Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Alternative or "in Lieu of" Service Description
High Fidelity Wraparound (HFW)

SERVICE NAME AND DESCRIPTION:

Service name:

High Fidelity Wraparound (HFW)

Description:

Information about Population to be Served:

Population	Age Ranges	Characteristics
Child MH/SU, dually diagnosed MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their diagnosis.	Ages 3-20	**Youth eligible for this service include:** • Children, youth, and young adults with Serious Emotional Disturbance (SED) if 3-17, Serious Mental Illness (SMI) if 18-20 and still covered by Child Medicaid; • Have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and/or substance use problems; • Involved in (or history of) multiple child-serving systems (e.g., child welfare, juvenile justice); • Have a history of placements in PRTF or other restrictive settings within the past year; • At risk of needing PRTF or other long term out-of-home placements; • Transition age youth in need of an increase and strengthening of family and community support to transition from DSS care or out of home placement to independent living (due to aging out of the system).

Treatment Program Philosophy, Goals and Objectives:

Treatment Program Philosophy:

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), who are experiencing serious emotional or

behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events.

For individuals with dual diagnoses, a case by case determination will be made related to appropriateness for HFW. Typically, this would be for youth with primary mental health diagnosis with co-occurring substance use disorder or an individual with co-occurring intellectual or developmental disabilities in the mild-moderate range. High Fidelity Wraparound is also utilized in a pro-active manner to serve those high-risk youth that are involved with multiple agencies. These youth may have used crisis services or have had psychiatric hospitalizations.

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 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).

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. The goals 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. 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. 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." HFW places an emphasis on integrating the youth into the community and building the family's social support network. The goal is to teach the family to be self-sufficient in planning advocacy and care for their child.

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.

The Ten Principles of the HFW Process

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.*

Expected Outcomes:

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

a) Decrease in the frequency of crisis episodes (e.g., use of ED, Mobile Crisis, and Facility Based Crisis);

b) Youth's sustained improvement in developmentally appropriate functioning as measured by the CANS (up to age 17) and CALOCUS or LOCUS for transition age youth.

c) Reduction of inpatient hospitalizations related to Mental Health or Substance Use Disorders.

d) Improved family assets as defined by the Transitional Readiness Scale/Score

e) Reduction in residential treatment days;

Utilization Management:

Entrance Process

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

Due to the complex nature and urgency of admission, a Comprehensive Clinical Assessment or Addendum with documentation of meeting the entrance criteria is acceptable for initiation of services with the submission of the PCP within 30 days of initial authorization.

Before any service can be billed to Medicaid, a written CCA and service order for medical necessity must be in place.

If a substantially equivalent assessment is used it 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 will accept any assessment provided it has all the elements required of a CCA per the service records manual.

Eligibility Criteria: Medicaid eligible children and adolescents ages 3 - 20 who meet the following criteria:

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

b) Based on the current comprehensive clinical assessment (completed within the past year), this service was indicated and there are no other more appropriate services; AND

c) Youth's symptoms and behaviors are unmanageable at home, school or community settings;

AND

Must meet all criteria a-c above, and then at least one of the criteria listed in d-j:

d) Is at risk of placement into a therapeutic residential setting, Level II Group or Level II Family setting or youth in these settings needing intensive support to transition home (note for these youth, a shortened length of stay in Level II would be expected); OR

e) Youth could be stepping down from PRTF, Level IV, III, of Level II Group or Level II family to other least restrictive community-based setting; OR

f) Youth has a recent history of multiple inpatient psychiatric hospitalizations (in the past year) or one stay that exceeded 14 days; OR

g) Youth is transitioning or has been discharged in the past six months from Juvenile Justice related facilities (e.g., Assessment Center, YDC, Detention, Eckerd, etc.); OR

h) Youth has Child Welfare involvement including congregate care; OR

i) Youth is an older adolescent whose family situation is such that they are moving toward independence; OR

j) Youth is in need of support with coordination of assessments to address co-occurring behavioral health and specialized medical needs.

Continued Stay Criteria

Medicaid eligible children and adolescents ages 3-20 are eligible for continued services if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home residential treatment based on current clinical assessment, history, and the tenuous nature of the functional gains;

AND

One of the following applies:

a) The youth has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;

b) The youth is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;

c) The youth is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the youth's premorbid level of functioning are possible; OR

d) The youth fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The youth's diagnosis should be re-assessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes a consideration of alternative or additional services.

Discharge Criteria

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

a) The youth has achieved goals and is no longer in need of High-Fidelity Wraparound services;

b) The youth's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

c) The youth is not making progress, or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;

d) The youth or legally responsible person no longer wishes to receive services; OR

e) The youth, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards.

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

A beneficiary may receive HFW for 60 days prior to discharge from PRTF or Residential Levels II-IV for transition/step down planning and engagement.

HFW may be provided during the same authorization period with the following services, 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);*
- *Youth Villages Life Set*

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

- *Community Support Team*
- *Substance Abuse Residential Services*
- *Assertive Community Treatment Team (ACTT)*
- *Targeted Case Management*
- *Therapeutic Foster Care*

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.

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

3. *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.*
4. *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:

- *Providers Manuals*
- *EPSDT provider page*

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.

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

Provider Requirements

The below requirements are standard for all sites and teams providing or wanting to provide High Fidelity Wraparound in the State of North Carolina. High Fidelity Wraparound services must be delivered by staff employed by a MH/SAS/IDD provider organization that meet the provider qualification policies, procedures, and standards established by the Division of mental Health, Developmental Disabilities and Substance Abuse Services and the requirements of 10A.N.C.A. C. 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being a member of the Trillium Health Resources provider network. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

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:

Responsibilities and Qualifications of the HFW Facilitator

- *Bachelor's Level Qualified Professional with two or more year's post-graduate experience with the population served.*
- *Must complete HFW training curriculum approved by Trillium Health Resources and MH/IDD/SAS, and be certified as a HFW Facilitator in accordance with model expectations (or be in the 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 or CANS.*

Knowledge in:

- *Functional limitations and health problems that may occur in clients with SED, dual diagnosis (MH/SU 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 typically weekly supervision with the Team Facilitator, as outlined in a supervision plan.

Responsibilities and Qualifications of the 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; 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 Wraparound or is in process of completing HFW 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.*

Responsibilities and Qualifications of the Youth Partner

- *Must have lived experience mental health or substance abuse challenges as an adolescence under the age of 21;*
- *Experience in navigating any of the child and family-serving systems;*

- *Bachelor's degree in a human services field from an accredited university; 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, Youth Peer Support is certified in the role of Youth Peer Support in High Fidelity Wraparound or is in process of completing HFW certification process within one year from hire*

Supervision:

As stated, HFW requires strong clinical supervision to manage utilization, quality, and outcomes at the child/family level.

Responsibilities and Qualifications of the HFW Supervisor/Coach

The Supervisor/Coach must be a NC Qualified Professional. One FTE Supervisor can supervise up to 4 Teams.

- *Master's Level Qualified Professional with two or more years of post-graduate experience with the population served.*
- *Must complete HFW training curriculum approved by Trillium Health Resources and MH/IDD/SAS, and be certified as a HFW Coach in accordance with model expectations (or be in the process of completing training and certification).*
- *Supervise and evaluate the Primary Facilitator's performance in all aspects of their position.*
- *Lead team coaching typically per week to monitor adherence to the wraparound principles and program protocols.*
- *Family Partner receives weekly supervision from the HFW Coach (exceptions are allowed for illness, holidays, etc. with corresponding documentation).*
- *Youth Partner receives weekly supervision from the HFW Coach (exceptions are allowed for illness, holidays, etc. with corresponding documentation).*

- *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.*

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.

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 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- 4 meetings. Most HFW work on transition occurs during the implementation phase.

Training:

All staff are required to complete HFW training.

Training, monitoring and credentialing tracks:

1. *There is one training and monitoring track which is provided by the North Carolina High Fidelity Wraparound Training Program (NC HFWTP).*
2. *There are two credentialing tracks:*
3. *NC HFWTP credentials all coaches.*
4. *NC HFWTP allows credentialed coaches to credential their team members.*
5. *All HFW staff, including coaches, must complete NC HFWTP foundational training with a NC HFWTP approved trainer.*
6. *The HFW coach must complete HFW coach credentialing within 9-12 months of employment.*
7. *The HFW Facilitator, Family Support Partner, and Youth Support Partner must complete their role-specific credentialing within 9-12 months of employment.*
8. *The Family Support Partner will complete the Federation of Families National Credentialing for Parent Family Peers as a Certified Parent Support Provider (CPSP) within 18 months of employment.*
9. *The NC HFWTP will observe and engage in teleconferences with Coaches based on the schedule for credentialing coaches and as needed for fidelity purposes.*
10. *Coaches will adhere to the expectations and requirements of coaching, and supervision, as prescribed in the NC HFWTP guidelines.*
11. *Once a team member is credentialed by the NC HFWTP, the team must adhere to the prescribed re-credentialing criteria set by NC HFWTP.*
12. *Once a coach is credentialed by the NC HFWTP, he/she is permitted to credential new team members, with the exception of new coaches.*

Trainings specific to the HFW Supervisor/Coach

- *The HFW coach must complete HFW coach credentialing within 9-12 months of employment.*
- *Provide training of theory and application of HFW services and assist in a variety of ways to ensure the success of the program.*

Trainings specific to the HFW Facilitator

- *Must complete HFW training curriculum and be certified as HFW Facilitator (or be in process of completing training and certification within 9-12 months of employment).*
- *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 or CANS.*
- *Safety and crisis planning;*

Trainings specific to the HFW Support Partner

- *Must complete role-specific credentialing within 9-12 months of employment.*
- *Must complete the Federation of Families National Credentialing for Parent Family Peers as a Certified Parent Support Provider (CPSP) within 18 months of employment.*

Trainings specific to the HFW Youth Support Partner

- *Must complete role-specific credentialing within 9-12 months of employment.*

B. Unit of Service:

1 unit per month

C. Anticipated Units of Service per Person:

9-12

D. Targeted Length of Service:

- *Targeted Length of service is up to 12 months, 12 units.*
- *Maximum Length of service is 18 months.*

E. Utilization Management

- *HFW will be for a maximum of 18 months.*
- *Prior authorization by the LME-MCO is required before or on the first date of service.*
- *Initial authorization will be for up to 180 days.*
- *Each reauthorization after that will be for no more than 60 days.*

F. 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.

Trillium Health Resources is transforming lives and building community well-being through partnerships and proven solutions. Trillium's 2019 Network Adequacy and Accessibility Analysis recognizes the need of supporting children and adolescents that often become involved within the child welfare and juvenile justice systems. In the 2019 Network Adequacy and Accessibility Analysis, gaps in the child treatment continuum of care for high-risk youth were identified. High-risk youth are identified as a special population needing more specialized services and increased treatment options. Some of the barriers and challenges noted for special populations, such as high-risk youth, can include: being on a waiting list for services and an identified lack of access to local services. Additionally, the 2019 Network Adequacy and Accessibility Analysis found that members, families, and stakeholders had identified the following needs to be addressed for the child treatment continuum: quality staff, consistent services, and more services for adolescents and children.

The data reflects that outpatient services and the non-needs assessment services make up just over 90% of the Medicaid services for children and adolescents. Additional data, per the needs and gaps analysis, reported 22% of members and families indicated a need for access to services and supports. With only 7% indicating that they have supportive relationships. Respondents for SFY 2018 indicated gaps in services included additional mental health services and supports, residential and support services, therapeutic services, and case management. By implementing a model of care and expanding services, children and adolescents served will achieve greater stability and have better outcomes.

Trillium's goal is that members will experience dramatically reduced adverse childhood events (ACES), and remain in their natural family settings with a decreased need for crisis services. In addition to prevention efforts via early access to services, Trillium wishes to expand High Fidelity Wraparound (HFW) to provide much needed support for children and adolescents who are already experiencing behavioral health symptoms and have been placed in a residential setting. It is Trillium's goal to reduce or eliminate the need for out of home care and return children and adolescents to their families or natural community setting, giving them a chance for greater permanency and normalcy.

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

- *Intensive care coordination (HFW facilitation)*
- *Access to family peer support (Family and Youth Partner)*
- *Individualized service planning process*
- *Multi system support and service coordination.*

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

High Fidelity Wraparound is currently available in North Carolina in five pilot sites which are grant funded. Trillium Health Resources was recently awarded the Tiered Care Management grant in Pitt County which includes High Fidelity Wraparound. Trillium developed this In Lieu of Service Definition to meet the requirements of the Tiered Care Coordination Pilot Award/Grant. In addition, and in preparation for the state plan to have High Fidelity Wraparound as the assigned Care Management for these youth in 2022, Trillium sees the need to expand the High Fidelity Wraparound Service availability through further future expansion to align with the future Care Management Model under the Tailored Plan.

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."*

  Joint CMCS and SAMHSA Informational Bulletin