Title:	High Fidelity Wraparound (HFW)	**Code:**	H0032HF
Type:	High Fidelity Wraparound (HFW)	**Group Code:**	
Effective Date:	March 5, 2018	**Units:**	Case Management, Family Partner, and Youth Partners services are bundled into 1 unit per 1 month

SERVICE DESCRIPTION

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

High Fidelity Wraparound (HFW) is a service that dedicates a full time HFW facilitator to work with small numbers of youth and families to:

- facilitate care planning and coordination of services for youth 5-20 years of age with serious emotional disturbance (SED);
- provide access to family and youth peer support services to promote engagement and completion of services;
- Engage youth and families to establish an individualized child and family team that develops and monitors a strengths-based plan of care;
- Address youth and family needs across domains of physical and behavioral health, social determinants of health, and natural supports.

HFW is built on system of care values: family and youth choice and voice, team-based, collaborative, individualized, and outcomes-based. HFW strategies include engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress. (Simons, Pires, Hendricks, Lipper, 2014).

The HFW Team consists of a Facilitator and most at family choice will include a, Family Partner, and/or a Youth Partner. Each Facilitator may serve 10-12 families. Each Family Partner and Youth Partner may serve up to 15 families across multiple HFW teams. The HFW team is provided coaching/supervision by a HFW coach. The HFW

Coach/Supervisor, is a North Carolina Licensed or Associate Licensed Professional. **One coach/supervisor for 4 facilitators, 2 family peer support partners, and 1 youth peer support partner for up to 48 youth/families.**

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

HFW is designed to facilitate a collaborative relationship among a youth with SED, his/her family and involved child-serving systems to support the family in meeting their family and specifically the designated youth's needs. The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process with four specific phases (engagement, plan development, implementation, and transition).

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

The HFW model is based on the National HFW Initiative which was formed in 2004 to define the HFW practice model, develop standards, compile specific strategies and tools, and disseminate information about how to implement the HFW model in a way that can achieve positive outcomes for youth and families.
The HFW Facilitator coordinates the development of a Child and Family Team (CFT) comprised of both formal and natural support persons who assist the family and youth in developing a HFW Plan including a Crisis/Safety to address needs and goals developed by the family; convenes CFT meetings; coordinates and communicates with the members of the CFT to ensure the implementation of the HFW Plan; works directly with the youth and family to implement elements of the HFW Plan; coordinates the delivery of available services; monitors and reviews progress toward HFW Plan goals and updates the HFW Plan in concert with the CFT.

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

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

HFW activities are grouped into four phases:

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

In *Engagement and Team Preparation* (2-4 weeks) the HFW Team Facilitator, along with the Family Partner and Youth Partner, initiates a strengths-based, non-judgmental engagement process that includes crisis stabilization, orientation to the HFW process, and identification of family and youth strengths, culture, and vision (goals) for the future.

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

During the *Plan Implementation phase* (2-12 months) of the HFW process, the HFW staff work with the family to build the transition assets that will prepare the family to move forward successfully after HFW ends. This includes transferring responsibility for the process to the family and natural supports. The HFW staff meet with the family frequently to review the status of the plan and identify indicators of progress toward the priority goals. The Facilitator supports the family to manage implementation within other team members to ensure the implementation of the plan of care, monitors completion of action steps, strategies, and successes in meeting needs that lead to the achievement of outcomes. Transition out of formal HFW is intended to occur when the team (with primary guidance from the family) agrees that the identified priority needs have been met.

The *Transition Phase* typically consists of 1 meeting. Most HFW work on transition occurs during the implementation phase. **The HFW Team Tasks & Responsibilities:**

The initial treatment decisions, ongoing care, and treatment monitoring are done within the child and family team.

HFW Facilitator

- Engagement and Assessment - Works with family to integrate information from multiple sources into the strengths needs and culture discovery.
- Assists the family to identify appropriate members of the Child & Family Team (CFT);
- Collects background information and plans from other agencies. The assessment process determines the needs and wants of the youth for any medical, educational, social, therapeutic, or other services/supports. Further assessments are arranged as needed and/or wanted; and
- Facilitates the CFT to develop an integrated mission to support the family.

Development of an Individual HFW Plan

- Convenes and facilitates the CFT meetings and the CFT supports the family to develop a youth- and family-centered - HFW Plan that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed or wanted by the youth and family specifying concrete interventions and strategies and identified responsible persons**.**
- Ensures the HFW Plan results in the best fit between the family vision, team mission, strengths, needs, and strategies, through a proactive and reactive planning process that is inclusive of a connected crisis plan.

Referral and related activities:

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

Monitoring and follow-up activities:

- Facilitates reviews of the HFW Plan to reflect the changing needs of the youth and family.
- Completes the required tools as scheduled to track progress.
- Monitors and documents the status of the youth and family's progress and effectiveness of the strategies and interventions outlined in the Plan of Care.
- Attends a minimum of one hour of group supervision and one hour of consultation per week to monitor adherence to the HFW principles.

Family Partner

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

Youth/Young Adult Peer Partner

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

- Helps build relationships and respect with family members, natural supports, community partners, and key stakeholders;
- Develops a working understanding of the young person's desires, goals, interests, and strengths;
- In addition to developing trust and mutual respect between the team and the individual, the team also works with the individual to bridge relationships with others, such as family members, teachers, employers, friends;
- Assists the young person with identifying goals and developing an action plan to steps to achieve these goals;
- Helping the young person navigate a system across several domains while focusing on personal effectiveness/wellbeing and life/community functioning;
- Help develop social responsibility and accountability - teaches the young person problem solving and decision - making skills that enable the young person to manage day to day life problems and opportunities;
- Build Support Network -A key element to a young person's identity and independence is his/her support system. The Youth Partner & HFW team works with the young person to understand the benefits of a

support system and identify those individuals and groups that advocate, provide encouragement, and the safety net necessary for success; and
- Enhance Social and Life Skills - assists the young person to become competent in any skill(s) that are vital to achieving his/her goals. Teaching the individual to become self-sufficient will build confidence and self-determination.

The Coach/Supervisor

- Provides supervision, ongoing consultation, and crisis support.
- Helps HFW Team understand the topics of training and develop an understanding of how to apply what they have learned through the structured professional development plan.
- Track certification of each team member and use professional development plan to assist each team member in mastering the core competencies of their role.
- Review cases regularly quidded by HRW principles

Coach/Supervisor also may carry a small - caseloads of up to two (2) families.

Access to psychiatric consultation for HFW staff:
Formal consultation is not required, although children/youth participating in HFW have access to all services available under the NC Medicaid benefit plan. A psychiatrist/APRN actively engaged in treatment with a child/youth should be invited to participate in each team meeting.

Population to Be Served			
The HFW Team Tasks & Responsibilities:	**The HFW Team Tasks & Responsibilities:**	**The HFW Team Tasks & Responsibilities:**	**The HFW Team Tasks & Responsibilities:**
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Entrance Process

A comprehensive clinical assessment or an abbreviated assessment and any other available clinical referral materials upon referral to HFW that demonstrates medical necessity shall be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information shall be obtained and be included in the Person - Centered Plan or the HFW Plan of Care.

If completing an abbreviated assessment, the format of the abbreviated assessment is determined by the individual provider based on the clinical presentation. Although the abbreviated assessment does not have a designated format, the assessment must be completed by a licensed professional and must include the following elements:

a. The individual's presenting problems;
b. The individual's needs and strengths;
c. A provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission;
d. A pertinent social, family, and medical history; and
e. Evaluations or assessments, such as psychiatric, substance use, medical, and vocational, as appropriate to the individual's needs.

Utilization Management

- HFW will be a maximum of 18 months.
- Prior authorization by the LME-MCO is required before or on the first date of service.
- Initial authorization is for 60 days and it is expected that Phase 1 (Engagement/Team Preparation) and Phase 2 (Plan Development) will be completed and Plan Implementation (Phase 3) will be initiated.
- The initial reauthorization will be for up to 180 days.
- Each reauthorization after that will be for no more than 60 days.

Eligibility Criteria

Medicaid eligible children and adolescents ages 5-20 who also meet the following criteria:

a. Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability AND
b. Based on the current comprehensive clinical assessment including the use of the CALOCUS or CANS, functional impairment is demonstrated to indicate this level of service. Less intensive services were considered or previously attempted, but were found to be inappropriate or not effective; AND
c. Are at risk of not being able to return to or maintain placement in a community setting; AND
d. Youth has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk - taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use); AND one of the following:

- Youth's symptoms and behaviors are unmanageable at home, school, or in other community settings without specialized support due to the deterioration of the beneficiary's mental health or substance use disorder condition and is at imminent risk of out-of-home residential care, requiring intensive, coordinated clinical interventions and is at risk of needing PRTF or other long term out-of-home placements; OR
- Youth is transitioning from PRTF, level III or II group care, therapeutic foster care, Youth Development Center and returning to community services; OR
- Transition age youth in need of an increase and strengthening of family and community support to transition from DSS care and/or out of home placement to independent living (due to aging out of system);

AND

e. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine); AND/OR
f. Youth requires coordination between two or more youth-serving agencies, including medical or non-medical providers; AND

Service Exclusions

A beneficiary may receive HFW from only one service provider organization during any active authorization period for this service. A beneficiary may receive the following services during the same authorization period as the following services:

a. Basic Outpatient services (includes individual, family, and group therapy, particularly in-home therapy services)
b. Therapeutic Foster Care
c. For 60 days prior to discharge from PRTF or Residential Level 3 for transition/step down planning and engagement
d. The Family Partner component may continue in situation where the youth enters a residential treatment program, and if the youth and family were already receiving HFW prior to the residential treatment.

HFW may be provided during the same authorization period with the following services for **youth with complex needs**, as identified in the North Carolina Department of Health and Human Services (DHHS) and Disability Rights North Carolina (DRNC) settlement agreement, October 14, 2016, when medical necessity has been met:

- Intensive In-home;
- Multisystem Therapy;
- Family Centered Treatment
- Day Treatment;
- Substance Abuse Intensive Outpatient Program (SAIOP);
- Substance Abuse Comprehensive Outpatient Therapy (SACOT);
- Intercept
- YV Life Set

*Exceptions for youth who do not meet the criteria for youth with complex needs, will be considered under EPSDT.

The following services are excluded and cannot be provided during the same authorization period:

- Community Support Team;
- Substance Abuse residential services.
- ACTT; Tenancy Support Team;

EPSDT Special Provision

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

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

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

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

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

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

EPSDT and Prior Approval Requirements

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

NC Tracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

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

Treatment Program Philosophy, Goals, and Objectives

The National HFW Initiative describes the program philosophy and goals as follows: "The HFW 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, HFW plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process – as well as availability of research-based interventions that can address priority needs of youth and caregivers; HFW 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 values of HFW, as expressed in its core principles, are fully consistent with the system of care framework. HFW'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 HFW. The values associated with HFW 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 HFW 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 HFW process should be "strengths based," including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities."

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

<u>The Ten Principles of the HFW Process</u>

1) *Family "voice and choice"* - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the HFW process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2) *Team based* - The HFW team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships. The "professional" members include the Team Facilitator, Parent Partner, and Young Adult Peer (as appropriate).
3) *Natural supports* - The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The HFW plan of care reflects activities and interventions that draw on sources of natural support.
4) *Collaboration* - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single HFW plan of care. The plan of care reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5) *Community-based* - The HFW team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
6) *Culturally competent* - The HFW process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
7) *Individualized* - To achieve the goals laid out in the HFW plan, the team develops and implements a customized set of strategies, supports, and services.

8) *Strengths based* - The HFW process and the HFW plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9) *Persistence or Unconditional Support* - Despite challenges, the team persists in working toward the goals included in the HFW plan of care until the team reaches agreement that a formal HFW process is no longer required.
10) *Outcome based* - The team ties the goals and strategies of the HFW plan of care to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

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

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

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

Expected Outcomes

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

a. Decrease in the frequency or intensity of crisis episodes;
b. Reduction in symptomatology;
c. Beneficiary and family or caregivers' engagement in the recovery process;
d. Improved beneficiary functioning in the home, school and community settings;
e. Ability of the beneficiary and family or caregiver to better identify and manage triggers, cues, and symptoms;
f. Beneficiary's sustained improvement in developmentally appropriate functioning as measured by the MCO approved outcome measure, i.e. CALOCUS;
g. Reduction in hospitalizations and admission and readmissions to residential care;
h. Caregiver and youth have increased ability for self-advocacy and resource gathering.
i. Increased use of coping skills and social skills that mitigate life stresses resulting from the beneficiary's diagnostic and clinical needs;
j. Reduction of symptoms and behaviors that interfere with the beneficiary's daily living, such as negative effects of the substance use disorder or dependence, psychiatric symptoms, or both;
k. Decrease in delinquent behaviors when present; and
l. Increased use of available natural and social supports by the beneficiary and family or caregivers.
m. Improved family assets as defined by the Transitional Readiness Scale/Score:

Staffing Requirements

HFW is provided by nationally accredited organizations/agencies that are enrolled in the LME/MCO network for enhanced children's services. The HFW Team consists of a
Primary Team HFW Facilitator, a Family Partner and Youth Partner as appropriate. Each team must have access to a Supervisor/Coach per the ratios and responsibilities outlined below. All staff are required to complete HFW training. HFW requires strong clinical supervision to manage utilization, quality, and outcomes at the child/family level. Each team serves up to 10-12 families. Qualifications and credentialing for each team member is as follows:

The **Supervisor/Coach** must be a Licensed or Associate Licensed Professional. One FTE Supervisor can supervise up to 4 Teams.

Responsibilities of the HFW Supervisor/Coach

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

The HFW Facilitator

- Must meet requirements as a qualified professional.
- Must complete HFW training curriculum and be certified as HFW Facilitator (or be in process of completing training and certification
- Pass background check, the child and adult abuse registry checks, and motor vehicle screens.
- Receive ongoing supervision by a master's level mental health professional who is certified as a HFW Coach (or in process of being certified a HFW Coach).
- Have received Motivational Interviewing training.
- Have training & knowledge in dual diagnosis (MHSU & IDD).
- Have received trauma informed care training.
- Have received training in CALOCUS/LOCUS and CANS.

Knowledge in:

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

Skills in:

- Negotiating with clients, family/caregivers, and service providers;
- Assessing, supporting, observing, recording, and reporting behaviors;

- Identifying, developing, or providing services to clients with SED, and
- Identifying services within the established services system and uncovering natural supports to meet the client's needs.
- Motivational interviewing behavior change strategies

Ability to:

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

The HFW team also consists of a **Family Partner and a Youth Partner** (peers are recommended primarily for older youth). The amount of time the Parent and/or Peer Partner spends with the family varies based on need and family choice. While there is ongoing supervision and coaching for the full team, both the Family Partner and the Youth/Young Adult Partner are required to have weekly supervision with the Team Facilitator, as outlined in a supervision plan.

Family Partner

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

Youth Partner

- Must have lived experience mental health or substance abuse challenges;
- Experience in navigating any of the child and family-serving systems;
- Bachelor's degree in a human services field from an accredited university and one year of experience working with the target population; or associate's degree in a human service field from an accredited school and one year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum of two years of experience working with children/adolescents/transition age youth;

- Over 21 years of age,
- Certification in Peer Support strongly preferred;
- Criminal Background check presents no health and safety risk to participants.
- Not listed in the NC Health Care Abuse Registry.
- Possesses a current/valid driver's license and an automobile with proof of auto insurance.
- When part of a HFW Team, Family Peer Support is certified in the role of Family Peer Support in High Fidelity HFW or is in process of completing certification process within one year from hire

Provider Agency

The provider ensures that HFW Facilitators and Family Peer Support and have successfully completed skill and competency-based training to provide HFWHFW and Family Peer Support as evidenced by certification in HFW.

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

Targeted Length of Service

Target length of stay is 12 months, with a maximum of 18 months

1. **Describe why this service is needed and is different than any State Plan or alternative service already defined. If implemented in other states, describe successful outcomes.**
   In the Partners Gaps and Needs Assessments, there are identified gaps in the child treatment continuum for serious emotionally disturbed youth.

   Services for at risk, high risk youth were identified in the Partners' 2015 Needs Assessment recommendations for case management, service integration and child/adolescent continuum of care. "Case management, while not a new issue, providers continued to express concern that either consumers they serve are not receiving the support they need to negotiate the provider network and receive a full range of coordinated services or that the provider ends up providing that service (i.e. case management) without compensation. Service integration between the historically separate systems of carved out behavioral health services and acute primary needs to be achieved. Initiatives begun in the last year need to be built and expanded upon. Input from the provider focus group and an analysis of service utilization data indicate a need to strengthen the continuum for children and adolescents. The data reflect that outpatient services and the non-needs assessment services make up just over 85% of the Medicaid services for children. In terms of adolescent Medicaid services, outpatient services and the non-needs assessment services make up just under 70% of the services used by adolescents. Additional data indicates important evidence based practices such as Medicaid funded Multi-Systemic Therapy is potentially underutilized as evidenced by only .03% of children and .79% for adolescents receiving these services".

   The needs assessment indicated a need to focus on consumer engagement in the treatment process and coordinate Partners initiatives with child protection and juvenile justice systems. HFW services meets the identified needs to "strengthen the support children /families need to negotiate the provider network" and community services, "enhance service integration with primary care" for children, increase consumer engagement in the treatment process and coordinate initiatives with other child protection and juvenile justice systems. The Partners' Provider Network Cross Functional Team identified HFW services as a priority for children.

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

- Intensive care coordination HFW)
- Access to family peer support (Family Partner)
- Individualized service planning process

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

HFW is currently not available in North Carolina except in five pilot sites which are grant funded. To develop more HFW teams to meet the need, an In Lieu of service definition is required.

HFW is different from LME/MCO Care Coordination in two ways. One, LME/MCO care coordination targets the most complex youth involved in high intensity level of services. Whereas, HFW targets youth receiving less intensive level of services. Thus, HFW and LME/MCO Care Coordination together meet the need of coordination of care across the continuum.

The second difference is that HFW has very low staff to family ratios (1:10/12), which allows for the facilitator to more effectively:

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

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

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

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

- "Reduced costs of care – The PRTF evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of $40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program.
- Improved school attendance and performance - After 12 months of service, 44 percent of children and youth improved their school attendance and 41 percent improved their grades as compared to their attendance and grades prior to participating in the program.
- Increase in behavioral and emotional strengths - 33 percent of youth significantly improved their behavioral strengths after 12 months of service and 40 percent after 24 months compared to their strengths as measured prior to participating in the program. Behavioral and emotional strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.
- Improved clinical and functional outcomes - According to caregiver reports, 40 percent of children served in the CMHI program showed a decrease in clinical symptoms from when they entered the program.

- More stable living situations - The percentage of children and youth in CMHI who remained in a single living situation rather than multiple living situations during the previous 6 months increased from 70 percent at intake to 81 percent at 24 months.
- Improved attendance at work for Caregivers - Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months of program participation, and to 2.8 days at 24 months of program participation.
- Reduced suicide attempts - Within 6 months of service in CMHI, the number of youth reporting thoughts of suicide decreased from intake into the program by 51 percent and the number of youth reporting a suicide attempt decreased by 64 percent.
- Decreased contacts with law enforcement - For youth involved in the juvenile justice system, arrests decreased by nearly 50 percent from intake into the program after 12 months of service in CMHI."

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

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

Description of comparable State Plan Service Payment Arrangements (include type, amount, frequency, etc.)

Service	Unit Definition	Units of Service	Cost of Service
PRTF located in a hospital	Per diem	Per episode	53,511*
Level III (4 beds of less)	Per diem $232.88	270 days	62,877**
Level III (5 beds of less	Per diem $189.75	270 days	51,232**
Level II Family Setting	Per diem $88.58	270 days	23,916**

*Based on Mercer's Data Summary of 2014 Medicaid Expenditures for PRTF Services located in licensed hospitals and expenditures for medical, outpatient, pharmacy, and professional services for children with SED who used psychiatric acute inpatient or hospital PRTF level of care as reported in 2015 draft 1915 c SED waiver application.
**Based on July 2013 DMA Medicaid Rates

Description of Payment Arrangements

Units of services are from 2015 draft 1915 c SED waiver application.

Service	Unit Definition	Units of Service	Cost of Service
HFW Facilitator plus Family Peer Support	Monthly case rate	9 months Plus 480 units (15 minutes) of Family Peer Support	Total: $16,060.
Family Peer Support plus HFWHFW and outpatient therapy	Monthly case rate	WF 9 months Plus 9 months or Family Peer Support and 36 sessions (38-52 minutes) outpatient therapy by LCSW/LPC/LMFT Facilitations	Total: $17,892 FPS=$7,348 WF=$8,712 OPT=$1,832

Partners Behavioral Health Management Data

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
PRTF	0911	Per Diem	142 youth - served; Average 124 units per youth	$7,921,419; Average cost per youth = $55,924
Level 3	H0019HQ & H0019TJ	Per Diem Residential Level 3, 4 beds or less; Residential Level 3, 5 beds or more	170 youth served; Average 134 units per youth	$5,248,982; Average cost per youth = $53,820
Inpatient Readmissions	0101, 0124, 0110, 0116, 0114	Per Diem All-inclusive room & board, Psychiatric, general room & board, & detoxification	551 youth served; Average 10 units per youth	$3,133,965; Average cost per youth = $5,840

Additional Data for Consumers with Top 10% Service Costs:

- 54 individuals
- 47 of 54 had Level III Behavioral Health Residential Treatment
- 29 had both Level III and an Inpatient Psychiatric Hospitalization Episodes of care
- 26 had PRTF, Level III, and Inpatient Psychiatric Hospitalization Episodes of care
- All 26 individuals also had at least one other service (crisis, Intensive In - Home, Outpatient, or Partial Hospitalization
- Sum of service costs for 47 individuals = $3,308,428.46

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

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service
High Fidelity Wraparound	Consider: H0032HF	Monthly Unit includes facilitator contact and case management services bundled with 40 (15 minute) units of Family partner and Youth Partner services.	Monthly Case Rate: 12 per youth (1 per month x 12 months) Family/Youth Partner: 40 units/month shared; maximum 480 units per episode	A. Total per episode = **$18,307.20** • Bundled Unit of Case Management and 40 units o Family/Youth Partner servic paid per monthly unit at rat **$1,525.60**

Cost Effectiveness Summary

High Fidelity Wraparound will prevent admissions to, and reduce length of stay for, PRTFs, Residential Level 3, and Inpatient bed days (especially Inpatient Readmissions). It will also prevent repetitive use of crisis services. It will also be used for the transitional youth population who are difficult to engage into adult services.

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

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

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

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

Description of Monitoring Activities

The MCO will review claims monthly to monitor patterns and trends in utilization of this service.
The MCO will monitor service utilization through prior authorizations, utilization management, and post payment reviews.
The MCO will monitor level of care and outcomes tracking with use of the CANS periodically and at discharge. The reviewed/updated scores/levels will be submitted with re-authorization requests. It is expected that this service would be effective and resulting in positive outcomes when a lower score is reported in the request for re-authorization. This would indicate a plan for successful transition back to basic services (OPT).

Description of Provider Level Monitoring Activities:

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

Documentation Requirements

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

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Oregon Health Authority, (2012). Department of Human Services, Statewide Children's HFW Initiative: Progress Review Summary, July. Retrieved from http://www.oregon.gov/oha/amh/child-mh-soc-in-plan-grp/reports/scwi-pro-review2012.pdf

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