

Invitation to Apply

**Child Tiered Care Coordination pilot
(Formerly Child Tiered Case Management)**

Applications are due by:

December 7, 2018 by 5:00 pm EST

Questions will be accepted until:

October 12, 2018 by 5:00 p.m.

A summary of all questions and answers will be posted at <http://www.ncdhhs.gov/about/grant-opportunities/mental-health-developmental-disabilities-substance-abuse-services-grant-opportunities> by October 19, 2018.

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Introduction

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 three to four judicial districts. The LME/MCO must also subcontract with a Provider who already has a demonstrated record of positive outcomes when serving youth involved with child welfare and juvenile justice. 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 Targeted Case Management for Youth with low to moderate level needs and access to DSS/JJ Liaisons and Family Navigator. 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 service 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 mental health and substance use concerns. The county's department of social services agency will use a screening instrument that is approved by the NC Division of Social Services.

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 3) additional positions at DMHDDSAS 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.

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. Shorter length of stay in residential services
5. Improved rates of completion of services
6. Improved connection to community resources

ELIGIBILITY AND INSTRUCTIONS FOR APPLICANTS

Eligible applicants are Local Management Entities-Managed Care Organizations (LME/MCOs). Local Management Entities-Managed Care Organizations are encouraged to review and consider submission of an application for these funds. LME/MCOs must select a judicial district within their catchment area, and LME/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.

Instructions to Interested LME/MCOs:

Each LME/MCO may submit up to two applications, each focused on 1-2 bordering judicial districts within 1 LME/MCO catchment area. Previous LME/MCO awardees for the Tiered Case Management Pilot project are eligible for this round of funding. Applications should be prepared in accordance with the instructions outlined in this section and elsewhere in this invitation.

Late applications will not be accepted. The Division of MH/DD/SAS will not be held responsible for the failure of any mail or delivery service to deliver an application prior to the stated due date and time. It is solely the applicant's responsibility to: (1) Ascertain all required and

necessary information, documents and attachments are included prior to submitting a response; and (2) ensure that the response is received at the correct location and time. No faxed or emailed responses will be accepted or considered.

Application Format

Applications should be prepared as simply as possible and provide a straightforward, concise description of the applicant's capabilities and partnerships. Formatting should be single-spaced in a minimum of 12-point font. Original signatures are required in blue ink on the letter of transmittal.

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

Please submit the application (one (1) original and five (5) hard copies) to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. An email pdf version is a helpful addition but will not be considered as the official submission. For **Regular Mail** Attn: Brenda T. Smith at 3004 Mail Service Center Raleigh, NC 27699-3004 or **Express Mail**: Attn: Brenda T. Smith at 306 N. Wilmington St., Suite 203, Raleigh, N.C. 27601 **by 5:00 p.m. on December 7, 2018**. Submissions posted after this date and time will not be considered. Please direct all questions concerning this Invitation to Brenda Smith at brenda.t.smith@dhhs.nc.gov. Questions will be accepted until 5:00 p.m. on October 12, 2018. A summary of all questions and answers will be posted at: <http://www.ncdhhs.gov/about/grant-opportunities/mental-health-developmental-disabilities-substance-abuse-services-grant-opportunities> by October 19, 2018.

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

1. Transmittal Sheet
2. Application Face Sheet (Form available in Attachment A of this document)
3. Name of Provider
4. Description of Capacity of Chosen Provider
5. LME/MCO Organizational Capacity
6. Judicial District
7. Proposed budget. Guidelines provided (Attachment C of this document). Salary range differences for Facilitators and Family Support Partner Workers should be less than 10%.
8. Letters of Support

FUNDING AVAILABILITY AND DURATION

The Division of MH/DD/SAS has funding for this pilot for the first year through June 30, 2019. This pilot will be funded for 24 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.

FUNDING METHODOLOGY

One LME/MCO will be selected to implement this pilot within one judicial district. The allocation per LME/MCO will not exceed \$1,760,064.

ALLOWABLE COST

Funding may be used for start-up costs and for ongoing operational costs related to direct provision of services. For SFY 19, 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.

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 Care Coordination model for youth involved with juvenile justice and child welfare. The primary target is youth involved in juvenile justice and child welfare for youth who are entering, currently placed and exiting out-of-home placements and youth who are at risk of residential placement. The LME/MCOs will also connect youth involved with DSS and Juveniles Justice, living in or transitioning back into the community, with assessment, family supports and services.

Contractor Duties:

The LME/MCO will be expected to carefully choose the judicial district and to limit its selection of Providers for this service to those who 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

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) currently placed in residential or 3) exiting residential and 4) youth at risk of entering residential placement and who also have significant functional impairment. Youth in the third tier will be served with high fidelity wraparound which combines service planning across multiple agencies with family and youth 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.
2. 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.

3. Ensures HFW teams are trained, coached, and monitored by the NC HFW Training program.
4. Hire two 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.
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.
6. Provide or arrange for training space for all project related trainings.
7. Address provider challenges as they arise.
8. 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.
9. 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.
10. Seek to develop or adapt services and supports to address the needs of the target population if they do not exist.
11. 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.
12. Provide enhanced rates for trauma informed comprehensive clinical assessments, assessments for youth with problematic sexual behavior, and evidenced based trauma interventions.
13. 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. If using JJSAMHP, supporting documentation should indicate that DSS is already engaged or willing to be engaged with this process with modifications based on DSS definitions.

14. Meet with state and local child welfare and juvenile justice staff and state project manager to develop protocols for referral.
15. 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.
16. 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.
17. 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.
18. 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.
19. Participate with provider, DSS, and Juvenile Justice in a continuous quality improvement process (client outcomes and system improvement) for the project.
20. 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/>)
21. Attend local Department of Social Services and Juvenile Court staff meetings as needed to explain pilot program activities (referral, services, discharge).
22. 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.

23. 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.
24. 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 two Wraparound teams 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.

Responsibilities of DMHDDSAS:

1. Provide .50 funding for a local project manager, .50 data collector, two full time LME/MCO DSS/ Juvenile Justice Liaisons, one full time Family Navigator, up to two High Fidelity Wraparound Teams, and the first three months of a targeted case management.
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 support local implementation and monitor the project.
4. Work with Center for Child and Family Health 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.

5. Provide training, certification and monitoring of HFW Coach and Teams through the NC HFWTP Implementation Specialists.

APPLICATION

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

1. LME/MCO Organizational Capacities

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

Please describe your LME/MCO's:

1. Current array of child/adolescent services including any services targeted for youth involved with child welfare or juvenile justice.
2. Current array of child crisis services.
3. How this tiered 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.
4. Collaborative efforts with the department of social services and juvenile justice office in your selected judicial district resulting in the improved outcomes or processes for youth involved in child welfare or juvenile justice.
5. Efforts to monitor the implementation of child/adolescent evidenced based practices and your LME/MCO's role in fidelity monitoring.
6. 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.
7. 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.

8. 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.
9. 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.)

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.

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.

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?

As an LME/MCO, what recommendations or suggestions do you have to enhance this pilot as currently described?

2. Name of Provider for High Fidelity Wraparound and Targeted Care Coordination

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

Please describe and provide examples of:

1. 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.
2. How this provider would hire and supervise the necessary staff in the required time frames to ensure the best matched, experienced staff are hired.
3. This provider's past collaborative efforts with your LME/MCO, local department of social services and juvenile justice.
4. 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.
5. 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.
6. 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.
 7. 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.

4. Judicial District

What Judicial District has been chosen?

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

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

Please describe any current or past collaborative efforts that support the Care for the selection of this judicial district for launching this tiered Care Coordination pilot.

5. Letters of Support

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.

EVALUATION CRITERIA – MAXIMUM 100 POINTS

LME/MCO Organizational Capacities up to 40 points

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

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

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

Judicial District up to 20 points

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

Name of Chosen Provider Pass/Fail

Letters of Support and Signatures Pass/Fail

SELECTION AND NOTIFICATION PROCEDURES

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

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

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

It is the Division's intent to provide funding for one pilot for this funding cycle. Continuation awards will depend on the availability of funds, progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of the award. An allocation letter will be processed and mailed to the selected LME/MCO applicant.

Attachment A: APPLICATION FACE SHEET

Name of LME/MCO: _____

Address: _____

Phone Number: _____

FAX Number: _____

Email Address: _____

LME/MCO Contact Name and Title: _____

Signature of LME/MCO CEO: _____

My signature stipulates that I have received and reviewed a copy of this application.

Signature of Chief Court Counselor: _____

Signature of Local DSS Director(s): _____

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

Tiers	Where Position Located	Target Population	Functions	Training Needed	#'s served
Tier 1 LME/MCO	Embedded DSS and JJ offices	Youth who are:	Assist DSS, Juvenile justice, and adult corrections staff connect youth to appropriate assessment and treatment.	Orientation to High Fidelity Wraparound (HFW) and On the Road to Family Driven Care.	None
DSS/Juvenile Justice Liaisons		Not connected to provider and need an assessment			
Family Navigators		Not able to access service/s recommended in clinical assessment	Troubleshoot with DSS and Juvenile Justice staff on problematic situations.	All other training is standard to LME/MCO care coordinators,	All levels of need.
		Short term involvement until youth is successfully connected to appropriate services.			
		Feedback to LME/MCO re: service gaps for DSS and justice involved youth as well as any unresolved provider issues.			
		Provides routine information to DSS and justice system partners on service criteria.	Family Navigator stay connected for up to 60 days.		

Tier II Targeted Care Coordination	Provider-Services primarily provided in the community.	Youth has:	Care Coordination Assessment	On the Road to Family Driven Care High Fidelity Wraparound Orientation Information on partner agencies (justice systems, social services, schools). Trauma informed care.	1:20
Family Navigator	Embedded at JJ and DSS	Mental health or substance use diagnosis. Can have co-occurring I/DD. and	Or other configuration of staffing to meet local need		
DSS/JJ Liaisons		Involvement in child protective/ foster care services or juvenile justice. and	Person Centered Planning across all agencies involved with the family Effective Referral and Linkage Monitoring and Follow-up		

		<p>Youth requires coordination between two or more agencies including medical or non-medical providers. and</p> <p>Youth is unable to manage his or her symptoms or maintain abstinence (independently or with family/caregiver support), due to at least three unmet needs including safe and adequate housing or food, or legal, educational, vocational, financial, health care, or transportation assistance for necessary services. OR</p> <p>Youth is in residential setting and needs coordination to transition to an alternate level of care. OR</p> <p>Youth has experienced two or more crisis episodes requiring intervention through emergency department, mobile crisis service, psychiatric hospitalization or detox within last three months.</p>	<p>Addresses transportation needs which could include transporting family members to appointments and assisting in meeting long-term transportation needs.</p>	<p>Working with dually diagnosed youth with IDD/DD and mental health.</p>	
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Attachment C: COST ESTIMATES

Cost Estimate of Two High Fidelity Wraparound Teams

Component	Calculation	Cost
Two Wraparound Coach/Supervisor	\$52,000 + 30% benefits	\$ 135,200
Eight Facilitators	\$42,000 + 30% benefits x 5 facilitators	\$ 436,800
Four Family Support Partners	\$40,000 + 30% benefits x 3 FPS	\$ 208,000
Two Youth Support Partners	\$32,000 + 30% benefits	\$ 83,200
Targeted Case Manager (3 months)	10,000	\$10,000
Mileage	2000 miles per month x 14 direct staff x 12 months	\$ 336,000
Mileage	1000 miles per month x 2 supervisors for 12 months	\$ 24,000
National NWIC conference	\$2000 x 17 staff	\$ 34,000
Communication	\$100 per phone x 16 staff x 12 months	\$ 19,200
Computers (one-time cost)	\$1000 x 16 staff	\$ 16,000
Training Manuals	\$58 x 16 staff	\$928
Administrative cost	3.5% of salary costs (\$863,200)	\$ 30,212
Total		\$1,333,540

Cost Estimate for LME/MCO project staff/ training

Component	Calculation	Cost
Family Navigator	\$50,000 + 30% benefits	\$ 65,000
Two Liaisons	\$55,000 + 30% benefits	\$ 143,000
Mileage	1500 miles per month x 2 direct staff x 12 months	\$ 36,000
.50 Project Manager	\$32,500 + 30% benefits	\$ 42,250
.50 Data Manager	\$32,500 + 30% benefits	\$ 42,250
National NWIC conference	\$2000 x 5 staff	\$ 10,000
Mileage	500 miles per month x 2 supervisors x 12 months	\$ 12,000
CCFH Trauma Assessment Training	\$75,000	\$ 75,000
Administrative costs	\$3.5% of salary costs (\$292,500)	\$1,024.00
Total		\$ 426,524

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.

Attachment E: Training

Training Arranged by DMH/DD/SAS for Tiers of Care Manages/Care Coordinators

High Fidelity Wraparound Training

Component	Cost
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Manuals per staff (16 x \$58) \$928

Total	\$928
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Overview of DSS, Juvenile Justice, and CCNC

Component	Cost
Training by partner agencies 1 day or three 2-hour trainings	---

Component	Cost
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/Youth Move

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

Attachment F:

Essential Program Elements for High Fidelity Wraparound and Targeted Case Management

1. High Fidelity Wraparound Staffing Requirements

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 and the coach will carry 2 Cares. So, one coach/supervisor can oversee the care

of 40-48 youth. Provider will maintain ratio of one facilitator to 10-12 youth/families. See HFW Training and Certification – “Attachment H”

2. Family Driven Care

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, & Blau, 2008)”

3. Targeted Case Management Staffing Requirements: Provider will follow existing targeted case management clinical policy requirements and for this pilot will maintain a caseload under 1:20. The comprehensive and culturally appropriate case management assessment may be chosen locally but will be monitored for implementation.

4. Case Management Assessment:

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 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.

5. Person Centered Treatment Planning

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

Person centered planning is at the center of self-direction and self-management. All good plans are done in partnership with the young person and their family. The care coordinator, who knows the requirements for a plan and what must be accomplished,

works in concert with the content experts who know the detail of what the plan needs to say. The content experts are the young person, their family, friends, and child serving professionals involved with the family who have lengthy experience with the young person.

Person centered planning is an ongoing process that drives the development and periodic revision of a plan based on the information collected from the young person, their family, other individual supports, and comprehensive clinical assessments or reassessments. The information gathered is translated into goals, outcome statements, and the actions necessary to address the medical, behavioral, social, and other service needs of the young person.

The primary reference documents for person-centered planning and Person-Centered Plans are the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) Person-Centered Planning Instruction Manual and the Records 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: <http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm>. 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.

6. Referral and Linkage

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

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

7. Monitoring and Follow-Up

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

1. Services are being provided in accordance with the young 's PCP
2. Services in the PCP are adequate and effective

3. There are changes in the needs or status of the young person
4. The young person is making progress toward his or her goals

High Fidelity Wraparound Facilitator will as scheduled track progress and ensures the TOMS and Transition Assets Tool are completed on a set schedule. The targeted case manager will complete NC TOPPs as scheduled. The duration of services will be based upon medical necessity and the youth and family's willingness to participate in the program.

8. Client Protections

The provider ensures that Wraparound Facilitators and Family and Youth Support Partner complete the state required certification 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 Certification 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 Partner, and Youth Support Partner as evidenced by certification as a High Fidelity Wraparound Coach.

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 certification and training requirements. Family Support Partner must also be certified as a National Parent Support Provider within one year from hire and the Youth Support Partner must attend Peer2Peer training one-year from hire.

Existing sites with a HFW Certified Coach may submit a plan for coaching and certifying the "new" Facilitator, Family or Youth Support Partner as part of the HFW certification process provided by the NC HFWTP. In addition, existing sites with a HFW Master Coach may submit a plan for coaching and certifying a "new" Coach. A plan must be submitted by the provider in writing to the NC HFWTP. Written approval with specific guidelines from the NC HFWTP must be received before the coaching and certifying plan is be put into action.

Wraparound Facilitator:

1. Must meet requirements as a qualified professional.
2. Must complete Wraparound Facilitation training curriculum and be certified as Wraparound Facilitator or complete training and certification 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 certified as a Wraparound Coach (or in process of being certified a Wraparound Coach).
6. Have received 13 hours of Motivational Interviewing training from a MINT trainer.
7. Juvenile justice, child welfare, and CCNC Basics
8. On the Road to Family Driven Care

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 PRTF placement criteria; federal, state, and local resources
4. Using assessments (including environmental, psychosocial, health, and functional factors) to develop a Wraparound Plan
5. Family driven and youth guided care including the client's and family/caregiver's right to make decisions about all aspects of their child's care;
6. The principles of human behavior and interpersonal relationships; and
7. General principles of record documentation.

Skills in:

1. Negotiating with clients, family/caregivers, and service providers;
2. 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 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 hire date. Family Partner 101 is part of National Certification Trainings for North Carolina. <http://www.ffcmh.org/certification>
5. Family Support Partner is certified in the role of Family Support Partner in High Fidelity Wraparound or completes certification process within 9 months from hire.

6. Family Support Partner is certified as a National Certified Parent Support Provider (CPSP) within one year from hire.
7. Criminal Background check presents no health and safety risk to participants.
8. Not listed in the NC Health Care Abuse Registry.
9. Family possesses a current/valid driver's license and an automobile with proof of auto insurance.
10. 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 certified in the role of Youth Support Partner in High Fidelity Wraparound or completes certification process within 9 months from hire.
5. Youth Support Partner must attend 2 training within one-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. Youth 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 Foundation 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

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

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

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

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

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

2. Problems with Providers:

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

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

Care Coordination was a top priority in the Governor's Task on Mental Health and Substance Use. Youth with complex needs are often involved with multiple child serving agencies and if their care across agencies and services is not coordinated, these young people often are placed in restrictive levels of care and have high use of crisis services while having poor outcomes. A tiered model of care and 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 or 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.

8.1. 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 & Certification 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:

Type of Site	Length of Training	Timeline to Complete	Training Provided By:
New Site	4 days	Within 30 days of employee start date	Implementation Specialist (IS)
Existing Site (training additional or incoming employees)	4 days or book review/independent learning with exercises if the coach is certified and approval is obtained from the Implementation Specialist	Within 30 days of employee start date	Implementation Specialist, Master Coach and/or Certified Coach

Coach Training:

Type of Site	Length of Training	Timeline to Complete	Training Provided By
New & Existing	4 days or book review/Independent Learning with exercises depending on needs of the site and/or coach	Within 30 days of completing the Foundations Training	Implementation Specialist or Master Coach

Certification of all Staff:

Type of Site	Timeline to Complete	Certified by
New Site (< 6 months of operation)	As indicated by the LME/MCO service definition Best practice expectation is 6 - 9 months	Certified Coach, Master Coach, Implementation Specialist <i>Note: If coach is certified, he/she is able to certify team members without the IS (all completed certification tracking tools must be submitted to IS for tracking. Certification of the coach is only done through the IS (unless there is an approved Master Coach on site).</i>
Existing site (> 6 months of operation)	6 months	Certified Coach, Master Coach and Implementation Specialist <i>Note: If coach is certified, he/she is able to certify team members without the IS. Further, Certified Coaches can train new coaches with oversight from the IS (all completed certification tracking tools must be submitted to IS for tracking). Certification of the coach is only done through the IS (unless there is an approved Master Coach on site).</i>

Training Plans:

Certified and Master Coaches must submit a training plan to the IS for each team member within **7 days** of the start date for that employee. Training plans must be reviewed with the IS prior to any training provided. The training plans must be updated when any activities are completed and resubmitted to the IS. Training plan must include the following:

- * Timeline
- * Certification activities to be completed
- * Other required trainings (i.e. provider based, Family Partner National Certification, etc.)

Non-Certified Coaches will collaborate with the IS or Master Coach (if applicable) to create a training plan AND certification tracking form for each team member and then follow the above guidelines.

Certification of Facilitators, Family Support Partners and Youth Support Partners:

Certified Coaches:

- * Submit all completed (certification) activity score sheets to the IS/Master Coach within **7 days** of completion
- * 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 certification completion for all team members and provided updated versions to the IS/Master Coach and team member as activities are completed

Non-Certified Coaches:

- * Submit all certification activities to the IS or Master Coach (either by video, audio, or documentation) within **7 days** of completion
- * IS/Master Coach and Coach will individually score each activity followed by a comparison of scoring and preparation with the Coach to debrief the team member on that activity scoring **within 7 days** of receiving the materials. Coach to debrief with team member no more than **7 days** following debrief with the IS/Master Coach.
- * Coach will 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 certification completion for all team members and provided updated versions to the IS/Master Coach and team member as activities are completed

Certification of Coaches:

- * IS or Master Coach will work with the coach to develop a timeline of certification activities
- * Coach will submit all completed certification activities (through video/audio/documentation) within **5 days** of completing the activity to the IS or Master Coach
- * IS or Master Coach will debrief with the Coach within **5 days** of receiving the materials or observing an activity.
- * IS or Master Coach will update the tracking of certification plan and provide these updates to the coach

Ongoing Training:

Coaches:

- * Shadow each staff member (Youth Support Partner, Family Support Partner, and Facilitator) at least once per month and use Wraparound Tools for structured scoring/feedback

- * 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:

- * Will receive ongoing training/boosters on High Fidelity Wraparound principles/tasks (these can be to , group-based, Coach led, and/or IS led)
- * IS will monitor all ongoing trainings to ensure completion

Fidelity Monitoring:

Site Reviews/Audits:

- * Quarterly site reviews/audits for teams/sites operating for less than 2 years and/or have a corrective action plan in place
- * Bi-annual site reviews/audits for teams/sites operating for over 2 years and most recent audit score is 80% or above
- * Review includes the following:
 - Review of a minimum of 4 current charts
 - Review of all team Group Coaching documentation
 - Review of all team member individual supervision documentation
 - Review of all training and certification plans
 - Review of all referrals received for that quarter/6-month period and the outcome (i.e. approved, denied, referred out, etc.)
- * IS will provide written and oral feedback to sites after any site review/audit within 3 days

Coaches:

- * Certified Coaches:
 - IS will observe (phone/in person) bi-monthly group coaching staff meetings
 - IS will debrief with Coach and create/update the coach's development plan within 2 days of the observation
 - IS and Coach will maintain an updated team development plan
- * Non-Certified Coaches:
 - IS will observe (phone/in person) monthly group coaching staff meetings

- IS will debrief with coach and create/update the Coach's development plan within 2 days of the observation
- IS and Coach will maintain an updated team development plan

Corrective Action Plans:

- * Are implemented due to the following:
 - Ongoing challenges completing training and/or certification for team members
 - Failing to submit required documentation in a timely manner (see timelines above)
 - 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.)
 - 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

Master Coaches:

This is a certified coach who has the ability to train and certify others to be coaches.

Requirements to become a Master Coach:

- * At least 1 year of experience being a Certified Coach in High Fidelity Wraparound
- * Absence of any corrective action plans within the year prior to request for Master Coach credentialing
- * HFW team(s) has an 80% successful discharge rate, with no more than 20% of youth being discharged to higher level of care within the past year.
- * Certified Coach requests permission to become a Master Coach in writing to North Carolina High Fidelity Wraparound and the assigned IS; within the request the following documents are required:
 - Proof of Fidelity scores for all certified team members at or above 85%.
 - Submission of HFW youth data reflecting successful discharges, moves, changes to higher level of care, etc.

- Submission of WFI-EZ tracking and use of individual and aggregate reports
- Submit a training plan, outline or matrix reflecting how they will train new coaches with specific training philosophy, agency culture, goals, and objectives, and how WFI-EZ data will be used to support ongoing trainings, debriefs, and feed-forward.
- * Consistent (80%+) submission of all required reports and documentation to the assigned Implementation Specialist