

Alternative or “in Lieu of” Service Description
Alliance Behavioral Healthcare

1. Service Name and Description: High Fidelity Wraparound Team

Service Name: High Fidelity Wraparound

Procedure Code: H0032-U3 Monthly Unit
H0032-U3-Z1 Encounter

License: n/a

Description:

High Fidelity Wraparound is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in Psychiatric Residential Treatment Facilities (PRTFs) or other institutional settings, or are aging out of Department of Social Services (DSS) care.

High Fidelity Wraparound (HFW) is a service that

- Facilitates care planning and coordination of services for youth 3-17 years of age with serious emotional disturbance (SED) or young adults 18-20 years of age with serious mental illness (SMI)
- Provides access to family peer support to promote engagement and completion of services.
- Engages youth and families to establish an individualized child and family team that develops and monitors a strengths-based plan of care;
- Addresses youth and family needs across domains of physical and behavioral health, social determinants of health, and natural supports

The Wraparound Facilitation Team provides a single point of accountability for ensuring that medically necessary services, pro social activities, and natural supports are considered, accessed, coordinated, and delivered in a strength- based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the need of the youth and family, are developed through a Wraparound planning process consistent with System of Care philosophy and values. The planning process results in an individualized, family-driven and youth-guided flexible Wraparound plan that is community based and culturally competent.

HFW is designed to facilitate a collaborative relationship among a youth with SED, or under the age of 21 year old members with SMI, his/her family and involved child-serving systems to support the parent/caregiver in meeting their youth’s needs. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process with four specific phases (engagement, plan development, implementation, and transition).

Through the team-based planning and implementation process, wraparound also aims to restore the problem-solving skills, coping skills, and self-efficacy of the young people and family members. The Wraparound planning process ensures that a Wraparound Facilitator organizes and matches care across providers and child-serving systems to enable the youth to be served in their home community. Wraparound utilizes family peer support to engage families in services and to teach families skills in navigating systems and involving natural support.

The HFW model is based on the National High Fidelity Wraparound Initiative that includes the fidelity assessment system, which is a multi-method approach to evaluating the quality of individualized care planning and coordination for youth with complex needs. The National HFW Initiative was formed in 2004 to define the HFW practice model, develop standards, compile specific strategies and tools, and disseminate information about how to implement the HFW model in a way that can achieve positive outcomes for youth and families.

The Wraparound Facilitator coordinates the development of a Child and Family Team (CFT) or Adult/Family Team comprised of both formal and natural support persons who assist the family and youth in identifying goals and developing a HFW Plan including a Crisis/Safety; convenes CFT meetings; coordinates and communicates with the members of the CFT to ensure the implementation of the HFW Plan; works directly with the youth and family to implement elements of the HFW Plan; coordinates the delivery of available services; monitors and reviews progress toward HFW Plan goals and updates the HFW Plan in concert with the CFT.

Delivery of HFW requires teaming with Family and Youth Partners. In HFW, the HFW Facilitator, Family Partner, and Youth Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CFT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals to the HFW Facilitator and CFT. The Family Partner educates and empowers parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the caregiver's access to these resources.

When implemented fully, the HFW process results in a set of strategies and services provided in the most inclusive and least restrictive settings possible. These strategies are tailored to meet the unique and holistic needs of the youth and family, including supports to family members to reduce stress and to ensure that services are accessed and treatments completed by the identified youth.

HFW activities are grouped into four phases:

- 1) Engagement and Team Preparation
- 2) Plan Development
- 3) Plan Implementation
- 4) Transition

In *Engagement and Team Preparation* (2-3 weeks) the HFW Team Facilitator, along with the Family and Youth Partner, initiates a strengths-based, non-judgmental engagement process that includes crisis stabilization, orientation to the HFW process, and identification of family and youth strengths, culture, and vision (goals) for the future.

The *Plan Development phase* (1-2 weeks) includes a discussion of treatments and strategies that have been successful in the past and identification of individuals who play key roles in the life of the youth and family (including extended family and community resources). Barriers to effective treatment are identified, strategies to stabilize crises that may interfere with treatment planning and follow through are developed, and these are all addressed in the plan. Throughout the process parents/caregivers are provided with support (especially through the Family Partner).

During the *Plan Implementation phase* (2-12 months) of the HFW process, the team meets frequently to review the status of the plan and identify indicators of progress toward the priority goals. The Team Facilitator supports the family and other team members to ensure the implementation of the plan of care, monitors completion of action steps, strategies, and successes in meeting needs that lead to the achievement of outcomes. Transition out of formal HFW is intended to occur when the team (with primary guidance from the family) agrees that the identified priority needs have been met.

The *Transition Phase* typically consists of 1-4 meetings. The goal of the transition phase is to plan a purposeful transition out of the formal HFW service that supports the youth and family in maintaining the positive outcomes achieved. The cessation of HFW service will be conducted in a manner that celebrates successes and frames transition proactively and positively. The average length of stay in the total HFW process is 12 months. Maximum stay is 18 months.

Staffing

The HFW Team consists of a Facilitator, Family Partner, and Youth Partner. Each Facilitator may serve up to 10-12 families. Each Family Partner and Youth Partner may serve up to 15 families across multiple HFW Teams. The HFW team is provided coaching/supervision by a HFW coach. The HFW Coach/Supervisor, is a Masters Qualified Professional with at least 1 year experience with the population. One coach/supervisor can supervise up to 4 facilitators, 2 family peer support workers, and 1 youth peer support worker for up to 40-48 youth/families

The HFW Team Tasks & Responsibilities:

HFW Facilitator:

Assessment for HFW criteria

- Reviews multiple tools, including the Child and Adolescent Needs and Strengths (CANS), CALOCUS/LOCUS or the Strengths and Needs Culture Discovery in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an individual HFW Plan and Crisis/Safety Plan;
- Assists the family to identify appropriate members of the Child & Family Team (CFT);
- Collects background information and plans from other agencies. The assessment process determines the needs and wants of the youth for any medical, educational, social, therapeutic, or other services/supports. Further assessments are arranged as needed or wanted; and
- Facilitates the CFT to identify strengths and, needs, and culture of the youth and family in meeting their prioritized needs;

Development of an Individual HFW Plan:

- Convenes and facilitates the CFT meetings and the CFT develops a youth- and family-centered HFW Plan that specifies the goals and actions to address the medical, educational, social,

therapeutic, or other services needed or wanted by the youth and family specifying concrete interventions and strategies and identified responsible persons.

- Ensures the HFW Plan results in the best fit between the family vision, team mission, strengths, needs, and strategies, through a proactive and reactive planning process that is inclusive of a connected crisis plan.

Referral and related activities:

- Works directly with the youth and family to implement elements of the HFW Plan
- Prepares, monitors, and modifies the HFW Plan in concert with the CFT;
- Identifies, actively assists the youth and family to obtain, and monitors the delivery of available services including medical, educational, social, therapeutic, or other services;
- Assembles child and family teams: assesses strengths and needs of the family unit, coordinates meetings, seeks community resources and completes all necessary documentation;
- Develops with the CFT a transition plan when the youth has achieved goals of the HFW Plan; and
- Collaborates with the other service providers and state agencies (if involved) on the behalf of the youth and family.

Monitoring and follow-up activities:

- Facilitates reviews of the HFW Plan to reflect the changing needs of the youth and family.
- Completes the CANS or CALOCUS/LOCUS (as age appropriate) and NC TOPPs as scheduled to track progress.
- Completes the ACORN Tool or other provider selected satisfaction survey tool as scheduled to track/monitor progress & effectiveness
- Monitors and documents the status of the youth and family's progress and effectiveness of the strategies and interventions outlined in the Plan of Care.
- Attends coaching per week to monitor adherence to the HFW principles.

Family Partner:

- Works one-on-one and maintains weekly contact with the parent(s)/caregiver(s) in order to provide information and support throughout the care planning process;
- Attends meetings like the Child and Family Teams and Individualized Education Plan (IEP) meetings and may assist the parent(s)/caregiver(s) in articulating the youth's/family's strengths, needs, and goals to the HFW Facilitator and CFT.
- Educates and empowers parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and
- Facilitates the parent's/caregiver's access to these resources.

Youth/Young Adult Peer Partner:

The team encourages the young person to utilize the talents and experiences of others. Youth/Young Adult Peer Partner provides mentor support, encourages leadership and promotes comradery. The Youth Partner:

- Helps re-build relationships and respect with family members, natural supports, community partners, and key stakeholders;

- Develops a working understanding of the young person’s desires, goals, interests, and strengths;
- In addition to developing trust and mutual respect between the team and the individual, the team also works with the individual to bridge relationships with others, such as family members, teachers, employers, friends;
- Assists the young person with identifying goals and developing an action plan to steps to achieve these goals;
- Helping the young person navigate a system across several domains while focusing on personal effectiveness/wellbeing and life/community functioning;
- Help redevelop social responsibility and accountability - reteaches the young person problem solving and decision making skills that enable the young person to manage day to day life problems and opportunities;
- Build Support Network -A key element to a young person’s identity and independence is his/her support system. The Youth Partner & HFW team works with the young person to understand the benefits of a support system and identify those individuals and groups that advocate, provide encouragement, and the safety net necessary for success; and
- Enhance Social and Life Skills - assists the young person to become competent in any skill(s) that are vital to achieving his/her goals. Teaching the individual to become self-sufficient will restore confidence and self-determination.

2. Information About Population to be Served:

| Population | Age Ranges | Projected Numbers | Characteristics |
|---|-------------------|--------------------------|--|
| Child MH/SU, dually diagnosed MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their diagnosis. | 3-20 | 600 | Youth eligible for this service include: <ul style="list-style-type: none"> ▪ Children, youth, and young adults with Serious Emotional Disturbance (SED) if 3-17, Serious Mental Illness (SMI) if 18-20 and still covered by Child Medicaid ▪ have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and substance use problems ▪ Involved in (or history of) multiple child-serving systems (e.g., child welfare, juvenile justice) ▪ Have history of placements in PRTF or other restrictive settings within the past year ▪ At risk of needing PRTF or other long term out-of-home placements ▪ Transition age youth in need of an increase and strengthening of family and community support to transition from DSS care or out of home placement to independent living (due to aging out of system) |

Eligibility Criteria:

There is a MH/SA diagnosis (as defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), or any subsequent editions of this reference material). There may be co-occurring intellectual or developmental disability but not a sole intellectual or developmental disability.

and

Youth requires .

one of the following:

- Youth is in residential treatment (Psychiatric Residential Treatment Facility, level III or II Program, level II family, or state run facility such as Wright School), Youth Developmental Center, and transitioning to community services in the next 30-45 days OR
- Youth has experienced one psychiatric hospitalization or detention stay that lasted 14 days or longer in the last 6 months or two stays of any length of any combination of psychiatric hospital, detention, or jail in the last 6 months OR
- A Comprehensive Clinical Assessment or Addendum completed by a Licensed Professional or Associate Level Licensed Professional finds the youth exhibits significant impairment across settings (home, school, community) as noted by a CALOCUS score of 5-6. Children with a CANS must have multiple scores of two or higher may also be eligible. Must be at imminent risk of out of home placement due to lack of parent engagement or deterioration of the youth's mental health or substance use disorder requiring intensive, coordinated interventions.
Youth requires coordination between two or more service youth-serving agencies, including medical or non-medical providers, specifically, Department of Social Services, Special Education, Juvenile Justice, Adult Probation, mental health, and/or substance use providers (including youth with co-occurring I/DD diagnoses and associated providers), and Specialty Medical Providers, exclusive of Primary Care Physician;

AND

Youth has current or past history within the last 6 months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use); AND one of the following:

- Youth's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the beneficiary's mental health or substance use disorder condition and is at imminent risk of out-of-home residential care, youth residential treatment or adult residential placement, requiring intensive, coordinated clinical interventions and is at risk of needing PRTF or other long term out-of-home placements; OR
- Youth is transitioning from PRTF, level III or II group care, therapeutic foster care, Youth Development Center and returning to community services; OR
- Transition age youth in need of an increase and strengthening of their family and community/natural supports to transition from DSS care or out of home placement to independent living (due to aging out of system);

AND

- a. There is no evidence to support that alternative interventions alone would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Continuing Care Criteria:

The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

- a. The beneficiary/family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
- b. The beneficiary/family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; or
- c. The beneficiary/family fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria

The beneficiary meets the criteria for discharge if any one of the following applies:

- a. The beneficiary has achieved goals and is no longer in need of HFW services;
- b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to services, other natural supports, or ;
- c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
- d. The beneficiary or legally responsible person no longer wishes to receive HFW services; or
- e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

3. Treatment Program Philosophy, Goals and Objectives:

The National HFW Initiative describes the program philosophy and goals as follows: "The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process – as well as availability of research-based interventions that can address priority needs of youth and caregivers; Wraparound also aims to re-develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The values of Wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Wraparound's philosophy of care begins from the principle of "voice and choice," which stipulates that the perspectives of the family – including the child or youth – must

be given primary importance during all phases and activities of Wraparound. The values associated with Wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent, and community based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the Wraparound process should be "strengths based," including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities."

The Wraparound philosophy is described through ten principles (Bruns et al. 2008). It is different from traditional service delivery in that the plan of care is not solely based on a diagnosis or a list of deficits. Wraparound is an ecological model, including consideration of the multiple systems in which the youth and family are involved, and the multiple community and informal supports that might be mobilized to successfully support the youth and family in their home and community.

The Ten Principles of the Wraparound Process

- 1) *Family "voice and choice"* - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- 2) *Team based* - The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships. The "professional" members include the Team Facilitator, Parent Partner, and Young Adult Peer (as appropriate).
- 3) *Natural supports* - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan of care reflects activities and interventions that draw on sources of natural support.
- 4) *Collaboration* - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan of care. The plan of care reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
- 5) *Community-based* - The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
- 6) *Culturally competent* - The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
- 7) *Individualized* - To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
- 8) *Strengths based* - The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- 9) *Persistence or Unconditional Support* - Despite challenges, the team persists in working toward the goals included in the wraparound plan of care until the team reaches agreement that a formal wraparound process is no longer required.

10) *Outcome based* - The team ties the goals and strategies of the wraparound plan of care to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

In the wraparound process, a dedicated Team Facilitator (QP) works together with the family and youth (if developmentally appropriate) to identify the strengths, needs, and potentially effective strategies, resulting in a single, coordinated, individualized plan of care. It is in the facilitation of this planning process that the wraparound guiding principles are operationalized. Utilization of the Family and Youth Partner are the decision of the family and youth.

The wraparound plan of care typically includes formal services that are balanced with *natural supports* such as interpersonal support and assistance provided by friends, family, and other people drawn from the family's social networks. The additional principles of *collaboration, cultural competence, strengths based, and outcome based* are all achieved and actualized through the team process with team members working cooperatively and sharing responsibility for a single plan of care, even when multiple providers and services are involved. The principle of *unconditional support* is achieved through wraparound teams not giving up on, blaming, or rejecting the youth or family, even in the face of significant needs and challenges.

<http://nwi.pdx.edu/wraparound-basics/#whatareimplementation>

Crisis Response: The High Fidelity Wraparound Team fulfills First Responder Role when not paired with another enhanced treatment service.

4. Expected Outcomes:

Expected system-wide outcomes include but are not limited to the following:

- Reduce costs of care in psychiatric residential treatment facility
- Improve school attendance and performance
- Increase in behavioral and emotional strengths
- More stable living situations
- Improve attendance at work for Caregivers
- Reduce suicide attempts
- No further charges or court involvement
- Decrease contacts with law enforcement

Expected clinical outcomes include but are not limited to the following:

- Decrease in the frequency or intensity of crisis episodes;
- Reduction in symptomatology;
- Beneficiary and family or caregivers' engagement in the recovery process;
- Improved beneficiary functioning in the home, school and community settings;
- Ability of the beneficiary and family or caregiver to better identify and manage triggers, cues, and symptoms;
- Beneficiary's sustained improvement in developmentally appropriate functioning as measured by the CANS or CALOCUS/LOCUS;
- Reduction in hospitalizations and admission and readmissions to residential care;

- Caregiver and youth have increased ability for self-advocacy and resource gathering.
- Increased use of coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs;
- Reduction of symptoms and behaviors that interfere with the beneficiary's daily living, such as negative effects of the substance use disorder, psychiatric symptoms, or both;
- Decrease in delinquent behaviors when present; and
- Increased use of available natural and social supports by the beneficiary and family or caregivers.
- Improved family assets as defined by the Transitional Readiness Scale/Score

5. Staffing Qualifications, Credentialing Process, and Levels of Supervision (Administrative and Clinical) Required:

HFW is provided by nationally accredited organizations/agencies that are enrolled in the LME/MCO network for enhanced children's services. The HFW Team consists of a Primary Team HFW Facilitator, a Family Partner and Youth/Young Adult Peer Partner (Youth Partner) as appropriate. Each team must have access to a Coach/Supervisor. All staff are required to complete High Fidelity Wraparound Foundations Training (4 day orientation training to the HFW model to be completed within 90 days) HFW requires strong clinical supervision to manage utilization, quality, and outcomes at the child/family level.

The HFW Team consists of a Facilitator, Family Partner, and Youth Partner. Each Facilitator may serve up to 10-12 families. Each Family Partner and Youth Partner may serve up to 15 families across multiple HFW Teams. The HFW team is provided coaching/supervision by a HFW coach. The HFW Coach/Supervisor, is a Master's Level Qualified Professional with at least 1 year experience with the population. One coach/supervisor can supervise up to 4 facilitators, 2 family peer support workers, and 1 youth peer support worker for up to 40-48 youth/families.

Qualifications and credentialing for each team member is as follows:

The **Coach/Supervisor** must be a Master's Level Qualified Professional with one year of experience with the population.

Responsibilities of the Wraparound Supervisor/Coach:

- Provide training of theory and application of wraparound services and assist in a variety of ways to ensure the success of the program.
- Provide ongoing supervision to the Wraparound Team
- Supervise and evaluate the Primary Facilitator's performance in all aspects of their position.
- Lead team coaching per week to monitor adherence to the wraparound principles and program protocols.
- Provide individual supervision at least monthly to the Facilitator, Family Partner, and Youth Partner. ,

The Team Facilitator

- Must meet requirements as a qualified professional.

- Must complete Wraparound Facilitation training curriculum and be certified as Wraparound Facilitator (or be in process of completing training and certification) If not certified at hire, must be fully certified within a year.
- Pass background check, the child and adult abuse registry checks, and motor vehicle screens.
- Receive monthly 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).
- Trained in CANS and CALOCUS/LOCUS within 90 days.
- Receive Motivational Interviewing training within 90 days.
- Receive trauma informed care training within 90 days.

Family Partner:

- Must have lived experience as a primary caregiver for a child who has/had mental health or substance use challenges
- 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
- 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 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
- 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. <http://www.ffcmh.org/certification>
- When part of a Wraparound Team, 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.

Receive monthly 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).

Youth Partner:

- Must have lived experience mental health or substance use challenges;
- Experience in navigating any of the child and family-serving systems;
- 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
- Holds Certification in Peer Support or will reach certification within one year of hire date;
- Receive monthly 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).

Provider Agency

The provider ensures that Wraparound Facilitators and Family Peer Support complete 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 have successfully completed skill and competency based training to supervise Wraparound Facilitators and Family Peer Support as evidenced by certification as Wraparound Coach.

The provider agency must have an ongoing fidelity monitoring plan approved by the LME-MCO.

6. **Unit of Service:** 1 unit = 1 month (minimum of 4 contacts each month)
Provider will report all contacts through encounter data.

7. **Anticipated Units of Service per Person:**

- Targeted Length of service is up to 12 months, 12 units.

Utilization Management

- Wraparound will be a maximum of 12 months.
- Prior authorization by the LME-MCO is required before or on the first date of service.
- The initial authorization will be for up to 180 days.
- Each reauthorization after that will be for no more than 60 days.

Service Exclusions and Limitations

A beneficiary may receive Wraparound from only one service provider organization during any active authorization period for this service.

There are not service exclusions for individuals with co-occurring MH/I/DD diagnoses. A beneficiary with co-occurring MH/I/DD diagnoses may receive Wraparound for 60 days prior to discharge from PRTF or Residential Level 2-3 for transition/step down planning and engagement.

A beneficiary with mental health and/or substance use diagnoses may receive the following services during the same authorization period as the following services:

- a. Basic Outpatient services (includes individual, family, and group therapy)
- b. Therapeutic Foster Care
- c. For 60 days prior to discharge from PRTF or Residential Level 2-3 for transition/step down planning and engagement

The following services are **excluded for Individuals with Mental Health and Substance Use Diagnoses** and cannot be provided during the same authorization period:

- Community Support Team;
- Substance Abuse residential services.
- ACT Team;
- Intensive In-Home Services

- Intercept
- Family Centered Treatment
- Multi-systemic Therapy
- Day Treatment
- SAIOP
- SACOT
- Outpatient Plus

EPSDT Special Provision

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1) That is unsafe, ineffective, or experimental or investigational.
- 2) That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

- 1) If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- 2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem

Entrance Process

A comprehensive clinical assessment or addendum and that demonstrates medical necessity shall be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, it may be utilized as a part of the current comprehensive clinical assessment or addendum. Relevant diagnostic information shall be obtained and be included in the Person Centered Plan or the Wraparound Plan of Care. If the member is receiving another enhanced service, the PCP must include High Fidelity Wraparound in the goals and interventions.

Due to the complex nature and urgency of admission, a Comprehensive Clinical Assessment or addendum with documentation of meeting the entrance criteria is acceptable for initiation of services .

8. Targeted Length of Service: Target length of stay is 12 months.

9. Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.

Youth with SED or SMI who have the most complex needs and who have been in restrictive residential care or who are at imminent risk for residential level of care require:

- Intensive care coordination (high fidelity wraparound facilitation)
- Access to family and youth peer support (Family and Youth Partner)
- Individualized service planning process

High Fidelity Wraparound packages all three of these requirements and provides a flexible, culturally responsive, and family driven service for the youth whose care requires working across multiple child serving agencies.

High Fidelity Wraparound is currently available in North Carolina in five pilot sites which are grant funded. Alliance was awarded the Tiered Case Management grant last year which includes High Fidelity Wraparound. Alliance developed the In Lieu of service definition to help meet the needs of our beneficiaries with high risk and complex needs.

High Fidelity Wraparound has very low staff to family ratios (1:10/12), which allows for the facilitator to more effectively:

- Assist the family in working with all the agencies involved in the child's life
- Assist the family in restoring the skills to navigate the system and address their child's unique and complex set of needs

In addition, all families served by Wraparound have access to trained Family Partner and Youth Partner who assist with family & youth engagement and link to natural support.

When the family is engaged with enhanced services that include case management services, Wraparound Facilitator coordinates all the service planning and delineates who will conduct which service including clarity on who performs case management functions. The Wraparound Facilitator is responsible for convening and maintaining the Child and Family Team.

In a joint CMS and SAMHSA bulletin in May 2013, the results from the PRTF Demonstration grants were shared and Intensive Care Coordination-Wraparound Approach and Family Peer Support were highlighted as critical services to reduce over-reliance on PRTFs. Here are the outcomes found in this PRTF Demonstration Pilot:

- "Reduced costs of care – The PRTF evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of \$40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program.
- Improved school attendance and performance - After 12 months of service, 44 percent of children and youth improved their school attendance and 41 percent improved their grades as compared to their attendance and grades prior to participating in the program.
- Increase in behavioral and emotional strengths - 33 percent of youth significantly improved their behavioral strengths after 12 months of service and 40 percent after 24 months compared to their strengths as measured prior to participating in the program. Behavioral and emotional strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.
- Improved clinical and functional outcomes - According to caregiver reports, 40 percent of children served in the CMHI program showed a decrease in clinical symptoms from when they entered the program.
- More stable living situations - The percentage of children and youth in CMHI who remained in a single living situation rather than multiple living situations during the previous 6 months increased from 70 percent at intake to 81 percent at 24 months.
- Improved attendance at work for Caregivers - Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months of program participation, and to 2.8 days at 24 months of program participation.
- Reduced suicide attempts - Within 6 months of service in CMHI, the number of youth reporting thoughts of suicide decreased from intake into the program by 51 percent and the number of youth reporting a suicide attempt decreased by 64 percent.
- Decreased contacts with law enforcement - For youth involved in the juvenile justice system, arrests decreased by nearly 50 percent from intake into the program after 12 months of service in CMHI."

<https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>

10. Cost-Benefit Analysis: Document the cost-effectiveness of this alternative service versus the State Plan services available.

Current ABH Medicaid Rates

PRTF \$ 300 /diem

Level 3 (4 beds or less) \$231.52/diem

Inpatient blended \$741.11/diem

Alliance Behavioral Health Data

| Service | Procedure Code | Unit Definition | Units of Service | Cost of Service |
|---------|-------------------------|--|------------------|----------------------------|
| PRTF | 0911 | Annual Cost | | \$14,063,623 (180 days) |
| Level 3 | H0019HQ & H0019TJ | Annual Cost Residential Level 3, 4 beds or less; Residential Level 3, 5 beds or more | | \$27,916,029 |

Description of Alternative Service Payment Arrangements (include type, amount, frequency, etc.)

| Service | Procedure Code | Unit Definition | Units of Service | Cost of Service |
|--------------------------|----------------|--|--|---------------------------------------|
| High Fidelity Wraparound | H0032-U3 | Monthly Unit includes facilitator contact and family partner, youth partner services when applicable | 12 per youth (1 per month x 12 months) | \$21,408 total cost; \$1784 per month |

Cost Effectiveness Summary:

High Fidelity Wraparound will prevent admissions to, and reduce length of stay for, PRTFs, and Residential Level 3. It will also prevent repetitive use of crisis services. It will also be used for the transitional youth population who are difficult to engage into adult services. The cost to serve 150 youth is 3.2 million, and we expect to see cost savings in bed days which will make it cost neutral. Provider eligibility is limited, therefore there will be limited capacity to serve youth and we do expect capacity to increase annually. A target for year one would be 50-100 youth, with incremental increases as the model allows.

Description of Process for Reporting Encounter Data (include record type, codes to be used, etc.)

Claims data will reflect fee for service billing. Data will be uploaded to DMA by the MCO.

Encounter Data will be recorded by providers with the minimum standard of a service note for each contact, service event, or intervention.

Providers will collect and report/provide access through sharing of the health record to all encounter data. At a minimum, this would include time spent on family based sessions, individual sessions, child and family teams, and indirect contacts.

Description of Monitoring Activities :

The MCO will review claims monthly to monitor patterns and trends in utilization of this service.

The MCO will monitor service utilization through prior authorizations, utilization management, and post payment reviews.

The MCO will monitor level of care and outcomes tracking with use of the CANS or CALOCUS periodically and at discharge. The reviewed/updated scores/levels will be submitted with re-authorization requests. It is expected that this service would be effective and resulting in positive outcomes when a lower score is reported in the request for re-authorization. This would indicate a plan for successful transition back to basic services (OPT).

Description of Provider Level Monitoring Activities:

- Wraparound Coach uses the High Fidelity Wraparound Instrument (HFWI).
- Wraparound Coach certifies the Wraparound Facilitator is conducting Wraparound Facilitation to fidelity through use of coaching and live shadowing.
- All Wraparound staff (Coach, Supervisor, Family Partner, and Youth Partner) completes certification for their role.
- Completion of CANS or CALOCUS and NC TOPPS to track outcomes for individual children. Aggregate data is reviewed to support provider in delivery of service.
- Adherence to model fidelity monitoring plan approved by the LME-MCO.

Documentation Requirements

A full service note for each contact or intervention (such as individual counseling, case management, crisis response) for each date of service, written and signed by the person(s) who provided the service will contain the following information: recipients name, service record number, Medicaid identification number if applicable, service provided, date of service, place of service, type of contact (face to face, telephone call, collateral), purpose of contact, providers interventions, time spent providing interventions, description of effectiveness of intervention, and signature and credentials of the staff member(s) providing the service. Beginning at the time of admission, all interventions/activities regarding discharge planning and transition with youth, family/caregiver, and child and family team will be documented.

A documented discharge plan shall be discussed with the individual and included in the service record.