of the plan. In many cases, the summary is the first part of the proposal package seen by the agency and can play an important role in the acceptance or the denial of the application.

## **2. Organization Background and Qualifications. (Describe the organization and its qualifications for funding) (Up to 100 points)**

Please describe the following (up to 40 points):

- A. Current array of child/adolescent services including any services targeted for youth involved with child welfare and/or juvenile justice.
- B. Current array of child crisis services.
- C. How this tiered care coordination pilot would support your LME/MCO's efforts to improve child/adolescent outcomes especially for youth involved with child welfare and juvenile justice.
- D. 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.
- E. Efforts to monitor the implementation of child/adolescent evidenced based practices and your LME/MCO's role in fidelity monitoring.
- F. Capacity for data tracking across the LME/MCO functions (such as care coordination, utilization management, etc.). Also, name the individual(s) at the LME/MCO who will be responsible for monitoring data being inputted for the project, de-identifying the data and providing it to UNC-Greensboro for analyses.
- G. Summary of other projects or grants which currently exist in this catchment area, especially HFW Teams, or for which an application has been submitted and is pending. Describe how the organization would manage the TCC project with the other awards including managing the necessary data collection processes with TCC, communication to stakeholders and provider about differences in protocols/processes among grants, and quality oversight.
- H. If you have a PRTF provider(s) or other residential provider(s) that you'd want to work with on this project, please elaborate on this partnership and provide some explanation regarding how TCC will be implemented.
- I. Capacity to coordinate and promote shorter lengths of stay and HFW delivered in conjunction with residential services to residential providers (PRTFs, residential program levels 3 and 4, foster care placements, etc.)
- J. What will the LME/MCO offer as an enhanced rate to support these Trauma Informed Clinical Assessments for youth involved with child welfare and juvenile court?
- K. As an LME/MCO, what recommendations or suggestions do you have to enhance this pilot as currently described?

- L. The selected LME/MCO 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.
- M. The selected LME/MCO will need to serve youth involved in juvenile justice and child welfare who are privately insured and uninsured. Please describe how these youths would have access to your system's array of state funded services. Also, describe how the outcomes of privately insured youth will be tracked.
- N. Name of Provider for High-Fidelity Wraparound and Targeted Care Coordination.
- O. Description of Capacities of Selected Provider to Meet the Needs of the Target Population: Please describe and provide examples of (up to 40 points):
- a. This provider's capacity to address the needs of youth with mental health, substance use disorders, and co-occurring intellectual/development disabilities. This includes any documentation of the number of youth involved with child welfare and juvenile justice that have been served by the provider.
  - b. How this provider would hire and supervise the necessary staff in the required time frames to ensure the best matched, experienced staff are hired.
  - c. This provider's past collaborative efforts with your LME/MCO, local department of social services and juvenile justice.
  - d. 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.
  - e. How this provider has consistently and innovatively improved the outcomes of youth involved with child welfare and juvenile justice. Attach relevant outcome summaries and examples of continuous quality improvement processes.
  - f. This provider's experience collaborating with residential providers and the ability to educate, communicate and implement the HFW Model to bring youth back to the community and ensure shorter lengths of stay.
  - g. Current involvement with family and youth members at the collaborative level. Please include description of roles and responsibilities family members provided (i.e. interviewing processes, collaborative team member/partner, policy input) 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 Coordination team member who will be directly responsible for implementation of this initiative.
- P. Judicial District (up to 20 points):
- a. What Judicial District has been chosen?
  - b. Provide the name, position, and contact information of the Chief Court Counselor who will be directly responsible for implementation of this initiative.
  - c. Provide the name, position, and contact information of the Department of Social Services staff who will be directly responsible for implementation of this initiative.
  - d. Please describe any current or past collaborative efforts that support the Care for the selection of this judicial district for launching this tiered Care Coordination pilot.

Q. Letters of Support (Pass/Fail): LME/MCO must demonstrate collaboration with their chosen provider as well as the Chief Court Counselor and Department of Social Services Director(s) in the chosen judicial district. Please attach letters from these three collaborators. There is also a page for signatures from these leadership staff reflecting they have reviewed the requirements of this application

R. Name of Chosen Provider (Pass/Fail)

**3. Applicant’s approach to the problem**

Provides an understanding and description of aligning the goals of the funding and the application. This section should also include the methods of achieving the set goals. Goals, objectives, and outcomes of the project shall be SMART (Specific, Measurable, Achievable, Realistic and Time-bound).

- A. Goals: A goal is something your organization is planning to achieve through this project. A goal should be realistic and measurable.
- B. Objectives: Objectives describe how the goal is going to be achieved. The objectives must be specific, measurable and achievable in a specified time.
- C. Outcomes: Outcomes reflect what is the expected result at the end of the performance period.

**Example of Goal, objectives and an outcome**

<b>Purpose of Funding</b>	<b>Goal</b>	<b>Objective</b>	<b>Outcome</b>
<p>Improve literacy skills for children and students from 1-12 grade in North Carolina.</p>	<p>By June 30, 2020, the after-school program will help 200 economically unprivileged children to read at grade level.</p>	<p>By August 31, 2019, test the all children’s reading level.</p> <p>By September 30, 2019, identify children who are reading lower than grade level.</p> <p>During October 01, 2019 - May 31, 2020, provide individual reading session for 30 minutes every day, provide age appropriate books to the children, and assist in comprehension.</p> <p>By June 30, 2020 retest and identify children’s reading levels.</p>	<p>By June 30, 2020, 50% economically challenged children in Dare County will be reading at grade level.</p>

#### **4. Project Narrative**

Explains the relevance of the project. It details the tasks and/or services that the applicant will provide. Applicant should include information like the implementation plan, schedule, and the desired outcomes.

#### **5. Budget and Narrative**

The RFA line item budget shall constitute the total cost to provide the services. The line items should be necessary, allowable, and reasonable. For example, if setting a salary for a position, check the fair market value for the salary of the similar position in the similar area. The budget should indicate a clear relationship with the project.

Every line item should have a narrative. A budget narrative is the justification of how and why a line item is required to meet the goal of the project.

#### **6. Supporting Documentation**

The applicant has an opportunity to provide more information to help the Division understand the services they are proposing to provide. Some example of supporting documentation are:

- An organizational chart identifying the personnel who will be assigned to work on this project.
- A description of how the applicant will staff the project, including the name, resume and qualifications of each of the proposed team members.
- Sustainability (Steps taken to ensure future successes or continuing the project beyond the awarded period, e.g. future financial support, staff requirements, continued community contribution).
- Resolution of Challenges: an analysis of the project's risk and limitations, including how these factors will be addressed or minimized. (regulatory, environmental or other constraints)
- Line Item Budget and Budget Narrative. Every item that appears in the budget should be explained clearly, so the evaluator/ reviewer will understand it.
- Accomplishments of the agency.

**ATTACHMENT A**

LINE ITEM BUDGET AND BUDGET NARRATIVE (SAMPLE).

CATEGORY	ITEM	NARRATIVE	AMOUNT
SALARY/WAGE			
FRINGE BENEFITS			
OTHER			
SUPPLIES MATERIALS			
EQUIPMENT			
TRAVEL			
RENT			
UTILITIES			
ADVERTISING			
DUES AND SUBSCRIPTIONS			
STAFF DEVELOPMENT			
PROFESSIONAL SERVICES			
CONTRACTUAL SERVICES			

**Attachment B: Target Population, Functions, and #'s served for each Tier**

Tiers	Location of Position	Target Population	Functions	Training Needed	#'s Served
Tier 1: LME/MCO <ul style="list-style-type: none"> <li>▪ DSS/Juvenile Justice Liaisons</li> <li>▪ Family Navigators</li> </ul>	Embedded in the DSS and JJ offices	Youth who are: <ul style="list-style-type: none"> <li>▪ Not connected to a provider and need an assessment</li> <li>▪ Not able to access service/s recommended in clinical assessment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Assist DSS, JJ, and adult corrections staff connect youth to appropriate assessment &amp; treatment</li> <li>▪ Troubleshoot with DSS and JJ staff on problematic situations</li> <li>▪ Short term involvement until youth is successfully connected to appropriate services</li> <li>▪ Feedback to LME/MCO re. service gaps for DSS and justice involved youth as well as any unresolved provider issues</li> <li>▪ Provides routine information to DSS and JJ system partners on service criteria</li> </ul>	<ul style="list-style-type: none"> <li>▪ Orientation to HFW and On the Road to Family Driven Care</li> <li>▪ All other training is standard to LME/MCO care coordinators</li> </ul>	Family Navigator stay connected for up to 60 days
Tier II: Targeted Care Coordination <ul style="list-style-type: none"> <li>▪ Family Navigator</li> <li>▪ DSS/JJ Liaisons</li> </ul>	Provider services primarily provided in the community.  Embedded at JJ and DSS	Youth has: <ul style="list-style-type: none"> <li>▪ Mental health or substance use diagnosis. Can have co-occurring IDD</li> <li>▪ Involvement in child protective/foster care services or juvenile justice</li> </ul> <p style="text-align: center;"><b>AND</b></p> <ul style="list-style-type: none"> <li>▪ Youth requires coordination between two or more agencies including medical or non-medical providers</li> </ul> <p style="text-align: center;"><b>AND</b></p>	<ul style="list-style-type: none"> <li>▪ Care Coordination Assessment</li> <li>▪ Or other configuration of staffing to meet local need</li> <li>▪ Person Centered Planning across all agencies involved with the family</li> <li>▪ Effective referral and linkage</li> <li>▪ Monitoring and follow-up</li> <li>▪ Addresses transportation needs which could include transporting family members to appointments and assisting in meeting long-term transportation needs</li> </ul>	<ul style="list-style-type: none"> <li>▪ On the Road to Family Driven Care</li> <li>▪ High-Fidelity Wraparound Orientation</li> <li>▪ Information on partner agencies (justice systems, social services, schools)</li> <li>▪ Trauma Informed Care</li> <li>▪ Working with dually diagnosed youth with</li> </ul>	1:20

		<ul style="list-style-type: none"> <li>▪ 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</li> <li style="text-align: center;"><b>OR</b></li> <li>▪ Youth is in residential or a youth development center setting and needs coordination to transition within 60-90 days to an alternate level of care</li> <li style="text-align: center;"><b>OR</b></li> <li>▪ Youth has experienced two or more crisis episodes requiring intervention through emergency department, mobile crisis service, psychiatric hospitalization or detox within the last three months</li> </ul>		<p>IDD/DD and mental health</p>	
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**Attachment C: Cost Estimates of One High-Fidelity Wraparound Teams**

(It is expected that the selected provider will be billing Medicaid if there is an in lieu of service definition in place, thereby reducing salary and fringe costs)

<b>Component</b>	<b>Calculation</b>	<b>Cost (6 months)</b>
One Wraparound Coach	\$52,000 + 30% benefits	\$33,800 (\$67,600)
Four Facilitators	\$42,000 + 30% benefits x 8 facilitators	\$109,200 (\$218,400)
Two Family Support Partners	\$40,000 + 30% benefits x 3 FPS	\$52,000 (\$104,000)
One Youth Support Partner	\$32,000 + 30% benefits	\$20,800 (\$41,600)
Targeted Case Manager (3 months)	\$10,000	\$10,000
Mileage	1500 miles per month x 7 direct staff x 6 months	\$34,650
Mileage	1000 miles per month x 1 supervisor for 6 months	\$275
National NWIC Conference	\$2,000 x 7 staff: CANCELLED DUE TO COVID	<del>\$14,000</del>
Communication	\$100 per phone x 7 staff x 12 months; \$100 per month x 3 months (Targeted Case Manager)	\$9,600
Computers (1-time cost)	\$1,000 x 8 staff	\$8,000
Training Manuals	\$58 x 8 staff	\$464
<b>Total</b>		<b>\$278,789</b>

**Cost Estimate for LME/MCO Project Staff/Training**

<b>Component</b>	<b>Calculation</b>	<b>Cost (6 MONTHS)</b>
Family Navigator	\$50,000 + 30% benefits	\$32,500 (\$65,000)
Two Liaisons (one JJ, one DSS)	\$55,000 + 30% benefits	\$71,500 (\$143,000)
Mileage	1000 miles per month x 2 direct staff x 6 months	\$6,600
.50 Project Manager	\$32,500 + 30% benefits	\$21,125 (\$42,250)
.50 Data Manager	\$32,500 + 30% benefits	\$21,125 (\$42,250)
National NWIC Conference	\$2,000 x 2 staff: CANCELLED	<del>\$4,000</del>
Mileage	500 miles per month x 1 supervisor x 6 months	\$1,650
CCFH Trauma Assessment Training	\$75,000	\$75,000
Administrative Costs	3.5% of salary costs (\$146,250)	\$5119
<b>Total</b>		<b>\$234,619</b>

## **Attachment D: Continuous Quality Improvement Process**

### **Individual Child Outcomes:**

1. Improved clinical outcomes
2. Engaged in school
3. No new legal involvement
4. Living at home/community
5. Reduced use of crisis services
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. Shorter length of stay in residential services
5. Improved rates of completion of services
6. 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
4. Sustainability plans are in place 6 months before the end of the pilot project

## Attachment E: Training

### Training arranged by DMH/DD/SAS for Tiers of Care Managers/Care Coordinators

#### High-Fidelity Wraparound Training

Component	Cost
Manuals	\$464
<b>Total</b>	<b>\$464</b>

#### Overview of DSS, Juvenile Justice, and CCNC

Component	Cost
Training by partner agencies: 1-day or 3 x 2-hour trainings	---
Family Partner 101 (3 days)	Offered by NC Families United
Family Driven Care (1 day)	Offered by NC Families United
Youth 2 Training (4 days)	Offered by NC Families United

## Attachment F: Essential Program Elements for High-Fidelity Wraparound and Targeted Case Management

1	<p><u>High-Fidelity Wraparound Staffing Requirements:</u>            One coach/supervisor may supervise the following:</p> <ul style="list-style-type: none"> <li>a. Four facilitators</li> <li>b. Two Family Support Partners; and</li> <li>c. One Youth Support Partner</li> </ul> <p>Each facilitator may work with 10-12 youth and families            Each coach will carry two cases            In summary, one coach can oversee the care of 40-48 youth.            The provider will maintain a ratio of one facilitator to 10-12 youth/families. See HFW Training and Credentialing</p>
2	<p><u>Family Driven Care:</u>            The National Federation of Families for Children’s Mental Health defines this working definition as “families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, State, tribe, territory and nation. This includes: choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing and evaluating programs; monitoring outcomes; and partnering in funding decisions” (Osher, Osher, &amp; Blau, 2008).</p>
3	<p><u>Targeted Case Management Staffing Requirements:</u>            Provider will follow existing targeted case management clinical policy requirements and for this pilot will maintain a caseload under 1:20. The comprehensive and culturally appropriate case management assessment may be chosen locally but will be monitored for implementation.</p>
4	<p><u>Case Management Assessment:</u>            A comprehensive and culturally appropriate assessment documents a youth’s service needs, strengths, resources, preferences, and goals to develop a Person-Centered Plan (PCP). The</p>

	<p>care coordinator 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 care coordinator 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 care coordinator assessment includes early identification of conditions and needs for prevention and amelioration. The 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 assessment includes periodic reassessment to determine whether the young person's needs or preferences have changed.</p>
5	<p><b>Person Centered Treatment Planning:</b>  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.</p> <p>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 care coordinator, who knows the requirements for a plan and what must be accomplished, works in concert with the context 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.</p> <p>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.</p> <p>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 Coordination 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: <a href="http://www.ncdhs.gov/mhddsas/servicedefinitions/serdefupdates/index.htm">http://www.ncdhs.gov/mhddsas/servicedefinitions/serdefupdates/index.htm</a></p> <p>The Care 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 Care Manager also contacts CCNC to obtain clinical information pertinent to establishing person-centered goals.</p>
6	<p><b>Referral and Linkage:</b></p>

	<p>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:</p> <ol style="list-style-type: none"> <li>a. Coordinating the delivery of services to reduce fragmentation of care and maximize mutually agreed upon outcomes</li> <li>b. Facilitating access to and connecting the young person and their family to services and supports identified in the PCP</li> <li>c. Making referrals to providers for needed services and scheduling appointments with the beneficiary</li> <li>d. Assisting the young person and their family as they transition through levels of care</li> <li>e. Facilitating communication and collaboration among all service providers and the young person and their family</li> <li>f. Assisting the young person in establishing and maintaining a medical home with a CCNC physician or other primary care physician</li> <li>g. Assisting the pregnant young person in establishing obstetrician and prenatal care as necessary</li> </ol>
7	<p><u>Monitoring and Follow-Up:</u>  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 help determine whether:</p> <ol style="list-style-type: none"> <li>a. Services are being provided in accordance with the young person’s PCP</li> <li>b. Services in the PCP are adequate and effective</li> <li>c. There are changes in the needs or status of the young person</li> <li>d. The young person is making progress toward his or her goals</li> </ol> <p>The High-Fidelity Wraparound Facilitator will as scheduled track progress and ensures the TOMS and Transition Assets Tool are completed on a set schedule. The targeted case manager will complete the 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.</p>
8	<p><u>Client Protections:</u>  The provider ensures that the Wraparound Facilitators and Family and Youth Support Partners complete the state required credentialing and training for High-Fidelity Wraparound, which ensures application of the HFW evidenced-based practice. Team members must successfully complete skill and competency-based training to provide Wraparound Facilitation, Family Support Partner, and Youth Support Partner as evidenced by completion of the NC HFWTP High-Fidelity Wraparound Training and Credentialing Requirements. The provider ensures that all Wraparound supervisory staff complete the NC HFWTP required training and have successfully completed skill and competency-based training to supervise Wraparound Facilitators, Family Support Partners, and Youth Support Partners as evidenced by credentialing as a High-Fidelity Wraparound Coach.</p> <p>Certification of team members must be completed within 9 months for new teams and 6 months for existing teams. Providers also must work closely with NC HFWTP Specialists to complete credentialing and training requirements. Family Support Partners must also be certified as a National Parent Support Provider within one year from credentialing and the Youth Support Partner must attend Peer2Peer training one year from hire.</p>

Existing sites with a HFW credentialed Coach may submit a plan for coaching and certifying new Facilitators, Family or Youth Support Partners as part of the HFW credentialing process provided by the NC HFWTP.
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**Wraparound Facilitator:**

1. Must meet requirements as a qualified professional
2. Must complete Wraparound facilitation training curriculum and be credentialed as a Wraparound Facilitator or complete training and credentialing within 9 months from hire
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 credentialed as a Wraparound Coach (or in process of being credentialed by a Wraparound Coach)
6. Have received 13 hours of Motivational Interviewing training from a MINT trainer
7. Juvenile justice, child welfare, and CCNC basis

**Knowledge in:**

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 PFTF 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. Brainstorming creative interventions based on family priorities and needs;
3. Assessing, supporting, observing, recording, and reporting behaviors;
4. Identifying, developing, or providing services to clients with SED;
5. Facilitating discussions to identify the least restrictive services necessary and identify step downs from residential as preferred by the family and supported by DSS and/or JJ systems, and
6. Uncovering natural supports to meet the client's needs and identifying services within the established services system

**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 Support Partner:**

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 a 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 Support partner or is actively working on completing certification and is on track to complete Family Support Partner certification within one year of Family Support Partner credentialing by the NC HFWTP. Family Partner 101 is part of National Certification Trainings for North Carolina: <http://www.ffcmh.org/certification>
5. Family Support Partner is credentialed in the role of Family Support Partner in High-Fidelity Wraparound or completes credentialing process within 1 year of hire.
6. Criminal background check presents no health and safety risk to participants
7. Not listed in the NC Health Care Abuse Registry
8. Possesses a current/valid driver's license and an automobile with proof of auto insurance
9. Juvenile justice, child welfare, and CCNC Basics

### **Youth Support Partner:**

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 is credentialed in the role of Youth Support Partner in High-Fidelity Wraparound or completes credentialing process with 1 year of hire.
5. Must attend 2 trainings within 1 year from hire, one of which is Peer2Peer training
6. Criminal background check presents no health and safety risk to participants
7. Not listed in the NC Health Care Abuse Registry
8. Possesses a current/valid driver's license and an automobile with proof of auto insurance
9. Juvenile justice, child welfare, and CCNC Basics

### **Targeted Case Manager:**

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 Facilitation training

### **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
6. 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 Liaisons to assist in connecting youth to clinical assessments
- The Liaisons 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:**

Care Coordination was a top priority in the Governor's Task Force 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 care coordination 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 a family navigator of HFW Family and Youth Support Partners. Family and Youth Support Partners 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 Support Partners 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.

**7. 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 coordination 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.

**8. 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 care coordination 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: NC High-Fidelity Wraparound Training and Credentialing Requirements

\*\* The below requirements are standard for all sites and teams providing or wanting to provide High-Fidelity Wraparound in the State of North Carolina. \*\*

### Foundation Training:

Training Description	Timeline to Complete	Training Provided By:
4 days of in the room training on High-Fidelity Wraparound Foundations broken up into 2 days of training with assigned supplemental activities/learning activities and then a couple weeks later 2 more days of training followed up with more supplemental/learning activities	As scheduled/offered by NC HFWTP (at least quarterly)	Implementation Specialist (IS)

### Coach Training (under development):

Training Description	Timeline to Complete	Training Provided By
Two-day Coaches Training (when there are enough participants) or independent learning with assigned exercises depending on needs of the site and/or coach	Independent learning and assigned exercises within 60 days of completion of the Foundations Training; 2-day Coaches Training not a requirement for credentialing activity	Implementation Specialist

### Credentialing of all Staff:

Timeline to Complete	Credentialed by
<b>Best practice expectation is 9 months. 12 months maximum</b>	Credentialed Coach or Implementation Specialist <i>Note: If coach is credentialed, he/she is able to certify team members without the IS (all completed credentialing tracking tools must be submitted to IS for tracking. Credentialing of any coach is only completed by the IS).</i>

### Training Plans:

Sometimes HFW Foundations training cannot be provided immediately for a Coach's new staff. The NC HFWTP is working to ensure that the training occurs at least quarterly in the state. In instances where coaches must wait until the training is offered, the Coach must develop an interim training plan to on-board their staff until training is scheduled. This activity is also a credentialing item, meaning the Coach will complete this regardless, but it may take priority in some cases. *(See Onboarding/Interim Training credentialing form in Coach Manual for details.)*

The coach should submit a plan that will provide the initial onboarding/interim training for new wraparound staff and have reflective discussions with staff on phases, principles, and wraparound specific tasks, until the Foundations Training can be completed by the NC HFWTP.

## **Credentialing of Facilitators, Family Support Partners and Youth Support Partners:**

### **Credentialed Coaches:**

- Submit all completed (credentialing) activity score sheets to the IS monthly.
- Include a brief description of how and when debriefing of the results with the team member occurred (with a focus on feed forward).
- Coach will maintain a tracking form for credentialing completion for all team members and provide updated versions to the IS and team member as activities are completed.

### **Non-Credentialed Coaches:**

- Submit all credentialing activities to the IS (either by video, audio, or documentation) within **7 days** of completion.
- IS and Coach will individually score each activity and then compare scoring sheets for inter-rater reliability. IS and Coach will prepare for Coach to debrief the activity and scoring with the team member that was scored. Scores must be completed between IS and Coach before sharing results with team members. These activities/steps should be completed as soon as possible but at least within **2 weeks** of the original activity.
- Coach will discuss with IS or submit a brief description of how and when debriefing of the results with the team member occurred (with a focus on feed forward).
- Coach will maintain a tracking form for credentialing completion for all team members and provide updated versions to the IS and team member as activities are completed.

### **Credentialing of Coaches:**

- IS will work with the coach to develop a timeline of credentialing activities.
- Coach will submit all completed credentialing activities (through video/audio/documentation) within **7 days** of completing the activity to the IS; this step is not necessary if IS is able to observe the activity either live or by phone.
- IS will debrief with the Coach within **7 days** of receiving the materials or observing an activity.
- IS will update credentialing tracking spreadsheet and provide these updates to the coach.
- Once Coach is credentialed, Coach can continue scoring all team members without direct involvement of IS.

## **Ongoing Training After Staff are Credentialed:**

### **Coaches:**

- Shadow each staff member (Youth Support Partner, Family Support Partner, and Facilitator) at least once per month and use Wraparound Credentialing Tools for structured scoring/feedback to prevent drift and ongoing skill development.
- Debriefs with each staff member within **2 days** of the shadowing. Debrief needs to be documented, signed, and dated by the staff member and coach.
- Coaches should attempt to observe different tasks/wraparound skills.

### **Teams:**

- Coach will provide ongoing training/boosters on High-Fidelity Wraparound principles/phases/TOC/tasks/etc. (these can be Topic Based Group Coaching, Coach led, and/or IS led).

## **Fidelity Monitoring:**

### **Coach/Supervision Site Audits:**

- Bi-annual site audits for teams
- Review includes the following:
  - Review of all team Group Coaching documentation
  - Review of all team member individual coaching/supervision documentation
  - Review of each team member's Professional Development Plan (PDP)
  - Review of Team Development Plan
  - Review of all training and credentialing plans and tracking spreadsheets
  - Review of all credentialed team member monthly activities conducted to prevent drift
  - Review documentation of training and skill development provided to team (may be completed within topic based Group Coaching or other ways)
- IS will provide written and oral feedback to sites after any site review/audit within 7 days.

### **Coaches:**

- Credentialed Coaches:
  - IS will observe (phone or in person) quarterly Group Coaching meetings, unless IS and/or Coach feels there is a need for more frequent observations.
  - IS will debrief with Coach and create/update the Coach's Development Plan (as needed) within 7 days of the observation.
  - Coach will maintain an updated Team Development Plan when needed and review with IS at least quarterly during coach call or visit.
- Non-Credentialed Coaches:
  - IS will observe (phone or in person) monthly group coaching meetings.
  - IS will debrief with coach and create/update the Coach's Development Plan (as needed) within 7 days of the observation.
  - Coach will maintain an updated Team Development Plan when needed and discuss/review with IS at least quarterly during coach call or visit.

## **Corrective Action Plans:**

- Are implemented due to the following:
  - Ongoing challenges completing training and/or credentialing for team members
  - Failing to submit required documentation in a timely manner (see timelines above)
  - Failing to collect and submit required quality improvement forms/data collection assigned by NC HFWTP
  - Ongoing staff turnover
  - Lack of fidelity to the model
  - Lack of incorporation of IS feedback over 90 days (e.g. coach observation tool, audit, etc.)
  - Consistent unfavorable audit/site review findings
  - A pattern of unsuccessful discharges/higher level of placements
- Plans are created with the specific site (coach, program manager, clinical director), IS, and any other persons agreed upon by site and IS
- Plans are reviewed every 30 days for updates, progress, and barriers
- Typical timeline for a corrective action plan is 90 days