

## **Coordinated System of Care (CSoC) Community Application**

### **Application Submission**

One complete, original application packet and 10 complete copies are to be submitted to the Department of Health and Hospitals – Office of Behavioral Health (DHH-OBH). Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS). Hand delivery is also acceptable.

**Applicants should make a copy of their completed application for their records prior to submission.**

**The application deadline is 3:30 pm Central Daylight Time on Friday, May 13, 2011.**

Applications must be received by the application deadline, or you must have proof of its timely submission as specified below.

For packages submitted via DHL, FedEx, or UPS, proof of timely submission shall be the date on the tracking label affixed to the package by the carrier upon receipt by the carrier. That date must be at least

- One day prior to the application deadline for packages shipped overnight,
- Two days prior to the application deadline for packages shipped with a two-day shipping option, and
- One week prior to the application deadline for packages shipped with a ground option.

The date affixed to the package by the applicant will not be sufficient evidence of timely submission.

For packages submitted via USPS, proof of timely submission shall be a postmark no later than:

- One day prior to the application deadline for packages shipped via Express Mail,
- Three days prior to the application deadline for packages shipped via Priority Mail, and
- One week prior to the application deadline for packages shipped via First Class Mail.

In addition to the postmark, applicants must be able to provide the following upon request by DHH-OBH:

- Proof of mailing using USPS Form 3817 (Certificate of Mailing); or
- Receipt from the Post Office containing the post office name, location, description of service type (Express, Priority or First Class Mail) and date and time of mailing.

The following addresses should be used accordingly:

#### **United States Postal Service Delivery**

LA Department of Health & Hospitals Office of Behavioral Health  
Attn: Coordinated System of Care, Unjel Smith  
P. O. Box 3868, Bin #9  
Baton Rouge, LA 70821

**DHL, FedEx, UPS or Hand Delivery**

LA Department of Health & Hospitals Office of Behavioral Health

Attn: Coordinated System of Care, Unjel Smith

628 N. 4th Street, 4th Floor

Baton Rouge, LA 70802

If you require a phone number for delivery, you may use (225) 342-2540.

Agencies will be notified by e-mail that their application has been received.

**Late applications will not be considered for review.** Please remember that mail sent to government facilities undergoes a security screening prior to delivery. Allow sufficient time for your package to be delivered. If an application is mailed to a location or office (including room number) that is not designated for receipt of the application, and that results in the designated office not receiving your application in accordance with the requirements for timely submission, it will cause the application to be considered late and ineligible for review.

**It is essential to provide accurate contact information for the applicant's primary contact person.** Changes in contact information (name, address, email address, phone and fax numbers) must be updated and provided to the DHH-OBH immediately. The Departments will bear no responsibility for undeliverable correspondence or an inability to make contact based on inaccurate contact information provided by applicants.

**Applications sent by facsimile or electronic mail will not be accepted or considered for review. Incomplete applications will not be considered for review.** OBH is not responsible for incomplete applications and will return to the applicant any application that does not include all items listed on the Application Checklist.

**Applications submitted by programs and/or agencies listed on the "DHH Banned from Business List" will not be considered for review.**

**Submission of an application packet does not indicate approval to participate in the Coordinated System of Care (CSoC).** All completed packets submitted by the deadline will be reviewed. In addition to the application packet, applying communities may also **be required to provide an on-site presentation.** The cumulative scores of the application packet and on-site presentations will be used to determine which communities will be selected to participate in the initial implementation phase.

**An "Intent to Apply" must be communicated to DHH-OBH by March 25, 2011,** via email to CSOC.HelpDesk@la.gov. The email must include the following:

- Specification of the region for which your group intends to apply and
- Contact information (name, address, email address, phone and fax numbers) for the person responsible for communication with DHH-OBH regarding the application during the application development period (updates to the contact information during the application development period should be sent to CSOC.HelpDesk@la.gov).

## Application Format Requirements

Application narrative in response to Section 2 of the RFA cannot exceed 30 pages in total, including any attachments, charts, graphs, footnotes, etc. The narrative should be typed single space using Arial 11 font with one inch margins (left, right, top, and bottom). In your response, please only include the headers and questions in ***bold italics*** from Section 2 of the RFA in order to help reviewers of your response know the questions to which you are responding. In order to ensure that you have sufficient space in which to answer these questions within the prescribed page limits, please do not repeat more of the content from this section in your response. Include only the headers and questions in ***bold italics***.

Application forms provided in the RFA (including the proposal checklist and acceptance forms) and letters of support do not count within the maximum page count.

## Sequence of Events

<b>EVENT</b>	<b>DATE</b>
<b>Distribution of Application Packet to Communities</b>	<b>March 11, 2011</b>
<b>Technical Assistance Initial Kick-Off Meeting for Communities Intending to Respond to RFA</b> DHH Bienville Building, 628 N 4th Street, Baton Rouge, LA, Room 118	<b>March 15, 2011</b> 9:00 to 12:30pm
<b>Weekly Technical Assistance Webinars Begin</b> Every Wednesday, 1:00 to 3:00 pm Dial in and conferencing instructions will be posted at the CSoC website ( <a href="http://www.dcfsl.a.gov/csoc">www.dcfsl.a.gov/csoc</a> )	<b>March 23, 2011</b> 1:00 to 3:00 pm
<b>“Intent to Apply” Email Due Date</b>	<b>March 25, 2011</b>
<b>Final Weekly Technical Assistance Webinar AND Deadline for Final Submission of Questions</b>	<b>May 4, 2011</b>
<b>Responses Received</b>	<b>May 13, 2011</b> 3:30 pm CDT
<b>Initial Evaluation of Responses</b>	<b>May 27, 2011</b>
<b>Presentation by Responders</b>	<b>June 3, 2011</b>
<b>Final Evaluation of Responses</b>	<b>June 10, 2011</b>
<b>Announcement of Awards</b>	<b>June 16, 2011</b>
<b>CSoC Launch Date</b>	<b>January 1, 2012</b>

This Request for Applications (RFA) consists of five sections:

1. Background Information to help the applicant understand the purpose of the RFA and the State's intent to develop a Coordinated System of Care (CSoC),
2. Questions regarding the applicant's general readiness and capacity to implement a CSoC,
3. General requirements for the implementation of a Wraparound Agency and Family Support Organization,
4. Questions regarding the applicant's specific capacity to implement a Wraparound Agency as part of the CSoC, and
5. Questions regarding the applicant's specific capacity to implement a Family Support Organization.

## Glossary of Key Terms and Acronyms

**Age of Majority:** Louisiana Civil Code, Article 29, provides that majority is attained upon reaching the age of eighteen years.

**BH:** Behavioral Health

**BHSF:** Bureau of Health Services Financing, Department of Health and Hospitals

**CANS – Child and Adolescent Needs and Strengths:** The CANS is a multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.<sup>1</sup>

**CASSP:** Child and Adolescent Service System Program

**CFR:** Code of Federal Regulations

**CFT:** Child and Family Team

**CMS:** Centers for Medicare and Medicaid Services

**COD:** Co-Occurring Disorders of substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders.

**CommunityCARE Program:** System of comprehensive health care based on a Primary Care Case Management (PCCM) model operated as a State plan option in Louisiana. Primary care physicians receive a monthly management fee in addition to the fee for service payment to coordinate their member’s healthcare.

**CSoC – Coordinated System of Care:** This is an evidence based model that is part of a national movement to develop family- and youth-driven care and keep children at home, in school, and out of the child welfare and juvenile justice system.

**CSoC Eligible:** Children and youth eligible for services under the CSoC, regardless of Medicaid eligibility.

**Covered Individuals:** Persons who are eligible for Medicaid

**DCFS:** Department of Children and Family Services

**DHH:** Department of Health and Hospitals

**DOE:** Department of Education

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<sup>1</sup> <http://www.praedfoundation.org/About%20the%20CANS.html>

**EBP:** Evidence Based Practice

**Eligible:** An individual qualified to receive Medicaid funded services

**ELMHS:** Eastern Louisiana Mental Health System

**Enrollee:** A person who is qualified for Medicaid and whose application has been approved but who may or may not be receiving services

**EPSDT:** Early and Periodic Screening, Diagnosis, and Treatment

**Family:** For the purpose of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the family support and training service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

**FFS:** Fee-for-Service

**FERPA:** Federal Educational Right to Privacy Act

**FSO:** Family Support Organization

**HCBS:** Home and Community Based Services

**HIPAA:** Health Insurance Portability and Accountability Act

**IDEA:** Individuals with Disabilities Education Act

**ISP:** Individualized Service Plan

**IT:** Information Technology

**JLCB:** Joint Legislative Committee on the Budget

**LEA:** Local Education Agency

**LGE:** Local Governing Entities

**Licensed Practitioner of the Healing Arts:** Under Medicaid regulations, medical necessity for rehabilitative services must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and they must be furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. This is generally held to be a physician or licensed practitioner (see the OLP definition) acting in his or her scope – but not every practitioner (e.g., LPC or LAC) can do everything under their scope.

**LMMIS:** Louisiana Medicaid Management Information System

**LOCUS:** Level of Care Utilization System: clinical tool that evaluates and determines level of care placements for psychiatric services

**Medicaid:** The federal-state entitlement program for low-income citizens of the United States authorized by Title XIX of the Social Security Act Amendment that became law in 1965. Medicaid offers federal matching funds to states including Louisiana for costs incurred in paying health care providers for serving covered individuals.

**Medicaid Management Information System (MMIS):** The claims processing and information retrieval system which includes all Providers enrolled in the Medicaid Program. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.

**Member:** Persons enrolled in the SMO

**MH/BH:** Mental Health/ Behavioral Health

**MHBG:** Mental Health Block Grant

**MIS:** Management Information Systems

**Must:** Denotes a mandatory requirement

**NCQA:** National Committee for Quality Assurance

**NWI:** National Wraparound Initiative – This initiative is a collaborative effort involving families, youth, providers, researchers, trainers, administrators and others to better specify the wraparound practice model, compile specific strategies and tools, and disseminate information about how to implement wraparound in a way that can achieve positive outcomes for youth and families.<sup>2</sup>

**OAD:** Office for Addictive Disorders (OAD became a part of OBH on July 1, 2010); OAD and OBH may be used interchangeably in the document.

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<sup>2</sup> <http://www.nwi.pdx.edu/index.shtml>

**OBH:** Office of Behavioral Health, Department of Health and Hospitals, formerly Office of Mental Health

**OCDD:** Office for Citizens with Developmental Disabilities

**OJJ:** Office of Juvenile Justice

**OMH:** Office of Mental Health, now Office of Behavioral Health, Department of Health and Hospitals

**OMH-IIS:** Office of Behavioral Health Integrated Information System - OBH web-based information system, operating over the OBH wide-area network on a central SQL server; planned to be comprehensive in scope, it has undergone a series of enhancements to sequentially replace the remaining separate, non-integrated LAN-based legacy systems now operated by OBH statewide.

**OPH:** Office of Public Health

**PCCM:** Primary Care Case Management – A Medicaid program that links Medicaid Enrollees to primary care physicians and operates statewide. The Louisiana Medicaid PCCM program is called CommunityCARE.

**PCCM Member:** Louisiana Medicaid Enrollee in the PCCM program

**PCMH:** Patient-Centered Medical Home

**PCP:** Primary Care Provider - A medical provider who manages the care of each Medicaid Enrollee by providing health education, preventive care, and acute care, and referral for specialist care or hospitalization when needed. The CommunityCARE PCP arranges for medical care coverage twenty-four (24) hours a day, seven (7) days a week and is reimbursed via a fee-for-service payment for care provided and a monthly management fee for each CommunityCARE enrollee linked to their practice.

**PHI:** Protected Health Information

**PIHP:** Prepaid Inpatient Health Plan

**POC:** Individualized Plan of Care – The POC identifies the waiver services as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. It must reflect the full range of a participant's service needs and include both the Medicaid and non-Medicaid services along with informal supports that are necessary to address those needs. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored. The POC must contain, at a minimum: the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. The POC must be revised as necessary to add or



delete services or modify the amount and frequency of services. The POC must be reviewed at least annually or whenever necessary due to a change in the participant's needs.

**Proposer:** Entity or company seeking contract to provide stated deliverables and services identified within a RFP document

**Provider:** A person, group or agency that provides a covered service.

**PRT:** Psychiatric Residential Treatment Facility

**QM:** Quality Management

**QA/QI:** Quality Assurance/Quality Improvement

**QAO:** Quality Assurance Officer

**Recipient:** Medicaid eligible individual who receives Medicaid funded services.

**RFA:** Request for Applications

**RFP:** Request for Proposal

**RHC/FQHC:** Rural Health Clinic/Federally Qualified Health Center

**ROI:** Return on Investment –The ratio of money gained or lost on an investment relative to the amount of money invested

**SAMHSA:** Substance Abuse & Mental Health Services Administration

**SAPT Block Grant:** Substance Abuse Prevention and Treatment Block Grant

**SCHIP:** State Children's Health Insurance Program

**SED:** Severe Emotionally Disturbed

**Shall:** Denotes a mandatory requirement

**Should:** Denotes a preference, but not a mandatory requirement

**SMO:** Statewide Management Organization

**SOC:** System of Care

**TA:** Technical Assistance

**TANF:** Temporary Assistance for Needy Families

**TBD:** To Be Determined

**UM:** Utilization Management

**UR:** Utilization Review

**WAA:** Wraparound Agency

**WF:** Wraparound Facilitation – An intensive, structured, creative and individualized team planning process that addresses the needs of youth within the context of the broader family unit and is designed to address a range of life areas.

**WFAS:** Wraparound Fidelity Assessment System – This is a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. WFAS instruments include interviews with multiple stakeholders, a team observation measure, a document review form, and an instrument to assess the level of system support for wraparound.<sup>3</sup>

**Will:** Denotes a mandatory requirement; failure to include is grounds for disqualification of the entire proposal

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<sup>3</sup> <http://depts.washington.edu/wrapeval/WFI.html>

## **Section 1: Background Information**

### **Purpose of this Request for Applications**

The coordinated systems of care (CSoC) is a research-based model that is part of a national movement to develop family- and youth-driven care and keep children with severe behavioral needs at home, in school, and out of the child welfare and juvenile justice system.

Louisiana's CSoC is an initiative of Governor Jindal being led by the Executives of these state agencies:

- Office of Juvenile Justice (OJJ)
- Department of Children and Family Services (DCFS)
- Department of Health and Hospitals (DHH)
- Department of Education (DOE)

These four agencies are working in collaboration with families to develop a CSoC that will offer an integrated approach to providing services for children and youth under age 22 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.

Louisiana's CSoC will initially serve children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement defined as:

- Addiction facilities,
- Alternative schools,
- Detention,
- Developmental disabilities facilities,
- Foster care,
- Homeless as identified by DOE,
- Psychiatric hospitals,
- Residential treatment facilities, and
- Secure care facilities.

The goals of the CSoC include:

- Reduction in the number of targeted children and youth in detention and residential settings,
- Reduction of the state's cost of providing services by leveraging Medicaid and other funding sources, and
- Improving the overall outcomes for these children and their caregivers.

Louisiana's CSoC:

- Incorporates a broad, flexible array of effective services and supports for a defined population,
- Is organized into a coordinated network,
- Integrates care planning and management across multiple levels,
- Is culturally and linguistically competent,
- Builds meaningful partnerships with families and youth at service delivery, management,

- and policy levels, and
- Has supportive policy and management infrastructure.

An important CSoC goal is the reduction of costly, highly restrictive out of home placements through the creation and maintenance of coordinated and effective community based services. CSoCs also create partnerships with public and private providers of services that target children, youth and their families in a multi-agency, multi-disciplinary system of services.

For more information on Louisiana's CSoC initiative, visit: <http://www.dcf.la.gov/csoc>.

Implementation of the CSoC will be organized by ACT 1225 Regions, with the exception of Jefferson Parish, which will be organized separately:<sup>4</sup>

- Region 1 – Orleans, Plaquemines, St. Bernard
  - **Jefferson Parish will respond separately**
- Region 2 – East / West Baton Rouge, East / West Feliciana, Iberville, and Pointe Coupee
- Region 3 – Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington
- Region 4 – Ascension, Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, and Terrebonne
- Region 5 – Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary, and Vermilion
- Region 6 – Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis
- Region 7 – Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn
- Region 8 – Bienville, Bossier, Caddo, Claiborne, Desoto, Jackson, Natchitoches, Red River, Sabine, and Webster
- Region 9 – Caldwell, East / West Carroll, Franklin, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, and Union

The purpose of this Request for Applications (RFA) is to serve as the first step towards statewide implementation of the CSoC by identifying (1) the regions in Louisiana that are ready to participate in the first phase of CSoC implementation and (2) the communities within those regions that are most prepared to be part of that initial phase, with a demonstrated strong history of the service delivery approaches, knowledge, skills and abilities necessary to a successful CSoC. Louisiana's statewide implementation is planned to develop systematically, beginning with regions and leading communities within them that are most ready to begin, followed by other communities in those regions, and ultimately all regions and communities across the state.

The CSoC will implement one Family Support Organization (FSO) and one Wraparound Agency (WAA) per region, and **each applying region can only support one FSO and WAA as part of their proposed CSoC under this RFA.**

The response to this RFA should reflect collaboration and partnership across your region, rather than the efforts of a single "lead agency" or similar entity. This RFA is seeking to understand the

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<sup>4</sup> Act 1225 refers to Act 1225 of 2003, incorporated as RS 46:2600.

level of community support and capacity to work towards CSoC development in your region, rather than looking for an individual agency or entity to manage implementation.

By responding to this RFA, collaborative partners are not individually committing to accomplish the set of activities set forth, but are instead signaling their capacity and commitment to work together towards successful CSoC implementation.

Community buy-in to this model is essential to success. The RFA process has been designed to spur and assess community ownership, collaboration and grassroots organization to cultivate the evolution of systems of care across Louisiana.

### **CSoC Technical Assistance Opportunities for Applicant Regions**

The following technical assistance resources have been planned to provide applicants with necessary information and support in developing their responses to this RFA. Any changes, additions, or updates to this technical assistance plan will be posted at the CSoC website ([www.dcfsl.a.gov/csoc](http://www.dcfsl.a.gov/csoc)).

#### **Phase 1 – Technical Assistance Initial Kick-Off Meeting for Communities Intending to Respond to Request for Applications**

**Date:** March 15, 2011, 9:00 am – 12:30 pm

**Location:** DHH Bienville Building, 628 N 4th Street, Baton Rouge, LA, Room 118

##### **Draft Agenda:**

Welcome	CSoC Leadership Team
Systems of Care: Impacts of Implementation	Michelle Zabel, Director, Innovations Institute, Baltimore, MD
Review of RFA	Shannon Robshaw and Peter Selby
Technical Assistance Opportunities	Shannon Robshaw and Peter Selby
Questions and Answers	Representatives from all CSoC agencies will be present to respond

**Phase II.A – Webinar Technical Assistance Meetings every Wednesday, 1:00 to 3:00 pm, from 3/23 through 5/4** (dialing and webinar log in information will be will be posted on the CSoC website)

03/23/11 Stakeholder and Family Leadership in Local Systems of Care

04/06/11 The Role of the WAA and its Relationship with the Statewide Management Organization in the Coordinated System of Care

04/13/11	National Wraparound Initiative (NWI)
04/20/11	Provider Issues and Related Medicaid Requirements
04/27/11	FSO and WAA Relationships with the Community
05/04/11	CSoC Training by the Maryland Innovations Institute

## **Phase II.B – Email Questions and posting of answers on website**

Questions maybe submitted via email to CSoC.HelpDesk@la.gov through 5/04/2011. Answers to questions will be posted regularly throughout the response period at the CSoC website ([www.dcfsl.a.gov/csoc](http://www.dcfsl.a.gov/csoc)).

Once regions with their local Wraparound Agency (WAA) and local Family Support Organization (FSO) are selected through this RFA, CSoC Leadership will work in partnership with the regions to build capacity locally to staff and manage child and family teams and ensure access to peer-to-peer support within the system of care. CSoC Leadership will also work with regions to build local provider capacity for key evidence based practices (EBPs) and other services and supports.

## **Background on Systems of Care**

### **History and Overview of the Systems of Care**

In 1983, with a mandate and funding from Congress, the National Institute of Mental Health initiated the Child and Adolescent Service System Program (CASSP), which provided funds and technical assistance to all 50 states, several U.S. territories, and a number of local jurisdictions to plan and begin to develop systems of care for children with serious emotional disturbance.

CASSP recognized that children with serious disorders often are involved in multiple public systems, such as education, child welfare, juvenile justice, and mental health, and that planning more effective services for these children requires interagency collaboration.

The definition of a system of care (SOC) for children with emotional disorders was first published in 1986:

*“A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.”<sup>5</sup>*

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<sup>5</sup> Stroul, B., & Friedman, R. A system of care for children and youth with severe emotional disturbances. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health, 1986.

Service coordination and interagency collaboration are elements of the system of care philosophy, as are family involvement and cultural competence. The development of the infrastructure for a system of care is important. But none of these elements is the sole focus of system of care development. First and foremost, systems of care are a range of treatment services and supports guided by a philosophy and supported by an infrastructure.

The **system of care** model is an organizational philosophy and framework that involves collaboration across agencies, families, and youths for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with serious behavioral health disorders and their families. Systems of care engage families and youth in partnership with public and private organizations to design behavioral health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.

### **Family Support and Involvement in the System of Care**

Support for and by family members within the system of care has emerged as a core strategy for improving the children's mental health system of care. The system of care approach has fundamentally changed the relationships that families of children and youth involved in child-serving systems have with the agencies within those systems. Increasingly, collaboration and partnership between families and service providers have been recognized as the threads that link successful programs, policies, and practices. The development of youth involvement in mental health systems of care closely follows the growth and acceptance of family peer-to-peer support and the broader family empowerment movement, as well as the growth of consumer-provided services. A recent literature review sponsored by the University of South Florida (USF) Research and Training Center for Children's Mental Health provides an excellent survey and synthesis of available evidence for the approach.<sup>6</sup>

A recent national survey of family organizations found that education, advocacy, and peer-to-peer support are key to family support.<sup>7</sup> Another review of family peer-to-peer support models provided a useful conceptualization of the key mechanisms underlying the effectiveness of this approach.<sup>8</sup> They identified four key areas:

- **Social support** helps caregivers feel a sense of belonging and being valued, and also provides new resources, both tangible and intangible.

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<sup>6</sup> Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, A. J., & Annis, S. (2008). Parent to parent: A synthesis of the emerging literature. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

<sup>7</sup> Hoagwood, K. E., Green, E., Kelleher, K., Schoenwald, S., Rolls-Reutz, J., Landsverk, J., Glisson, C., & Mayberg, S. (2008). Family Advocacy, Support and Education in Children's Mental Health: Results of a National Survey. *Admin Policy Mental Health*, 35, 73 - 83.

<sup>8</sup> Ireys, H. T., DeVet, K. A., & Sakwa, D. (1998). Family support and education. In M.H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional Disorders and their Families: Programs and Evaluation Best Practices* (pp. 154-175). Austin, TX: Pro-Ed.

- Peer-to-peer support providers serve as **links to broader social networks**, in which peer-to-peer support connects caregivers to community resources, people, or institutions and thus serves as a relationship or social network bridge-builder.
- **Social comparison** occurs when caregivers are better able to maintain and build self esteem in the context of receiving support from a peer who has been through a similar experience, as opposed to situations where unintended negative consequences emerge as supports or services are received from someone who has not experienced similar challenges. Because of similar experiences, the peer can understand what the caregiver is going through, but avoid the potential negative consequences of threatening comparisons.
- **Empowerment** appears to be supported through the peer-to-peer interaction as caregivers see the peer-to-peer support provider as a model of success and as they learn strategies and access resources to help deal with their child's and family's situation.

In Louisiana's Coordinated System of Care, family involvement, support and development, at all levels of the system, will be structured to support family involvement and engage the diversity of families affected by the system of care, including families of children involved in the child welfare or juvenile justice systems. Regions are expected to be thoughtful about the different structures and Family Support Organizations (FSOs) in their Region in order to understand how they will affect different stakeholders' experiences, level of involvement and attainment of system goals. Through local FSOs, family members will participate in the wraparound planning process and provide support and training to families being served by the CSoC.

In general, an important component of meaningful family support is that it is delivered by family peers, defined as follows: a family member of a child or youth with significant behavioral health challenges or co-occurring disorders served by multiple, public child-serving systems for at least one year.

By featuring family members as full partners working within the system of care, the Louisiana Coordinated System of Care hopes to stimulate behavioral change across the system and support development of family-friendly policies and procedures within the provider agencies and among community partners. Emphasizing FSOs as system partners will support full family involvement in systems of care becoming the rule, rather than the exception.

### **Wraparound Facilitation and Systems of Care<sup>9</sup>**

Wraparound Facilitation is often associated with systems of care but is actually a distinct component of a system of care. Since the term was first coined in the 1980s, "wraparound" has been defined in different ways. It has been described as a philosophy, an approach and a service. In recent years, wraparound has been most commonly conceived of as ***an intensive, individualized care planning and management process***.

The organizations providing Wraparound Facilitation in Louisiana's CSoC are Wraparound Agencies (WAAs). There will be one WAA in each region. WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within

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<sup>9</sup> See the National Wraparound Initiative website (<http://nwi.pdx.edu/overall.shtml>) for additional information.



the CSoC needing such supports, with the goal of “one family, one plan of care, one Wraparound Facilitator.”

Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. 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 address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to 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 wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, joined by parent and youth support staff from the FSO, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family (for additional information on the phases of the wraparound process, see information [http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf))

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.

Providing comprehensive care through the wraparound process, thus, requires a high degree of collaboration and coordination among the child- and family-serving agencies and organizations in a community. These agencies and organizations need to work together to provide access to flexible resources and a well-developed array of services and supports in the community. In addition, other community- or system-level supports are necessary for wraparound to be successfully implemented and sustained. Research

on wraparound implementation<sup>10</sup> coordinated by the National Wraparound Initiative has defined these essential community and system supports for wraparound, and grouped them into six themes:

- **Community partnership:** Representatives of key stakeholder groups, including families, young people, agencies, providers and community representatives have joined together in a collaborative effort to plan, implement and oversee wraparound as a community process.
- **Collaborative action:** Stakeholders involved in the wraparound effort work together to take steps to translate the wraparound philosophy into concrete policies, practices and achievements that work across systems.
- **Fiscal policies and sustainability:** The community has developed fiscal strategies to support and sustain wraparound and to better meet the needs of children and youth participating in wraparound.
- **Access to needed supports and services:** The community has developed mechanisms for ensuring access to the wraparound process, as well as to the services and supports that wraparound teams need to fully implement their plans.
- **Human resource development and support:** The system supports wraparound staff and partner agency staff to fully implement the wraparound model and to provide relevant and transparent information to families and their extended networks about effective participation in wraparound.
- **Accountability:** The community implements mechanisms to monitor wraparound fidelity, service quality and outcomes, and to oversee the quality and development of the overall wraparound effort.

## Cultural Competence in the System of Care

Effective systems of care respect and make every effort to understand and be responsive to cultural differences. Cultural competence is a fundamental foundation for providing individualized services and supports.

In addition to recognizing that all children and families bring a unique cultural background with them, the system of care must also acknowledge and address the disparities in access and treatment that, historically, have been the experience of diverse families in traditional systems.

The Louisiana System of Care will specifically address the impact of culture, ethnicity, race, gender, sexual orientation and social class within the service delivery process, the ability of families to access and use services and how systems within and across each Region operate. Building cultural proficiency into the system of care will be a significant priority for the initiative. Regions are expected to consider the fit and relevance of services and service providers to the communities within each region, and address strategies to optimally engage children, youth and their families in ways that reflect their culture and experiences.

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<sup>10</sup> <http://depts.washington.edu/wrapeval/>

## **Background on the Administrative Requirements for the Louisiana CSoC**

The administrative structure of Louisiana's CSoC will consist of the following components with the indicated functions at the level described below. Lead entities will be developed by the State in each of the areas that follow:

### **Statewide Governance Body**

- Provides multi-departmental oversight
- Ensures strong family leadership
- Directs use of multiple funding sources and state purchaser contracting with a Statewide Management Organization (SMO) to define such things as:
  - Eligibility criteria and procedures for enrollment in WAAs
  - Parameters of service utilization and criteria for applying those parameters, including out-of-home placement
  - Quality indicators, reporting mechanisms and quality feedback mechanisms
  - Requirements for WAAs and providers, as well as mechanisms for approving and monitoring providers
  - Quality and timeliness requirements for payment system
- Monitors project outcomes including quality and cost
- Establishes policy and monitors adherence

### **Statewide Management Organization Role (contractor to the State Office of Behavioral Health – OBH)**

- Register children into the statewide system
- Conduct telephonic screening of children seeking services utilizing the Child and Adolescent Needs and Strengths (CANS) Brief tool and referral to the WAA, FSO, and Independent Evaluator conducting the CANS Comprehensive assessment
- Determine appropriateness for WAA enrollment, based on information submitted by the WAA, including results of the CANS Comprehensive
- Oversee ongoing authorization of community-based services and approval of child and family plans, with the goal of moving toward more oversight and less direct authorization role over time
- Track children, services and costs
- Carry out utilization management/utilization review at the system level and for individual outlier cases
- Provide quality assurance at the system level and for individual outlier cases
- Manage and monitor outcomes at the system level and for individual outlier cases
- Work with regional WAAs to organize and manage the provider network to ensure that a broad array of services and supports is available statewide, and that providers meet credentialing standards
- Provide and coordinate training and capacity building across the CSoC, including development of WAAs, FSOs and local providers
- Implement a management information system capable of the needed tracking and monitoring functions and integrated with local WAA management information systems (MIS)
- Pay all provider claims, WAA, and FSO costs, except for some services provided in schools by school systems

### **Wraparound Agency (WAA) Role at the Local Level in Each Region**

- Serve as the single WAA within each region
- Carry out intake activities for CSoC referrals from the SMO, including coordinating with independent licensed mental health professional to secure initial assessment using the CANS
- Work with licensed mental health professional to ensure the recommendation and initial authorization of community-based services for up to 30 days or until the plan of care is developed and approved by the SMO, with the goal of moving toward a more ongoing service authorization role over time
- Partner with juvenile courts, child welfare agencies, and local schools for intake of eligible at risk youth and their families
- Staff and manage child and family team process, including development of plan of care within first 30 days of enrollment and care coordination through intensive care management with small staff to child ratios (for example, 1:10)
- Link families and youth to youth/family support and training, provider services, and mobile response and stabilization
- Track individual children, services provided and costs of services
- Carry out utilization management/utilization review of individual children
- Provide quality assurance at the local level
- Manage and monitor outcomes for individual children
- Input individual child data into a management information system capable of needed tracking and monitoring functions and integrated with SMO MIS
- Work with the SMO to monitor and support development of local provider capacity for purpose of filling gaps in service availability
- Work with family support organizations to provide Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists and support their participation in quality assurance processes
- Develop treatment plans consistent with federal requirements in conjunction with the SMO under the State's Medicaid 1915(b) waiver
- Work with families to expand access to federal funding when available (i.e., help them complete Medicaid applications)

### **Family Support Organization Network**

Each local Family Support Organization (FSO) will be a family-run, nonprofit corporation governed by a board of directors known as its Local Coordination Council (LCC). The statewide FSO network will coordinate its local and state activities through the creation of a State Coordinating Council. The initial local FSOs will partner with the CSoC leadership's FSO Implementation Workgroup to support and participate in the development of the State Coordinating Council (SCC) to ensure state-level participation of family and youth of the CSoC.

### **Local FSOs Governed by Local Coordinating Council**

- Serve as the single FSO within each region
- Provide and build capacity for Certified Family and Cultural Support Specialists
- Provide and build capacity for Certified Parent Trainer/Group Facilitators
- Provide and build capacity for Certified Youth Support and Training Specialists

- Participate in child and family team process
- Provide direct youth and family support and training services to families and youth as providers enrolled in the SMO network under the State's Medicaid 1915(c) CSoC SED waiver and in coordination with the broader provider network's delivery of service
- Participate in quality assurance and outcomes management/monitoring at local and state levels
- Participate in planning, policy making and system oversight at local and state level

#### State Coordinating Council

- Provide initial and on-going training to ensure the capacity of family members to participate in quality monitoring activities and policy setting at the state level, as well as to provide representation on the State Governance Body (SGB)
- Provide family representatives to serve in quality monitoring and policy-making processes conducted by the SMO, OBH, SGB committees and others, as needed
- Provide and maintain membership on the SGB to include two family representatives, two family apprentices (non-voting), and one youth member
- Serve as an advisory council to the SGB, as needed
- In coordination with the SMO, assist in the development and oversight of the general policies and procedures of the Family Support Organization Network
- Provide/maintain direct supervision of the SCC State Family Support Network Executive Director and provide direction on staff roles related to the coordination of statewide efforts (for example Statewide Advocacy, Statewide Training and Technical Assistance Coordination)
- Assist in the development and ongoing support of local FSOs (the SCC and the SCC Staff are not charged with the direct supervision or direct management of the FSOs, Local Coordinating Councils [LCCs] or their members/employees, and will act only to assist and support local FSO and LCC entities)

#### **Providers of Services and Natural Supports**

Effective and competent providers are also essential to the success of the CSoC. Providers of services participating in CSoC network will be required to meet Medicaid and other state standards that will be established to ensure quality and efficiency, including any needed training concerning the Louisiana Children's Code, participation in wraparound planning, collaborating with FSO peer providers, related functions of the juvenile justice, child welfare, and education systems, and the new array of Medicaid services. WAAs, FSOs, and providers will need to ensure that natural supports of families are explored, developed and utilized to establish the long-term viability of each family. One of the keys to success for the CSoC is the emphasis on local/natural supports and strengthening families. Not all families will have private insurance or Medicaid eligibility, and thus other sources of funding will need to be accessed. One of the primary roles of the SMO will be to track eligibility for Medicaid, for other sources of State funding, and for private insurance. However, while as many as possible of the services developed for the CSoC are intended to be funded by those resources, the proposing community should understand that not all needed services, nor all children to be served through the CSoC program, will be eligible for state, federal and private reimbursement. While there are no specific match requirements for this RFA, it is imperative that the community understands

and develops supports for families to ensure success for the enrolled children.

Additionally, in order to facilitate the effective treatment of children and families in the context of their homes, schools, and communities, pre-service competency training shall be required of all staff authorized to deliver services within an individualized plan of care before working with a CSoC family. Practitioners authorized to deliver services within an individualized care plan must demonstrate, either through attestation or endorsement, the completion of training equivalent to content areas of pre-service training identified below. Louisiana Coordinated System of Care providers will have the opportunity to participate in specialized pre-service training to facilitate and promote their professional development.

Through OBH's Essential Learning System, training opportunities will be made available to providers for a fee, in each pre-service competency. Providers may also demonstrate competency through completion of courses through other means or through experience in the specific competency area. Service providers within the Coordinated System of Care will be expected to demonstrate competency in the following areas:

- Professionalism,
- Ethics,
- Confidentiality and Health Insurance Portability and Accountability Act (HIPAA) requirements,
- Diversity,
- Engagement,
- Assessment,
- Wraparound,
- System of Care,
- Ecological Model,
- Evidence Based Practices,
- Co-Occurring Disorders,
- Crisis Response,
- Suicide Prevention,
- Behavioral Interventions,
- Working with School Systems,
- Communication and Collaboration Skills,
- Documentation,
- Trauma Informed Care,
- Motivational Interviewing, and
- Supervision (supervisors only).

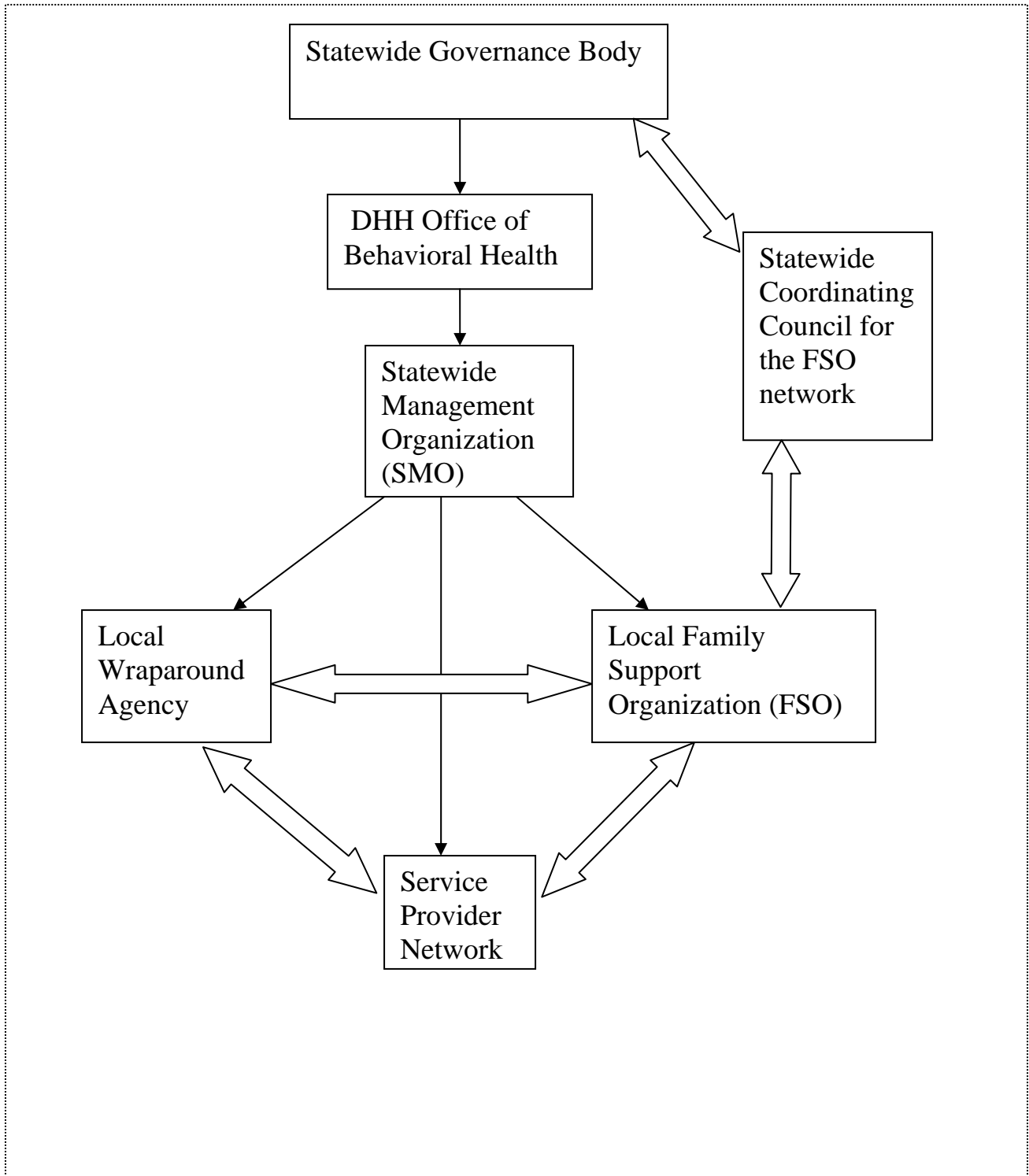
Continuing Education (CE) Credit will be available for those trainings that meet the CE requirements of the relevant licensing board.

A diagram is provided on the following page showing the functional relationships between the main organizational components of the CSoC:

- The Statewide Governance Body,
- DHH Office of Behavioral Health,
- Statewide Management Organization (SMO),

- Statewide Coordinating Council for the FSO network,
- Local Wraparound Agency (WAA),
- Local Family Support Organization (FSO), and the
- Service Provider Network.

Please note that the diagram simply illustrates the broad coordinating and reporting relationships between the above-noted organizational components of the CSoC. It is not intended to describe the details and complexity of those relationships or the broader CSoC. Additional detail regarding these relationships is provided in narrative form throughout the entire RFA.





## Section 2: General CSoC Capacity Questions

This section contains six subsections (A – F) describing the primary questions this RFA is asking communities to answer. In your response, please only include the headers and questions in ***bold italics*** in order to help reviewers of your response know the questions to which you are responding. In order to ensure that you have sufficient space in which to answer these questions within the prescribed page limits, please do not repeat more of the content from this section in your response. Include only the headers and questions in ***bold italics***.

Please keep in mind that the CSoC will implement only one FSO and one WAA per region, and each applying region can only support one FSO and WAA as part of their proposed CSoC under this RFA.

### ***A. Community Partnership (70 points)***

The core of the CSoC is the community partnership; the heart of that partnership is the Wraparound Agency (WAA) and Family Support Organization (FSO). This section asks for a description of the group of people and agencies in your region that have come together to develop the CSoC, with an emphasis on the range and depth of commitment among the agencies and stakeholders in your region to implement the system described in this RFA. In particular, the base of past experience, current practice, and capacity to partner with youth and families is key to your readiness to implement the WAA and the FSO.

***1. Please identify your Act 1225 of 2003 Region (“Region”) and describe the specific communities (cities/towns, parishes, groups of parishes, other jurisdictional subdivisions within the Region, etc.) that have come together to respond to this RFA with the intent to implement a CSoC.*** These will be referred to as the “Initial Communities” throughout this RFA. (No points for this response.)

***2.*** For these Initial Communities ONLY:

***a. Please describe the initial group of stakeholders and collaborative partners that have come together and made a commitment to moving forward with developing the CSoC.*** This should include as many representatives as possible from the stakeholders listed under Question 3 in this section that have been involved in the initial planning for the CSoC carried out as of the date of this application. (10 points)

***b.*** Firm commitment on the part of key stakeholders to implement the CSoC within the Region, including identification of an agency to serve as WAA and development of a FSO, is critical to successful implementation. ***Please describe the level of commitment by all relevant regional agencies and stakeholders, referring, as needed, to the individual letters of commitment provided by each agency/stakeholder.*** Please describe the level of commitment (for example, level of participation in past or current projects with similar goals; recent events developing stakeholder’s understanding of the importance of efforts such as the CSoC; ability to bring to the project resources such as knowledge, experience, person hours, etc.) by all

relevant regional agencies and stakeholders, referring, as needed, to the individual letters of commitment provided by each agency/stakeholder. (15 points)

**3. Does this group currently include, or is it actively reaching out to:** (20 points)

**a. Family members and youth and/or young adults who are “system experienced”**

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing the experience of the Initial Communities in your Region with, or current capacity for, family participation in governance. Additional questions about plans for a Family Support Organization in your region are provided in a separate section further below.

**b. Representatives of child- and family-serving organizations**

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing involvement of key agencies in the Initial Communities.<sup>11</sup>

**c. Representatives of the key cultural groups and communities**

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing involvement of representatives of the cultural groups that comprise the Initial Communities.

**d. Agency and organization leaders who are able to commit resources and lead efforts to change policies**

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing current capacity including, for example, current interagency agreements, current or recent collaborative initiatives, current examples of blended or braided resources, etc.

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<sup>11</sup> Examples of potential agency partners include courts exercising juvenile jurisdiction, schools, DCFS, human service districts/authorities, community and faith-based organizations, service providers, district attorneys, law enforcement, Truancy Assistance Service Centers, Families in Need of Services offices, other juvenile justice agencies, Act 555 Children and Youth Services Planning Boards, and other agencies identified locally for participation.

- 4. Please describe the current involvement in your region of schools, child welfare agencies, juvenile justice agencies, and courts in order to intervene and divert children and youth from expulsion, out-of-home placement, and adjudication.** Given that a goal of the System of Care is to keep children and youth in their home and community, describe specific partnerships or plans to partner with schools, child welfare agencies, juvenile justice agencies, and courts to prevent out-of-home placement, expulsion and adjudication of youth. To the extent possible, provide concrete and specific examples of programs or initiatives currently in place or planned. (15 points)
- 5.** It is planned that over time, the System of Care will be extended beyond the Initial Communities to encompass your entire Region. ***Please describe the commitment of each of the organizations involved in this proposal to assist in the regional development process.*** Describe the linkages, relationships and other capacities of local leaders to support that process, including relationships with neighboring parish leaders, judges, school administrators, family and youth organizations and other key leaders of child and family-serving organizations (including child welfare and juvenile justice agencies) across the Region. (10 points)

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**Scoring For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 70 possible points.**

**B. Collaborative Activity (30 points total)**

1. **The people who are planning implementation of the local CSoC have a solid understanding of – and commitment to – core System of Care principles and practices.** (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing how partners demonstrate understanding and/or commitment to System of Care principles.

2. **The people who are planning implementation of the local CSoC have a solid understanding of – and commitment to – implementing Wraparound, with fidelity to core principles and practices.** (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing how partners demonstrate understanding and/or commitment to high-fidelity Wraparound implementation.

3. **The people who are planning implementation of the local CSoC are willing to make changes in both their own organizations and in the larger system.** (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please describe the evidence of this willingness, including examples of past changes made.

4. **The people who are planning implementation of the local CSoC have developed or identified outreach strategies to identify and engage eligible youth from across systems.** (The CSoC will initially serve children and youth who have significant behavioral health challenges or co-occurring disorders and who are in, or at imminent risk of, out-of-home placement, defined as: detention, secure care facilities, psychiatric hospitals, residential treatment facilities, development disabilities facilities, addiction facilities, alternative schools, homeless as identified by DOE, and foster care.) (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing possible strategies to identify and engage youth. Please offer concrete and specific examples to the extent possible.

5. ***The people who are planning implementation of the local CSoC have a solid understanding of – and commitment to – the inclusion of family members in all facets of planning, implementation and oversight of the WAA.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing how families will be represented on all levels to create a family and youth-driven system of care.

6. ***The people who are planning implementation of the local CSoC have developed or identified a plan for regional and community collaboration from OJJ, DCFS (including Child Welfare), local education agencies, Mental Health, and Substance Abuse agencies in the Initial Communities.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing the plan and the commitment and expected range of involvement of each of the agencies listed. Please also explain the history of collaboration among these agencies and other factors related to the readiness of these agencies to carry out the plan and levels of involvement described.

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For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 30 possible points.

**C. Access to Needed Services and Supports (60 points total)**

Systems of care emphasize support for families in caring for their children, since in most cases, families are the most important and life-long resource for their children. Beyond services available through the formal service system, successful systems of care access and enhance the supports available through the family's natural community and informal resources.

1. ***The people who are planning for CSoC implementation in your Region understand that many services now supported only through state general fund contracts will be refinanced through Medicaid where eligible beneficiaries, services, and providers exist, and that Initial Communities will need to have in place providers with the organizational capacity to provide care in a Medicaid regulatory environment.*** (10 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by listing those providers in the Initial Communities that have experience providing Medicaid reimbursable services and/or the organizational capacity to comply with Medicaid requirements and deliver such services. These capacities include: understanding of, and ability to comply with, provider credentialing requirements, billing systems able to comply with fee-for-service requirements and bill electronically, necessary financial and cost-accounting processes, increased documentation requirements, access to supervision by licensed mental health practitioners, and other capacities to ensure compliance with Medicaid medical services billing requirements. As new services come on line, each participating State department in the CSoC will reach out to its existing provider networks, communicate with those networks regarding the new services, determine any needed technical assistance, and arrange for that assistance to be provided.

2. ***The people who are planning implementation of the CSoC in your Region have identified current capacity and plans to expand that capacity, over time, to provide the full array of services needed to support the System of Care, including non-traditional services and supports and are actively strategizing about how to fill gaps in the array.*** This includes services for youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, trauma related to abuse and neglect, as well as more broadly, and AD/HD issues that lead to costly and oftentimes ineffective out-of-home services or excessive use of other therapeutic supports and services. Please refer to the Ideal Service Array resource available on the CSoC website as a guide.<sup>12</sup> (15 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

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<sup>12</sup> [http://www.dss.state.la.us/assets/docs/searchable/OS/CSoC/061010\\_ISARecsandLetter.pdf](http://www.dss.state.la.us/assets/docs/searchable/OS/CSoC/061010_ISARecsandLetter.pdf)

Please describe local capacity in the Initial Communities for each of the following service categories. Include detail for each service category regarding available evidence based and promising practices that have some level of evidence for their effectiveness.

Describe (1) current capacity, (2) current gaps, (3) plans to address gaps, (4) ways that technical assistance, provided through the State, might be used to support efforts to expand the service array, (5) the level of capacity that could realistically be developed for implementation by January 1, 2012, and (6) priority areas for developing and/or expanding capacity over the first year of the project for EACH of the following service categories:

- Screening using the CANS assessment
- Diagnostic and evaluation services
- Community-based services provided in a family's home, school, office, primary health or behavioral health clinic
- Emergency services available 24/7, including mobile crisis and crisis stabilization
- Intensive home-based services available 24/7
- Intensive behavioral health and addiction services provided in a community setting
- Respite care
- Therapeutic foster care
- Out-of-home care, including residential and inpatient services
- Family support and training
- Youth support and training
- Other individualized supports, such as therapeutic recreational activities, training, prevention, advocacy, local education agencies, vocational and health

One of the keys to success for the CSoC is the emphasis on local/natural supports and strengthening families. Not all families will have private insurance or Medicaid eligibility and thus other sources of funding will need to be accessed. One of the primary roles of the SMO will be to track eligibility for Medicaid, other sources of State funding, and private insurance. However, while as many as possible of the services from the Ideal Service Array developed for the CSoC are intended to be funded by those resources, the proposing community should understand that not all of the services of the Ideal Service Array, nor all children to be served through the CSoC program, will be eligible for state, federal and private reimbursement. While there are no specific match requirements for this RFA, it is imperative that the community understands and develops supports for families to ensure success for the enrolled children.

Additionally, the State recognizes that Medicaid funding has not previously been available to support the full array of services described above. The State is pursuing State Plan Amendments and Medicaid waivers to enable the CSoC to be funded. Developing the full service array will necessarily be challenging for many communities and will require a multi-year commitment on the part of both the State and the participating communities.

3. ***The people who are planning implementation of the CSoC in your Region understand the role that informal and community supports play in systems of care and are actively strategizing about how to increase community capacity to build and use such supports.*** (10 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing the role of informal and community supports and any strategies to increase this capacity.

4. ***The people who are planning implementation of the CSoC in your Region understand the importance of peer-to-peer supports in systems of care and are actively strategizing about how to ensure access to peer-to-peer supports for both families and youth.*** (10 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing the role of peer-to-peer support for both families and youth and any strategies to ensure access to peer-to-peer support, including coordination with, or development of, the FSO.

5. ***The people who are planning implementation of the CSoC in your Region are actively strategizing about how to ensure the cultural competence of the available services and supports.*** (10 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure cultural competence. If available, please include any documentation of cultural competence in the partner agencies, including formal measures or other evidence.

6. ***Please acknowledge your Region's commitment to use technical assistance (TA) provided by the State to improve capacity in the areas addressed under this theme.*** (5 points)

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Scoring For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 60 possible points.



**D. Wraparound Agency Policies and Supports (50 points total)**

As noted above, Wraparound Facilitation represents an important component in a System of Care for children and families. Wraparound is defined as an intensive, individualized care planning and management process. Wraparound is not a treatment. Instead, wraparound facilitation is an intensive care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. 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.

In successful systems of care, WAAs serve as the locus for access, accountability, service coordination and utilization management functions. There will be one WAA in each region. The WAA is responsible for facilitating the wraparound process, developing individualized plans of care that cross agencies and assigning one accountable individual to coordinate care. They act as a bridge between the Statewide Management Organization and families to independently plan and coordinate care. They will work locally with children and youth, their families, providers, regional agency staff, courts, child welfare agencies, schools, community organizations and the regional FSO to coordinate care planning and access to comprehensive services and supports. Service coordination by the WAA, in collaboration with the FSO, will be guided by the Wraparound process, which is defined by the ten principles established by the National Wraparound Initiative (information on NWI is available at: <http://www.nwi.pdx.edu/index.shtml>; information on the ten principles is available at [http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-\(10-principles-of-wrap\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf)).

- 1. Please identify the agency within your Region that you propose to serve the role of the WAA for your Region. If a WAA has not been identified for your Region, how are you going to identify a WAA and ensure that it has the capacity to implement the required wraparound? Is this agency ready to take on the role of WAA?** (10 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by offering a specific and concrete description of agency capacity including, for example, the level of administrative and board support, consistency of the organization's culture, experience with utilization management functions, experience with performance monitoring, policies and procedures consistent with the Wraparound model, experience with providing intensive care coordination, organizational history of implementing supports consistent with the Wraparound model, etc.

2. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of what it takes to provide adequate training and coaching for key roles in the WAA (facilitators, supervisors) and are committed to participation in required state sponsored training, ongoing education and monitoring activities within the identified WAA.*** See Section 4 for definitions of these roles. (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure capacity for training and coaching.

3. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of typical staffing plans (including caseload sizes and approaches to ensure racial, ethnic and gender diversity) that allow people in key roles (facilitators, supervisors) sufficient time to provide high quality wraparound and are actively strategizing about how to ensure this for the WAA.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure staffing that supports high quality wraparound.

4. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of typical staffing plans and composition (including racial, ethnic and gender diversity) that ensure people in key roles can provide culturally-appropriate wraparound and are actively strategizing how to ensure this capacity for the WAA.*** (10 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure staffing plans able to provide culturally-appropriate wraparound. If available, please include any documentation of cultural competence for the proposed WAA, including formal measures or other evidence.

5. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of the structures and processes that are needed to ensure that people in key roles in providing wraparound have high quality supervision and are actively strategizing about how to ensure this for the WAA.*** (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please explain the answer you checked by describing strategies to ensure access to high quality supervision.

6. ***The people who are planning for CSoC implementation in your Region understand the need to build region-wide support for wraparound among service providers and community partners and are actively strategizing about how to do this.*** (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please explain the answer you checked by describing strategies to build region-wide support.

7. ***The people who are planning for CSoC implementation in your Region understand the administrative requirements for the WAA outlined in the introduction of this document and how those relate to the role of the SMO, including agreement to implement an information technology (IT) system for the WAA that is compatible with the requirements of the SMO, agreement to coordinate local goals with the broader system goals of the SMO and understanding of the overall requirements for measuring utilization, costs and expenditures.*** (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please explain the answer you checked by describing your understanding and approach to these administrative requirements. Include a description of your understanding of managing utilization and quality at the local level, in partnership with the SMO.

8. ***Please describe how your Region would use TA provided by the State to improve capacity in the areas addressed under this theme*** (for example, increasing capacity to provide high quality supervision within the Wraparound Agency or increasing the capacity to provide culturally-appropriate wraparound, etc.). (5 points)

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For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 50 possible points.

***E. Family Support Organization Policies and Supports (60 points total)***

As noted above, the role of the Family Support Organization (FSO) is at the heart of the planned system of care. By featuring family members as full partners working within the system of care, the Louisiana CSoC hopes to stimulate behavioral change across the system and support development of family-friendly policies and procedures within the provider agencies and among community partners. Emphasizing FSOs as system partners will support full family involvement in systems of care becoming the rule, rather than the exception. In Louisiana's CSoC, family involvement, support and development at the local level will be structured through the FSO to support family involvement and engage the diversity of families affected by the system of care. Through the local FSO, family members will participate in the wraparound planning process and provide support and training to families being served by the CSoC. Core activities of the local FSO will include the following activities:

- Serve as the single FSO within each region,
- Provide and build capacity for Certified Family and Cultural Support Specialists,
- Provide and build capacity for Certified Parent Trainer/Group Facilitators,
- Provide and build capacity for Certified Youth Support and Training Specialists,
- Participate in the child and family team process,
- Provide direct youth and family support and training services to families and youth, in coordination with the broader provider network's delivery of service,
- Participate in quality assurance and outcomes management/monitoring at local and state levels, and
- Participate in planning, policy making, and system oversight at the local level.

FSOs will be subject to DHH and the Centers for Medicare and Medicaid Services (CMS) regulatory requirements and will provide services that are Medicaid reimbursable. For FSOs, this will require a professional working knowledge of the Medicaid rules and regulations, and expertise in Medicaid billing and coding, as well as the ability to comply with contracting requirements from the Statewide Management Organization. This knowledge will be developed through training and technical assistance provided and coordinated by the State initially and by the SMO once it is in place and functioning.

Local FSOs will provide an array of supports centering on Parent Support and Training to support and to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For the purposes of this service, "family" is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the family support and training service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

Examples of how this service will be delivered by Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists include:

- FSO staff may attend meetings with the family and assist in helping the family to effectively contribute to planning and accessing services, including assistance with removing barriers.
- FSO staff assists in describing the program model and providing information as needed to assist the family.
- Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (for example, parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (for example, training on system navigation and Medicaid interaction with other child serving systems).
- FSO staff may also conduct follow-up with the families regarding services provided and continuing needs.

#### FSO Network Governance

The CSoC will include a broad-based governance structure, providing families and youth representing the CSoC target population with a variety of opportunities to participate in the governance functions of the CSoC and to ensure families and youth are effectively involved in decision-making at all levels of authority, thus reflecting their role as full partners with fellow decision-makers, managers and staff. This governance structure will be culturally and linguistically competent and ensure diverse family and youth participation representative of the communities and the target population served, thus providing families and youth an authentic voice in CSoC governance. There are three main bodies of governance in which family members will participate:

1. State Governance Body (SGB) of the CSoC,
2. State Coordinating Council (SCC) of the FSO Network, and
3. Local Coordinating Councils (LCCs) within the FSO Network.

Family members serving on each governing body will be selected by family members and will be representative of the target population served by the CSoC, including family members and where appropriate, youth members. Selection will be conducted through an approved process, beginning with the FSO Implementation Workgroup, which will in turn provide recommendations for appointment to and by the SGB regarding selection and appointment of membership to the initial SCC. Once established, the SCC will be responsible for the membership selection process to both the SGB and the SCC for any future vacancies. Membership on each of these governing bodies will be voluntary, with appropriate travel reimbursement in accordance with

state regulations and stipends for attendance. The function of each governing body is further detailed below.

#### State Governance Body of the CSoC

- Family members representing the CSoC target population will partner with Secretaries from each of the designated state agencies to participate in the general oversight and governance of the CSoC as a whole.
- Membership to the State Governance Body of the CSoC nominated by families will include, as follows:
  1. Two family members and two apprentice family members. Apprentice members will be nonvoting members, but will attend all SGB meetings in order to build capacity for families to govern at the State level.
  2. One advocate member.

#### State Coordinating Council of the FSO Network

The FSO network will coordinate its local and state activities through the creation of a State Coordinating Council. The initial local FSOs will partner with the CSoC leadership's FSO Implementation Workgroup to support and participate in the development of the State Coordinating Council (SCC) to ensure state-level participation of family and youth of the CSoC. It is expected that full statewide participation by family members from all regions will be achieved over time. This council will have a majority of its representation (60%) as family members who meet the criteria of the CSoC target population. In addition, it is anticipated that the council may include individuals of statewide family and child serving organizations, district attorneys, judges, school system representatives, and others as determined by the SCC. The SCC's roles are anticipated to be as follows:

- Provide initial and ongoing training to ensure the capacity of family members to participate in quality monitoring activities and policy setting at the state level, as well as to provide representation on the State Governance Body,
- Provide family representatives to serve in quality monitoring and policy-making processes conducted by the SMO, OBH, SGB committees, and others, as needed,
- Provide and maintain membership on the SGB to include two family representatives, two family apprentices (non-voting), and one advocate member,
- Serve as an advisory council to the SGB, as needed,
- In coordination with the SMO, assist in the development and oversight of the general policies and procedures of the Family Support Organization Network,
- Provide/maintain direct supervision of the SCC State Family Support Network Executive Director and provide direction on staff roles related to the coordination of statewide efforts (for example Statewide Advocacy, Statewide Training and Technical Assistance Coordination), and
- Assist in the development and ongoing support of local FSOs (The SCC and the SCC Staff are not charged with the direct supervision or direct management of the FSOs, LCCs, or their members/employees, and will act only to assist and support local FSO and LCC entities).

Local Coordinating Councils within the FSO Network

Each local FSO will be a family-run, nonprofit corporation governed by a board of directors known as its Local Coordination Council (LCC). The LCC will promote culturally and linguistically competent representation and ensure diverse family and youth representation from the communities and target population served. Each FSO's LCC should be comprised of 60% family members and also include individuals from local family and child serving organizations (including child welfare and juvenile justice agencies), district attorneys, judges, school system representatives, faith-based organizations, community leaders, and others as determined appropriate by each individual LCC. The LCC will be responsible for the fiscal and technical oversight of the FSO and will provide representation, if requested, on the SCC. Additionally, the executive director/program director of the FSO will report directly to the LCC. If an existing family-run organization serves as the local FSO and already has an existing Board of Directors, it shall create a separate LCC with the characteristics just described to oversee the FSO-specific activities of the organization.

*Note: Please keep in mind that each region will have only one FSO. The services provided – by families to families – must be delivered through a single organization in each region and cannot be divided across more than one family-run non-profit.*

As demonstrated throughout the RFA, family members of children and youth meeting the criteria of the target population are necessary members for all discussion and decision-making regarding a region's readiness assessment and implementation planning for the CSoC. Additionally, selecting the FSO requires more than simply family participation in the discussions and the decision-making. Family members should be at the forefront in selecting the organization serving as the FSO, with agencies and other stakeholders also participating in the process.

1. ***In developing your plans for a FSO, how was it ensured that families have driven the process?*** Please use the following as a guide to developing the FSO plan and selection. (5 points)
  - a. At least one public forum, specifically held to solicit the input of families who are in the target population, has been held as part of the FSO selection process. The forum should be led by at least one family member to obtain input as to what families see as important attributes of their local FSO. Please include dates on which forums were held and the number of families in attendance across the forums. Please also describe how information from the forums was incorporated into the selection process.
  - b. A family member of a child or youth from the target population has chaired the selection/design committee for the FSO. Please identify the family member.
  - c. Family Members of children and youth from the target population comprised at least 60% of the FSO selection/design committee. Please list family committee members and their proportion of the overall committee.

- d. Who else was involved in the FSO selection/design committee? The committee should include, but is not limited to the following. List all that were members, including the specific agency and person(s) representing each of the following:
- Local Mental Health Agencies
  - Local Mental Health Advocates
  - Local School System Representatives
  - Representatives from the Local Court System/Juvenile Judges/Probation/Detention
  - Local Child-serving Organizations
  - Representatives from agencies serving Children in Need of Care (foster care system)
  - Representative from the Proposed WAA
- e. Who should avoid a conflict of interest in the design/selection process?
- Family members or agency members who have an affiliation with applying organizations (staff, board members, immediate family members of staff, etc)
  - Family members or agency members who have an affiliation with the agencies who are applying as the Wraparound Agency (staff, board members, immediate family members of staff, etc)
- f. What additional steps were taken to ensure that culturally and linguistically competent family voices were incorporated into your selection? Describe the process used to solicit family input representative of the cultural groups to be served and how this input weighed into the design/selection process.
- g. If the community has selected an existing organization as its FSO, did those participating in the selection process:
- Review data from this organization regarding its experience in serving families?
  - Review this organization's audits for a minimum of three years to determine solvency?
  - If the applying organization receives mental health funding, review how these funds were utilized? If the organization did not receive mental health funding, review how they assisted families of children and youth from the target population who asked for help?
  - Interview family members who received services from this organization to determine their experience?
- h. If the proposal is to develop a new organization to house the FSO, did those participating in the selection process:
- Ensure the development of the new organization will be led by a family member of a child or youth from the target population?
  - Ensure the initiative to plan and design the new FSO has a minimum of 60% family members of children and youth from the target population?
  - Review the resumes of those persons involved as leaders of the initiative to ensure the planners have appropriate experience or assistance in planning such an organization?



2. ***Please identify the agency within your Region that you propose to serve in the role of the FSO for your Region. If a FSO has not been identified for your Region, describe the capacity in the Initial Communities to provide family leadership for the CSoC and what strategies you propose to partner with families to build on this capacity to develop a FSO. Does your community have the capacity to develop a FSO?*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by offering a specific and concrete description of current capacity including, for example, the level of administrative and board support within existing organizations; consistency of local agency cultures, policies and procedures with the family support model; community history of implementing supports consistent with the family support model; partnerships with the range of organizations and leaders required for the Local Coordinating Council; etc. Please explain, in detail, how your selection for FSO (if applicable) has demonstrated serving children and youth with behavioral health needs in your community. If you have not selected a FSO please identify strategies you will employ to ensure the FSO will focus on the CSoC target population.

3. ***Do the people who are planning for CSoC implementation in your Region agree to volunteer to participate on the Local Coordinating Council and, if requested, the State Governance Body and/or the State Coordinating Council?*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by briefly describing how your Local Coordinating Council will be organized and who in your region has agreed to become a member, including family members, as well as individuals from local family and child serving organizations (including child welfare and juvenile justice agencies), district attorneys, judges, school system representatives, faith-based organizations, community leaders, and others as determined appropriate to represent the Initial Communities. Please also describe involvement of representatives of the cultural groups that comprise the Initial Communities.

In the event the proposed FSO is located within an existing family-run nonprofit, it is mandated that a Local Coordinating Council be established to govern the specific functions of the FSO. If the proposed FSO is an established nonprofit with a current Board of Directors, please also (1) explain that the people planning the implementation of a FSO agree to the creation and success of a Local Coordinating Council that will act with the authority to govern the FSO activities and services and (2) briefly explain how the LCC will coexist with the current Board of Directors.

4. Unlike any other structures found in Louisiana, the FSO network is a family organization embedded within the CSoC, not simply a standalone organization purposed to serve the CSoC through contracted deliverables. Because the FSO will represent the CSoC, it is important to ensure the FSO understands its roles and responsibilities in representing the philosophies and goals of the CSoC. ***Do the people planning the implementation of the FSO understand its relationship to the CSoC as a whole and agree to abide by the philosophies of the CSoC (as found on the website) and the direction and guidance of the State Governance Body and the State Coordinating Council?*** (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please explain the answer you checked by briefly describing how your FSO will demonstrate its cohesiveness within the CSoC as a whole.

5. ***As with all nonprofits, reliance on local community support is essential for long-term success, often including working with the private business sector. Does your Region, specific to family support, have relevant experience with partnerships with local private business entities to enhance services for families?*** (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please briefly state how your Region partners or will partner with local businesses to enhance supports for families and any plans for outreach to the business community as a whole.

6. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of what it takes to provide adequate training and coaching for key roles in the FSO (Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, Certified Youth Support and Training Specialists, supervisors) and are committed to participation in required state sponsored training, ongoing education and monitoring activities required for the FSO.*** See Section 5 for definitions of these roles. (5 points)

**Check the best summary**

Not really

Some

Quite a bit

Please explain the answer you checked by describing strategies to ensure capacity for training and coaching.

7. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of the FSO staffing requirements (including caseload sizes and approaches to partner effectively with the SMO and the proposed WAA in the delivery of Wraparound Facilitation and Child and Family Team supports) that allow people in key roles (Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, Certified Youth Support and Training Specialists, supervisors) sufficient support to provide high quality family support, and are actively strategizing about how to ensure this for the FSO.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure staffing that supports high quality family support.

8. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of required FSO staffing plans and composition (racial, ethnic and gender diversity) that ensure people in key roles can provide culturally-appropriate wraparound, and are actively strategizing how to ensure this capacity for the FSO.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure staffing plans able to provide culturally-appropriate family support.

9. ***The people who are planning for CSoC implementation in your Region have a realistic understanding of the structures and processes that are needed to ensure that people in key roles in providing family support have high quality supervision and access to licensed clinicians as appropriate for back-up, and are actively strategizing about how to ensure this for the FSO.*** (5 points)

**Check the best summary**

***Not really***

***Some***

***Quite a bit***

Please explain the answer you checked by describing strategies to ensure access to high quality supervision.

- 10. The people who are planning for CSoC implementation in your Region understand the need to build region-wide support for family support among service providers and community partners, and are actively strategizing about how to do this.** (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing strategies to build region-wide support. Please include current collaborations with non-profit and for profit providers. If your community plans to develop a FSO, please describe your outreach plan and how you intend to collaborate with the local stakeholders who provide children's mental health and family support services.

- 11. The people who are planning for CSoC implementation in your Region understand the operational requirements for the FSO outlined in the introduction of this document and how those relate to the role of the Statewide Coordinating Council and the SMO, including agreement to implement an information technology (IT) system for the FSO that is compatible with the requirements of the SMO; agreement to coordinate local goals with the broader system goals of the Statewide Coordinating Council, the Local Coordinating Council, and the SMO; and understanding of the overall requirements for measuring utilization, costs and expenditures.** (5 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing your understanding and approach to these administrative requirements:

- 12. Please describe how your Region would use TA provided by the State to improve capacity in the areas addressed in this area** (for example, increasing understanding and capacity to implement a FSO, increasing outreach to stakeholders and community partners, etc.). (5 points)

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For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 60 possible points.

**F. Accountability (30 points total)**

1. **The people who are planning for CSoC implementation in your Region have developed realistic, shared expectations about what outcomes are expected from the effort overall.** (10 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing outcomes expected from the CSoC in your Region.

2. **The people who are planning for CSoC implementation in your Region have developed realistic goals for the local system of care.** (10 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please describe these goals.

3. **The people who are planning for CSoC implementation in your Region are committed to fully participate and comply with requirements for measuring child/youth and family outcomes in the local system of care, in coordination with the SMO, including child/youth and family satisfaction and other outcomes that families and youth care about.** (10 points)

**Check the best summary**

**Not really**

**Some**

**Quite a bit**

Please explain the answer you checked by describing evidence of this commitment.

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For State Staff only: Total (sum of scores across all items): \_\_\_\_ out of 30 possible points

For State Staff only: Sum of All General CSoC Capacity Question Totals: \_\_\_\_ (out of maximum possible score of 300 points)

### **Section 3: General Requirements for the WAA and FSO**

This section describes general requirements that apply to both the WAA and the FSO. The organizations (or groups developing organizations) that seek to fill these roles must understand and agree to comply fully with the requirements of this section. There are not specific questions in this section for response. Instead, the proposed leadership for the WAA and the FSO must complete the attestation statements provided with this RFA attesting to their understanding of and willingness to comply with these requirements, as described below.

The Wraparound Agency (WAA) and the specific specialists delivering support and training services within the Family Support Organization (FSO) will need to be credentialed and certified by the Statewide Management Organization (SMO) after that entity has been selected and initiated under contract. The WAA and FSO will be required to contract with the SMO for reimbursement.

#### **A. Program Authority**

The FSO and WAA will be authorized via the Statewide Governance Body as empowered by an Executive Order and funded with a variety of sources. One of the primary funding sources is Medicaid because most, but not all, children and services will qualify for that funding source.

To secure Medicaid funding, the State has submitted to the federal Centers for Medicare and Medicaid Services (CMS) a set of Medicaid state plan amendments and concurrent waivers under which the Coordinated System of Care (CSoC) program will operate. Authority for Medicaid funding within the CSoC will reside in a concurrent 1915(b) (c) program that includes a Severely Emotionally Disturbed (SED) 1915(c) Home and Community Based Waiver administered through the 1915(b) mandatory enrollment and selective services contracting authority operating as a non-risk bearing prepaid inpatient health plan (PIHP). More information on these waivers will be posted on [www.dcf.la.gov/csoc](http://www.dcf.la.gov/csoc). This specialized Medicaid program will be operated by the Statewide Management Organization (SMO), which will be competitively bid.

The SMO will also manage non-Medicaid funding streams and services for the CSoC, ensuring a single management organization that can provide a single point of entry for all at-risk Louisiana children. It will be the responsibility of the SMO to ensure that individuals eligible for different funding streams are identified and tracked in an accountable fashion and that the appropriate funding sources are held accountable.

The SMO will oversee a provider network providing all covered services. Under the auspices of the SMO, only WAAs will be able to provide Wraparound Facilitation and only FSOs will be able to provide family / youth support and training.

## **B. Enrolled Populations**

All children will be eligible for all medically necessary services in the CSoC, if they meet functional criteria described in later sections. Individuals found eligible for the CSoC will be enrolled in the SMO. If a child is enrolled in the SMO but does not meet the CSoC functional criteria, the child will be eligible for a reduced package of services. The following individuals will be eligible for Medicaid reimbursement under the SMO program:

- Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
- TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

The WAA and the FSO will also serve children and youth that meet program criteria, but that are not currently Medicaid eligible or eligible for the Medicaid 1915(c) waiver, such as children receiving services from OJJ, DCFS, OBH, OCDD (Office for Citizens with Developmental Disabilities), or OPH who are not Medicaid eligible. This includes children with private insurance who meet criteria for CSoC. For these children, the SMO will carry out coordination of benefits with the insurer. As stated above, all children functionally eligible for the CSoC will be eligible to receive all medically necessary services in the CSoC.

## **C. Free Choice of Providers**

Enrollees will have free choice of providers within the CSoC and may change providers. The SMO will contract with the WAA as an administrative activity and freedom of choice is not required. Since there will only be one WAA in each region, enrollees and their families will have free choice of Wraparound Facilitators within the WAA. All Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists must be employed by a FSO under contract with the SMO. There will also only be one FSO in each region, and enrollees and their families will have free choice of staff with which to work within the FSO.

In addition, consistent with requirements in 42 CFR 438 and because of historic quality of care issues related to behavioral health in the State, the FSO must comply with the credentialing and recredentialing policies consistent with federal and state regulations of the SMO.

The SMO will evaluate every prospective subcontractor's ability to perform delegated activities prior to contracting with any provider or subcontractor. The SMO is not obligated to contract with any provider unable to meet contractual standards and to continue to contract with a provider that does not provide high quality services or outlier utilization of services according to peer providers and/or the expectations of the SMO and State. The SMO's provider selection policies

and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The SMO must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

The SMO will monitor all subcontractors' performance, including that of the WAA and the FSO, on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. The SMO will identify deficiencies or areas for improvement, and the subcontractor must take corrective action or be terminated if substantial progress toward corrective action is not taken. The WAA and FSO must comply with these requirements.

#### **D. Training Requirements**

All WAA and FSO staff must participate in training provided by the state prior to the delivery of treatment planning or services under this contract. The state will provide certification for Wraparound Facilitators employed by the WAA and Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists employed by the FSO, certifying completion of the required training. This certification will be part of the credentialing / subcontracting process administered by the SMO (and described in more detail below). As part of this, all staff that interacts with children or youth will need to undergo criminal background checks.

The following sets of training are required.

**Orientation to the Coordinated System of Care:** An orientation session will be provided that includes information about each agency within the communities' Coordinated System of Care and defines how the agencies involved in the CSoc will work together. Each agency involved in the CSoc will be provided a standard format for this training and asked to provide key information to all participating agencies that will foster and support collaboration and cooperation within the system of care.

**Foundational Training Domains:** Training in the following specific topic areas will be offered for all provider agencies and independent practitioners associated with the Coordinated System of Care, including WAA and FSO staff. The expectation is that all facilitators / providers / practitioners will have competency in the foundational domains. Training in these foundational domains will be provided by national experts in the areas defined:

- 1 . Wraparound / System of Care (to be provided by an external vendor with demonstrated expertise)
- 2 . Child and Adolescent Needs and Strengths (CANS) Assessment
- 3 . Cultural and Linguistic Competency (CLC)
- 4 . FSO services

Continuing Education (CE) credit will be available for those trainings that meet the CE requirements of the relevant licensing board.



Training providers will:

- Deliver face-to-face training in Wraparound, CANS, Cultural Competency and FSO concepts.
- Conduct site visits at provider facilities or otherwise monitor to assure that training concepts are being implemented in the work place.
- Provide online and phone technical assistance to initial implementers.
- Modify training, as needed, to address identified needs as a result of training.
- Prepare online versions of training that can be used for remediation and refreshers for members of the workforce.
- Utilize technology to maximize the effectiveness of the training process, with consideration of capacity issues in rural areas.

Adult learning techniques will be used to assure retention of training topics and the ability of trainees to apply their learning in practice within the work environment in the following ways:

- Peer-to-peer learning opportunities throughout the initial implementation.
- On-line refreshers for previously trained members of the workforce.
- On-line/phone technical assistance from identified national experts, and ultimately from skilled trainers within the state of Louisiana.
- On-site observation of the workforce following training to assure learning is transferred to the workplace.
- On-site coaching to support classroom training.

It is expected that the following types of workers within the Coordinated System of Care will attend the trainings described in previous pages:

- Family Support Organizations (FSO) Certified Family and Cultural Support Specialist, Certified Parent Trainer/Group Facilitator, Certified Youth Support and Training Specialist staff and their supervisors will be required to participate in overview training for each of the topic areas (Wraparound, CANS, and CLC).
- Wraparound Agency (WAA) Wraparound Facilitator staff and their supervisors will be required to participate in all three levels of training for each foundational topic area.
- Other interested members of the initial implementing communities will be able to participate in the overview training for each of these topic areas.

As noted above, supervisors in both the WAA and FSO must meet the core training requirements dependent on the organizational representation.

As training needs are identified within the initial CSoc sites and as the implementation process continues, additional training topics linked to the ideal service array and evidence based practices (EBPs) will be identified.

## **E. Attestation**

The agency leadership for the WAA and the FSO must complete the attestation statements provided with this RFA attesting to their understanding of and willingness to comply with these requirements, as well as the specific requirements in the following sections that are applicable to each.

## **Section 4: Specific Requirements for the WAA**

This section describes specific requirements that apply to the WAA. The organization that seeks to fill this role must understand and agree to comply fully with the requirements of this section. There are not specific questions in this section for response. Instead, the proposed leadership for the WAA must complete the attestation statements provided with this RFA attesting to their understanding of and willingness to comply with these requirements, as described below.

Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. 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 address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to 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 organizations providing Wraparound Facilitation in Louisiana's CSoC are Wraparound Agencies (WAAs). WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of "one family, one plan of care, one Wraparound Facilitator."

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.

Providing comprehensive care through the wraparound process, thus, requires a high degree of collaboration and coordination among all the child- and family-serving agencies and organizations in a community, including child welfare, juvenile justice and local school agencies. These agencies and organizations need to work together to provide access to flexible resources and a well-developed array of services and supports in the community. In addition other community- or system-level supports are necessary for wraparound to be successfully implemented and sustained.

The WAA will provide Wraparound Facilitation (WF) for children using Child and Family Teams (CFTs) to carry out specific delegated administrative activities of the SMO. The CFT will coordinate development of a treatment plan for high-needs individuals in accordance with requirements under the new Medicaid waivers,<sup>13</sup> which requires the identification, assessment and development of treatment plans for high-needs individuals. This treatment plan is referred to as an “Individualized Plan of Care,” in accordance with the WF planning model used by CFTs in Louisiana.

For the purposes of Medicaid reimbursement, WF by the CFT is part of the joint treatment planning, administrative coordination and continuity of care activity conducted by SMOs and involving members, providers, caseworkers and others important to those members, for members who are accessing multiple services concurrently or consecutively. Joint treatment planning facilitates the development of an Individualized Plan of Care consistent with Medicaid<sup>14</sup> treatment planning requirements and may also result in an integrated plan for funding and delivering services when representatives of other delivery systems, in addition to the SMO, commit financial resources to fund a plan. It does not substitute for the service planning requirements of the behavioral health providers involved; instead it coordinates treatment and other services and supports across multiple plans through the Individual Plan of Care it develops.

Costs associated with planning activities that are the responsibility of other child-serving systems are not eligible for Medicaid reimbursement and will need to be tracked and paid separately. When determining if the meeting time is reimbursable by Medicaid, as opposed to other services, the purpose of the planning meeting is the key differentiating factor. If the purpose is to coordinate medical and non-medical supports for the ultimate purpose of advancing medical treatment goals (for example, facilitating diversion from an accredited residential treatment facility), then the CFT activities are Medicaid reimbursable. However, if the primary purpose of the planning meeting is to develop a permanency plan for a child welfare placement, CFT activities are not Medicaid reimbursable and must be supported with non-Medicaid funds. As a result, close coordination is essential between the WAA Wraparound Facilitator and DCFS to align behavioral health services and supports to support and inform the DCFS-developed permanency plans. In addition, consistent with Medicaid managed care rules, the Louisiana Office of Behavioral Health (OBH) will ensure that all CFTs are aware of and utilize the SMO medical necessity criteria for any behavioral health medical services recommended as part of an Individualized Plan of Care.

In addition to the wraparound and intensive care coordination functions, WAAs also help manage utilization and quality – and are outcomes-focused across agencies – in partnership with the SMO, at the child and family level.

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<sup>13</sup> 42 CFR 438.208(c)

<sup>14</sup> Specifically in 42 CFR 438.208 (c)(3)

## **A. Compliance with Federal Requirements**

As noted above, CFT provides an administrative joint treatment planning activity provided under Medicaid requirements<sup>15</sup> for developing and facilitating implementation of Individualized Plans of Care for children and youth who meet the definition of complex behavioral healthcare needs. When identifying children with complex behavioral healthcare needs, the SMO will ensure the assessment of each enrollee to determine a course of treatment or regular care monitoring. The assessment mechanism must meet the requirements outlined in this document.<sup>16</sup> The Individualized Plan of Care should be developed in coordination with the child's physical health primary care provider (PCP). If applicable, this includes coordination with the Coordinated Care Network (CCN) in which the provider participates. The CFT will take the lead in the development of the Individualized Plan of Care and will coordinate with the enrollee's primary care and behavioral healthcare providers, with enrollee participation, and in consultation with any other providers caring for the enrollee.

The Individualized Plan of Care will also be approved by the SMO in a timely manner, as described below under subsection F. Referral Process. The Individualized Plan of Care will comply with all State quality assurance and utilization standards as noted in the Referral Process subsection. In accordance with this, enrollees with special behavioral healthcare needs determined by an assessment through the SMO to need CFT support of a course of treatment or regular care monitoring will be allowed to directly access needed behavioral healthcare providers (for example, through a standing referral or a set number of visits approved by the SMO in accord with medical necessity requirements) as appropriate for the enrollee's condition and identified needs, in compliance with the State Quality Improvement Strategy and requirements for identification, assessment and treatment planning defined in 438.208(c). An approved licensed behavioral health practitioner will sign off on the care plan to ensure that services by individuals that are not licensed to practice independently are medically necessary.

## **B. Conflicts of Interest**

Because of the inherent conflicts of interest that might arise if WAAs also directly provide the services they manage, WAAs will not also act as service providers. In cases where local capacity constraints are such that a service provider may be the best possible choice to also provide care coordination, the CSoC Governance entity will weigh if by limiting the WAAs utilization management functions and delegating more authority to the SMO, thereby creating firewalls which eliminate conflicts of interest to the satisfaction of CMS, a waiver of this rule would be in the best interest to the taxpayer and the families to be served.

In the unlikely event that the WAA is allowed under waiver to be a provider of other direct services, the provider must describe how they will ensure that there is no conflict of interest. The provider must include a description of the process by which they will ensure that the WAA staff and the youth and families served will be provided information about the community's full array of providers and will not be unduly influenced to use these services as opposed to natural

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<sup>15</sup> More broadly in 42 CFR 438.208(c)

<sup>16</sup> These are specifically found at 42 CFR 438.208(c)(2).

supports or other services of the youth or family's choice. They must also describe the monitoring strategies they will use to oversee this process.

On behalf of the State, the SMO will ensure the independence of the licensed mental health professional administering the Child and Adolescent Needs and Strengths (CANS) assessment and developing plans of care. The SMO's written conflict of interest standards ensure that persons performing these functions are not:

- Related by blood or marriage to the individual, or any paid caregiver of the individual,
- Financially responsible for the individual,
- Empowered to make financial or health-related decisions on behalf of the individual, or
- Providers of State Plan/Home and Community Based Services (HCBS) for the individual, or those who have interest in or are employed by a provider of State Plan/HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections.

### **C. WAA Provider Agency Certification Requirements**

In order to develop Medicaid Plans of Care (POC) through CFT activities and access funding through the administrative portion of the SMO, each WAA must be credentialed by the SMO. Central to that credentialing will be certification by OBH of Wraparound Facilitators working for the WAA, as described above in Section 3. Once a region is selected for CSoC implementation, the State will provide training and establish a timeline and process through which OBH will certify the WAA. After this, the SMO will credential the WAA as compliant with required criteria in advance of WAA operations (including required criminal background checks, as appropriate).

The OBH certification process primarily centers on documenting that individual WAA staff members have completed training, as described in Section 3 above. OBH will provide evidence of this certification to the SMO for the credentialing process. Once credentialed by the SMO, the use of Medicaid reimbursement to support WF delivery through the administrative portion of a SMO's capitation rate will be allowed, subject to the limitations defined in this document.

### **D. Requirements for Wraparound Facilitators and Supervisors**

Over the course of the first 24 months of program operation, applicants will need to meet certain requirements in order to maintain certification. These requirements are still in the process of being developed and will involve substantial commitments of time on the part of Wraparound Facilitators and Supervisors engaging in a process facilitated by external trainers and coaches with demonstrated expertise in Wraparound, who will be selected and contracted by the State. Staff will also be required to complete standardized measures to demonstrate fidelity to the Wraparound model. The certification process will be developed by OBH and will consist of a comprehensive certification program paid for by the State. The program will involve both didactic and coaching components, as well as documentation reviews of POCs and observation of activities such as family visits, home visits, and CFT meetings.

## E. Target Population

Wraparound Facilitation (WF) may be delivered to children and youth whose complex behavioral health needs are identified as follows. In order to be eligible, the child or youth must also have functional needs as demonstrated by the Child and Adolescent Needs and Strengths (CANS) assessment. The SMO will provide to the WAA results from the CANS Brief in order to establish initial eligibility for WAA supports. The SMO will refer the child to an independent assessor who conducts the CANS comprehensive in collaboration with the CFT. Staff from the WAA will ensure administration of the CANS Comprehensive Assessment with sign off by approved licensed behavioral health clinicians as part of the CFT process. The licensed practitioner of the healing arts overseeing the care and the CFT will work together to determine when reassessment will be needed, individualizing that timing for each child and family, in accord with existing Medicaid regulations. Children identified as meeting the criteria for the CSoC as determined by the CANS, may include:

- Children and youth ages 0 – 21. Under EPSDT rules, services may be provided up to the time the individual turns 21.
- Significant behavioral health challenges or co-occurring disorders documented in the Individualized Plan of Care. This includes youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, substance-related disorders, and AD/HD issues that lead to costly and oftentimes ineffective out-of-home services or excessive use of other therapeutic supports and services. Co-occurring disorders (COD) refer primarily to the presence of mental health and substance-related disorders. Children and youth with COD have one or more substance-related disorders as well as one or more mental health disorders.
- For children with behavioral health disorders and developmental disabilities, if the child has a severe emotional disturbance and otherwise meets criteria for the CSoC, they are eligible for services within the CSoC for their severe emotional disturbance. Services related to the developmental disability will continue to be provided by OCDD.
- Imminent, current or previous placement in a restrictive, intensive or intrusive level of behavioral healthcare, such as:
  - Addiction facilities,
  - Alternative schools,
  - Detention,
  - Development disabilities facilities,
  - Foster care,
  - Homeless as identified by the Department of Education,
  - Psychiatric hospitals,
  - Residential treatment facilities, and
  - Secure care facilities.

All WAA staff will receive training in the CANS, as described above.

In addition to the child or youth receiving services, parents and other family members may participate in the CFT process. Parents, legal guardians, other adult caregivers, siblings and other family members typically participate in the CFT process, as specified in the Individualized

Plan of Care of the child or youth served by the WAA, in addition to other natural helpers that family or youth identifies as important to the team. Families will be encouraged to provide their own perspectives on their strengths and needs.

In addition, representatives from other agencies in which the child/family is involved, such as child welfare or juvenile services, also are typically involved to add their perspectives to the development of the plan of care.

The primary care provider of the child or youth must also be involved. While the CFT coordinates services and provides oversight for the implementation of the Individualized Plan of Care, the CFT must document its attempts to coordinate with the child's primary care provider (PCP) in the development of the Individualized Plan of Care. If the child's PCP wishes to take part in the development of the Individualized Plan of Care (POC), then the CFT must ensure that the PCP is involved to the extent he or she desires. If the PCP chooses not to participate in the care planning process, then the CFT must initiate communication with the PCP and ensure that a copy of the Individualized Plan of Care is sent to the PCP. Note: Any behavioral health treatment must be ordered and overseen by a physician or other licensed practitioner of the healing arts to comply with other federal requirements.<sup>17</sup> The CFT does not provide or oversee treatment services.

All coordination of care activities must protect each enrollee's privacy in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable.

## **F. Referral and Authorization Process**

The SMO will develop and implement a data-driven approach to identifying members who meet the criteria for a WAA referral based on the Child and Adolescent Needs and Strengths (CANS). The SMO will determine appropriateness for WAA enrollment, based on the assessment information submitted by the WAA, including results of the CANS tool.

The SMO will send referrals and initial 30 day authorization to the appropriate WAA electronically upon completion of the telephonic interview for those applicants determined to be eligible for the CSoC.

- The SMO will authorize the WAA to arrange for community services necessary to support the child and family for up to 30 days while establishing the CFT and beginning the wraparound planning process. Inpatient or other out-of-home placements must be pre-authorized by the SMO during the initial 30 day and subsequent authorization periods. An

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<sup>17</sup> **Licensed Practitioner of the Healing Arts:** Under Medicaid regulations, medical necessity for rehabilitative services must be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law, and they must be furnished by or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and/or restoration of a individual to his/her best age-appropriate functional level. This is generally held to be a physician or licensed practitioner (see the OLP definition) acting in his or her scope – but not every practitioner (e.g., LPC or LAC) can do everything under their scope.

approved licensed behavioral health practitioner will sign off on any treatment to ensure that services by unlicensed individuals are medically necessary.

- The WAA will work with the family to gain access to federal funding when available (i.e., help them complete a Medicaid application).
- The WAA shall initiate the CFT process immediately upon receipt of the referral by the SMO. Upon referral to the WAA, the SMO will also authorize an assessment to be conducted by a licensed mental health professional using the CANS. The assessment findings will be sent to the WAA Wraparound Facilitator to assist the CFT with the wraparound planning process.
- The WAA Wraparound Facilitator assembles the CFT, which conducts the wraparound planning process, identifies the individual needs and strengths of the child and family, and develops a customized wraparound approach and plan of care.
- The child/youth and family support network comprise the majority of the CFT. The CFT, with the assistance of the WAA Wraparound Facilitator, develops a sustainable and Individualized Plan of Care (POC) consistent with the CANS results, individual needs, SMO utilization management (UM) guidelines, evidence based practices and use of natural and informal supports whenever possible. The SMO and WAA shall expect providers to participate on the CFT. The SMO shall align incentives to support provider participation.
- The WAA shall work closely with the Family Support Organization (FSO) to integrate the provision of supports from Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists in support of the CFT. To the fullest extent possible, the WAA and FSO will collaborate to initiate contact with the team. In some cases staff from both agencies will initiate contact together; in other cases it may be preferable for the FSO to lead. It is expected that personnel from the FSO will have ongoing active involvement on the CFT unless the family chooses not to have them involved or the CFT, in consultation as needed with the physician overseeing the care, determines FSO involvement to be clinically contra-indicated. It is expected that family and youth support and training will be a key component of the array of services and supports included in the POC.
- The WAA shall work closely with the child welfare, juvenile justice, and local education agencies to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies, the juvenile justice system, and local education agencies will have active involvement on the CFT unless clinically contra-indicated.
- The WAA Wraparound Facilitator works with the child/youth and family/caregiver to determine membership of the CFT. The CFT, with the assistance of the WAA Wraparound Facilitator, develops a sustainable POC that is consistent with the wraparound planning goals.
- An approved licensed behavioral health practitioner will sign off on any treatment on the POC to ensure that services by unlicensed individuals are medically necessary.
- The WAA Wraparound Facilitator submits the POC to the SMO for review prior to the end of the initial 30-day authorization period.
- The SMO reviews the POC for consistency with the child/youth and family's strengths and needs (as identified by the CANS, broader assessment and the POC) and utilization guidelines. If the POC meets these criteria, the SMO provides authorization for a period of up to 90 days. Ongoing authorizations provided by the SMO will be for up to 90-day periods for most children/youth. (Authorizations may exceed 90 days for some children/youth, as determined by medical and social necessity for the service).



- If the POC appears to be inconsistent with assessed strengths and needs and the utilization guidelines for the desired services, or if it exceeds the cost of care limitations, the SMO and the WAA Wraparound Facilitator will discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT. The WAA Wraparound Facilitator will work with the CFT to develop a sustainable plan. The expectation is that the SMO will have clear, transparent utilization guidelines that are developed with and approved by the state CSoC governance and widely shared throughout the CSoC.

The following must be completed within 30 days of the start of WAA involvement (and the SMO may require proof that these requirements have been met through periodic audits of select cases or providers):

- Individualized Plan of Care – A copy of the initial assessment and Individualized Plan of Care developed by the CFT must be completed within 30 days of the start of WAA involvement. The Individualized Plan of Care must be developed with adherence to National Wraparound Initiative (NWI) standards and treatment planning requirements consistent with 42 CFR 438.208(c)(3).
- CFT meeting documentation – The initial CFT meeting must be held within 30 days of the start of WAA involvement. A sign-in form from each CFT meeting will be completed and kept in the child's record.

Under the 1915(b)/1915(c) concurrent waivers, the SMO conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using Wraparound Facilitators employed by State certified Wraparound Agencies. The Wraparound Facilitator must be employed by a Wraparound Agency and meet the following qualifications: have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education with one year of experience, complete Wraparound Facilitation/Community Support Training according to a curriculum approved the OBH (and described above in Section 3) within six (6) months of hire, and pass a Louisiana criminal history background check and motor vehicle screens. The Wraparound Facilitator formalizes the plan of care developed by the child and family team. The child and family team shall include the child/youth, parents or caregivers of the child/youth, behavioral health providers, and other individuals invited to participate in the development of the plan of care. The Wraparound Facilitator provides adequate notice of the plan of care development to the child and family team. To ensure the planning process is timely, Wraparound Agencies will comply with the basic service delivery standards as outlined in the SMO and Wraparound Agency contracts. The independent practitioner will complete a CANS Assessment which is forwarded to the SMO and team to identify the appropriate services provided for the plan of care. The Wraparound Facilitator is responsible for writing the plan of care based upon the determinations made by the child and family team. The Wraparound Facilitator indicates on the plan of care who is responsible for each task. The independent evaluator must sign off on any recommended services in the POC to be provided by unlicensed practitioners (e.g., Multisystemic Therapy).

As part of the initial referral process and prior to approval of the initial plan of care, the WAA will conduct a "Pre-certification Home Visit." At this visit, WAA staff will review with the individuals receiving care and/or their authorized representative's information regarding "feasible

alternatives” under the waiver, including the choice of either institutional or home and community-based services.

## **G. Goals and Process Design**

**Purpose of the process** – Wraparound Facilitation (WF) by the WAA is performed as an administrative joint treatment planning activity under SMO requirements in 42 CFR 438.208(c) to develop and facilitate implementation of Individualized Plans of Care for children and youth who meet the definition in Section 6 of complex behavioral healthcare needs. These children may be experiencing significant involvement in two or more child-serving systems, but such involvement will not be a condition to receive services.

**Qualifications** – WF is carried out by Wraparound Facilitators, working as a team with Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists from the Family Support Organization. The Wraparound Facilitator facilitates the CFT under the oversight of a WF supervisor. The primary assessment and care planning activity guiding the CFT is WF, delivered with adherence to the standards of the National Wraparound Initiative (NWI)<sup>18</sup> and referred to as WF. WF is a team-based, collaborative process for helping children and youth with complex behavioral healthcare needs and their families identify and use their strengths and community resources to develop and implement Individualized Plans of Care to reduce the use of other restrictive behavioral health services. The therapeutic goals of the process are to 1) meet the behavioral health needs prioritized by the youth and family, 2) improve their ability and confidence to manage their own services and supports, 3) develop and strengthen their natural social support system over time and 4) integrate the work of all child-serving systems and natural supports into one streamlined plan to address the child’s diagnosed behavioral health needs in order to restore the child to a developmentally appropriate level of functioning. The CFT will identify specific goals to enhance the functioning of the child, and recommended services will be consistent with the medical necessity criteria of the SMO.

**Process design** – WF activities are carried out by Wraparound Facilitators. The reimbursable activities for each staff member include the following activities, when delivered to a specific enrolled child/youth or the family of that child/youth in support of the child/youth’s overall treatment plan.

Activities center on development of an Individualized Plan of Care. Using the information collected through an assessment, the Wraparound Facilitator convenes and facilitates the Child and Family Team (CFT) and, together with the CFT, develops a person and family-centered Individual Plan of Care that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Wraparound Facilitator works directly with the child/youth, the family (or the child/youth’s authorized health care decision maker) and others to identify the strengths, needs and goals of the

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<sup>18</sup> Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.

child/youth and the strengths, needs and goals of the family in meeting the child/youth's needs.

The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment and crisis/safety plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of CSoC services (including relevant clinical and agency service information provided by provider and other agency members of the CFT), as well as natural supports that are built into the POC to assist the child/youth in meeting their goals. The Wraparound Facilitator plays a role in this process by facilitating the POC development through documentation of the decisions made by the CFT, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time should needs or circumstances change.

The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the Wraparound Facilitator.

Additionally, Family Support Organizations provide the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their behavioral health needs and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that affect the child with behavioral health needs while living in the community. For the purposes of this service, "family" is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the family support and training service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

**Intensive care coordination.** The wraparound process also centers on intensive care coordination by the CFT, as coordinated by the Wraparound Facilitator. The CFT is the primary point of responsibility for coordinating the many services and supports with which the youth and family are involved, and the family and youth ultimately drive the goals of the CFT. Over time, the wraparound process involves multiple phases over which responsibility for care coordination

increasingly shifts from the wraparound facilitator and the CFT to the family (for additional information on the phases of the wraparound process, see information at [http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf)). Key activities of the Wraparound Facilitator during the implementation phase of the care coordination process from that source include:

- Supporting the action steps of the POC by checking in and following up with CFT members, educating providers and other system and community representatives about the wraparound process as needed, and identifying and obtaining necessary resources.
- Monitoring progress on the actions steps of the POC by tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the POC, and completion of planned interventions.
- Guiding the CFT in evaluating whether selected strategies are helping meet the youth and family's needs.
- Encouraging the team to acknowledge and celebrate success when progress has been made, when outcomes or indicators have been achieved, or when positive events or achievements occur.
- Supporting the CFT to determine when strategies for meeting needs are not working or when new needs should be prioritized and guiding the CFT in a process of considering new strategies and action steps using the process described above for developing the POC.
- Making use of available information to assess CFT members' satisfaction with and commitment to the CFT process and POC, sharing this information with the CFT as appropriate and welcoming and orienting new CFT members who may be added as the process unfolds.
- Helping to maintain CFT cohesiveness and satisfaction, supporting fidelity to wraparound principles and activities, and guiding the CFT in understanding and managing any disagreements, conflicts, or dissatisfactions that may arise.
- Maintaining/updating the POC and maintaining/distributing CFT meeting minutes to document results of reviews of progress, successes, and changes to the CFT and POC over time.

The final phase of activity centers on the transition from the CFT to natural supports. During this phase, the Wraparound Facilitator and CFT focus on planning for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the regular Medicaid or behavioral health system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities. However, this is the primary focus of the transition phase of the wraparound process.

## **H. WF Staff Activities**

The Wraparound Agency (usually the Wraparound Facilitator) contacts the child/youth and/or the parent/caregivers of the child/youth before the initial wraparound meeting. During this contact, the Wraparound Facilitator (or WAA staff), in collaboration with the assigned FSO Certified Family and Cultural Support Specialist (and, as appropriate, at times letting the FSO staff member take the lead), assures the delivery of the CSoC brochure that describes the CSoC services, free choice of providers, and how to report abuse and neglect. Each CSoC

child/youth will be a member of the SMO and will be provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. If the child/youth is eligible for the 1915(c) waiver, the Wraparound Facilitator will also ensure that the family is offered the choice of either institutional or home and community-based waiver services using the BHSF Form LTC/CS (Long Term Care/Choice of Services).

The Wraparound Facilitator guides the development of the POC. The POC is developed based upon the CANS assessment and identified goals as determined by the Child and Family Team. The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment and crisis plan. Other relevant information and testing may be provided by the CFT (including current and past providers of care, as appropriate and in accord with the desires of the family) to support the development of the POC. In addition, caregivers may share additional information based on their observations and experiences with their child's presenting challenges. Input of all members of the CFT is used to identify the appropriate frequency and duration of waiver services and natural supports that are built into the POC to assist the child/youth in meeting their goals. The Wraparound Facilitator plays a role in this process by facilitating the POC development through documentation of the decisions made by the CFT, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time should needs or circumstances change. The Wraparound Facilitator assures Plans of Care are entered into the SMO's database and Electronic Health Record, ensuring that compliance with HIPAA and Federal Educational Right to Privacy Act (FERPA) standards is maintained.

The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the Wraparound Facilitator.

An Individualized Plan of Care (POC) must be in place within 30 days of intake for any child/youth accessing services through the SMO. If new to the SMO provider system, the child/youth will be receiving services based upon a POC developed by the approved licensed behavioral health practitioner working with the WAA, in order to access community based services within the first 30 days after referral to the WAA while the wraparound process is being completed. The CSoc-specific POC is developed by the CFT led by the Wraparound Facilitator. The wraparound meeting is scheduled at the earliest convenience of the child/youth and parents or caregivers of the child/youth. During the wraparound meeting, a POC is developed that incorporates both formalized and natural supports to address the identified goals of the POC.

An independent practitioner completes the CANS assessment. Input into the CANS is given by all members of the CFT, particularly the child/youth and parents or caregivers of the child/youth. Provider and agency staff will provide relevant information on clinical and other agency service perspectives. The CANS addresses the following domains: life domain functioning, youth strengths, acculturation, caregiver strengths and needs, youth behavioral / emotional needs, and youth risk behaviors. Goal development is directly related to the CANS. Goals are established based upon the child/youth's needs and interventions for goals are built upon the child/youth's identified strengths. The CFT identifies goals and interventions based upon the

Strengths and Needs Assessment. POC goals identified by the child/youth and parents or caregivers of the child/youth as being the most pertinent or pressing are given preference.

During preliminary discussions of treatment, the child/youth and their parents or caregivers are informed by the WAA of the array of services that may be accessed through the CSoC. The array of services available to the family includes waiver-specific services and also includes services available in the system of care outside of the SED waiver. Examples of such services would be traditional behavioral health services such as a medication management and individual therapy provided in the home. Non-traditional community-based services such as family/youth support and training, as well as psychosocial treatment group would also be available. Natural occurring supports outside of the behavioral health system are also utilized to support the family. Formalized services are not incorporated to take the place of existing or identified natural supports.

The core values of the Community-Based Services are strengths-based, family-centered, culturally respectful, and community-based. These core values are the foundation for the training that is provided to Community-Based Service providers throughout the state. In keeping with these core values, the wraparound process is a participant-driven process where the child/youth and the parents or caregivers of the child/youth direct the membership of their CFT. Membership is reflective of individuals the family has identified as a source of support, individuals in the community that may be able to provide support in the future through natural supports, representatives from other systems in which the child or family is involved, and providers of service. All services are coordinated first through the CFT's development of the POC. It is the responsibility of the CFT to develop the POC.

The Wraparound Facilitator guides that process by facilitating wraparound meetings and ensuring the waiver requirements are met. The Wraparound Facilitator is responsible for assisting the CFT in identifying resources for the child/youth and the parents or caregivers of the child/youth. The Wraparound Facilitator is a part of the development process and a member of the CFT. The Wraparound Facilitator then takes on the responsibility of assuring that the needed resources are implemented for the child/youth and parents or caregivers of the child/youth. Continuous monitoring of the plan occurs through 90-day and semi-annual reviews of the POC.

The POC identifies the assigned task and person responsible for implementing the identified support to attain a specific POC goal. This includes community partners identified by the CFT to provide natural supports for the family to meet the child/youth's needs. Each POC has an identified crisis and safety plan section that identifies potential crisis scenarios, what action steps or strategies need to be implemented, and the persons responsible to mitigate the risk, as discussed further below.

The POC is updated at a minimum on a semi-annual basis through the wraparound process. However, a CFT meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child/youth require the CFT to meet on a more frequent basis to best coordinate care.

The child/youth and parents or caregivers of the child/youth must be involved in the development of the POC. Participation is documented through the signatures of the child/youth and parents or caregivers of the child/youth on the POC. In addition, the SMO must operate from one integrated treatment plan. This reinforces the wraparound process and results in the POC encompassing all services that may be accessed through the SMO.

Each POC is required to contain a crisis and safety plan. Crisis plans are developed in conjunction with the POC during the CFT meeting based upon the individualized preferences of the child/youth and parents or caregivers of the child/youth. As with the POC itself, the child/youth and parents or caregivers of the child/youth may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the CFT. Training provided to Wraparound Facilitators highlight the need to identify different levels of intervention on a crisis plan, the different stages of crisis, and how a crisis may be defined differently by each family.

The crisis plan includes action steps as a backup plan if the crisis cannot be averted. The action steps are developed through the wraparound process by the CFT and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line, or contacting the Wraparound Facilitator. The SMO is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to children/youth and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their POC in order to have access to the identified information should a crisis occur.

Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The SMO is required to have staff on-site available by a toll free phone number 24 hours a day/365 days a year to respond to calls.

Wraparound Facilitators may conduct the following joint treatment planning activities that will vary in intensity over the course of the wraparound process:

- Completion and maintenance of an Individualized Plan of Care that adheres to NWI requirements and the requirements of 42 CFR 438.208(c)(3).
- Staff facilitation of the CFT meeting, when not facilitated by the parent or caregiver.
- Planning activities, including completion of the strengths, needs and culture discovery and gathering of information to help complete the CANS, per 42 CFR 438.208(c)(2).
- Facilitation of planning activities by the CFT, including crisis/safety planning and participation in the planning of other service systems to support the coordination of behavioral health services.
- Establishing linkages to natural supports and any service options for the youth and family that further the behavioral health goals of the Individualized Plan of Care. Transportation of the client is not a reimbursable component of WF. The WAA will coordinate with local Medicaid transportation supports and also help children and families connect with natural supports to provided needed transportation as part of the CFT process. In addition, the WAA

provider may develop other local funds to cover staff and travel costs to provide transportation. Any safety concerns related to transportation will be addressed as part of the CFT crisis/safety planning process.

- Monitoring the effectiveness of the Individualized Plan of Care via e-mail, telephone, face-to-face interactions and other communication interactions with the youth, family and team members, ensuring compliance with HIPAA and FERPA standards for all communication.

The Wraparound Facilitator must work with FSO Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators and Certified Youth Support and Training Specialists as they carry out the following activities in support of the joint treatment planning:

- Activities to support the development of the Individualized Plan of Care by the Wraparound Facilitator.
- Participation in the CFT as an additional advocate for the youth or family if selected as such by the youth or family.

In addition, there are WAA and FSO staff that are involved in evaluation activities required to ensure that the WF activities are being done in accordance with principles and practices of the NWI. Costs for these staff are reimbursable as a direct operating expense of the program to the extent that the evaluation activities are specific to the assessment of WF fidelity and related factors. If the evaluation activities are broader based (for example, multi-program outcome assessment), only the pro rata share attributable to CFT oversight is reimbursable as a general administrative expense.

Children/youth and their families will have free choice of providers within the SMO and may change providers. Once enrolled in the SMO, if a child/youth is already established with a therapist who is not a member of the network, the SMO is required to make every effort to arrange for the child/youth to continue with the same provider if the child/youth so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a child/youth needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, children/youth will be given the choice between at least two providers. Exceptions would involve highly specialized services that are usually available through only one agency in the geographic area. This information will be provided in the SMO's member handbook which is given to children/youth and their families upon enrollment in the waiver. Member handbooks will also be available on the SMO website.

The CFT develops the child/youth's POC using the CANS assessment developed through the wraparound process under the oversight of an approved licensed behavioral health practitioner. Once developed, that same information is submitted electronically for prior authorization to the SMO's Care Management team through the electronic health record and other applicable databases. The SMO provides Medicaid-reimbursable mental health services (including SED waiver services) under OBH oversight.

It is expected that the amount of WF will be more intensive during the initial period of engagement and Individualized Plan of Care development (for example, six to ten hours weekly, subject to individualization), somewhat less intensive during the period of Individualized Plan of



Care implementation (for example, three to six hours weekly, subject to individualization) and less intensive during the period of transition from WF to natural supports (for example, one to three hours weekly, subject to individualization). Duration of the WF planning process is based on the child's needs and is expected to vary in length between three to 18 months. Fidelity to NWI standards will be the primary determinant of frequency and duration, individualized to the needs and strengths of each youth and family served.

The WAA will also employ a full time Quality Improvement and Data Director who will oversee the following local data tracking, utilization management and quality assurance activities:

- Tracking of individual children, services provided and costs of services using datasets defined by the SMO,
- Utilization management/utilization review of individual children in collaboration with and under the oversight of the SMO,
- Quality assurance at the local level coordinated with the broader quality oversight role of the SMO,
- Outcomes management/monitoring of individual children using criteria defined by the SMO, and
- Input of individual child data into a management information system capable of needed tracking and monitoring functions and integrated with SMO MIS.

The Quality Improvement and Data Director will be supported in these activities by a full time Community Resource Specialist who will assist with tracking and quality improvement activities and also support the identification and tracking of community resources (services and natural supports) for WAA staff.

In addition, the WAA will employ the following full time administrative staff to lead and support the overall organization:

- Executive Director,
- Business / Information Technology Manager, and
- Administrative Assistant.

### **I. Non-Reimbursable Activities**

No direct services may be provided by the CFT team members as part of their contractually defined WAA role. The WAA staff may not provide direct services to any child for whom he or she has assisted in developing the POC. Any CFT team members providing direct services outside of their WAA role must ensure that there is no conflict of interest between their direct care activities and their WAA responsibilities. Any direct services would be reimbursed separate from WAA reimbursement in accordance with SMO contractual relationships with the provider. Any direct service expense would be reported along with medical service expenses in the financial and encounter reporting processes.

The following activities by Wraparound Facilitators are not allowable:

- Activities that are not delivered to a specific enrolled child or youth or the family of that child/youth in support of the child/youth's treatment.

- Activities that are the responsibility of another State agency and are excluded from Medicaid coverage (such as child welfare permanency planning). The WAA must ensure that only specifically documented coordination and delivery of behavioral health services and supports are reimbursed by the SMO.
- Transportation of the client is not a reimbursable component of WF. The WAA will coordinate with local Medicaid transportation supports and also help children and families connect with natural supports to provided needed transportation as part of the CFT process. In addition, the WAA provider may develop other local funds to cover staff and travel costs to provide transportation.
- Participation by other Medicaid providers in the joint treatment planning process should be reimbursed separately only if appropriate and in accordance with the guidelines for service delivery for that provider. A degree of non-billable case consultation is built into the rate assumptions for most providers and would not be separately covered. However, to the extent that the provider is allowed to bill for separate case consultation with or without the enrollee present or that a SMO has established its own protocols to fund such involvement, either on an individually approved or regular basis, some limited separate billing may be permissible. In the case of individual SMO protocols, such costs would only be allowed to be built back into subsequent capitation rate setting if they were shown to be cost-effective substitutes per the process already put in place by the SMO to oversee such determinations.

## **J. Reimbursement**

Each WAA provider will receive reimbursement from the SMO based on the number of children currently receiving wraparound facilitation from that particular agency. Reimbursement will be in the form of a daily rate for each day of the month that a child is registered on the WAA's caseload list, as maintained by the SMO and indicating the number of children receiving wraparound facilitation from that WAA. The days subject to reimbursement include days in which WAA staff perform specific wraparound facilitation activities for a particular child, as well as days without specific activities, according to the contract between the WAA and SMO.

A number of the staff positions described in subsection 4.L below are required regardless of the size of the wraparound agency. Therefore, the State has developed a reimbursement structure that differentiates the rates for each agency based on the number of teams of Wraparound Facilitators the agency employs (one team consists of eight Wraparound Facilitators). The State is also considering options related to funding the ramp-up associated with expanding from one to two teams or two to three teams. This may include paying the single team rate when the WAA has only one team for a yet to be determined period of time, while the agency hires additional Wraparound Facilitators for additional teams as the WAA increases its case load.

The following daily rate schedule identifies the per child per day estimated reimbursement. These rates are provided for planning purposes and should not be interpreted as the final payment rates each agency should expect to receive from the SMO. They are provided to assist with financial planning.

<b>Agency Size (in terms of wraparound teams)</b>	<b>Daily Rate per Child</b>
One Team Wraparound Agency (capacity of 80 children)	\$44
Two Team Wraparound Agency (capacity of 160 children)	\$37
Three Team Wraparound Agency (capacity of 240 children)	\$34

It is expected that WAA caseloads will build over the first 12 months up to full capacity. The State will provide supplemental funds to support start up while caseloads ramp up. The specific schedule and rate will be determined between the WAA and the SMO, but for planning purposes applicants should assume an even build up by month going from zero cases in month one to a full caseload by month 12.

In addition, current plans are for each WAA to receive a set amount of flexible funding for each child on the team to support non-medical supports necessary to the wraparound process and implementation of the POC. The specific rate and funding source for the flexible funds has not yet been finalized, but for planning purposes applicants should use the amount of \$42 per child per month (prorated daily).

**K. SMO Monitoring**

In order to maintain WAA certification, all team members must be credentialed for their specific roles on the team. Standards for certification include participation in fidelity monitoring using the Wraparound Fidelity Assessment System (WFAS) and additional minimum fidelity requirements established by the SMO. Documentation of annual re-credentialing will be provided to the SMO to document continued adherence to the fidelity standards. SMO certification of the WAA will be withdrawn if current credentialing and documentation is not maintained.

The NWI fidelity standards include requirements for cultural competency.

Monitoring of compliance with NWI requirements and outcome assessment will be carried out by the SMO using the WFAS.

Documentation of initial credentialing and subsequent re-credentialing for WF supervisors and Wraparound Facilitators will be monitored on an annual basis by the SMO. The SMO will also review fidelity data tracked and reported to the SMO on an annual basis.

Oversight of WAA certification and re-certification will be carried out by the SMO. Certified WAAs will be reviewed annually by the SMO in order to ensure that certification requirements continue to be met.

**L. Staffing Requirements/Qualifications**

In order to maintain WAA certification and to ensure compliance with WF fidelity requirements, WAA staff must meet the following educational and experience requirements as well as achieve and maintain credentialing as specified below.

**Wraparound Facilitator:** The Wraparound Facilitator must meet the following requirements:

- Bachelor's-level degree in a human services field or Bachelor's-level degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the Bachelor's-level degree requirement in individual cases subject to approval by OBH.
- Completion of the required training and credentialing process for WF Wraparound Facilitators.
- Demonstration of high fidelity to NWI standards through ongoing participation in wraparound fidelity monitoring using the WFAS.

WAA staff will work together with FSO Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists in a team to ensure that the child and their family are at the center of planning at all times.

Certified WAAs must also employ staff to supervise the Wraparound Facilitators. People serving in supervisory capacities do not provide WF services. Requirements include the following:

- Master's-level or higher graduate degree in a human services field.
- Minimum of three years of full-time experience working in relevant family, children/youth or community service capacity.
- Completion of the required training and credentialing process for WF supervisors.
- If the supervisor also functions in part as a Wraparound Facilitator, they must also meet the requirements for a Wraparound Facilitator described above.
- The WF supervisor must provide regular supervision to WF service delivery staff, including completion of all supervisor requirements for wraparound fidelity monitoring using the WFAS as required.
- The WF supervisor must have good interpersonal skills for supporting development in others. The supervisor should have a broad base of experience and possess a diverse view of what families need to live better lives. The supervisor must collaborate closely with other supervisors in other child-serving agencies in the community. A wraparound supervisor must have an outgoing personality that supports engaging people from different cultures, ages and backgrounds. A preferred supervisor characteristic is an understanding of and experience with different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor must oversee the work of the WF service delivery staff on an ongoing basis.

### **M. Staffing Guidelines for Wraparound Agencies**

The recommended staffing for a WAA includes the following full-time equivalent (FTE) and part-time hourly positions (as listed in the table below) that will serve 240 youth and their families. Column one includes the name of the position, column two indicates the number of FTEs and column three describes the staffing ratio used in the guidelines. The required staffing ratio for Wraparound Facilitators to children/families is 1 FTE staff to 10.

<b>Position</b>	<b>FTE</b>	<b>Staffing ratio</b>
Executive Director (or Program Director if part of an existing organization)	1 FTE	One per agency
Business Manager / Information Technology Manager	1 FTE	One per agency – May be part time if WAA is part of a larger organization
Administrative Assistant	5 FTE	Based on 20 staff FTE (full time and hourly)
Quality Improvement/Data Director	1 FTE	One per agency
Community Resource Specialist	1 FTE	One per agency
Licensed Clinical Director / Team Supervisor	1 FTE	One per agency
Wraparound Facilitators Team Supervisors	2 FTE	1 per 80 families (the Clinical Director also supervises a team)
Wraparound Facilitators	24 FTE	1 per 10 youth
<b>Total</b>	<b>36 FTE</b>	

**N. IT and Other Administrative Requirements**

As noted above, the SMO will define data system and other system administrative standards with which the WAA must be able to comply and coordinate. The WAA must attest to its willingness to comply with these data and system requirements, ensuring compliance with HIPAA and FERPA standards. The WAA will be given a reasonable timeframe and appropriate supports by the state to facilitate such compliance.

## **Section 5: Specific Requirements for the Family Support Organization (FSO)**

This section describes general requirements that apply to the FSO. The organization (or group developing an organization) that seeks to fill this role must understand and agree to comply fully with the requirements of this section. There are not specific questions in this section for response. Instead, the proposed leadership for the FSO must complete the attestation statements provided with this RFA attesting to their understanding of and willingness to comply with these requirements, as described below.

By featuring family members as full partners working within the system of care, the Louisiana CSoC hopes to stimulate behavioral change across the system and support development of family-friendly policies and procedures within the provider agencies and among community partners. Emphasizing FSOs as system partners will support full family involvement in systems of care becoming the rule, rather than the exception. In Louisiana's CSoC, family involvement, support and development at the local level will be structured through the FSO to support family involvement and engage the diversity of families affected by systems of care. Through the local FSO, family members will participate in the wraparound planning process and provide support and training to families being served by the CSoC.

### **A. Compliance with State and Federal Requirements**

FSOs will be financed using a concurrent Medicaid managed care 1915(b) and home and community based 1915(c) waiver authority. FSOs will be subject to DHH and CMS regulatory requirements and will provide services that are Medicaid reimbursable. For FSOs, this entails a professional working knowledge of the Medicaid rules and regulations and expertise in Medicaid billing and coding. Key requirements from the waiver include the following.

**Youth Support and Training Requirements.** Youth Support and Training is provided by Certified Youth Support and Training Specialists working for FSOs.

Youth Support and Training services are child/youth centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's Individualized Plan of Care (POC). The structured, scheduled activities provided by this service emphasize the opportunity for children/youth to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Youth Support and Training is a face-to-face intervention with the child/youth present. Services must be provided individually; they cannot be provided in a group setting. The majority of Youth Support and Training contacts must occur in community locations where the person lives, works, attends school and/or socializes. This service may include the following components:

- Helping the child/youth to develop a network for information and support from others who have been through similar experiences.
- Assisting the child/youth with regaining the ability to make independent choices and take a proactive role in treatment, including discussing questions or concerns about medications, diagnoses or treatment with their clinician.
- Assisting the child/youth with identifying and effectively responding to or avoiding identified precursors or triggers that result in functional impairments.
- Assisting the child/youth with the ability to address the behaviors and reduce reliance on youth support over time, including: reducing rebelliousness, addressing early initiation of antisocial behavior (for example, early initiation of drug use), decreasing attitudes favorable toward drug use, decreasing perceived risks of drug use, reducing antisocial behaviors toward peers, reducing contact with friends who use drugs, gang involvement, and intentions to use drugs.

Limitations to the delivery of Youth Support and Training are as follows:

- Local Education Agencies may not provide this service. Only FSOs may provide this service.
- Limit of 750 hours of Youth Support and Training per calendar year. This limit can be exceeded when medically necessary through prior authorization.
- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child/youth's medical record.
- The Youth Support and Training provider must be supervised by a person meeting the qualifications for a Certified Youth Support and Training Specialist Supervisor.

**Parent Support and Training Requirements.** These services are provided by Family Cultural Support Specialists and Parent Trainer/Group Facilitators working for FSOs.

Parent Support and Training is designed to benefit the Medicaid eligible child/youth experiencing a serious emotional disturbance who, without CSoC waiver services, would require state psychiatric hospitalization or nursing facility institutionalization. This service provides the training and support necessary to support and to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The specialist may attend meetings with the family and assist in helping family to effectively contribute to planning and accessing services, including assistance with removing barriers. The specialist assists in describing the program model and providing information as needed to assist the family. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (for example, parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their behavioral health needs and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting

with understanding policies, procedures and regulations that impact the child with behavioral health concerns while living in the community (for example, training on system navigation and Medicaid interaction with other child serving systems). The specialist may also conduct follow-up with the families regarding services provided and continuing needs. For the purposes of this service, "family" is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the family support and training service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual. Services may be provided individually or in a group setting.

Limitations to the delivery of Parent Support and Training are as follows:

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost.
- Services may be provided concurrent with development of the treatment plan to ensure parent support and training and must be intended to address the needs identified in the assessment and to achieve the goals or objectives identified in the child's POC.
- The Family Cultural Support Specialist/Parent Trainer/Group Facilitator provider must be supervised by a person meeting the qualifications for a Family Support Supervisor.
- The individuals performing the functions of the Family Cultural Support Specialist/Parent Trainer/Group Facilitator may be full-time or part-time (for example, a Family Cultural Support Specialist may be a part-time employee separate and distinct from a part-time Parent Trainer and/or Group Facilitator).

## **B. FSO Provider Agency Certification Requirements**

In order to provide family support, each FSO must be credentialed as a family support provider by the SMO. Central to that credentialing will be certification of Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists employed by the FSO by OBH, as described above in Section 3. Once a region is selected for CSoC implementation, the State will provide training and establish a timeline and process through which OBH will certify the FSO. After this, the SMO will credential any FSOs as compliant with required criteria in advance of FSO operations (including required criminal background checks, as appropriate).

The OBH certification process centers on documentation that individual FSO staff members have completed required training, as described in Section 3 above. OBH will provide evidence of this certification to the SMO. Once credentialed by the SMO, the use of Medicaid



reimbursement to support FSO delivery under the waiver will be allowed, subject to the limitations defined in this document.

### **C. Requirements for FSO Staff and Supervisors**

The Certificate Program is 12-24 month process and must be satisfactorily completed within 24 months of hire date. Over the course of the certification process applicants will need to meet certain requirements in order to receive certification. These requirements are still in the process of being developed and will involve substantial commitments of time on the part of Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, Certified Youth Support and Training Specialists, and their supervisors engaging in a process facilitated by external trainers and coaches with demonstrated expertise in Wraparound and family support, who will be selected and contracted by the State. Staff will also be required to complete standardized measures to demonstrate fidelity to the Wraparound model. The certification process will be developed by OBH and will consist of a comprehensive certification program paid for by the State. The program will involve both didactic and coaching components, as well as documentation reviews of POCs and observation of activities such as family visits, home visits, and CFT meetings.

### **D. Goals and Process Design**

FSOs will provide an array of supports centering on Parent Support and Training to support and to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For the purposes of FSO services overall, "family" was defined above as the primary care giving unit, inclusive of the wide diversity of primary care giving units in our culture. For the purposes of the family support and training service, "family" was defined as the persons who live with or provide care to a person served on the waiver.

Examples of how this service will be delivered by Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists include:

- These staff may attend meetings with the family and assist in helping the family to effectively contribute to planning and accessing services, including assistance with removing barriers.
- These staff may assist in describing the program model and providing information as needed to assist the family.
- Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (for example, parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by

service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (for example, training on system navigation and Medicaid interaction with other child serving systems).

- These staff may also conduct follow-up with the families regarding services provided and continuing needs.

## E. FSO Staff Activities

Parent Support and Training is designed to benefit the CSoC eligible child/youth experiencing a serious emotional disturbance who, without waiver services, would require state psychiatric hospitalization or nursing facility institutionalization. This service provides the training and support necessary to support and to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The specialist may attend meetings with the family and assist in helping family to effectively contribute to planning and accessing services, including assistance with removing barriers. As noted in the previous subsection, the specialist assists in describing the program model and providing information as needed to assist the family. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (for example, parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community. The specialist may also conduct follow-up with the families regarding services provided and continuing needs. For the purposes of FSO services overall, "family" was defined above as the primary care giving unit, inclusive of the wide diversity of primary care giving units in our culture. For the purposes of the family support and training service, "family" was defined as the persons who live with or provide care to a person served on the waiver. Services may be provided individually or in a group setting.

1. Services provided to children and youth must include communication and **coordination** with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to the recipient at no cost. The FSO may not provide identical training to individuals in the community free of charge or as unfunded charity care. It can charge the training to a block grant or other funding source such as DCFS or OBH though.
3. Services may be provided concurrent with development of the treatment plan to ensure parent support and training and must be intended to address the needs identified in the

assessment and to achieve the goals or objectives identified in the child's Individualized POC.

4. Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists must be supervised by a person meeting the qualifications for a FSO Supervisor.

Additionally, FSOs and their staff provide the training and support necessary to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. As noted above, training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. For the purposes of FSO services overall, "family" was defined above as the primary care giving unit, inclusive of the wide diversity of primary care giving units in our culture. For the purposes of the family support and training service, "family" was defined as the persons who live with or provide care to a person served on the waiver.

#### **F. Reimbursement**

Each FSO provider will receive reimbursement from the SMO based on the units of family / youth support and education delivered to children enrolled with the WAA and their families (using the definition of family noted above). Reimbursement will be available only for children registered on the WAA's caseload list (as maintained by the SMO) and their families for the period of time during which the child is on the caseload list.

The following rate schedule identifies the per unit estimated rates. These rates are provided for planning purposes and should not be interpreted as the final payment rates each agency should expect to receive from the SMO. They are provided to assist with financial planning.

<b>Types of FSO Service Units to be Provided</b>	<b>Unit Rate</b>
Youth Support and Training - Individual	\$10.00 per 15 minutes
Parent Support and Training - Individual	\$10.00 per 15 minutes
Parent Support and Training - Group	\$2.50 per 15 minutes

It is expected that FSO staffing and caseloads will build over the first 12 months up to full capacity. The State will provide supplemental funds to support start up while caseloads ramp up. The specific schedule and rate will be determined between the FSO and the SMO, but for planning purposes applicants should assume an even build up by month going from zero cases in month one to a full caseload by month 12.

For planning purposes, the following service delivery assumptions went into the development of the rates. When at full capacity (and fully staffed per the requirements in Section 5.H below):

- Each FSO will serve a caseload of 240 children and their families,
- 15% of the children and youth will access Youth Support and Training – Individual for an average of 2.0 hours per week,
- 100% of the families of enrolled youth will access Parent Support and Training - Individual for an average of 1.5 hours per week, and
- 100% of the families of enrolled youth will access Parent Support and Training - Group for an average of 2.0 hours per week.

## **G. Staffing Requirements/Qualifications**

In order to maintain FSO certification and to ensure compliance with DHH and CMS standards, FSO staff must meet the following educational and experience requirements.

- Executive Director/Program Director: New agencies must hire an executive director that meets the following qualifications (existing organizations must hire a program director that meets the following qualifications):
  - High School Diploma or equivalent is required. Associate's degree is preferred.
  - Certification of Family Support Training according to a curriculum approved by OBH prior to providing the service.
  - Experience in public speaking, workshop presentations, and assisting others on the telephone or has a willingness to learn immediately.
  - Experience in a management or supervisory position.
  - Demonstrated success in resolving children's issues within the system.
  - Commitment to be active in on-going training, organizational development and capacity building of the CSoC.
  - Family member of a child/youth with significant behavioral health challenges or co-occurring disorders served by multiple public child-serving systems for at least one year.
  - Has no familial, financial or supervisory relationship with elected or appointed state government officials or staff overseeing activities that are part of the system of care.
- Business Manager/IT
  - Bachelor's-level degree in business administration, accounting, finance, IT, or related field with two years professional experience.
  - Experience with medical billing and coding
- Community Resource Specialist: Serves as an information officer for the organization. Publishes the website, newsletter, and informational guide on community services available.
  - High school diploma or equivalent is required.
- Certified Youth Support and Training Specialist Supervisor
  - Bachelor's-level degree in a human services field or Bachelor's-level degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the Bachelor's-level degree requirement in individual cases subject to approval by OBH.
- Certified Youth Support and Training Specialist: Provides youth support and training services that are child/youth centered services with a rehabilitation and recovery focus

designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.

- Must be at least 18 years of age.
- High School Diploma or equivalent or currently seeking diploma.
- Must pass criminal, abuse/neglect registry and professional background checks.
- Must complete a standardized basic training program approved by OBH.
- Self-identify as a present or former child recipient of behavioral health services.
- Certified Parent Trainer/Group Facilitator: Provides parent training and support. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth.
  - High School diploma or equivalent.
  - Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience (preference is given to parents or caregivers of children with significant emotional / behavioral health challenges).
  - Certification of Family Support Training according to a curriculum approved by OBH prior to providing the service.
  - Pass criminal history background check, DCFS child abuse check, adult abuse registry and motor vehicle screen.
  - A licensed mental health practitioner shall be available at all times to provide back up, support, and/or consultation.
- Certified Family and Cultural Support Specialist: Provides the support necessary to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned. The specialist serves as a member of the Child and Family Team (CFT). The specialist assists in describing the program model and providing information as needed to assist the family.
  - High School diploma or equivalent.
  - Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience (preference is given to parents or caregivers of children with significant emotional / behavioral health challenges).
  - Certification of Family Support Training according to a curriculum approved by OBH prior to providing the service.
  - Pass criminal history background check, DCFS child abuse check, adult abuse registry and motor vehicle screen. A licensed mental health practitioner shall be available at all times to provide back up, support, and/or consultation.

## H. Staffing Guidelines for Regional Family Support Organizations

The recommended staffing for the regional FSO includes the following full-time equivalent (FTE) and part-time hourly positions (as listed in the table below) that will serve 240 youth and their families. Input from the FSO Work Group suggests that Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Certified Youth Support and Training Specialists will predominantly be part-time hourly employees. This model allows for both full- and part-time employees. Full-time employees would have benefits. Column one includes the name of the position, column two indicates whether the position is full time with benefits or part time hourly positions, and column three describes the staffing ratio used in the guidelines. The required staffing ratio for parent support or youth support is 1 FTE staff to 20 families.

<b>Position</b>	<b>Full time (FT) and FTE hourly positions</b>	<b>Staffing ratio</b>
Executive Director (or Program Director if part of an existing organization)	1 FT	One per agency
Business Manager / Information Technology Manager	1 FT	One per agency
Administrative Assistant	4 FTE	Based on 20 staff FTE (FT and hourly)
Community Resource Specialist	1 FTE	One per agency
Certified Parent Trainer / Group Facilitators	2 FT/ 3 FTE hourly	1 per 160 families
Certified Family and Cultural Support Specialists	3 FT / 2 FTE hourly	1 per 20 families
Certified Youth Support and Training Specialist Supervisor	1FT / 1 FTE hourly	1 per 80 youth
Certified Youth Support and Training Specialists	1 FT / 1 FTE hourly	1 per 20 youth
Licensed clinician	0.20 FTE hourly	8 hours per week

## I. IT and Other Administrative Requirements

As noted above, the SMO will define data system and other system administrative standards with which the FSO must be able to comply and coordinate. The FSO must attest to its willingness to comply with these data and system requirements, ensuring compliance with HIPAA and FERPA standards. The FSO will be given a reasonable timeframe and appropriate supports by the state to facilitate such compliance.