COORDINATED SYSTEM OF CARE WRAPAROUND MODEL

The Coordinated System of Care (CSoC) is an approach designed for Medicaid members, between five and 20 years of age, who have a severe emotional disturbance (SED) or a serious mental illness (SMI), and who are in or at risk of an out-of-home placement. The CSoC utilizes the Wraparound model which is guided by the following system of care (SOC) values and principles:

1. Family driven;
2. Youth guided;
3. Culturally and linguistically competent;
4. Home and community-based;
5. Strength based;
6. Individualized;
7. Integrated across systems, bringing agencies, schools and providers together to work with families;
8. Connected to natural helping networks;
9. Data driven and outcome oriented; and
10. Unconditional care.

The Wraparound model is fully consistent with the SOC 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.

In CSoC, Wraparound agencies (WAAs) serve as the locus for access, accountability, service coordination, and utilization management functions. There is one WAA in each region of the State.

The WAA is responsible for facilitating the Wraparound process, developing individualized plans of care (POC) that cross agencies, and assigning the Wraparound Facilitator (WF) to coordinate care. The WF works with the child/youth and their parent/primary caregiver to build a team, which includes formal provider(s), system partners currently working with the family, as well as the family's natural/informal supports. Once enrolled in CSoC, children/youth and families have access to parent support/training and youth support/training specialists, who are employed by the Family Support Organization (FSO).

The WF is responsible for assisting the family in building a team and facilitating the child and family team (CFT) meeting process with support and coaching from a WF supervisor/coach. The WF acts as a bridge between the CSoC contractor and families, and assists the family in building a CFT.

The CFT works with the family to create **one** cohesive plan to coordinate care and address identified needs. The WF will work with children and youth, their families, providers, regional agency staff, courts, child welfare agencies, schools, community organizations, and the FSO to coordinate care planning and access to comprehensive services and supports. Service coordination by the WAA, in collaboration with the FSO, will be guided by the four phase Wraparound process, which is defined by the standards and principles established by the National Wraparound Initiative (NWI). (See Appendix A of this manual chapter for links to the NWI website and information on the ten principles of wraparound).

Eligibility Criteria/Process

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) comprehensive assessment. Children identified as meeting the criteria for CSoC, as determined by the CANS, may include:

1. Children and youth, five to 20 years of age with significant behavioral health (BH) challenges or co-occurring disorders documented in the Individualized Behavioral Health Assessment (IBHA). This includes youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, substance-related disorders and attention deficit hyperactivity disorder issues that lead to costly, and oftentimes, ineffective out-of-home services or excessive use of other therapeutic supports and services. Co-occurring disorders (COD) primarily refer to the presence of mental health and substance-related disorders. Children and youth with COD have one or more substance-related disorder(s), as well as one or more mental health disorder(s);

2. For children with BH disorders and developmental disabilities, if the child has a SED and otherwise meets criteria for CSoC, they are eligible for services within CSoC for their SED;

3. Individuals with an Office of Citizens with Developmental Disabilities (OCDD) statement of approval who receive waiver supports or state funded supports via the local governing entity (LGE), these services will continue to be coordinated by the identified support coordinator. Other services to meet the youth's needs related to their intellectual/developmental disability will be coordinated by the appropriate entity based on the youth's enrollment status and identification of agency responsibility (i.e., Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will be coordinated via the fee–for–service (FFS) process if youth is not enrolled in a health plan or by the health plan if they are; school services will be coordinated by the school); and

   NOTE: Children/youth cannot be enrolled in more than one home and community based services (HCBS) 1915(c) waiver at a time. However, a child/youth can be enrolled in a 1915 (c) and the 1915 (b)(3) waiver programs authorized under section 1915 (c) and 1915 (b) of the Social Security Act.

4. Children in an out-of-home placement, or at risk of being placed out of home including:

   a. Addiction facilities;

   b. Detention;

   c. Homeless (as identified by the Department of Education (DOE));

   d. Intellectual/developmental disabilities facilities;

   e. Non-medical group home;

   f. Psychiatric hospitals;

   g. Psychiatric residential treatment facilities;

   h. Secure care facilities;

   i. Therapeutic foster care; and

   j. Therapeutic group home.

In addition to the child/youth receiving services, parents/primary caregivers must participate in the CFT process. Other adult caregivers, siblings, extended family members, and other natural supports, identified by the youth and family, may also participate in the CFT process. In addition, representatives from other agencies in which the child/family is involved, such as child welfare or

juvenile services, are also typically involved to add their perspectives to the development of the POC. Families will be encouraged to provide their own perspectives on their strengths and needs.

In order to determine eligibility, the CSoC contractor will conduct a brief CANS comprehensive assessment over the phone with the child or parent. If the brief assessment indicates that the child is (presumed) eligible for CSoC, the CSoC contractor will send referrals and initial 30-day authorization to the appropriate WAA electronically upon completion of the telephonic interview.

The CSoC contractor will authorize the WAA to arrange community services necessary to support the child and family for up to 30 days while establishing the CFT and beginning the Wraparound planning process.

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

The WAA will work with the family to gain access to federal funding when available (i.e., help them complete a Medicaid application). The WAA shall initiate the CFT process immediately upon receipt of the referral by the CSoC contractor.

The following must be completed within 30 days of the start of WAA involvement:

1. CANS comprehensive assessment and IBHA;

2. Individualized POC – A copy of the initial assessment and individualized POC developed by the CFT must be completed within 45 days of the start of WAA involvement. The individualized POC must be developed with adherence to NWI standards and treatment planning requirements consistent with 42 Code of Federal Regulations (CFR) 438.208(c)(3); and

3. CFT meeting documentation – The initial CFT meeting must be held within 45 days of the start of WAA involvement. Participation in the CFT process is documented through the signatures of the child/youth, parents or caregivers of the child/youth and other CFT members on the POC.

The CSoC contractor may require proof that these requirements have been met through periodic audits of select cases or providers.

CSoC Level of Care Process

Level of care (LOC) is determined using the CANS comprehensive assessment in conjunction with a bio-psychosocial assessment, the IBHA. The CANS comprehensive assessment is completed based on an interview with the child and parent(s) and additional supporting information. The

CANS assessment 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 assessment. The initial CANS comprehensive assessment is completed by a CANS certified licensed mental health professional (LMHP) after the member/beneficiary scores positive on the Brief CANS and is referred to the WAA for services. (See Appendix D of this manual chapter for LMHP definition). The initial comprehensive CANS must be completed within 30 days of the referral and is used to develop the initial POC.

CANS comprehensive assessment must be completed on each child/youth enrolled in CSoC at a minimum of every six months, or more frequently if conditions warrant re-evaluation. These conditions would include evidence that the child/youth has had a significant change in risk factors, an extended need for increased services has been identified, or a decision regarding changes in LOC is required. Reassessment must be completed by a CANS certified LMHP.

Re-evaluation must take into account any clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive LOC and clinical evidence of symptom improvement.

Goals are established based upon the child's/youth's needs. Interventions for goals are built upon the child's/youth's identified strengths. CFT identifies goals and interventions based upon the CANS comprehensive assessment as well as the child/youth, parent(s) or primary caregiver(s) and other team members input. POC goals identified as being the most pertinent or pressing by the child/youth and parents/caregivers of the child/youth are given preference.

The Wraparound Model

The NWI website (see Appendix A) is the source of the following information. Wraparound is an intensive, creative and individualized care planning and management process. Wraparound is not a treatment, per se. Instead, Wraparound 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 because 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 their family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The Wraparound process is facilitated by a WF, who works with the child/youth and their parent/primary caregiver to create a CFT. The child/youth and the family comprise the core of the CFT members, joined by parent and youth support/training staff from the FSO, providers involved in the care of the family, representatives of agencies with which the family is involved and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The Wraparound process involves four phases over which responsibility for care coordination increasingly shifts from the Wraparound facilitator and the CFT, to the family.

The goals of the Wraparound process are to:

1. Meet the behavioral health needs prioritized by the youth and family;

2. Improve the family's ability and confidence to manage their own services and supports;

3. Develop and strengthen the family's 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 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 that will be consistent with the medical necessity criteria of the CSoC contractor.

Phase One: Engagement and Team Preparation

During this phase, the WF is responsible for establishing the groundwork of trust and shared vision among the family and Wraparound team members. The WF orients the youth and family to the Wraparound process; stabilizes immediate crisis; explores the strengths, needs, vision and culture of the family; begins to identify potential team members, including formal and informal supports; engages potential team members, with the consent of the family; and begins to prepare for the first CFT meeting. (*Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model*. (See Appendix A of this manual chapter).

Key Activities During Phase One: Engagement and Team Preparation

1. Upon referral to the WAA, the CSoC contractor will authorize completion of CANS comprehensive assessment and IBHA to be conducted by a CANS certified LMHP, to confirm the clinical eligibility of the youth/child. The findings will be sent to the WF to assist the CFT in the Wraparound planning process;

2. The WF shall work closely with the FSO to integrate the provision of supports from parent and youth support/trainers. It is expected that personnel from the FSO will have ongoing active involvement on the CFT, unless the family chooses not to have them involved or the CFT in consultation, as needed, with the physician overseeing the care determines, FSO involvement to be clinically contra-indicated. It is expected that parent support and training (PST) and youth support and training (YST) will be a key component of the array of services and supports included in the POC;

3. During the initial contact with the youth and family, the WF ensures the delivery of the CSoC brochure describing the CSoC services, free choice of providers and how to report abuse and neglect. Each CSoC child/youth will be a member of the CSoC contractor and will be provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. The WF will also ensure that the family is offered the choice of either institutional or HCBS waiver services, using the Freedom of Choice (FOC) form;

4. During preliminary discussions of treatment, the child/youth and their parents or caregivers are informed by the WF of the array of services that may be accessed through the CSoC. The array of services available to the family includes waiver-specific services and also includes services available in the SOC outside of the SED waiver. Examples of such services would be traditional behavioral health services (BHS), such as medication management and individual therapy provided in the home. Non-traditional community-based services, such as PST and YST, as well as psychosocial treatment group, would also be available. Naturally 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;

5. During the initial meetings the WF will work closely with the child/youth and family/caregiver to determine membership of the CFT;

6. The WF shall work closely with the child welfare, juvenile justice and local education agencies (LEAs) to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies, the juvenile justice system and LEAs will have active involvement on the CFT unless clinically contra-indicated;

7. With the child/youth, family and other identified team members, including information from the CANS assessment/IBHA, the WF will conduct a strengths, needs and cultural discovery, to assist the family in identifying a family vision and produce a narrative 'family story' document, to share with the youth, family and other team members; and

8. The WF is responsible for coordinating with the youth, family and other team members to schedule and prepare for the first CFT.

Phase Two: Initial Plan Development

During Phase Two, trust and mutual respect are built while the team creates an initial POC. With the CFT, the WF assists in determining the ground rules of the meetings; eliciting and documenting strengths from all team members; creating the team mission; describing and prioritizing needs/goals; determining plan objectives and indicators for each objective; selecting strategies that utilize both formal and informal supports; assigning action steps; assessing potential risks; and development of a crisis plan and an initial POC. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model*. (See Appendix A of this manual chapter).

Key Activities during Phase Two: Initial Plan Development

1. The child/youth and parents or caregivers of the child/youth must be involved in the development of the POC. In addition, behavioral health providers, representatives of agencies legally responsible for the care or custody of the child and other individuals are strongly encouraged to participate in the development of the POC;

2. Participation in the CFT process is documented through the signatures of the child/youth, parents or caregivers of the child/youth, and other CFT members on the POC. –The CSoC contractor must operate from one integrated POC. This reinforces the Wraparound process and results in the POC encompassing all services that may be accessed through the CSoC contractor;

3. The WF is responsible for communicating with the child/youth's primary care physician (PCP). The WF must document attempts to communicate and coordinate with the child's PCP in the development of the individualized POC. If the child's PCP wishes to take part in the development of the individualized POC, then the WF must ensure that the PCP is involved to the extent they desire. If the PCP chooses not to participate in the care planning process, then the WF must initiate communication with the PCP and ensure that a copy of the individualized POC is sent to the PCP;

   NOTE: BH treatment must be ordered and overseen by a physician or other LMHP to comply with other federal requirements.

4. The POC is developed based upon the CANS comprehensive assessment and identified goals, as determined by the CFT. The child/youth and parents or

caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs and the development of a risk assessment and crisis/safety plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of CSoC services (including relevant clinical and agency service information provided by providers and other agency members of the CFT, as well as natural supports that are built into the POC to assist the child/youth in meeting their goals;

5. The WF plays a role in this process by facilitating POC development through documentation of the decisions made by the CFT, facilitating the overall meeting and ensuring that all members of the team have the opportunity to participate. Should needs or circumstances change, the child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time;

6. The WF will provide adequate notice of the CFT meetings to all of the CFT members. To ensure the planning process is timely, WAAs will comply with the basic service delivery standards as outlined in the CSoC contractor and WAA contracts. The WF is responsible for writing the POC, based upon the determinations made by the CFT;

7. Once developed, the WF will ensure POCs are entered into the CSoC contractor's database and electronic health record, ensuring that compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Federal Educational Right to Privacy Act (FERPA) standards are maintained. The WF will submit the POC to the CSoC contractor for review prior to the end of the initial 45-day authorization period;

8. The CSoC contractor reviews the POC for consistency with the child/youth and family's strengths and needs (as identified by the CANS comprehensive assessment, IBHA, broader assessment and the POC and utilization guidelines. If the POC meets these criteria, the CSoC contractor provides authorization for a period of up to 180 days. On-going authorizations provided by the CSoC contractor will be for up to 180-day periods for most children/youth;

   NOTE: Authorizations may exceed 180 days for some children/youth, as determined by medical and social necessity for the service.

9. If the POC appears to be inconsistent with assessed strengths and needs and the utilization guidelines for the desired services, or if it exceeds the cost of care limitations, the CSoC contractor and the WAA WF discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT;

10. An approved licensed BH practitioner must approve any treatment on the POC to ensure that services by unlicensed individuals are medically necessary;

11. Each POC is required to contain a crisis and safety plan. Crisis plans are developed in conjunction with the POC during the CFT meeting, based upon the individualized preferences of the child/youth and parents or caregivers of the child/youth. As with the POC itself, the child/youth and parents or caregivers of the child/youth may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the CFT; and

12. 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 WF, etc. The CSoC contractor is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to children/youth and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their POC in order to have access to the identified information should a crisis occur.

Phase Three: Plan Implementation

During Phase III, the initial POC is implemented, progress and success are continually reviewed, and changes are made to the plan based on observations and data, then implemented. It is the role of the WF to maintain team cohesion and mutual respect. The activities of this phase are repeated until the identified team mission is achieved and formal Wraparound is no longer needed. The WF is responsible for ensuring that there is an implemented action step for each strategy on the plan; tracking progress on action steps, with the CFT evaluating success of the strategies, celebrating successes; considering new strategies, when needed; maintaining awareness of team members 'buy-in'; addressing issues of team cohesion and trust; completing necessary documentation of the CFT process. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model*. (See Appendix A of this manual chapter).

Key activities during Phase Three: Plan Implementation

1. The WF is responsible for monitoring and follow-up activities, including intensive care coordination and reviewing the POC with the CFT, at minimum, monthly, (more frequently, if needed) to update the POC to reflect the changing needs of the child/youth. The WF and CFT reviews: 1) whether services are being provided in

accordance with the POC, 2) whether the services in the POC are adequate, and 3) whether there are changes in needs or status of the individual and, if so, adjusting the POC as necessary. The CFT is the primary point of responsibility for coordinating the many services and supports with which the youth and family are involved, and the family and youth ultimately drive the goals of the CFT. Over time, the responsibility for care coordination increasingly shifts from the WF and the CFT to the family; and

2. 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 WF is responsible for the following:

1. Supporting the action steps of the POC by checking in and following up with CFT members, educating providers and other system and community representatives about the Wraparound process, as needed, and identifying and obtaining necessary resources;

2. Monitoring progress on the action steps of the POC by tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the POC and completion of planned interventions;

3. Guiding the CFT in evaluating whether selected strategies are helping meet the youth's and family's needs;

4. Encouraging the team to acknowledge and celebrate success when progress has been made, when outcomes or indicators have been achieved or when positive events or achievements occur;

5. Supporting the CFT to determine when strategies for meeting needs are not working or when new needs should be prioritized, and guiding the CFT in a process of considering new strategies and action steps using the process described above for developing the POC;

6. Making use of available information to assess CFT members' satisfaction with and commitment to the CFT process and POC, sharing this information with the CFT, as appropriate, and welcoming and orienting new CFT members who may be added as the process unfolds;

7. Helping to maintain CFT cohesiveness and satisfaction, supporting fidelity to Wraparound principles and activities and guiding the CFT in understanding and managing any disagreements, conflicts or dissatisfactions that may arise; and

8. Maintaining/updating the POC document including results of reviews of progress, successes and changes to the CFT and POC over time and maintaining/distributing copies of the POC to CFT members.

Phase Four: Transition

During this phase, plans are made for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community. The focus on transition is continual during all of the Wraparound process and the preparation for transition is apparent even during the initial engagement phase and activities. The WF is responsible for assisting the CFT in creating a transition plan; creating a post-transition crisis management plan; modifying the Wraparound process to reflect transition; documenting the teams work, celebrating success and checking in with the family after discharge. *Source: Phases and Activities of the Wraparound Process: Building Agreement about a Practice Model*. (See Appendix A).

Key activities of Phase Four: Transition

The final phase of activity centers on the transition from the CFT to natural supports. During this phase, the Wraparound facilitator and CFT focus on planning for a purposeful transition out of formal Wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system).

The focus on transition is continual during the Wraparound process, and the preparation for transition is apparent even during the initial engagement activities. However, this is the primary focus of the transition phase of the Wraparound process.

Wraparound Agency Requirements

There is one WAA for each of the Act 1225 regions. WAAs were selected by community teams which included local state agency leaders and other members of the community. The WAA is responsible for conducting the Wraparound process for eligible youth in their region.

Wraparound Agency Qualification Requirements

1. Arranges for and maintains documentation that all persons, prior to employment, pass criminal background checks and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses

against a child/youth or an elderly or disabled person, the WAA provider shall not hire and/or shall terminate the employment (or contract) of such individual. The WAA provider shall not hire an individual with a record as a sex offender nor permit these individuals to work for the provider as a subcontractor. Criminal background checks must be performed as required by La. R.S. 40:1203.1 *et seq*., and in accordance with La. R.S. 15:587 et seq.;

2. The WAA shall not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. The WAA provider shall maintain the results of an individual's criminal background check in the individual's personnel record and comply with the confidentiality requirements of La. R.S. 40:1203.4;

3. The WAA must review the Department of Health and Human Services' (DHHA) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the Louisiana Department of Health (LDH) State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare program by Louisiana Medicaid or the DHHS OIG. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch;

4. The WAA is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare program by Louisiana Medicaid or the DHHS OIG. The WAA provider shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual's personnel record;

5. Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use;

6. Maintains documentation that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire, which shall be renewed within a time period recommended by the AHA;

7. Ensure and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which shall be updated annually; and

8. Maintains documentation of verification of staff meeting educational and professional requirements, as well as completion of required trainings for all staff.

Wraparound Agency Certification and Credentialing Requirements

In order to develop CSoC POCs through CFT activities and access funding through the administrative portion of the CSoC contractor, each WAA must be credentialed and certified by the CSoC contractor.

In order to maintain CSoC certification, all WAA staff must meet the current provider qualifications as defined in the most recent ~~Behavioral Health Ser~~BHS~~vices~~ manual chapter of the Medicaid Services Manual. The WAA must ensure that all WF supervisors and facilitators are participating in ongoing Wraparound training that is in alignment with the NWI's fidelity standards and approved by OBH. In addition, all Wraparound supervisors must complete all required trainings and conduct face-to-face observations of staff they supervise in CFTs and other meetings on an on-going basis as defined in the WAA Certification application. In addition, the certification process includes documenting that individual WAA staff members have completed training, as described in the section below.

Wraparound Agency Staff Qualification Requirements

1. Satisfactory completion of criminal background check pursuant to La. R.S. 40:1203.1 *et seq*., La R.S. 15:587 (as applicable), and any applicable state or federal law or regulation;

2. Employees and contractors must not be excluded from participation in the Medicaid or Medicare program by Louisiana Medicaid or the DHHS OIG;

3. Staff must not have a finding on the Louisiana State Adverse Action List;

4. Pass drug screening tests as required by WAA provider's policies and procedures; and

5. Complete AHA recognized First Aid, CPR and seizure assessment training.

   NOTE: psychiatrists, advanced practice registered nurses (APRNs), physician assistants, registered nurses (RNs) and licensed practical nurses (LPNs) are exempt from this training.

Staffing Requirements and Qualifications

In order to maintain WAA certification and to ensure compliance with Wraparound fidelity requirements, WAA staff must meet the following educational and experience requirements, as specified below. The WAA must maintain documentation of verification of completion of required trainings for all staff.

Staffing Guidelines for Wraparound Agencies

Positions/functions include an executive director or program director, business manager, WFs with a caseload of no more than 10 families (unless approved by the Office of Behavioral Health (OBH)), Wraparound supervisors/coaches with a recommended ratio of one supervisor/coach per eight WF (unless approved by OBH), quality improvement/data director, community resource specialist, administrative assistants and 1.0 full-time employee (FTE) LMHP clinical director, quality improvement/data director.

Wraparound Facilitator

The WF must meet the following requirements:

1. 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 experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by LDH; and

2. Completion of the required training for WFs.

Certified WAAs must also employ staff to supervise and coach the WFs.

Requirements include the following:

1. Master's-level or higher graduate degree in a human services field (see Appendix B of this manual chapter);

2. Master's level or higher graduate degree in any field, with a minimum of three years of full-time experience working in relevant family, children/youth or community service capacity. Relevant experience shall include working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. Relevant alternative experience may substitute for the degree requirement in individual cases, subject to approval by LDH;

3. Completion of the required training for WF supervisors/coaches;

4. If the supervisor/coach also functions, in part, as a WF, they must also meet the requirements for a WF described above;

5. The WF supervisor/coach must provide regular supervision and coaching to WF service delivery staff, including completion of all supervisor and coaching requirements for high fidelity Wraparound; and

6. The WF supervisor/coach must have expertise, knowledge and skills in the Wraparound model and possess the ability to teach and develop those skills in the WF. Previous wraparound experience is preferred. A Wraparound supervisor/coach must have a high degree of cultural awareness and the ability to engage families from different cultures, and backgrounds. A preferred supervisor/coach characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor/coach must oversee the work of the WF on an ongoing basis.

Core Training Requirements for the Wraparound Supervisors/Coaches and Facilitators

All Wraparound direct care staff, including but not limited to supervisors/coaches and facilitators, are required to participate in OBH approved trainings described below.

Introduction to Wraparound (Three-Day)

This is the first training of the series for frontline Wraparound practitioners, supervisors/coaches, and directors who may participate in a child and family team process. Through attendance at this training, participants will be able to:

1. Gain an understanding of the critical components of the Wraparound process in order to provide high fidelity Wraparound practice; and

2. Practice the steps of the process to include eliciting the family story from multiple perspectives, reframing the family story from a strengths perspective, identifying functional strengths, developing vision statements, team missions, identifying needs, establishing outcomes, brainstorming strategies, and creating a POC and crisis plan that represents the work of the team and learn basic facilitation skills for running a CFT meeting.

Wraparound supervisors/coaches and facilitators must participate in the Introduction to Wraparound within the first 60 days of employment and repeat the training at least once during their first two years of practice.

Child and Adolescent Needs and Strengths Training

Within the first 90 days of employment Wraparound supervisors/coaches and facilitators must be trained on the CANS for Louisiana Comprehensive Multisystem assessment. All supervisors/coaches, LMHPs and facilitators must be recertified on an annual basis. See Appendix A of this manual chapter for a link to the PRAED Foundation's collaborative training website.

Ongoing Training Activities for Wraparound Facilitators and Supervisors/Coaches

Each staff member must participate in training activities to address new information and deficiencies identified by their supervisor.

Additional Training Requirements

Any additional training and professional development initiatives as required by the waiver and/or required by OBH to support fidelity to Wraparound practice.

Observation of Wraparound Facilitators by Supervisor/Coach

Supervisors/coaches are required to observe Wraparound facilitators as follows:

1. Three observations within the first six months of hire (two CFT meetings; One – supervisor's choice); and

2. Minimum of one CFT observation every six months, after six months of hire.

Additional Training Requirements for Wraparound Supervisors/Coaches

An 'Introduction to Coaching' training which must be approved by OBH, is mandatory for local supervisors/coaches in the WAA. Through attendance at this training, participants will be able to:

1. Identify the skills necessary to support high-fidelity Wraparound practices;

2. Develop an increased understanding of the roles and responsibilities of the local supervisor/coach; and

3. Develop skills to support WFs in high-fidelity Wraparound practices.

Allowed Provider Types

Wraparound process is not considered a service; therefore, it is included in the administrative rate.

Limitations and Exclusions

All coordination of care activities must protect each member'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.

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 WF and the Department of Children and Family Services (DCFS) to align BHS ~~services~~ and supports to support and inform the DCFS-developed permanency plans. In addition, consistent with Medicaid managed care rules, CSoC contractor will ensure that all CFTs are aware of and utilize the CSoC contractor's medical necessity criteria for any BH medical services recommended as part of an individualized POC.

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 act as service providers:~~.~~

1. General Prohibition:
   WAAs shall not directly provide any Medicaid-reimbursable BHS included on the CSoC POC. This prohibition is required to ensure compliance with federal conflict-free case management standards and to maintain the independence of care coordination functions;

2. Parent Organization Restrictions:
   The parent organization of a WAA shall not provide BHS to any individual enrolled with, referred by, or assigned to the WAA. The parent organization must ensure that no real or perceived conflict of interest exists related to service referral, authorization, or service provision;

3. Allowable Parent Organization Activities:
   The parent organization of a WAA may operate a separate BHS entity only when all the following conditions are met:

   a. The service-providing entity maintains a separate legal structure and holds a distinct behavioral health services provider (BHSP) license;

   b. The service-providing entity is enrolled and credentialed as a separate Medicaid provider;

   c. The service-providing entity operates independently from the WAA, including separation of staffing, supervision, governance, and programmatic oversight; and

   d. All requirements of sections 4 and 5 below are met.

4. Firewalls and Safeguards:
   A parent organization operating both a WAA and a BHS entity must implement and maintain robust firewalls, which shall include, at a minimum:

   a. Separate administrative, fiscal, and programmatic structures;

   b. No shared clinical, supervisory, or care coordination staff;

c. Policies ensuring that protected health information (PHI) obtained by the WAA is not shared with the service-providing entity except as permitted by law;

d. Documentation demonstrating the absence of financial incentives that could influence referral or authorization decisions; and

e. Internal controls preventing preferential referrals or steering to affiliated entities.

5. Allowable Services by Parent Organizations:
Subject to compliance with all provisions above, the parent organization of a WAA may provide the following services under a separate, licensed, and enrolled BHS entity:

a. Adult BHS:
BHS for adults ages 18–20 may be provided in any region of the state, regardless of whether the parent organization operates a WAA in that region;

b. Youth BHS:
BHS for individuals under age 18 may be provided only in regions where the parent organization does not operate as a WAA, to ensure conflict-free case management and avoid both real and perceived conflicts of interest; and

c. EBP Services:
EBP models (e.g., Dialectical Behavior Therapy (DBT), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST)), may be provided when delivered through a distinct, separately licensed, and enrolled provider entity, and only in accordance with the age- and region-specific parameters in items (a) and (b) above.

6. Prohibited Activities:
Notwithstanding the allowances above, a WAA or its parent organization shall not:

a. Provide any service to a youth or young adult assigned to that WAA;

b. Participate in, influence, or attempt to influence authorization decisions for services delivered by an affiliated provider entity; or

c. Utilize shared programmatic leadership, quality management staff, clinical supervisors, or direct service personnel across WAA and service-delivery functions.

7. State Oversight:
The State reserves the right to review, audit, or request documentation at any time to ensure compliance with conflict-free case management requirements, including organizational charts, policies and procedures, staffing assignments, PHI protection protocols, and financial separation. Non-compliance may result in corrective action, suspension of activities, or termination of provider enrollment.

NOTE: This language does not preclude the parent agency of a WAA, from providing regionally-based crisis response services, under a separate ~~behavioral health services provider~~BHSP license, enrolled and credentialed as a separate entity.

Non-Reimbursable Activities

Direct services may not be provided by the CFT members as part of their contractually defined WAA role. The WAA staff may not provide direct services to any child for whom they have assisted in developing the POC. Any CFT 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 CSoC contractor 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 WFs are not allowable:

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

2. 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 (~~BHS~~)~~ and supports are reimbursed by the CSoC contractor; and

3. Transportation of the member 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.