

Coordinated System of Care (CSoC) Community Application

Application Submission

One complete, original application packet and 10 complete copies are to be submitted to DHH-OBH. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

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

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

For packages submitted via DHL, Federal Express (FedEx), or United Parcel Service (UPS), proof of timely submission shall be the date on the tracking label affixed to the package by the carrier upon receipt by the carrier. That date must be at least 24 hours prior to the application deadline. The date affixed to the package by the applicant will not be sufficient evidence of timely submission.

For packages submitted via the United States Postal Service (USPS), proof of timely submission shall be a postmark no later than the specified deadline, and the following upon request by DHH-OBH:

- Proof of mailing using USPS Form 3817 (Certificate of Mailing); or
- Receipt from the Post Office containing the post office name, location, and date and time of mailing.

The following addresses should be used accordingly:

United States Postal Service

Regular Delivery

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

DHL, Federal Express (FedEx), or United Parcel Service (UPS)

Overnight or Hand Delivery

LA Department of Health & Hospitals Office of Behavioral Health
Att: Coordinated System of Care
628 N. 4th Street, 4th Floor
Baton Rouge, LA 70802

] If you require a phone number for delivery, you may use (225) 342-2540. Agencies will be notified by e-mail that their application has been received.

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

Applications sent by facsimile will not be accepted or considered for review.

Incomplete applications will not be considered for review. OBH is not responsible for incomplete applications and will return to the applicant any application that does not include all items listed on the Application Checklist.

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

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

Application Format Requirements

Application narrative in response to Section 2 of the RFA cannot exceed 30 pages in total, including any attachments, charts, graphs, footnotes, etc. The narrative should be typed single space using Arial 12 font with one inch margins (left, right, top, and bottom). In your response, please only include the headers and questions in ***bold italics*** from Section 2 of the RFA in order to help reviewers of your response know the questions to which you are responding. In order to ensure that you have sufficient space in which to answer these questions within the prescribed page limits, please do not repeat more of the content from this section in your response. Include only the headers and questions in ***bold italics***.

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

Sequence of Events

EVENT	DATE
Distribution of Application Packet to Community	March 15, 2011
Responses Received	May 13, 2011
Initial Evaluation of Responses	May 27, 2011
Presentation by Responders	June 3, 2011
Final Evaluation of Responses	June 10, 2011
Announcement of Awards	June 16, 2011

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

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

Section 1: Background Information

Purpose of this Request for Applications

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

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

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

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

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

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

The goals of the CSoC include:

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

Louisiana's CSoC:

- Incorporates a broad, flexible array of effective services and supports for a defined population
- Is organized into a coordinated network
- Integrates care planning and management across multiple levels

- Is culturally and linguistically competent
- Builds meaningful partnerships with families and youth at service delivery, management, and policy levels
- Has supportive policy and management infrastructure.

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

For more information on Louisiana's CSoC initiative, visit:

<http://www.dss.state.la.us/index.cfm?md=pagebuilder&tmp=home&pid=272>

Implementation of the CSoC will be organized by ACT 1225 Regions:¹

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

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

The response to this RFA should reflect collaboration and partnership across your region, rather than the efforts of a single "lead agency" or similar entity. This RFA is seeking to understand the level of community support and capacity to work towards CSoC development in your region, rather than looking for an individual agency or entity to manage implementation.

¹ Act 1225 refers to Act 1225 of 2003, incorporated as RS 46:2600.

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

Technical assistance will be made available to regions as they develop their application, including:

- An initial kick off meeting in person in March 2011, date to be determined (TBD),
- Weekly webinars during the RFA process dates TBD, and
- Questions and answers via email and posted on the CSoC website.

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

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

Background on Systems of Care

History and Overview of the Systems of Care

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

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

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

“A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.”²

Service coordination and interagency collaboration are elements of the system of care philosophy, as are family involvement and cultural competence. The development of the

² Stroul, B., & Friedman, R. A system of care for children and youth with severe emotional disturbances. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health, 1986.

infrastructure for a system of care is important. But none of these elements is the sole focus of system of care development. First and foremost, systems of care are a range of treatment services and supports guided by a philosophy and supported by an infrastructure.

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

Family Support and Involvement in the System of Care

Support for and by family members within the system of care has emerged as a core strategy for improving the children's mental health system of care. The system of care approach has fundamentally changed the relationships that families of children and youth involved in child-serving systems have with the agencies within those systems. Increasingly, collaboration and partnership between families and service providers have been recognized as the threads that link successful programs, policies, and practices. The development of youth involvement in mental health systems of care closely follows the growth and acceptance of family peer-to-peer support and the broader family empowerment movement, as well as the growth of consumer-provided services. A recent literature review sponsored by the University of South Florida (USF) Research and Training Center for Children's Mental Health provides an excellent survey and synthesis of available evidence for the approach.³

A recent national survey of family organizations found that education, advocacy, and peer-to-peer support are key to family support.⁴ Another review of family peer-to-peer support models provided a useful conceptualization of the key mechanisms underlying the effectiveness of this approach.⁵ They identified four key areas:

- **Social support** helps caregivers feel a sense of belonging and being valued, and also provides new resources, both tangible and intangible.
- Peer support providers serve as **links to broader social networks**, in which peer support connects caregivers to community resources, people, or institutions and thus serves as a relationship or social network bridge-builder.

³ Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, A. J., & Annis, S. (2008). *Parent to parent: A synthesis of the emerging literature*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

⁴ Hoagwood, K. E., Green, E., Kelleher, K., Schoenwald, S., Rolls-Reutz, J., Landsverk, J., Glisson, C., & Mayberg, S. (2008). Family Advocacy, Support and Education in Children's Mental Health: Results of a National Survey. *Admin Policy Mental Health*, 35, 73 - 83.

⁵ Ireys, H. T., DeVet, K. A., & Sakwa, D. (1998). Family support and education. In M.H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional Disorders and their Families: Programs and Evaluation Best Practices* (pp. 154-175). Austin, TX: Pro-Ed.

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

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

In general, an important component of meaningful family support is that it is delivered by family peers, defined as follows⁶:

1. Currently raising or has raised a child or youth with emotional, behavioral or mental health challenges,
2. Current knowledge of the [children's behavioral health] system, and
3. Experience with, and consciousness of, the struggle; recognizes the standpoint of the parent.

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

Wraparound Facilitation and Systems of Care⁷

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

⁶ (2008) National Federation of Families for Children's Mental Health

⁷ See the National Wraparound Initiative website (<http://nwi.pdx.edu/overall.shtml>) for additional information.

The organizations providing Wraparound Facilitation in Louisiana's CSoC are Wraparound Agencies (WAAs). WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of "one family, one plan of care, one Wraparound Facilitator."

Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The values of wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Wraparound's philosophy of care begins from the principle of "voice and choice", which stipulates that the perspectives of the family – including the child or youth – must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the wraparound process should be "strengths based", including activities that purposefully help the child and family to recognize, utilize, and build talents, assets and positive capacities.

Providing comprehensive care through the wraparound process, thus, requires a high degree of collaboration and coordination among the child- and family-serving agencies and organizations in a community. These agencies and organizations need to work together to provide access to flexible resources and a well-developed array of services and supports in the community. In addition other community- or system-level supports are necessary for wraparound to be successfully implemented and sustained. Research on wraparound implementation⁸ coordinated by the National Wraparound Initiative has defined these essential community and system supports for wraparound, and grouped them into six themes:

- **Community partnership:** Representatives of key stakeholder groups, including families, young people, agencies, providers and community representatives have joined together in a collaborative effort to plan, implement and oversee wraparound as a community process.
- **Collaborative action:** Stakeholders involved in the wraparound effort work together

⁸ <http://depts.washington.edu/wrapeval/>

to take steps to translate the wraparound philosophy into concrete policies, practices and achievements that work across systems.

- **Fiscal policies and sustainability:** The community has developed fiscal strategies to support and sustain wraparound and to better meet the needs of children and youth participating in wraparound.
- **Access to needed supports and services:** The community has developed mechanisms for ensuring access to the wraparound process, as well as to the services and supports that wraparound teams need to fully implement their plans.
- **Human resource development and support:** The system supports wraparound staff and partner agency staff to fully implement the wraparound model and to provide relevant and transparent information to families and their extended networks about effective participation in wraparound.
- **Accountability:** The community implements mechanisms to monitor wraparound fidelity, service quality and outcomes, and to oversee the quality and development of the overall wraparound effort.

Cultural Competence in the System of Care

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

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

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

Background on the Administrative Requirements for the Louisiana CSoc

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

Statewide Governance Body

- Multi-departmental oversight
- Strong family leadership
- Direct use of multiple funding sources and state purchaser contracting with a Statewide

Management Organization (SMO) to define such things as:

- Eligibility criteria and procedures for enrollment in WAAs
- Parameters of service utilization and criteria for applying those parameters, including out-of-home placement
- Quality indicators, reporting mechanisms and quality feedback mechanisms
- Requirements for WAAs and providers, and mechanisms for approving and monitoring providers
- Quality and timeliness requirements for payment system
- Monitors project outcomes including quality and cost
- Establishes policy and monitors adherence

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

- Registration of children into the statewide system
- Telephonic screening of children seeking services utilizing the Child and Adolescent Needs and Strengths (CANS) Brief tool and referral to the WAA.
- Determination of appropriateness for WAA enrollment, based on information submitted by the WAA, including results of the CANS Comprehensive.
- Ongoing authorization of community-based services and approval of child and family plans, with the goal of moving toward more oversight and less direct authorization role over time
- Tracking of children, services and costs
- Utilization management/utilization review at the system level and for individual outlier cases
- Quality assurance at the system level and for individual outlier cases
- Outcomes management/monitoring at the system level and for individual outlier cases
- Work with regional and local WAAs to organize and manage the provider network to ensure that a broad array of services and supports is available statewide, and that providers meet credentialing standards
- Training and capacity building across the CSoC, including development of WAAs, FSOs and local providers
- Implementation of a management information system capable of the needed tracking and monitoring functions and integrated with local WAA management information systems (MIS)
- Pay all provider claims, WAA, and FSO costs, except for some services provided in schools by school systems

Wraparound Agency Role at the Local Level in Each Region

- Intake of referrals from SMO and initial assessment using the CANS
- Work with licensed mental health professional to ensure the recommendation and initial authorization of community-based services for up to 30 days or until the plan of care is developed and approved by the SMO, with the goal of moving toward a more ongoing service authorization role over time
- Partner with juvenile courts, child welfare agencies, and local schools for intake of eligible at risk youth and their families
- Staff and manage child and family team process, including development of plan of care within first 30 days of enrollment and care coordination through intensive care management with small staff to child ratios (for example, 1:8 – 1:10)
- Link families and youth to peer support and mobile response and stabilization

- Tracking of individual children, services provided and costs of services
- Utilization management/utilization review of individual children
- Quality assurance at the local level
- Outcomes management/monitoring of individual children
- Input of individual child data into a management information system capable of needed tracking and monitoring functions and integrated with SMO MIS
- Work with the SMO to monitor and support development of local provider capacity for purpose of filling gaps in service availability
- Work with family support organizations to provide Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists and support their participation in quality assurance processes
- Develop treatment plans consistent with federal requirements in conjunction with the SMO under the State's Medicaid 1915(b) waiver

Family Support Organization Network

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

Local FSOs Governed by Local Coordinating Council

- Provide and build capacity for Certified Family and Cultural Support Specialists
- Provide and build capacity for Certified Parent Trainer/Group Facilitators
- Provide and build capacity for Youth Certified Peer Support Specialists
- Participation in child and family team process
- Provide direct peer and family support, including psychoeducation services to families and youth as providers enrolled in the SMO network under the State's Medicaid 1915(c) CSoC SED waiver and in coordination with the broader provider network's delivery of service
- Participation in quality assurance and outcomes management/monitoring at local and state levels
- Participation in planning, policy making and system oversight at local and state level

State Coordinating Council

- Provide initial and on-going training to ensure the capacity of family members to participate in quality monitoring activities and policy setting at the state level, as well as to provide representation on the State Governance Body (SGB)
- Provide family representatives to serve in quality monitoring and policy-making processes conducted by the SMO, OBH, SGB committees and others, as needed
- Provide and maintain membership on the SGB to include two family representatives, two family apprentices (non-voting), and one youth member
- Serve as an advisory council to the SGB, as needed
- In coordination with the SMO, assist in the development and oversight of the general policies and procedures of the Family Support Organization Network

- Manage SCC State Family Support Network Executive Director and provide direction on staff roles related to the coordination of statewide efforts (for example Statewide Advocacy, Statewide Training and Technical Assistance Coordination)
- Assist in the development and ongoing support of local FSOs
- The SCC and the SCC Staff are not charged with the direct supervision or direct management of the FSOs, Local Coordinating Councils (LCCs) or their members/employees, and will act only to assist and support local FSO and LCC entities

Providers of Services and Natural Supports

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

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

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

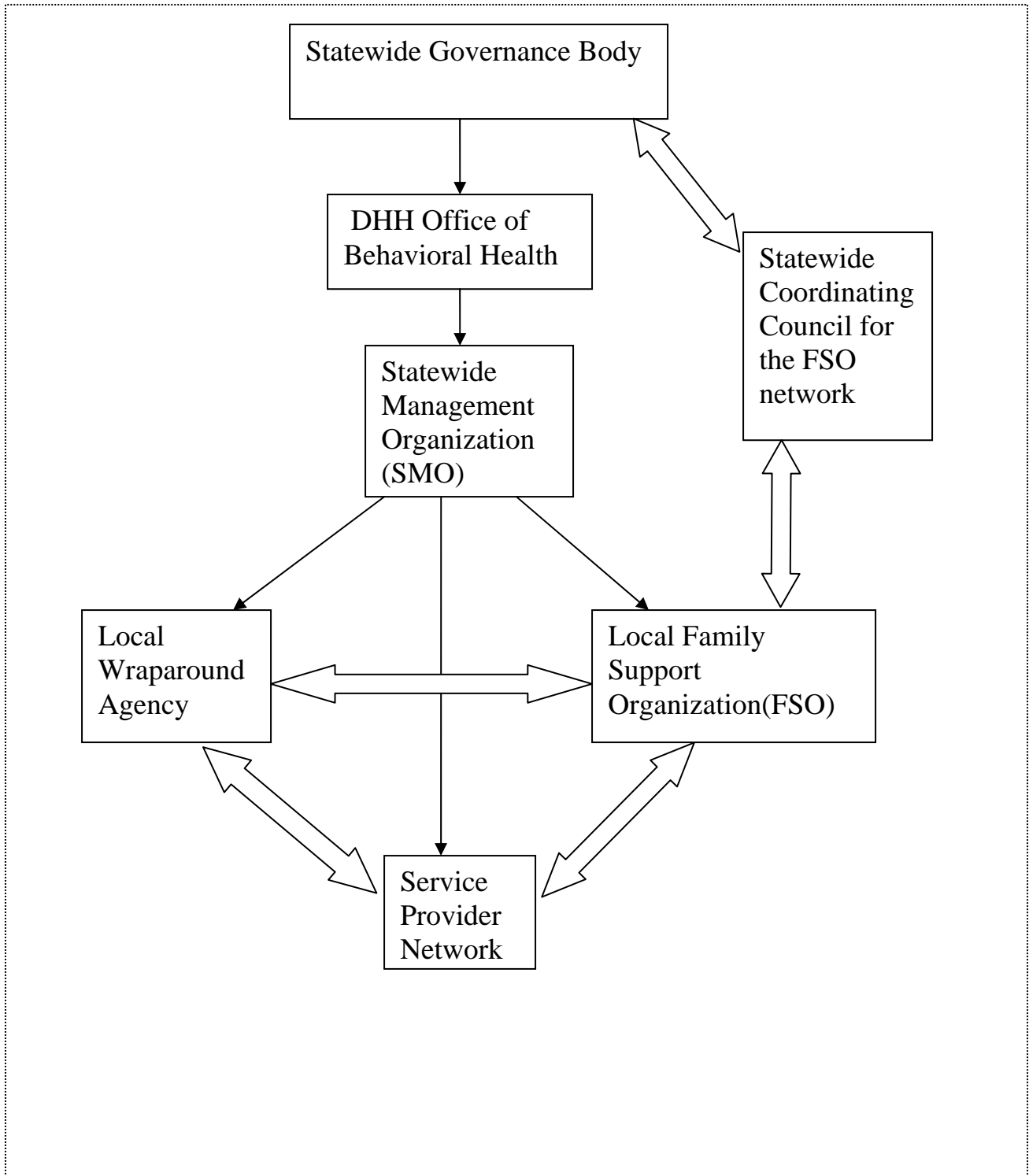
- Professionalism,
- Ethics,
- Confidentiality and Health Insurance Portability and Accountability Act(HIPAA) requirements,
- Diversity,
- Engagement,

- Assessment,
- Wraparound,
- System of Care,
- Ecological Model,
- Evidence Based Practices,
- Co-Occurring Disorders,
- Crisis Response,
- Suicide Prevention,
- Behavioral Interventions,
- Working with School Systems,
- Communication and Collaboration Skills,
- Documentation,
- Trauma Informed Care,
- Motivational Interviewing, and
- Supervision (supervisors only).

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

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

- The Statewide Governance Body,
- DHH Office of Behavioral Health,
- Statewide Management Organization (SMO),
- Statewide Coordinating Council for the FSO network,
- Local Wraparound Agency (WAA),
- Local Family Support Organization (FSO), and the
- Service Provider Network.



Section 2: General CSoC Capacity Questions

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

A. Community Partnership (70 points)

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

1. ***Please identify your Act 1225 of 2003 Region (“Region”) and describe the specific communities (cities/towns, parishes, groups of parishes, other jurisdictional subdivisions within the Region, etc.) that have come together to respond to this RFA with the intent to implement a CSoC.*** These will be referred to as the “Initial Communities” throughout this RFA. (No points for this response.)
2. For these Initial Communities ONLY:
 - a. ***Please describe the initial group of stakeholders and collaborative partners that have come together and made a commitment to moving forward with developing the CSoC.*** This should include as many representatives as possible from the stakeholders listed under Question 3 in this section that have been involved in the initial planning for the CSoC carried out as of the date of this application. (10 points)
 - b. Firm commitment on the part of key stakeholders to implement the CSoC within the Region, including identification of an agency to serve as WAA and development of an FSO, is critical to successful implementation. ***Please describe the level of commitment by all relevant regional agencies and stakeholders, referring, as needed, to the individual letters of commitment provided by each agency/stakeholder.*** Please describe the level of commitment (for example, level of participation in past or current projects with similar goals; recent events developing stakeholder’s understanding of the importance of efforts such as the CSoC; ability to bring to the project resources such as knowledge, experience, person hours, etc.) by all relevant regional agencies and stakeholders, referring, as needed, to the individual letters of commitment provided by each agency/stakeholder.(15 points)

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

Please explain the answer you checked by describing involvement of key agencies in the Initial Communities⁹

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

⁹ Examples of potential agency partners include courts exercising juvenile jurisdiction, schools, DCFS, human service districts/authorities, community and faith-based organizations, service providers, district attorneys, law enforcement, Truancy Assistance Service Centers, Families in Need of Services offices, other juvenile justice agencies, Act 555 Children and Youth Services Planning Boards, and other agencies identified locally for participation.

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

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

B. Collaborative Activity (30 points total)

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

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

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

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

Check the best summary

Not really Some Quite a bit

Please explain the answer you checked by listing those providers in the Initial Communities that have experience providing Medicaid reimbursable services and/or the organizational capacity to comply with Medicaid requirements and deliver such services. These capacities include: understanding of, and ability to comply with, provider credentialing requirements, billing systems able to comply with fee-for-service requirements and bill electronically, necessary financial and cost-accounting processes, increased documentation requirements, access to supervision by licensed mental health practitioners, and other capacities to ensure compliance with Medicaid medical services billing requirements.

- 2. The people who are planning implementation of the CSoC in our Region have identified current capacity and plans to expand that capacity, over time, to provide the full array of services needed to support the System of Care, including non-traditional services and supports and are actively strategizing about how to fill gaps in the array .**This includes services for youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, trauma related to abuse and neglect, as well as more broadly, and AD/HD issues that lead to costly and oftentimes ineffective out-of-home services or excessive use of other therapeutic supports and services. Please refer to the Ideal Service Array resource available on the CSoC website as a guide.¹⁰(15 points)

Check the best summary

Not really Some Quite a bit

Please describe local capacity in the Initial Communities for each of the following service categories. Include detail for each service category regarding available evidence-based and promising practices that have some level of evidence for their effectiveness. Describe (1) current capacity, (2) current gaps, (3) plans to address gaps, (4) ways that

¹⁰ http://www.dss.state.la.us/assets/docs/searchable/OS/CSoC/061010_ISARecsandLetter.pdf

TA, provided through the State, might be used to support efforts to expand the service array (5) the level of capacity that could realistically be developed for implementation by October 1, 2011 and (6) priority areas for developing and/or expanding capacity over the first year of the project for EACH of the following service categories:

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

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

Please explain the answer you checked by describing strategies to ensure cultural competence.

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

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

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

As noted above, Wraparound Facilitation represents an important component in a System of Care for children and families. Wraparound is defined as an intensive, individualized care planning and management process. Wraparound is not a treatment. Instead, wraparound facilitation is an intensive care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.

In successful systems of care, WAAs serve as the locus for access, accountability, service coordination and utilization management functions. The WAA is responsible for facilitating the wraparound process, developing individualized plans of care that cross agencies and assigning one accountable individual to coordinate care. They act as a bridge between the Statewide Management Organization and families to independently plan and coordinate care. They will work locally with children and youth, their families, providers, regional agency staff, courts, child welfare agencies, schools, community organizations and FSOs to coordinate care planning and access to comprehensive services and supports. Service coordination by the WAAs, in collaboration with the FSOs, will be guided by the Wraparound process, which is defined by the ten principles established by the National Wraparound Initiative (available at www.nwi.org).

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

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

E. Family Support Organization Policies and Supports (55 points total)

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

- Provide and build capacity for Certified Family and Cultural Support Specialists,
- Provide and build capacity for Certified Parent Trainer/Group Facilitators,
- Provide and build capacity for Youth Certified Peer Support Specialists,
- Participation in the child and family team process,
- Provide direct peer and family support, including psychoeducation services to families and youth, in coordination with the broader provider network's delivery of service,
- Participation in quality assurance and outcomes management/monitoring at local and state levels, and
- Participation in planning, policy making and system oversight at the local level.

FSOs will be subject to DHH and the Centers for Medicare and Medicaid Services (CMS) regulatory requirements and will provide services that are Medicaid reimbursable. For FSOs, this will require a professional working knowledge of the Medicaid rules and regulations, and expertise in Medicaid billing and coding, as well as the ability to comply with contracting requirements from the Statewide Management Organization.

Local FSOs will provide an array of supports centering on Parent Support and Training to support and to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For the purposes of this service, "family" is defined as the persons who live with or provide care to a child or youth meeting the CSoC target population criteria, and may include a parent, spouse, children, relatives, grandparents, guardians, or foster parents. Examples of how this service will be delivered by Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists include:

- FSO staff may attend meetings with the family and assist in helping the family to effectively contribute to planning and accessing services, including assistance with removing barriers.
- FSO staff assists in describing the program model and providing information as needed to assist the family.
- Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (for example, parenting children with various behavior challenges). This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs

of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child/youth's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (for example, training on system navigation and Medicaid interaction with other child serving systems).

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

FSO Network Governance

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

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

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

State Governance Body of the CSoC

- Family members representing the CSoC target population will partner with Secretaries from each of the designated state agencies, as well as other selected community members, to participate in the general oversight and governance of the CSoC as a whole.
- Membership to the State Governance Body of the CSoC nominated by families will include, as follows:

1. Two family members and two apprentice family members. Apprentice members will be nonvoting members, but will attend all SGB meetings in order to build capacity for families to govern at the State level.
2. One advocate member.

State Coordinating Council of the FSO Network

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

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

Local Coordinating Councils within the FSO Network

Each local FSO will be a family-run, nonprofit corporation governed by a board of directors known as its Local Coordination Council (LCC). The LCC will promote culturally and linguistically competent representation and ensure diverse family and youth representation from the communities and target population served. Each FSO's LCC should be comprised of 60% family members and also include individuals from local family and child serving organizations (including child welfare and juvenile justice agencies), district attorneys, judges, school system representatives, faith-based organizations, community leaders, and others as determined appropriate by each individual LCC. The LCC will be responsible for the fiscal and technical oversight of the FSO and will provide representation, if requested, on the SCC.

Additionally, the executive director/program director of the FSO will report directly to the LCC. If an existing family-run organization serves as the local FSO and already has an existing Board

of Directors, it shall create a separate LCC with the characteristics just described to oversee the FSO-specific activities of the organization.

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

act with the authority to govern the FSO activities and services and (2) briefly explain how the LCC will coexist with the current Board of Directors.

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

Please explain the answer you checked by describing strategies to ensure capacity for

training and coaching.

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

Check the best summary

Not really

Some

Quite a bit

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

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

For State Staff only: Total (sum of scores across all items): ____ out of 55 possible points.

F. Accountability (20 points total)

1. ***The people who are planning for CSoC implementation in our Region have developed realistic, shared expectations about what outcomes are expected from the effort overall.*** (5 points)

Check the best summary

Not really

Some

Quite a bit

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

2. ***The people who are planning for CSoC implementation in our Region have developed realistic goals for the local system of care.*** (5 points)

Check the best summary

Not really

Some

Quite a bit

Please describe these goals.

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

Check the best summary

Not really

Some

Quite a bit

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

For State Staff only: Total (sum of scores across all items): ____ out of 20 possible points

For State Staff only: Sum of All General CSoC Capacity Question Totals: ____ (out of maximum possible score of 280 points)

Section 3: General Requirements for the WAA and FSO

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

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

A. Program Authority

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

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

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

B. Enrolled Populations

All children will be eligible for all services in the CSoC, if they meet functional criteria described in later sections. Individuals found eligible for the CSoC will be enrolled in the SMO. The following individuals will be eligible for Medicaid reimbursement under this program.

- Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

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

The WAA and the FSO will also serve children and youth that meet program criteria, but that are not currently Medicaid eligible or eligible for the Medicaid 1915(c) waiver, such as children receiving services from OJJ, DCFS, OBH, OCDD, or OPH who are not Medicaid eligible.

C. Free Choice of Providers

Enrollees will have free choice of providers within the CSoC and may change providers as often as desired. The SMO will contract with the WAA as an administrative activity and freedom of choice is not required. When there is only one WAA, enrollees and their families will have free choice of Wraparound Facilitators within the WAA. All Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists must be employed by a FSO under contract with the SMO.

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

The SMO will evaluate every prospective subcontractor's ability to perform the activities to be delegated prior to contracting with any provider or subcontractor. The SMO is not obligated to contract with any provider unable to meet contractual standards and to continue to contract with a provider that does not provide high quality services or outlier utilization of services according to peer providers and/or the expectations of the SMO and State. The SMO's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The SMO must have a written contract that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation, terminating contracts, or imposing other sanctions if the subcontractor's performance is inadequate.

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

D. Training Requirements

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

The following sets of training are required.

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

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

- 1 . Wraparound / System of Care (University of Maryland Medical School, Innovations Institute model)
- 2 . Child and Adolescent Needs and Strengths (CANS) Assessment
- 3 . Cultural and Linguistic Competency (CLC)
- 4 . FSO services

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

Training providers will:

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

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

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

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

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

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

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

E. Attestation

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

Section 4: Specific Requirements for the WAA

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

Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The organizations providing Wraparound Facilitation in Louisiana's CSoC are Wraparound Agencies (WAAs). WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of "one family, one plan of care, one Wraparound Facilitator."

The values of wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Wraparound's philosophy of care begins from the principle of "voice and choice", which stipulates that the perspectives of the family – including the child or youth – must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the wraparound process should be "strengths based", including activities that purposefully help the child and family to recognize, utilize, and build talents, assets and positive capacities.

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

The WAA will provide Wraparound Facilitation (WF) for children using Child and Family Teams (CFTs) to carry out specific delegated administrative activities of the SMO. The CFT will coordinate development of a treatment plan for high-needs individuals in accordance with requirements under the new Medicaid waivers,¹¹ which requires the identification, assessment and development of treatment plans for high-needs individuals. This treatment plan is referred to as an “Individualized Plan of Care,” in accordance with the WF planning model used by CFTs in Louisiana.

For the purposes of Medicaid reimbursement, WF by the CFT is part of the joint treatment planning, administrative coordination and continuity of care activity conducted by SMOs and involving members, providers, caseworkers and others important to those members, for members who are accessing multiple services concurrently or consecutively. Joint treatment planning facilitates the development of an Individualized Plan of Care consistent with Medicaid¹² treatment planning requirements and may also result in an integrated plan for funding and delivering services when representatives of other delivery systems, in addition to the SMO, commit financial resources to fund a plan. It does not substitute for the service planning requirements of the behavioral health providers involved; instead it coordinates treatment and other services and supports across multiple plans through the Individual Plan of Care it develops.

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

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

¹¹ 42 CFR 438.208

¹² Specifically in 42 CFR 438.208 (c)(3)

A. Compliance with Federal Requirements

As noted above, CFT is an administrative joint treatment planning activity provided under Medicaid requirements¹³ for entities such as the SMO for developing and facilitating implementation of Individualized Plans of Care for children and youth who meet the definition of complex behavioral healthcare needs. When identifying children with complex behavioral healthcare needs, the SMO will ensure the assessment of each enrollee to determine a course of treatment or regular care monitoring. The assessment mechanism must meet the requirements outlined in this document.¹⁴ The Individualized Plan of Care should be developed in coordination with the child's physical health primary care provider (PCP). If applicable, this includes coordination with the Coordinated Care Network (CCN) in which the provider participates. The CFT will take the lead in the development of the Individualized Plan of Care and will coordinate with the enrollee's primary care and behavioral healthcare providers, with enrollee participation, and in consultation with any other providers caring for the enrollee.

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

B. Conflicts of Interest

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

In the unlikely event that the WAA is allowed under waiver to be a provider of other direct services, the provider must describe how they will ensure that there is no conflict of interest. The provider must include a description of the process by which they will ensure that the WAA staff

¹³ More broadly in 42 CFR 438.208

¹⁴ These are specifically found at 42 CFR 438.208(c)(2).

and the youth and families served will not be unduly influenced to use these services as opposed to natural supports or other services of the youth or family's choice. They must also describe the monitoring strategies they will use to oversee this process.

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

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

C. WAA Provider Agency Certification Requirements

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

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

D. Requirements for Wraparound Facilitators and Supervisors

Over the course of the first 24 months of program operation, applicants will need to meet certain requirements in order to maintain certification. These requirements consist of:

1. Submission of the Advanced Wraparound Practitioner Certification Application Form,
2. Completion of core training requirements,
3. Completion of nine (9) categorized Wraparound Practitioner Training Units,
4. Participation in on-site coaching sessions from Innovations Institute trainer/coach for a minimum of one (1) year,
5. Participation in practice observations conducted by Innovations Institute Trainer/Coach including at least:

- Two (2) Initial Family Meetings,
 - Two (2) Home Visits,
 - Two (2) CFT Observations (1 could be scored using the Team Observation Measure as described below), and
 - Two (2) Documentation Reviews of Plans of Care (1 could be scored using the Document Review Measure as described below)
6. Completion of three (3) CFT/Initial Visit Observations utilizing the Team Observation Measure (TOM) (collected every four months) for Wraparound Facilitators. At least one observation will be conducted by Innovations Institute trainer/coach. The additional two (2) TOMs are conducted by the agency supervisor. Practitioners must reach fidelity based on their combined score. This Wraparound Facilitator and Supervisor certification requirement is met by supervisors observing the Wraparound Facilitators in a child and family team meeting.
7. Completion of three (3) Documentation Review Measures (DRM) (collected every four months) for Wraparound Facilitators with a combined score that meets fidelity. At least one DRM will be completed by Innovations Institute trainer/coach with the additional two (2) DRMs being conducted by agency supervisors. This Wraparound Facilitator and Supervisor certification requirement is met by supervisors reviewing the care coordinators individualized plans of care.

E. Target Population

Wraparound Facilitation (WF) may be delivered to children and youth whose complex BH needs are identified as follows. In order to be eligible, the child or youth must also have functional needs as demonstrated by the Child and Adolescent Needs and Strengths (CANS) assessment. The SMO will provide to the WAA results from the CANS Brief in order to establish initial eligibility for WAA supports. Staff from the WAA will ensure administration of the CANS Comprehensive with sign off by approved licensed behavioral health clinicians as part of the CFT process. Children identified as meeting the criteria for the CSoC as determined by the CANS, may include:

- Children and youth ages 0 – 21. Services may be provided up to the time the individual turns 22, as long as services began prior to age 21.
- Significant behavioral health challenges or co-occurring disorders documented in the Individualized Plan of Care. This includes youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, substance use disorders, and AD/HD issues that lead to costly and oftentimes ineffective out-of-home services or excessive use of other therapeutic supports and services.
- Imminent, current or previous placement in a restrictive, intensive or intrusive level of behavioral healthcare, such as:
 - Addiction facilities,
 - Alternative schools,
 - Detention,
 - Development disabilities facilities,
 - Foster care,
 - Homeless as identified by the Department of Education,

- Psychiatric hospitals,
- Residential treatment facilities, and
- Secure care facilities.

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

In addition to the child or youth receiving services, parents and other family members may participate in the CFT process. Parents, legal guardians, other adult caregivers, siblings and other family members typically participate in the CFT process, as specified in the Individualized Plan of Care of the child or youth served by the WAA, in addition to other natural helpers (such as coaches) that family or youth identifies as important to the team.

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

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

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

F. Referral and Authorization Process

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

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

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

authorized by the SMO during the initial 30 day and subsequent authorization periods. An approved licensed behavioral health practitioner will sign off on any treatment to ensure that services by unlicensed individuals are medically necessary.

- The WAA shall initiate the CFT process immediately upon receipt of the referral by the SMO. Upon referral to the WAA, the SMO will also authorize an assessment to be conducted by a licensed mental health professional using the CANS. The assessment findings will be sent to the WAA wraparound facilitator to assist the CFT with the wraparound planning process.
- The WAA wraparound facilitator assembles the CFT, which conducts the wraparound planning process, identifies the individual needs and strengths of the child and family, and develops a customized wraparound approach and plan of care.
- The child/youth and family support network comprise the majority of the CFT. The CFT, with the assistance of the WAA wraparound facilitator, develops a sustainable and Individualized Plan of Care (IPoC) consistent with the CANS results, individual needs, SMO utilization management (UM) guidelines, evidence-based practices and use of natural and informal supports whenever possible. The SMO and WAA shall expect providers to participate on the CFT. The SMO shall align incentives to support provider participation.
- The WAA shall work closely with the Family Support Organization (FSO) to integrate the provision of supports from Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists in support of the CFT. It is expected that personnel from the FSO will have active involvement on the CFT unless clinically contra-indicated and that peer support will be a key component of the array of services and supports included in the IPoC.
- The WAA shall work closely with the child welfare, juvenile justice, and local education agencies to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies, the juvenile justice system, and local education agencies will have active involvement on the CFT unless clinically contra-indicated.
- The WAA wraparound facilitator works with the child/youth and family/caregiver to determine membership of the CFT. The CFT, with the assistance of the WAA wraparound facilitator, develops a sustainable IPoC that is consistent with the wraparound planning goals.
- An approved licensed behavioral health practitioner will sign off on any treatment on the IPoC to ensure that services by unlicensed individuals are medically necessary.
- The WAA wraparound facilitator submits the IPoC to the SMO for review prior to the end of the initial 30-day authorization period.
- The SMO reviews the IPoC for consistency with the child/youth and family's strengths and needs (as identified by the CANS, broader assessment and the IPoC) and utilization guidelines. If the IPoC meets these criteria, the SMO provides authorization for a period of up to 90 days. Ongoing authorizations provided by the SMO will be for up to 90-day periods for most children/youth. (Authorizations may exceed 90 days for some children/youth, as determined by medical and social necessity for the service).
- If the IPoC appears to be inconsistent with assessed strengths and needs, and the utilization guidelines for the desired services, the SMO and the WAA wraparound facilitator discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT. The WAA wraparound facilitator will work with the CFT to develop a sustainable plan. The expectation is that the SMO will have clear, transparent utilization guidelines that are developed with and approved by the state CSoC governance and widely shared throughout the CSoC.

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

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

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

As part of the initial referral process and prior to approval of the initial plan of care, the WAA will conduct a "Pre-certification Home Visit." At this visit, WAA staff will review with the individuals receiving care and/or their authorized representative's information regarding "feasible alternatives" under the waiver, including the choice of either institutional or home and community-based services.

G. Goals and Process Design

Purpose of the process –Wraparound Facilitation (WF) by the WAA is performed as an administrative joint treatment planning activity under SMO requirements in 42 CFR 438.208 to develop and facilitate implementation of Individualized Plans of Care for children and youth who meet the definition in Section 6 of complex behavioral healthcare needs. These children may be

experiencing significant involvement in two or more child-serving systems, but such involvement will not be a condition to receive services.

Qualifications –WF is carried out by wraparound facilitators, working as a team with Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists from the Family Support Organization. The wraparound facilitator facilitates the CFT under the oversight of a WF supervisor. The primary assessment and care planning activity guiding the CFT is WF, delivered with adherence to the standards of the National Wraparound Initiative (NWI)¹⁵ and referred to as WF. WF is a team-based, collaborative process for helping children and youth with complex behavioral healthcare needs and their families identify and use their strengths and community resources to develop and implement Individualized Plans of Care to reduce the use of other restrictive behavioral health services. The therapeutic goal of the process is to 1) meet the behavioral health needs prioritized by the youth and family, 2) improve their ability and confidence to manage their own services and supports, 3) develop and strengthen their natural social support system over time and 4) integrate the work of all child-serving systems and natural supports into one streamlined plan to address the child’s diagnosed behavioral health needs in order to restore the child to a developmentally appropriate level of functioning. The CFT will identify specific goals to enhance the functioning of the child, and recommended services will be consistent with the medical necessity criteria of the SMO.

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

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

The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment and crisis/safety plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of CSoC services, as well as natural supports that are built into the IPoC to assist the child/youth in meeting their goals. The Wraparound Facilitator plays a role in this process by facilitating the IPoC development through documentation of the decisions made by the CFT,

¹⁵ *Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.*

facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time should needs or circumstances change.

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

Additionally, Family Support Organizations provide the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their behavioral health needs and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that affect the child with behavioral health needs while living in the community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served under the waiver, and may include a parent, spouse, children, relatives, grandparents, guardians, or foster parents.

H. WF Staff Activities

The Wraparound Agency (usually the Wraparound Facilitator) contacts the child/youth and/or the parent/caregivers of the child/youth before the initial wraparound meeting. During this contact, the Wraparound Facilitator (or WAA staff) assures the delivery of the CSoC brochure that describes the CSoC services, free choice of providers, and how to report abuse and neglect. Each CSoC child/youth will be a member of the SMO and will be provided a member handbook. In the member handbook, the member's rights and responsibilities are identified.

The Wraparound Facilitator guides the development of the IPoC. The IPoC is developed based upon the CANS assessment and identified goals as determined by the Child and Family Team. The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment and crisis plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of waiver services and natural supports that are built into the IPoC to assist the child/youth in meeting their goals. The Wraparound Facilitator plays a role in this process by facilitating the IPoC development through documentation of the decisions made by the CFT, facilitating the overall meeting, and assuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time should needs or circumstances change. The wraparound facilitator assures Plans of Care are entered into the SMO's database and Electronic Health Record.

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

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

A CANS assessment is conducted as a part of the wraparound process. Input into the CANS is given by all members of the CFT, including the child/youth and parents or caregivers of the child/youth. The CANS addresses the following domains: life domain functioning, youth strengths, acculturation, caregiver strengths and needs, youth behavioral / emotional needs, and youth risk behaviors. Goal development is directly related to the CANS. Goals are established based upon the child/youth's needs and interventions for goals are built upon the child/youth's identified strengths. The CFT identifies goals and interventions based upon the Strengths and Needs Assessment. IPoC goals identified by the child/youth and parents or caregivers of the child/youth as being the most pertinent or pressing are given preference.

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

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

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

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

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

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

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

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

attachment to their IPoC in order to have access to the identified information should a crisis occur.

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

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

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

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

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

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

Children/youth and their families will have free choice of providers within the SMO and may change providers as often as desired. Once enrolled in the SMO, if a child/youth is already

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

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

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

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

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

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

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

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

I. Non-Reimbursable Activities

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

The following activities by wraparound facilitators are not allowable:

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

J. Reimbursement

Note: The anticipated reimbursement rate will be included here in the final distribution version.

K. SMO Monitoring

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

The NWI fidelity standards include requirements for cultural competency.

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

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

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

L. Staffing Requirements/Qualifications

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

Wraparound facilitator: The wraparound facilitator must meet the following requirements:

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

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

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

- Master's-level or higher graduate degree in a human services field.
- Minimum of three years of full-time experience working in relevant family, children/youth or community service capacity.

- Completion of the required training and credentialing process for WF supervisors.
- If the supervisor also functions in part as a wraparound facilitator, they must also meet the requirements for a wraparound facilitator described above.
- The WF supervisor must provide regular supervision to WF service delivery staff, including completion of all supervisor requirements for wraparound fidelity monitoring using the WFAS as required.
- The WF supervisor must have good interpersonal skills for supporting development in others. The supervisor should have a broad base of experience and possess a diverse view of what families need to live better lives. The supervisor must collaborate closely with and supervisors in other child-serving agencies in the community. A wraparound supervisor must have an outgoing personality that supports engaging people from different cultures, ages and backgrounds. A preferred supervisor characteristic is an understanding of and experience with different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor must oversee the work of the WF service delivery staff on an ongoing basis.

M. Staffing Guidelines for Wraparound Agencies

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

(1) Position	(2) FTE	(3) Staffing ratio
Executive Director (or Program Director if part of an existing organization)	1 FTE	One per agency
Business Manager / Information Technology Manager	1 FTE	One per agency – May be part time if WAA is part of a larger organization
Administrative Assistant	5 FTE	Based on 20 staff FTE (FT and hourly)
Quality Improvement/Data Director	1 FTE	One per agency
Community Resource Specialist	1 FTE	One per agency
Licensed Clinical Director / Team Supervisor	1 FTE	One per agency
Wraparound Facilitators Team Supervisors	2 FTE	1 per 80 families (the Clinical Director also supervisors a team)
Wraparound Facilitators	24	1 per 10 youth
Total	36 FTE	

N. IT and Other Administrative Requirements

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

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

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

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

A. Compliance with State and Federal Requirements

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

Peer Support Requirements. Peer Support is provided by Youth Peer Support Specialists working for FSOs.

Peer Support services are child/youth centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's Individualized Plan of Care (IPoC). The structured, scheduled activities provided by this service emphasize the opportunity for children/youth to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Peer support is a face-to-face intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of Peer Support contacts must occur in community locations where the person lives, works, attends school and/or socializes. This service may include the following components:

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

Limitations to the delivery of Peer Support are as follows:

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

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

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

the CSoC process, such as the crisis plan and plan of care process; training on understanding the child's diagnoses; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with behavioral health concerns while living in the community (for example, training on system navigation and Medicaid interaction with other child serving systems). The specialist may also conduct follow-up with the families regarding services provided and continuing needs. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on by the CSoC, and may include a parent, spouse, children, relatives, grandparents, guardians, or foster parents. Services may be provided individually or in a group setting.

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

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

B.FSO Provider Agency Certification Requirements

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

The OBH certification process centers on documentation that individual FSO staff members have completed required training, as described in Section 3 above. OBH will provide evidence of this certification to the SMO. Once credentialed by the SMO, the use of Medicaid reimbursement to support FSO delivery under the waiver will be allowed, subject to the limitations defined in this document.

C. Requirements for FSO Staff and Supervisors

The Certificate Program is 12-24 month process and must be satisfactorily completed within 24 months of hire date. Over the course of the certification process applicants will need to meet certain requirements in order to receive certification. These requirements consist of:

1. Submission of the Advanced Wraparound Practitioner Certification Application Form,
2. Completion of core training requirements,
3. Completion of 9 categorized wraparound practitioner Training Units,
4. Participation in monthly on-site coaching sessions from Innovations Institute trainer/coach
5. Participation in practice observations conducted by Innovations Institute trainer/coach including at least:
 - Two (2) Initial Family Meetings,
 - Two (2) Home Visits,
 - Two (2)CFT Observations (1 could be scored using the Team Observation Measure as described below), and
 - Two (2) Documentation Reviews of Plans of Care (1 could be scored using the Document Review Measure as described below)
6. Completion of 3 CFT/Initial Visit Observations utilizing the Family Support Partner Observation Measure (FSPOM) (collected every 4 months) for Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists. At least one observation will be conducted by Innovations Institute trainer/coach. The additional two FSPOMs are conducted by the agency supervisor. Practitioners must reach fidelity based on their combined score. This Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, Youth Certified Peer Support Specialists and Supervisor certification requirement is met by supervisors observing the Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators and Youth Certified Peer Support Specialists in a child and family team meeting.

D. Goals and Process Design

FSOs will provide an array of supports centering on Parent Support and Training to support and to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, guardians, or foster parents. Examples of how this service will be delivered by Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists include:

- These staff may attend meetings with the family and assist in helping the family to effectively contribute to planning and accessing services including assistance with removing barriers.
- These staff may assist in describing the program model and providing information as needed to assist the family.

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

E. FSO Staff Activities

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

1. Services provided to children and youth must include communication and **coordination** with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
2. Parent Support and Training will not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.
3. Services may be provided concurrent with development of the treatment plan to ensure parent support and training and must be intended to address the needs identified in the assessment and to achieve the goals or objectives identified in the child's individualized plan of care.
4. Certified Family and Cultural Support Specialists, Certified Parent Trainer/Group Facilitators, and Youth Certified Peer Support Specialists must be supervised by a person meeting the qualifications for a FSO Supervisor.

Additionally, FSOs and their staff provide the training and support necessary to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and plan of care process; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, guardians, or foster parents.

F. Reimbursement

Note: The anticipated reimbursement rate will be included here in the final distribution version.

G. Staffing Requirements/Qualifications

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

- Executive Director/Program Director: New agencies must hire an executive director that meets the following qualifications (existing organizations must hire a program director that meets the following qualifications):
 - High School Diploma or equivalent is required. Associate's degree is preferred.

- Completion of OBH approved training program for Family Support Specialist and Peer Support Specialist.
- Experience in public speaking, workshop presentations, and assisting others on the telephone or has a willingness to learn immediately.
- Experience in a management or supervisory position.
- Demonstrated success in resolving children's issues within the system.
- Commitment to be active in on-going training, organizational development and capacity building of the CSoC.
- Family member of a child/youth with significant behavioral health challenges or co-occurring disorders served by multiple public child-serving systems for at least one year.
- Has no familial, financial or supervisory relationship with elected or appointed state government officials or staff overseeing activities that are part of the system of care.
- Business Manager/IT
 - Bachelor's-level degree in business administration, accounting, finance, IT, or related field with two years professional experience.
 - Experience with medical billing and coding
- Community Resource Specialist: Serves as an information officer for the organization. Publishes the website, newsletter, and informational guide on community services available.
 - High school diploma or equivalent is required.
- Certified Peer Support Supervisor
 - Bachelor's-level degree in a human services field or Bachelor's-level degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the Bachelor's-level degree requirement in individual cases subject to approval by OBH.
- Youth Certified Peer Support Specialist: Provides peer support services that are child/youth centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills.
 - Must be at least 18 years of age.
 - High School Diploma or equivalent or currently-seeking diploma.
 - Must pass criminal, abuse/neglect registry and professional background checks.
 - Must complete a standardized basic training program approved by OBH.
 - Self-identify as a present or former child recipient of behavioral health services.
- Certified Parent Trainer/Group Facilitator: Provides parent training and support. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth.
 - High School diploma or equivalent.
 - Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience; (preference is given to Parents or caregivers of children with significant emotional/behavioral health challenges).

- Certification of Family Support Training according to a curriculum approved by OBH prior to providing the service.
- Pass criminal history background check, DCFS child abuse check, adult abuse registry and motor vehicle screen.
- A LMHP shall be available at all times to provide back up, support, and/or consultation.
- Certified Family and Cultural Support Specialist: Provides the support necessary to ensure engagement and active participation of the family in the care planning process and with the ongoing implementation and reinforcement of skills learned. The specialist serves as a member of the child and family team at the WAA. The specialist assists in describing the program model and providing information as needed to assist the family.
 - High School diploma or equivalent.
 - Must be 21 years of age and have a minimum of 2 years experience living or working with a child with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of life/work experience and education with one year of education substituting for one year of experience; (preference is given to Parents or caregivers of children with significant emotional/behavioral health challenges).
 - Certification of Family Support Training according to a curriculum approved by OBH prior to providing the service.
 - Pass criminal history background check, DCFS child abuse check, adult abuse registry and motor vehicle screen. A LMHP shall be available at all times to provide back up, support, and/or consultation.

H. Staffing Guidelines for Regional Family Support Organizations

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

(1) Position	(2) Full time (FT) and FTE hourly positions	(3) Staffing ratio
Executive Director (or Program Director if part of an existing organization)	1 FT	One per agency
Business Manager / Information Technology Manager	1 FT	One per agency
Administrative Assistant	4 FTE	Based on 20 staff FTE (FT and hourly)
Community Resource Specialist	1 FTE	One per agency
Certified Parent Trainer / Group Facilitators	2 FT/ 3 FTE hourly	1 per 160 families
Certified Family and Cultural Support Specialists	3 FT / 2 FTE hourly	1 per 10 families
Youth Certified Peer Support Specialists Supervisor	1FT / 1 FTE hourly	1 per 80 youth
Youth Certified Peer Support Specialists	1 FT / 1 FTE hourly	1 per 10 youth
Licensed clinician	0.20 FTE hourly	8 hours per week

I. IT and Other Administrative Requirements

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