

FREE THROUGH
Recovery

Program Guidance

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Glossary of Terms and Abbreviations

Free Through Recovery (FTR)

Free Through Recovery is a community based behavioral health program designed to increase recovery support services to individuals involved with the criminal justice system who have behavioral health concerns.

FTR Administrator

Member of the Behavioral Health Division (BHD) and serves the FTR program by delivering technical assistance, training, regional leadership/collaboration, and reconciliation of monthly outcomes and payment sheets for providers. Serves as part of the care team.

FTR Lead Administrator

Oversees the FTR program statewide including trainings and documentation reviews and is the FTR Administrator's supervisor.

FTR Clinical Administrator (DOCR FTR-CA)

Approves referrals and discharges as well as serves as part of the DOCR staff. This position also helps lead documentation reviews and serves as part of the care team on an as needed basis. Provides training and guidance on Corrections Best Practices.

Behavioral Health Division (BHD)

The Behavioral Health Division provides leadership for the planning, development, and oversight of the state's behavioral health system. FTR is one of BHD's several initiatives.

Department of Corrections and Rehabilitation (DOCR)

Responsible for the direction and general administrative supervision, guidance, and planning of adult and juvenile correctional facilities and programs in North Dakota. Probation/Parole Officers, as well as the FTR Clinical Administrator are extensions of the DOCR.

Probation/Parole Officer (PO)

The supervision officer overseeing the participant's involvement in the criminal justice system. The PO makes the FTR referrals and gets Releases of Information (ROI) signed for the FTR participant and serves as part of the care team.

Release of Information (ROI)

The authorization to disclose information forms a participant signs before entering FTR. This covers BHD, DOCR, and chosen provider to talk freely about the participant's case.

Provider Agreement (PA)

The agreement and clarification of responsibilities between BHD and the provider.

Provider

The organization or agency that provides services to FTR participants.

Care Coordinator (CC)

Provides a source of connection and support for FTR participants as well as assisting participants with achieving motivation for long-and short- term goals while creatively problem-solving barriers. Serves as part of the care team.

Peer Support Specialist (PSS)

An individual who uses their lived experience and skills learned through formal training to deliver services to promote mind-body recovery and resiliency, as well as serves as part of the care team.

Care Team

Consists of the CC, PSS, PO, FTR Administrator and when needed the FTR Clinical Administrator. The care team staffs cases regarding level changes, discharges, transfers and any other situations where a staffing is needed.

Docstars

Abbreviation for “Department Of Corrections Subject Tracking And Reporting System”

Database used for care plans, documentation, outcomes, participant identifying information, referral information, etc.

Chronos

Notes entered in Docstars to record all interaction (actual & attempted) and other “work” done on behalf of a participant.

Reporting Period

Starts on the 21st of the month and ends on the 20th of the following month. Example, 1/21/2021 to 2/20/2021.

Weekly Engagement

Based on a calendar week

Outcomes

Identify participant results in the areas of housing, employment, recovery supports, and criminal justice involvement.

Reconciling

The process of vetting participant’s outcomes and determining payment to the provider.

Payment Sheets

What FTR Administrators send to providers each month that breaks down how providers are paid for the reporting period.

Evidence Based Practices

Any practice that relies on scientific evidence for guidance and decision making.

Best Practice

A method or practice that has shown to be most effective.

Person-Centered

Describes the effort to ensure that services are centered on the needs and desires of the participant. It means that participants set their own recovery goals and have choices in the services they receive, and they can select their own recovery support team. For mental health providers person-centered care means assisting consumers in achieving goals that are personally meaningful.

Background: Enrolled Senate Bill 2015

As part of legislation enacted in Senate Bill 2015 and House Bill 1041 during North Dakota's 65th Legislative Assembly (2017), the Department of Human Services (DHS) and the Department of Corrections and Rehabilitation (DOCR) collaborated to establish a community-based behavioral health program, Free Through Recovery (FTR). The program was designed to increase access to recovery support services for individuals engaged with the criminal justice system who have serious behavioral health concerns. The goal of this project was to contain jail and prison population growth and reinvest savings into strategies that reduce recidivism, increase public safety, and improve public health outcomes. On February 1st, 2018, FTR began receiving referrals.

Providers who contract with the Department of Human Services (DHS) to participate in this program will act as a member of a multidisciplinary team to offer comprehensive care coordination and recovery support services to individuals who are at risk to commit a violation or a new crime and have complex behavioral health concerns.

Section 4. Appropriation – Department of Human Services

There was appropriated from special funds derived from federal funds and other income, the sum of \$7,000,000, or so much of the sum as may be necessary, to the department of human services for the purpose of implementing the community behavioral health program, for the biennium beginning July 1, 2017, and ending June 30, 2019. The department was authorized six full-time equivalent positions to implement the community behavioral health program.

Section 9. Century Code

A new section to chapter 54-23.3 of the North Dakota Century Code was created and enacted as follows:

Community behavioral health program – Reports to legislative management and governor

1. The Department of Corrections and Rehabilitation shall establish and implement a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions, as a term and condition of parole under chapter 12-59, and as a sentencing alternative under section 12.1-32-02.
2. In developing the program under this section, the Department of Corrections and Rehabilitation shall collaborate with the Department of Human Services to:
 - a. Establish a referral and evaluation process for access to the program,
 - b. Establish eligibility criteria that includes consideration of recidivism risk and behavioral health condition severity,
 - c. Establish discharge criteria and processes, with a goal of establishing a seamless transition to post program services to decrease recidivism,
 - d. Develop program oversight, auditing, and evaluation processes that must include:
 - (1) Oversight of case management services through the Department of Human Services;
 - (2) Outcome and provider reporting metrics; and
 - (3) Annual reports to the legislative management and the governor on the status of the program.
 - e. Establish a system through which
 - (1) The Department of Human Services:
 - (a) Contracts with and pays behavioral health service providers; and
 - (b) Supervises, supports, and monitors referral caseloads and the provision of services by contract behavioral health service providers.
 - (2) Contract behavioral health service providers accept all eligible referrals, provide individualized care delivered through integrated multidisciplinary care teams, and continue services on an ongoing basis until the discharge criteria are met.

- (3) Contract behavioral health service providers receive payments on a per-month-per-referral basis. The payment schedule must be based on pay-for-performance model that includes consideration of identified outcomes and level of services required.
- (4) Contract behavioral health service providers bill third parties for services and direct payment to the general fund.

3. The Department of Human Services may adopt rules as necessary to implement this program.

Section 11. Legislative Management Study - Criminal Justice System Behavioral Health Needs

During the 2017-2018 interim, the legislative management shall consider continuing its study of alternatives to incarceration, with a focus on the behavioral health needs of individuals in the criminal justice system. The study must include receipt of reports on the status, effectiveness, and sustainability of the community behavioral health program for individuals in the criminal justice system which must include caseload data, any recognized savings to the department of corrections and rehabilitation, an overview of the training requirements for contract behavioral health service providers, and recommendations. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-sixth legislative assembly.

Current Enrolled Senate Bill 2015

Free Through Recovery continues to be a successful collaboration between ND DOCR and the North Dakota Department of Human Services Behavioral Health Division. As of August 2020, there were 38 different agencies providing care coordination and peer support services to participants, which has grown from 11 at the program's start. Services are presently offered statewide, including participants residing in the most rural areas of North Dakota. Since February 1, 2018, there have been 2,709 individual participants. The 2021 Senate bill 2015 expanded funding for Free Through Recovery.

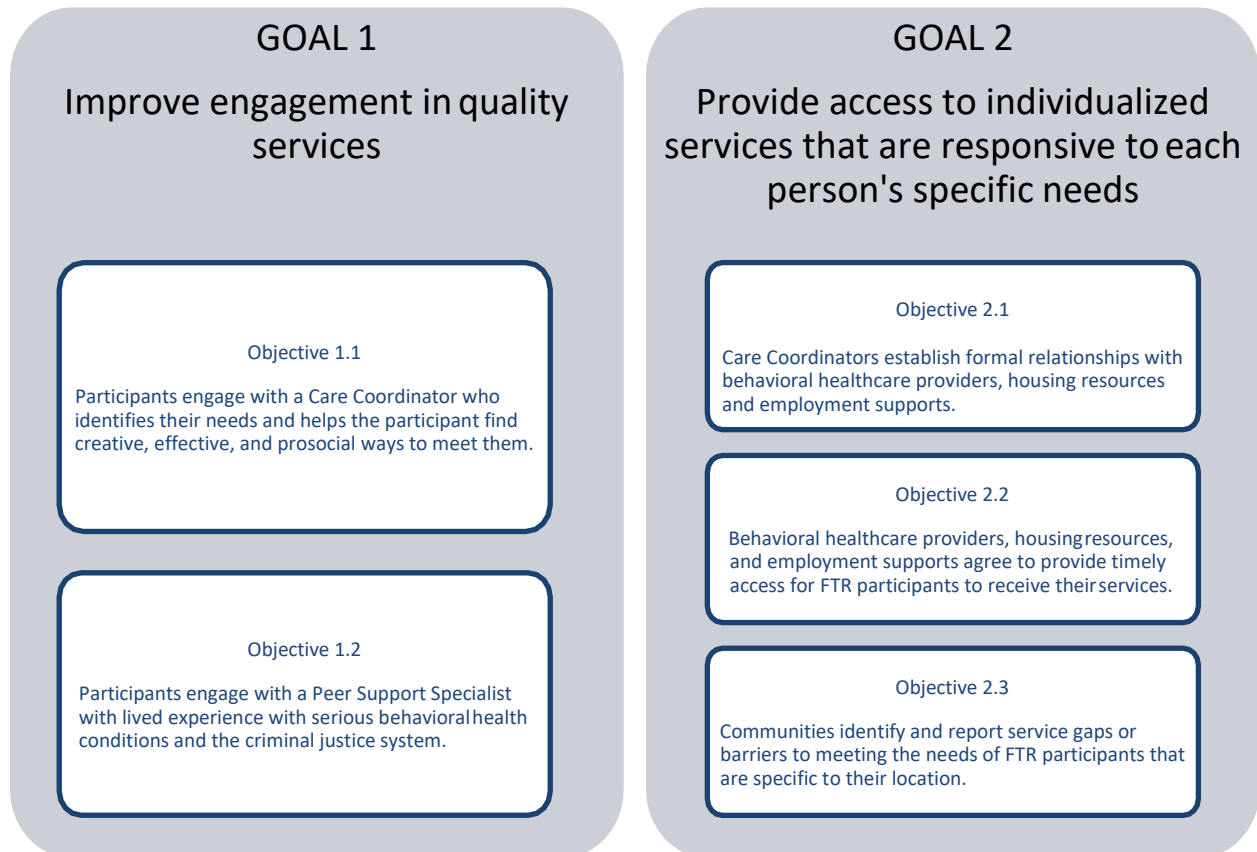
Free Through Recovery Program Mission, Goals and Principles

Mission and Goals

The mission of Free Through Recovery is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision.

Problem	Intervening Variables	Strategies	Short Term Goals	Long Term Goals
Individuals with serious behavioral healthcare needs who are involved with the criminal justice system require more comprehensive and ongoing supports than are currently available.	Individuals have barriers to accessing needed services to achieve recovery, which, for some, contributes to additional criminal behavior leading to incarceration.	Free Through Recovery <i>Care Coordination</i> <i>Recovery Services</i> <i>Peer Support</i>	Improve engagement in recovery services. Provider access to individualized services that are responsive to each person's specific needs.	Lives are improved, people recover, and criminal recidivism is reduced, along with the use of incarceration for people with serious behavioral health needs.

Recovery Services include access to nourishment assistance programs, supportive housing, educational opportunities, meaningful employment, leisure activities and wellness, family and community social supports, parenting education, spiritual engagement, and any other individualized resources the person needs to help them lead a healthy and fulfilling life.



Shared Principles

The DOCR and BHD commit to the shared principles outlined below. These principles were developed by integrating the core values put forth by the Department of Human Services and the Eight Evidence-Based Correctional Practices (Latessa & Lowenkamp, 2006) which guide services provided by the DOCR (See the publication “Evidence Based Correctional Practices” prepared by the Colorado Department of Corrections Office of Research and Statistics in August 2007 for more information). Both agencies recognize that these principles are not comprehensive and other values and best practice approaches may guide the development and implementation of this program. The principles are provided here as education and information for vendors, who are expected to adhere to these principles in their work as it relates to this program.

Best Practice

Assess Offender Risk and Need Levels Using Actuarial Tools: Each participant will receive a comprehensive clinical assessment driven by identification of criminogenic risk and need, behavioral health diagnoses, and behavioral health functional status. This assessment will serve as the basis for case coordination and referral to appropriate services based on individual needs.

Target Interventions: Interventions will address the thinking that initiates and maintains high risk behaviors and teach cognitive and behavioral skills for use in risky situations.

Provide Skills Training for Staff and Monitor Their Delivery of Service: Program staff will receive training in communicating effectively with participants and teaching cognitive and behavioral skills. Delivery of interventions will be monitored through direct observation and ongoing data collection.

Data Driven

Measure Relevant Practices and Processes: Outcome measures will be identified, tracked, and reported for use in determining the overall success of the program at assisting participants in improved behavioral health functional status. Data will be used to determine which specific aspects of the program correlate to the success of its participants.

Person-Centered

Enhance Motivation: Providers are expected to utilize effective engagement and motivational interviewing strategies to improve the likelihood that participants will engage in that program and successfully transition from the program after having met their individual goals.

“Care that is based on the person’s and/or family’s self-identified hopes, aspirations, and goals, which build on the person’s and/or family’s own assets, interests, and strengths, and which is carried out collaboratively with a broadly defined recovery management team that includes formal care providers as well as others who support the person’s or family’s own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.”

Source: *Glossary of Recovery Terms*: Retrieved 2015, May 18 from <http://media.samhsa.gov/recoverytopractice/glossaryofterms.aspx>

“Person-Centered Care describes the effort to ensure that mental health care is centered on the needs and desires of the consumer. It means that consumers set their own recovery goals and have choices in the services they receive, and they can select their own recovery support team. For mental health providers person-centered care means assisting consumers in achieving goals that are personally meaningful.”

Source: *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions*. HHS Publication No. SMA-09-4371. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010, Page 5. Retrieved 2015, May 27 from <http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf>

Person-Centered Care Guiding Principles/Core Competencies

- Transparency, individualization, recognition, respect, dignity, and choice related to one's person, circumstances, and relationships.
- Support the decision-making abilities and preferences of all individuals for treatment and recovery.
- Involve persons served in the design, administration, and delivery of treatment and recovery services.
- Respond to every individual in the context of their strengths, hopes, culture, and spirituality.
- Interventions tailored to unique preferences, strengths, vulnerabilities, and dignity of each person.

Recovery-Oriented

Engage Ongoing Support in the Community: The program emphasizes the importance of access to a full continuum of behavioral healthcare, beyond traditional treatment strategies. To that end, recovery-based services such as peer support, recovery coaching, physical healthcare, and housing and employment support are engaged.

“Systems of health and human services that affirm hope for recovery, exemplify a strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery from which they and their families may choose.”

Source: Glossary of Recovery Terms: Retrieved 2015, May 18 from <http://media.samhsa.gov/recoverytopractice/glossaryofterms.aspx>

Guiding Principles of Recovery-Oriented Systems

- There are many pathways to recovery
- Recovery is self-directed and empowering
- Recovery involves a personal recognition of the need for change and transformation
- Recovery is holistic
- Recovery has cultural dimensions
- Recovery exists on a continuum of improved health and wellness
- Recovery emerges from hope and gratitude
- Recovery involves a process of healing and self-redefinition
- Recovery involves addressing discrimination and transcending shame and stigma
- Recovery is supported by peers and allies
- Recovery involves (re)joining and (re)building a life in the community
- Recovery is a reality

Source: Sheedy C.K., and Whitter M., Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do We Know from the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009, pages 1 & 2. Retrieved 2015, May 1 from http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf.

Transparent

Provide Measurement Feedback: Data will be provided to stakeholders at various levels to guide their participation and practices relevant to the program. Feedback will be provided to inform decision-making and improve practices related to the program.

Trauma-Informed

A strengths-based service delivery approach is grounded in an understanding of the responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors. This approach creates opportunities for survivors to rebuild a sense of control and empowerment. Staff is expected to communicate with participant and provide services with an interpersonal approach that emphasizes developing supportive, mutually

respectful, and friendly relationships between staff and participants. Providing verbal and tangible reinforcement, effective disapproval, effective use of authority, and other de-escalation techniques when necessary and also strategies to reduce the impact of trauma on participants.

“A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.”

Trauma-informed involves four key elements of a trauma-informed approach:

1. Realizing the prevalence of trauma;
2. Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
3. Responding by putting this knowledge into practice; and
4. Resisting retraumatization.

“Trauma-Informed Care is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.”

Source: SAMHSA News (Spring 2014, Volume 22, Number 2), Trauma-informed Care – New Publication, Key Terms: Definitions. Retrieved 2015, May 27 from http://www.samhsa.gov/samhsanewsletter/Volume_22_Number_2/trauma_tip/key_terms.html.

Guiding Principles of Trauma-Informed Care:

- **SAFETY:** Throughout the organization, staff and the people they serve feel physically and psychologically safe.
- **TRUSTWORTHINESS & TRANSPARENCY:** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
- **PEER SUPPORT & MUTUAL SELF-HELP:** These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
- **COLLABORATION & MUTUALITY:** There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizing that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
- **EMPOWERMENT, VOICE & CHOICE:** Throughout the organization and among the clients served, individuals’ strengths are recognized, built on, and validated and new skills developed as necessary. The organization aims to strengthen the staff’s, clients’ and family members’ experience of choice and recognize that every person’s experience is unique and requires an individualized approach. This includes a belief in resilience and in the ability of individuals, organizations and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
- **CULTURAL, HISTORICAL, & GENDER ISSUES:** The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Source: SAMHSA News (Spring 2014, Volume 22, Number 2) Guiding Principles of Trauma Informed Care, retrieved 2015 May 1st from http://www.samhsa.gov/samhsanewsletter/Volume_22_Number_2/trauma_tip/key_terms.html

Individual Eligibility

To meet the criteria for FTR an individual must meet the following criteria:

- Resides in North Dakota
- 18 years of age or older
- Involved in the criminal justice system in one of the following ways:
 1. The person has been charged with a crime and granted pre-trial release;
 2. The person was sentenced to a term of supervised probation without a preceding term of incarceration in a DOCR facility; OR
 3. The person was incarcerated in a DOCR facility and is transitioning on parole status or serving a term of supervised probation to follow incarceration.
- The individual evidences criminogenic risk indicated by a Levels of Service Inventory, Revised (LSI-R) score of 34 or greater*
- The individual evidences a serious behavioral health condition (see image 1)

*The LSI-R (Level of Service Inventory - Revised) is an assessment tool used by the DOCR to score the level of risk of recidivism. The primary population FTR will serve will have a score of 34 or higher. However, exceptions may be made by the FTR Clinical Administrator based on additional risk factors identified.

Image 1: Serious Behavioral Health Conditions

A DSM-5 diagnostic profile* that includes one or more of the following:

1. Delusional Disorder
2. Psychotic Disorders of all types including Schizophrenia
3. Major Depressive Disorder
4. Bipolar and Related Disorders
5. Obsessive Compulsive Disorder (OCD)
6. Panic Disorder
7. Posttraumatic Stress Disorder (PTSD)
8. Borderline Personality Disorder
9. Moderate and Severe Substance Use Disorders

AND functional impairment in one of the following domains:

1. Housing
2. Education or employment
3. Social support, to include friendships and family and intimate partner relationships
4. Financial stability
5. Leisure/recreation
6. Ability to actively engage in community supervision

*Individuals who have not been formally diagnosed may be considered based on signs of functional impairment related to a behavioral health condition.

*Participants do **not** need to be diagnosed with both a serious mental illness and a substance use disorder to be eligible.

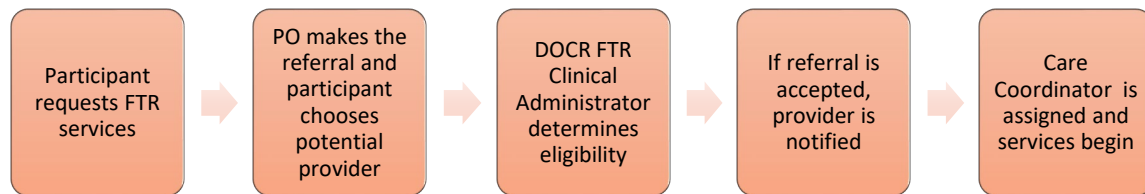
Roles and Responsibilities



Providers must participate in a care team. The care team will consist of at least one supervision officer employed by the DOCR's Parole and Probation Division (if on active supervision), an FTR Administrator employed by the Behavioral Health Division of DHS, and a CC and PSS employed by the provider. The care team staffs cases regarding level changes, discharges, transfers and any other situations where a staffing is needed. These meetings can be requested by the participants themselves, or by a member of the care team. The DOCR's Free Through Recovery-Clinical Administrator (FTR-CA) may also participate in these local care team meetings and participant in specific meetings on an as-needed basis.

Referral Process

Participants may be referred by their supervision officer or, if the person is transitioning from prison, through an internal DOCR assessment process. The referring individual should provide information regarding the participant's preference for a specific provider to facilitate consumer choice whenever possible. All referrals will be reviewed by the DOCR FTR Clinical Administrator for a final eligibility determination. In some cases, the DOCR FTR Clinical Administrator may conduct in-person interviews or evaluations of potential participants if there are unanswered questions regarding that person's diagnostic profile or functional status.



Participants will generally be assigned to the provider of their choosing unless that provider has reached maximum capacity for participants or if there is a compelling reason to assign them to another agency. Once a participant has been determined eligible for participation in the FTR program and is assigned to a provider, the provider and assigned FTR Administrator will be notified. The provider will be given basic demographic information and background regarding the participant, including behavioral health diagnoses and functional information, as well as information regarding their key areas of criminogenic risk.

Since the choice of provider is up to the participant, BHD does not guarantee any certain number of referrals to any agency. It's up to the provider to market themselves in the provider description and recovery community.

Becoming a Provider

The strength of the behavioral health workforce in North Dakota comes from wide range of providers, consisting of large, statewide organizations to one-person shops, all serving the community. Providers represent every area of service, culture, gender, faith, etc. and work together to support participant's choice and the many different roads to recovery.

Provider Requirements

Providers must at a minimum:

- Hold an intake meeting with each participant (within three business days of referral)
- Provide a comprehensive, collaborative care plan with each participant (within 10 business days of referral) that is reviewed and updated on a monthly basis
- Offer creative, individualized care coordination services that focus on addressing criminogenic risk and behavioral health need
- Match participants to a peer support specialist based on demographics, personality, and lived experience
- Participate in a local, multidisciplinary care team with representatives of DHS and DOCR
- Demonstrate experience providing services to individuals with complex needs including mental illness, substance use disorders, criminal behavior, and difficulties meeting their needs around housing, education, employment, etc.
- Establish and maintain formal relationships with community agencies to ensure clients have timely access to a full continuum of behavioral healthcare, including recovery support services such as supportive housing and employment
- Submit written documentation confirming formal collaboration with community agencies
- Accept all referrals from DHS and DOCR unless at program capacity

Additionally, providers must:

- Participate in meetings, training, and certification programs, as well as technical assistance, as required by DHS or DOCR, including regular performance and progress assessments
- Share information regarding the maximum number of clients the provider can effectively serve
- Collect and share data regarding program participants, services and outcomes related to housing, employment, substance use, criminal activity, law enforcement involvement, incarceration, engagement in treatment or other services, discharge planning, etc.
- Bill third parties for clinically eligible services and direct payments to the general fund as appropriate
- Receive skill training and coaching from DHS and/or DOCR
- Ensure 24-hour access to agency personnel for emergencies
- Ensure participants have access to 24-hour crisis intervention services
- Provide written notice within 2 business days to the FTR Administrator and DOCR Clinical Administrator when a Care Coordinator or Peer Support Specialist is no longer working in the program, including the reason for leaving, date effective, and the plan for program participants.

Providers are also required to demonstrate the following:

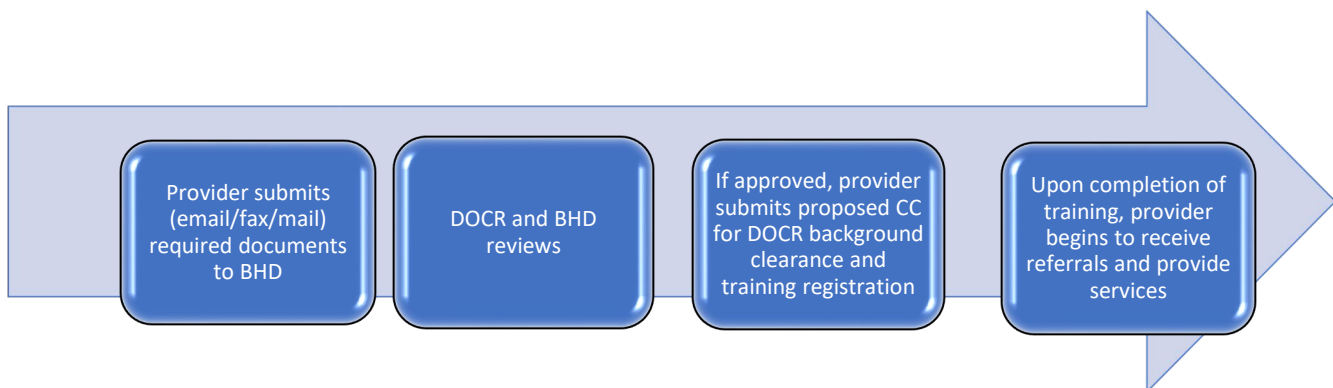
- Assessment of the participant's needs that limit their ability to live a healthy, independent, and crime-free life
- Development of warm, empathetic, and helpful professional relationships with participants
- Maintenance of positive relationships with community members, service providers, the local care team, court personnel, local leadership, probation or parole staff, and other partners
- Timely completion of requested documentation, data, reports, and plans
- Identification and reporting of gaps between needed and available community-based support services, as well as development of creative plans to fill identified gaps, to positively impact participant outcomes

Applying to Become a Provider

If an organization or individual desires to become a provider and they meet the requirements, they may start the process by completing the Provider Agreement (PA) and additional documentation including:

- ✓ Verification of insurance - meeting all requirements as stated in section 12 of PA
- ✓ Certification of Good Standing with North Dakota Secretary of State
- ✓ W-9
- ✓ Documentation of formal relationships with other community organizations and clinical providers
- ✓ Provider description
- ✓ Complete PA with DOCR in order to have access to Docstars

The application/PA can be found here: <https://www.behavioralhealth.nd.gov/addiction/FTR>



After the provider application and service agreement is submitted via email, fax, or mail, it will be reviewed by BHD and DOCR for approval/denial. Once a provider is approved, all proposed CC's must clear a DOCR background check in order to be eligible for care coordination training. Once a CC has been cleared, the provider may register their CC's for the next care coordination training. After completion of this training, CC's may begin receiving referrals and providing services. For information regarding upcoming trainings please visit www.behavioralhealth.nd.gov/bh-events

Care Coordination

What is Care Coordination?

Includes an ongoing source of connection, helping participants access treatment and recovery support services, and creatively addressing barriers to individual success. It also includes the provision of assessment, care planning, referrals, and monitoring collaboration with clinical services and probation and parole.

Participants in FTR will have serious and complex behavioral health conditions but also criminogenic risks and needs. Effective interventions require integrated, multidisciplinary, multi-agency approaches. **Care coordination** helps ensure a comprehensive, coordinated and effective utilization of resources.

Qualifications

Key competencies for Care Coordinators include:

- Understand the resources that are available within the local community
- Collaborate with participants to establish short and long-term specific, measurable recovery goals and update these goals as participants make progress and their needs evolve
- Monitor participants' progress toward goals and effectively address barriers
- Help participants schedule necessary appointments
- Provide transportation for participants when needed
- Attend outside appointments if requested by the participant
- Assist participants in applying for assistance programs including ND Medicaid
- Respond effectively to crisis situations
- Understand the basics of the criminal justice system and its impact
- Maintain ongoing communication and effective collaborations with community partners
- Utilize Recovery-oriented principles and Trauma Informed Care in communication and skills development with participants
- Establish professional, supportive relationships with participants while maintaining appropriate boundaries and adhering to ethical obligations

Suggested qualifications include a bachelor's degree in social work, psychology, criminal justice, or a related field and previous experience providing supportive services to people with serious behavioral health concerns and/or criminal justice involvement.

How to become a Care Coordinator

1. Be hired by a provider
2. Complete a background check through the DOCR for Docstars access
3. Complete training approved by BHD and DOCR

Background checks

Department of Corrections and Rehabilitation (DOCR) Background Checks are required in the following situations:

- All newly hired care coordinators, including those that transfer from one agency to another or were previously employed by the provider, will need to pass a DOCR Background Check.

Expectations of a Care Coordinator

- Complete an intake with the participant within three business days of receiving the referral
- Develop a comprehensive case plan within 10 business days of referral
- Identifying the participant's goals, particularly those that relate to addressing criminogenic risk and behavioral health needs
- Link client to services that address key needs
- Facilitate service coordination and communication among service providers
- Matching clients with agencies, professionals and peers that are a good fit for their specific needs
- Ensuring access to behavioral healthcare as needed
- Providing a source of connection and emotional support to clients, outside of the criminal justice system
- Helping clients achieve greater motivation for short and long-term change
- Keeping clients engaged with positive, pro-social activities that support recovery
- Providing clients with recovery services based on their individual needs
- Recovery services may include access to nourishment, supportive housing, educational opportunities, employment, family and parenting services, leisure and wellness activities, spiritual engagement, and other community resources.
- Creatively problem-solving around barriers to these resources
- Some common challenges include transportation, accessing more intensive behavioral healthcare services such as residential treatment or psychiatric care, securing meaningful employment that provides a living wage, and securing safe, supportive, permanent housing

Care Coordination Services

- Every participant should be provided with the opportunity for face-to-face care coordination
- Tele-behavioral health/video options for care coordination is supported in the following instances:
 - In addition to face-to-face to increase contact
- The CC should reside in the same region in North Dakota as the program participant they are serving, unless this has been pre-approved by the FTR Administrator and was participant's choice

Peer Support

What is Peer Support?

Peer Support is a recognized, evidence-based practice for the treatment of mental health and substance use challenges that seeks to increase:

- Recovery and wellness of both the Peer Support Specialist and the individual receiving services, who build relationships and develop additional recovery capital as a natural outcome of providing/receiving peer support services.
- An individual's ownership and achievement of their goals when the Peer Support Specialist encourages and supports the individual receiving services to actively participate in self-directed care.
- The individual's engagement and self-determination of their selected and agreed upon array of supports to achieve and maintain recovery and wellness.

Peer support is an evidence-based practice, is endorsed by BHD and DOCR, and has shown to help with the recovery process through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

- **Health:** Choices that support one's overall well-being
- **Home:** A safe and stable place to live
- **Purpose:** Meaningful daily activities such as; job, school, or volunteering
- **Community:** Relationships and social networks that provide support, friendship, and love

Peer support is effective:

- Improves quality of life
- Improves whole health, including conditions like diabetes
- Improves engagement and satisfaction with services and support
- Decreases hospitalizations and inpatient stays
- Reduces health care costs

What is a Peer Support Specialist?

Peer Support Specialists are individuals who have first-hand or lived experience with behavioral health challenges and who have been involved with the criminal justice system. Peer support specialists utilize their experiences to help shape and support the recovery of the individuals they work with, while serving as an advocate and mentor.

Participants of FTR struggle finding the support and resources they need to maintain recovery. Building relationships through peer support allows individuals to establish networks. These networks can be navigated successfully with the guidance and support received from someone who empathizes with the struggles that recovery can bring.

Qualifications

Key Competencies for Peer Specialists include:

- Scheduling regular meetings and outings with participants based on their individual needs
- Establish rapport within friendly, supportive relationships with participants while maintaining appropriate boundaries and ethical obligations
- Work with a CC to assist participants in achieving their identified goals
- Provide information, guidance, and feedback on recovery-oriented resources
- Attend recovery-oriented and prosocial events and leisure activities with participants
- Include participants in supportive networks
- Offer insight to the care team regarding the participants' status, successes, and needs
- Serve as a prosocial model for participants
- Respond appropriately to crisis situations
- Seek guidance and supervision from professional staff as needed

Peer Support Provider Expectations

- Follow the requirements identified in the PA
- To offer every participant the opportunity to have the support of a PSS and attempt to match every participant with a PSS based on demographics, personality, and lived experience
- Participants that do not want a PSS must opt out of peer support, and CC's must document the reason given by the participant
- The same person should not provide care coordination and peer support services to a participant
- A provider may not hire or contract for peer support services with a current participant they are serving in FTR
- The CC must document all PSS contact before the end of each monthly reporting period
- Hire or contract with a Certified Peer Support Specialist I or II
- Understand and comply with job duty differences between the CC and a PSS

Peer Support Services

- Ensuring clients are connected with peer support specialists based on demographic characteristics, personality, and lived experience
- Providing a source of connection and emotional support from someone who has similar lived experiences
- Connecting clients with other community members in recovery
- Helping clients develop fulfilling lives in recovery that include participation in fun leisure activities that support connection, socialization, and personal growth
- Every participant should be provided with face-to-face peer support as available.
- Tele-behavioral health/video options for peer support is supported in the following instances:
 - In addition to face-to-face to increase contact; in rural areas, where face-to-face peer support is not available, telehealth/video options may be used

Differences Between a Care Coordinator and Peer Support Specialist

Care Coordinator	Peer Support Specialist
<ul style="list-style-type: none"> Engage participant in services Establish positive rapport Develop a care plan with participant Assist participant in accessing services to address their needs Cross-sector partnership and collaboration, working with public and private providers regarding participant's care 	<ul style="list-style-type: none"> Establish positive rapport Serve as pro-social model Share their lived experience and recovery story to instill hope, foster trust, and build mutuality Provide support focused on advocacy, coaching, and mentoring Offer insight to the participants care team

Ways to Hire a Peer Support Specialist

- Follow your established agency practices on hiring, no different than any other position
- Request a list of all Certified PSS in North Dakota and reach out to individuals. To request a list, email peersupport@nd.gov
- Subcontract with a community agency or individual to provide peer support. This option is only approved if the written subcontract acknowledges the expectations of the PA signed between the provider and BHD.

For more information on peer support, including information on peer support certification, training, and frequently-asked-questions, please go to www.behavioralhealth.nd.gov/addiction/peer-support

BHD and DOCR does not endorse any peer.

BHD and DOCR does not regulate or determine wages of PSS.

The providing agency does not have authority to contract for or incur obligations on behalf of BHD and DOCR.

Recovery Services and Resources

Recovery services includes access to nourishment assistance programs, supportive housing, educational opportunities, meaningful employment, leisure activities and wellness, family and community social supports, parenting education, spiritual engagement, and any other individualized needs the person has to help them lead a healthy and fulfilling life.

Some important things to keep in mind:

- Recovery looks differently for everyone
- Involvement from supportive family members can result in successful recovery. Encourage participants to include support people in appointments, meetings, and events.
- Empower participants by facilitating consumer choice as much as possible. Be supportive if they have concerns about a certain provider and help them problem solve.
- Connection and community engagement are keys to success. Consider helping participants access support groups, spiritual or religious organizations and activities, volunteer opportunities, and positive community events.
- Identify strengths and positive attributes of the individual on an ongoing basis. Acknowledge these strengths often and use them as a guide for recovery. Remember to identify specific things the participant is doing well and reinforce them through praise or other means.
- Make a genuine effort to get to know the person and be curious about their insights. Learn who they are aside from their diagnoses and past crimes. Actively listen and meet in locations where the individual feels safe and comfortable.
- Be willing to self-disclose when appropriate, things about yourself, within your personal and ethical boundaries, to facilitate connection and rapport
- Gather information about the person's goals outside of the realm of "treatment", such as educational, recreational, relational, spiritual, and financial goals

Resources

Providers should become familiar with local and statewide resources available for participants. Below are some organizations and websites that may be beneficial to utilize:

Recovery Talk is a free, anonymous, and confidential phone line available 24/7 for recovery support with a PSS. Phone: 1.844.44.TALK2. Website: <https://www.behavioralhealth.nd.gov/24-7recoverytalk>

FirstLink is a free, confidential service available to anyone 24/7/365 for listening and support, referrals to resources/help and crisis intervention. FirstLink answers the 211 help line, the National Suicide Prevention Lifeline and communicates via Text line 898-211. FirstLink provides these services across the entire state of North Dakota and parts of Minnesota. Website: <https://myfirstlink.org/>

The Behavioral Health Division (BHD) works with partners within the Department of Human Services (DHS) and the state behavioral health system to improve access to services, address behavioral health workforce needs, develop policies, and ensure quality services are available for those with behavioral health needs. Find resources on addiction, mental health, and prevention. Website: <https://www.behavioralhealth.nd.gov/>

The North Dakota Department of Human Services (DHS) provides services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. Website: <http://www.nd.gov/dhs/>

Human Service Centers are located across the state. Each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services and other human services. Website: <http://www.nd.gov/dhs/info/pubs/docs/hsc-contact-info.pdf>

SAMHSA – The Substance Abuse and Mental Health Services Administration leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Website: <https://www.samhsa.gov>

Facebook pages to follow:

- Free Through Recovery, Community Connect & 1915i Providers
- Behavioral Health Division
- Parents Lead
- North Dakota Peer Support Specialists
- North Dakota Department of Corrections and Rehabilitation

Ordering FTR Materials

To order FTR materials, among other recovery materials, please go to <https://prevention.nd.gov/materials>

Materials are free and will be mailed. Most FTR materials will be found under “Recovery Talk” and “Recovery”.

Engagement Guidance

Engagement vs Check-in

Providers are to ensure each participant has the opportunity for engagement appropriate for their level of care (see levels guidance). Documentation in the Docstars system must reflect that these contacts occurred or were offered if the person declined or did not respond to attempts at contact. While PSS will not directly document their contacts in Docstars, the CC must document that the peer contact occurred or was offered if it is to take the place of a care coordination contact. If a participant will not be offered weekly meetings, or if a participant declines weekly meetings, the case must be staffed with the FTR Administrator to discuss the reasoning for reducing contacts to less than weekly.

Part of the CC's role is to offer person-centered care for each participant. When engaging with the participant, the CC should engage the care plan and address goals/barriers the participant may have. CC's should go beyond a check-in/status update when engaging with the participant and reflect that true care coordination took place, such as addressing their needs in a person-centered way. For example, if a participant is unemployed, a CC may help with filling out job applications, connecting them to Job Service, practicing interview skills, etc. True engagement reflects person-centered care. **Engagement centered on the care plan is still expected when the participant is incarcerated.**

Collaboration with Parole and Probation

The CC should be communicating with the PO on a regular basis as they are part of the care team. The CC should reach out the PO once a referral is received and inquire how to best engage with the participant, to indicate initiation of care coordination services, and to identify any safety concerns. It's important to establish communication and staff cases at least once a month to discuss various areas of progress or address specific concerns as it pertains to the individual participant. If a CC is having difficulty reaching the participant, by week two the CC should staff the case with the PO for an engagement strategy.

Self-Reporting Strategies

Occasionally a participant will report issues to a CC such as: reoccurring substance use, new criminal charges, or violations of their probation. Our goal is to support participants in taking ownership of these issues by self-reporting to their PO. A conversation may be held with the participant stating a timeline of when the participant will have this conversation/report to their PO. The CC may then follow up to verify that the participant has followed through and may otherwise have to notify the PO if the participant will not. Chronos may generally notate without specifics in order to inform the PO and keep an open line of communication within the care team. CC's should never be deceptive in chronos. If the reported activity puts any individual at risk, this activity should be reported to the PO immediately.

Docstars

Docstars is the DOCR system that is used for documentation by PO's and providers. A potential CC must complete and pass a background check through the DOCR before Docstars access can be granted. The FTR Administrator will train CC's on this system once Docstars access is approved and can serve as a CC. All persons must pass a background check by the DOCR in order to view and have access to Docstars. A CC cannot share their password or give access to their Docstars account to another person, this includes other CC's within the same provider. Each CC is responsible for entering their own documentation. Unauthorized use of the Docstars system or information may result in criminal prosecution and/or termination of the provider's PA. Providing false documentation to support being paid for a service is an illegal activity and is in violation of the DOCR Agreement section 7 and 8.

Documentation Guidance

Three types of documentation:

1. Care plan
2. Chronos
3. Outcomes/comments

Documentation Expectations

- CC's are responsible to ensure that all person-centered care, contact, attempted contact, and work being done on behalf of the participant is documented.
- Documentation should be objective and include facts, avoid opinions, bias, assumptions and slang terms, unless quoting what a participant states.
- If the CC documents in a note there is a plan to meet and then fails to note the face-to-face meeting or what occurred, this creates a gap. This type of gap in documentation creates questions when reviewing notes and should be avoided.
- Documentation topics should include, but are not limited to:
 - Housing
 - Employment
 - Recovery
 - Criminal Justice Involvement
 - Parenting
 - Barriers or needs and plan to address
 - Successes
 - Referrals; including documentation of cross sector-partnership and collaboration
 - Care plan development and updates

Legality/Factual Notes

Anything noted in Docstars is a legal and official document. Avoid opinions, bias, assumptions, and slang terms when documenting. For example, if there is suspicion a participant may be under the influence, report what you observe, "The participant presented today with slurred speech and droopy eyelids".

Timelines

All documentation must be completed in a timely manner. The expectation is to record all documentation within 48 hours in order to ensure accuracy and keep the care team up to date. If the documentation does not include information to support engagement or attempted engagement as required in each level, the provider may be ineligible for payment. Please see the level guidance for further information regarding engagement expectations.

Transfers

When a participant transfers to another provider, the current CC will make sure all documentation is up to date. Once a participant is transferred, the previous provider will no longer have access to that participant's chronos.

For further training on documentation, please refer to the documentation trainings on our FTR website found here:

<https://www.behavioralhealth.nd.gov/addiction/FTR>

Care Plan Guidance

What is a Care Plan?

- The care plan is a guide or blueprint to outline a participant's needs, strengths, and establish goals.
- A care plan guides the participant towards reaching their goals and assists CC's and PSS to monitor progress and adjust plan when needed.

Care Plan Expectations

- People are experts in their own lives and the CC's role is to guide and encourage the person to make their own choices while being informed.
- It is essential that the care plan is developed in a collaborative manner with the participant, CC and PSS - identifying the participant's goals, particularly those that relate to addressing criminogenic risk and behavioral health needs.
- In developing the care plan, the CC has the opportunity to discuss with the participant what they want to accomplish and to assist with identifying their strengths and needs.
- CC's shall become knowledgeable in the principles of person-centered care and utilize motivational interviewing skills to assist the participant in developing their care plan.
- All updates to the care plan must be completed with the participant.
- Goals are to be identified by the participant based on what they want to achieve. Goals should not be based on what the CC wants the individual to do. Goals can be placed in quotes to indicate the participant's words.
- When a participant completes a goal, it is the CC's responsibility to guide and assist them in developing their next goal.

Timelines

Care plans should be initiated within 10 business days of referral and is reviewed and updated on a monthly basis

Care Plan Section	Expectation
Strengths/Needs	Identify several strengths/needs in collaboration with the participant. This section is separate from the "Care plan" tab in Docstars.
Risk/Need	Choose the best risk/need that correlates with the goal.
Status	The status of the goal/activity steps
Goal/Objective	The participants identified goal, use quotes to identify the participants words.
Date Created	The date the participant identified and developed the goal to include the month, date, and year. This date should not change once it is created.
Activity Steps	<ul style="list-style-type: none"> • Activity steps are the movements or progress that the participant is taking or plans to take to reach their goal. • Must use SMART principles (Specific, Measurable, Attainable, Relevant, and Time Specific). • Activity steps will be on-going, and participants may be working on multiple goals that involve multiple action steps at a time.
Date Started	This is the date that the participant agrees to start working on their goal/activity step.
Date Ended	This is the date that the participant completes the activity step identified.
Notes	Comments detailing information on the progress or lack of progress towards activity steps may be provided here. There is no requirement for a comment to be included, it can be a useful tool to the CC if needed.

Chronological Notes (Chronos) Guidance

- Chronological Notes or “Chronos” are the designated place in Docstars that all contact, attempted contact or work that the provider completes on behalf of the participant should be documented
- Chronos provide communication with the care team about how a participant is doing, frequency of contact, and barriers that are being focused on
- Chronos allow the FTR Administrator to reconcile, vet outcomes and verify that the appropriate level of service was provided to the participant

Types of Chronos

Attempted Contact

Care team member called/texted/left message - made an attempt to reach the participant with no response.

Collateral Contact

Care team member called an organization, or person on the participant’s behalf. For example, called Job service to find out job openings, or called a thrift store asking about furniture for a participant. Any time you are taking time out of your day to follow up on a participant’s behalf, use this type. Remember to maintain confidentiality, if there is no ROI, no participant information can be released.

Face-to-Face

Care team member is in the presence of the participant and engaging in conversation. This will only count towards engagement standards if the documentation records conversation centered around areas identified in the care plan.

No Show

There was an actual meeting planned, and the participant did not show up.

Offender Communication

When the care team member is having a conversation with the participant by phone, email, text, etc. This will only count towards engagement standards if the documentation records conversation centered around areas identified in the care plan.

Treatment Staff

This would be the participant’s provider at a licensed treatment facility. Examples include human service centers or any licensed community providers. A ROI is required for the CC to communicate with any provider regarding the participant.

Care Coordination Team

Anytime there is contact with the participant’s PO, FTR Administrator, or case staffing, this type of documentation is utilized.

A CC may use multiple types of communication. For example, a CC reached out to the PO, but they did not answer. This would be “Care Coordination Team” and “Attempted Contact.” Same goes for calling an organization on the participants behalf, but they were out of the office – “Collateral Contact, Attempted Contact.” This can be done on most computers by pressing the CONTROL key and then clicking on the types that are appropriate.

Edit of Chronos and Wrong entries

Chronos can be edited within 24 hours after the initial submission and can be done by clicking the “Edit” button next to the chrono. After the 24-hour window the edit button disappears and the chrono cannot be modified, therefore it’s important to double check notes before submitting. If a mistake was entered or submitted under the wrong participant, please reach out to your FTR Administrator for guidance.

Outcomes and Provider Payment Guidance

Outcomes identify participant progress towards or maintenance in the areas of housing, employment, recovery and criminal justice involvement. Outcome measures will assist with future planning and funding efforts, identify where targeted training and technical assistance is needed, and to provide information to the ND Legislature, Governor, and Stakeholders.

Person-centered outcomes indicate that every time we answer an outcome, we are considering a participant's choices, circumstances and characteristics. What is progress for one participant might not be for a different participant. For example, if one participant is living in an unstable, unhealthy environment and then becomes housed at a supportive shelter that reporting period the outcome in housing would likely be "Yes". However, if a participant that was in stable, supportive housing becomes placed in a shelter due to being evicted from their home, that reporting period the outcome would likely be "No" in housing.

Outcome Expectations

- Care Coordinators will answer outcomes each month regarding each participant's progress in the outcome areas.
- Chronos and care plan documentation should support the data reported in the monthly outcomes comments.
- The CC is responsible to answer each outcome with yes, no, or NA. The CC comments are required to be filled out and must include comments that supports the outcome answer
- Outcome documentation should be objective and include facts, avoid opinions, bias, assumptions, and slang terms
- Failure to complete outcomes will result in the provider being ineligible for payment
- The PSS or the PO cannot take the place of participant engagement with the CC when determining outcomes.
- If the CC does not have engagement with the participant during the reporting period, they are unable to answer the outcomes.

Engagement

- Engagement is defined as a phone, virtual, or face-to-face connection in which the care plan or outcome areas were discussed (Exceptions to face-to-face engagement must follow levels guidance. Chrono documentation must support why face-to-face could not occur.) Providers ensure each participant has the opportunity for a contact with either their CC or PSS as expected in each level. Documentation must reflect that these contacts occurred or were offered.
- If a participant does not appear for an appointment or does not want to meet, this documentation should be included in chronos.
- If the CC or PSS has not had engagement with the participant during the reporting period, the CC must answer the engagement question in Docstars "no". The outcomes will then auto populate to N/A.
- The corresponding monthly chronos documentation must demonstrate the attempted engagement by the CC and PSS.

Timelines

- Monthly outcomes are required for each program participant.
- The CC may submit monthly outcome documentation from the 15th to 20th of month, the outcomes must be submitted by no later than the 20th of each month for the reporting period.

Process & Outcome Measures

	Process Measures	Outcome Measures
What is it?	Describes what was <i>DONE</i>	Identifies <i>RESULTS</i>
What is an example?	How many individuals were served or how many individuals completed treatment	What percentage of individuals experienced improvement in health, home, community, and purpose
How is it captured?	Each provider agency or organization is responsible for submitting their care coordination plans to the Human Services Program Administrator assigned to their region on a monthly basis.	Providers and probation officers (where applicable) will provide data on whether each individual client has achieved certain identified outcomes on a monthly basis.
Why is this important?	Process Measures will assist with identifying what services were provided across ND and who accessed them and with what frequency.	Outcome measures will identify the effectiveness of the services provided under the Community Behavioral Health Program.
Is this information kept confidential?	The Behavioral Health Division is required to maintain confidentiality consistent with 42 CFR Part 2 and 45 CFR Part 164 requirements	

Ultimately, process and outcome measures will assist with future planning and funding efforts, identify where targeted training and technical assistance is needed, and to provide information to the ND Legislature, Governor, and Stakeholders.

A participant will receive a positive “Yes” outcome if they demonstrate progress toward or maintenance of identified outcome measures within the reporting period.

Outcomes Sections	Outcomes Descriptions
Housing	<p>Progress towards and maintenance of housing will vary for each participant. A participant is considered housed if:</p> <ul style="list-style-type: none"> • They are living in a place that best meets their needs and is safe and supportive of recovery. - Independent housing, living with family, friend, halfway house, safe housing, etc.
Employment	<p>Progress and maintenance will vary for each participant. Below are some scenarios to consider:</p> <ul style="list-style-type: none"> • The participant is currently job seeking/ taking steps to gain employment • The participant is employed • The participant can meet their needs from their economic resources • They are enrolled in work alternatives such as school, workforce training, unpaid work/internship.
Recovery	<p>Is the person demonstrating effort to reduce their substance use or the harm associated with their use and/or improve their mental health functioning? Consider the following:</p> <ul style="list-style-type: none"> • They are refraining from using non-prescribed, mood altering substances that violate terms of their parole/probation • They did use substances however, there is evidence to support that they are engaging in strategies to avoid more serious/problematic substances, or there is evidence that they are scaling back the amount or intensity of their use (Harm reduction strategies) • The participant is honest with their provider/team about their use of substances and continues to work towards recovery. • Is the participant making progress or maintaining their recovery? This recovery can widely vary from person-to-person. The person is connected to prosocial relationships that support their recovery. • The participant is demonstrating effort to improve mental health functioning and/or reporting a decrease in symptoms. The participant is seeking or participating in medication treatment and/ or mental health therapy. The participant has initiated/ is taking steps to seek supportive relationships such as peers or spiritual, self-help resources, education, etc.
Criminal Justice Involvement	<p>The participant will get credit for this outcome if they meet ALL of the following:</p> <ul style="list-style-type: none"> • The participant is reporting to their probation/parole officer as required by their supervision. If the participant is on probation/parole, they had no violations resulting in revocation. The participant has not been arrested for a new offense.
CC Comments	<p>Comments show how the outcomes were determined and explains why it’s a yes or no. What is the evidence that determines the outcomes? For example, if housing is a “Yes”, the comment could state “Has own apartment that is safe and supportive.” Comments are required.</p>
Administrator Comments	<p>The FTR Administrator will determine the outcome answer after review of the chronos, care plan and outcome documentation. The FTR Administrator will include a comment to support the outcome and leave feedback for the CC, if applicable. CC’s are responsible for reviewing the comments left by the FTR Administrator for further guidance.</p>

Participation Level Guidance

The following guidance will outline reimbursement rates and levels, provide a description of the rates of reimbursement and levels to assist each provider with delivering the appropriate person-centered level of service.

What are Levels?

The purpose of levels is to provide person-centered services that provide support for participants by adjusting the level of services according to their goals and needs, allowing participants to maintain long-term connections with their chosen provider.

Process

- All participants referred will start at level 3
- The CC will assist with the development of the care plan, identifying goals and barriers, and connecting a participant to a PSS (if chosen), before staffing for a change from level 3
- A participant change in level should also be discussed with the participant, remaining person-centered is imperative. If a participant has had numerous months of positive outcomes and there is a natural decline in the number of needs and engagement by the provider, a change in level should be discussed with the participant first and then the care team.
- Participants may step down one level at a time, unless deemed necessary by the care team
- The care team will staff the proposed change considering the input from the participant
- When approved, the FTR Administrator will document the level change within the chronos



Level 3: Entry Level for all Participants

Objectives: The CC should focus on building rapport, referring for PSS, developing a care plan, assessing on-going needs and progress, making referrals to community-based services and resources, and providing cross-sector partnership and collaboration with all providers involved in providing care to the participant

Engagement

The CC and/or PSS will provide the opportunity to engage face-to-face weekly with the participant during each reporting period. This may be once a week or several times a week, depending on the needs/barriers of the participant. If you have incidental contact with the participant in the community, for example at a meeting or grocery store this is incidental contact, not face to face engagement and doesn't meet criteria for weekly face to-face engagement. In order to enter outcomes, the CC must engage (face-to-face) with the participant at least once during the reporting period.

Reimbursement for Level 3

Ineligible: \$0	The provider has not met the engagement standards outlined, there is no documentation to support that weekly engagement (face-to-face) during the reporting period was offered by the CC or PSS during the reporting period.
CC Diligence/No Engagement: \$200	There is documentation indicating that the participant had "at least" weekly opportunities to engage (face-to-face) during the reporting period with the CC and/or PSS. If the provider is not able to engage the participant, there must be supporting documentation demonstrating that the care team was engaged to assist with a strategy for engagement. (PO if on supervision, FTR Administrator if off supervision).
Engagement Pay: \$400	There is documentation indicating that the CC and/or PSS engaged (face-to-face) at least weekly during the reporting period, and the participant has less than 3 positive outcomes.
Outcome Pay: \$480	There is documentation indicating that the CC and/or PSS engaged (face-to-face) at least weekly during the reporting period, and the participant has 3 or more positive outcomes.

Level 2: Engagement with Community Resources

Objectives: To connect the participant to long-term community-based services and support in order to assist with maintaining positive outcomes

Engagement

The CC will engage (face-to-face) with the participant at least once a month during the reporting period. During this meeting the provider must assess the effectiveness of the care plan, identify new objectives/goals and further develop the care plan to meet the needs of each participant. Care should be transitioning from resolving immediate/urgent needs towards long-term stability and connection. The PSS can continue to engage with the participant. If a participant is struggling to maintain positive outcomes the CC and/or PSS can work with the participant to determine if level 3 needs to be considered. In order to enter outcomes, the CC must engage (face-to-face) with the participant at least once during the reporting period.

Reimbursement for Level 2

Ineligible: \$0	The provider has not met the engagement standards outlined, there is no documentation indicating that monthly engagement (face-to-face) during the reporting period was offered by the CC.
CC Diligence/No Engagement: \$150	There is documentation indicating that the participant had opportunities for engagement (face-to-face) during the reporting period. A one-time attempt at engagement during the reporting period, does not meet diligence criteria. If the provider is not able to engage with the participant, there must be supporting documentation demonstrating that the care team was engaged to assist with a strategy for engagement. (PO if on supervision, FTR Administrator if off supervision).
Engagement Pay: \$200	There is documentation indicating that the CC engaged (face to face) at least once during the reporting period, and the participant has less than 3 positive outcomes. If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team.
Outcome Pay: \$280	There is documentation indicating that the CC engaged (face to face) at least once during the reporting period, and the participant has 3 or more positive outcomes.

Level 1: Extended Recovery Support

Objectives: The CC and/or PSS must be accessible to the participant in order to quickly respond to changes in the participant’s needs and care plan

Engagement

The CC will engage (via phone call) with the participant once a reporting period to connect and assess collaboratively the need for continuing in level 1 or a higher level. During the engagement the care plan must be reviewed, along with assessing each outcome area. The CC must ensure that the participant is aware of the ability to request a higher level at any time, if their needs change. The CC will remain available to the participant, if the needs of the participant change, a higher level of care can be staffed with the care team. The PSS can continue to engage with the participant. There is no option for CC Diligence/No Engagement reimbursement, if the CC does not connect with the participant, they are not eligible for reimbursement. The minimum standard for engagement is a video/phone call, however the CC can engage (face-to-face) if desired. In order to enter outcomes and be eligible for reimbursement the CC must engage (via video/phone) with the participant at least once during the reporting period.

Reimbursement for Level 1

Ineligible: \$0	The provider has not met the engagement standards outlined, there is no documentation indicating that engagement (via video/phone call) was offered by the CC.
Engagement Pay: \$100	There is documentation supporting that the CC had engagement (via video/phone call) at least once during the reporting period, and the participant has less than 3 positive outcomes. If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team. (PO if on supervision, FTR Administrator if off supervision).
Outcome Pay: \$180	There is documentation supporting that the CC had engagement (via video/phone call) at least once during the reporting period, and the participant has 3 or more positive outcomes.

Levels FAQ

What if the CC and/or PSS cannot engage with a participant?

If the provider cannot engage with the participant, the provider and care team will staff the case to determine next steps. After two months of CC Diligence/No Engagement the provider will be ineligible for payment and discharge/transition will be discussed.

What is the reporting period?

The reporting period is the duration of time specified to provide and document services provided to participants. The reporting period starts on the 21st and ends on the 20th the following month. For example, all documentation of services provided from 1/21/2021 to 2/20/2021.

What if I forget to document my attempted contacts with the participant?

All attempts at engagement must be documented in chronos no later than the 20th of the reporting period. If the provider does not enter notes, they would become ineligible for payment.

What if the CC and PSS are attempting to contact the participant but the participant is not returning calls or texts and we cannot meet?

The CC should reach out to the FTR Administrator and PO for assistance in engaging the participant, this information must be documented. If after 60 days of attempted contact the participant cannot be engaged, the CC should staff a discharge request with the FTR Administrator.

What happens if a participant changes levels during the middle of a reporting period? Can a participant change level during the middle of a reporting period?

Yes, an individual can change levels during a reporting period. The provider will be reimbursed at the highest level that the participant was in anytime during the reporting period, as long as documentation supports the level of care.

Does the participant have to stay on each level for a certain amount of time?

No, levels are determined based on the participants needs, goals and barriers identified on their care plan.

Gap Funding

The following guidance will outline the expectations of a gap funding, provide the timelines, and provide a description of proper utilization and reimbursement. All gap funding forms can be found on the FTR website.

What is Gap Funding?

Gap funding was created to help fill a “Gap” when all other resources/funding have been exhausted in the community. The purpose of Gap funding is to help address barriers and should only be considered after all other community resources have been utilized. If a participant is facing a financial obstacle that is preventing them from meeting their desired outcomes and goals, gap funding may be considered.

Provider Expectations

- Each provider may have their own internal processes that must align with this guidance and may include steps specific to the provider’s internal protocols. Please consult your provider’s administration to determine what your provider’s protocols are.
- All provider records must be retained for four (4) years including Gap Funding Request Forms, Participant Category Tracker and accompanying receipts

Step 1: Determine Need

If a participant is facing a financial obstacle that is preventing them from meeting their desired outcomes and goals, gap funding may be considered.

- The CC will work with the participant to determine what options they have to cover the identified expense and what other possible community resources may be utilized. The CC will assist the participant in accessing community referrals to meet the need.
- The CC will determine if the participant can cover a portion of the request
- If the CC has worked with the participant to exhaust all other options, then gap funding may be utilized
- The CC will work to establish a plan with the participant to cover the expense in the future, if it’s a recurring expense

Step 2: Determine Type of Approval

If the request is on the Gap Funding Category list AND is less than \$100 for the 12-month period total, prior approval from BHD is not needed.

If the request meets one of these categories, the provider may proceed with the purchase.

- The provider must fill out and retain a copy of the Gap Funding Request Form and an itemized receipt for each purchase
- The provider must add this purchase and category to the Participant Category Tracker

If the request is not on the Gap Funding Categories list, or if it is on the list but will cost more than \$100 per 12-month period total, approval from BHD is required to be considered for reimbursement.

- If the request falls into this category, the provider must submit via email a Gap Funding Request form to the BHD Admin Assistant
- Allow a minimum of one week for a response from the BHD Admin Assistant regarding approval/denial, or the provider will be notified if more information is needed
- If the request is approved, complete the purchase
- The provider must retain a copy of the Gap Funding Request Form and an itemized receipt. The itemized receipt should only contain gap funding items purchased
- The provider must add this purchase and category to the Participant Category Tracker

Step 3: Reimbursement

The provider will submit the Participant Category Tracker Form, the Gap Funding Monthly Reimbursement Form, and all matching receipts to the BHD Admin Assistant by the 15th of each month for reimbursement. All reimbursements must be submitted within 60 days of purchase otherwise the purchase is not eligible for reimbursement. The provider must add this purchase and category to the Participant Category Tracker.

Gap Funding Audits

BHD will conduct periodic audits of gap funding requests and reimbursements. The guidance below details what this audit process includes so that each provider can be prepared if selected for an audit.

Providers will be notified by the BHD Admin Assistant that they have been selected for an audit.

- The provider must submit all Gap Funding Requests Forms and receipts that correlate with the Gap Funding Monthly Reimbursement Forms selected
- Provider will submit Participant Category Tracker which will be used to verify the number of participant requests

During the audit, BHD will review the Monthly Reimbursement Form and match all Gap Funding Request Forms and receipts. A provider will “pass” an audit if all expenditures are on the Gap Funding Categories list or have been approved by BHD and all purchases are accompanied by a matching receipt. If there are ANY items on the receipt that have not been approved, the entire receipt will be rejected. The provider will be responsible for reimbursing BHD within 30 days of notification for the entire amount of the rejected receipt. If the provider does not pass an audit, gap funding services will be suspended for that provider until the discrepancies are reconciled and settled with BHD. Not passing an audit may result in indefinite suspension of gap funding services. Abuses of gap funding or any evidence of fraud may result in discontinuing the PA with the provider.

Transferring Participants

If a participant transfers from one provider to another, the gap funding history must transfer through the FTR Administrator unless the participant has signed a ROI authorizing the provider to pass this information directly. If this ROI has not been obtained, it is the responsibility of the new provider to request the gap funding history through their assigned FTR Administrator. The new provider will enter the history of transferred participant into the new provider’s Participant Category Tracker. The 12-month period is based on the participant’s referral date. The date will not reset upon transfer.

Gap Funding Categories List

If the participant's gap funding request does not meet any of the criteria described below, the provider must submit a Gap Funding Request Form to the BHD Admin Assistant for BHD approval. If gap funding purchases are made before approval, they may be declined for reimbursement. All gap funding purchases should be included on the Participant Category Tracker.

Housing <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Housing expenses include: rental application fees, utility bill assistance, security deposit, after working hours request for emergency overnight shelter (hotel/housing), rent assistance (rent assistance requests must include a copy of the lease agreement).</p> <p>The provider must retain a copy of the application, lease or bill that must include the participant's name. This must be attached to the Gap Funding Request Form as a receipt.</p>
Transportation <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Transportation expenses include: gas (reimbursement for gas purchased at the pump must include a copy of the receipt as we are unable to provide reimbursement for gas cards), bike, bus fare, Uber, Lyft or taxi (excluding tips or donations), driver's license or state ID fees.</p> <p>Transportation expenses for CC's or PSS are not included.</p>
Employment <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Employment expenses include: work-related attire (boots, shoes, uniforms, clothing), tools or other supplies necessary to gain or sustain employment.</p>
Education <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Education expenses include: application fees or textbooks if the education experience is a part of the process for the participant to gain future employment.</p>
Basic Needs <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Basic need expenses include: toilet paper, toothpaste, toothbrush, soap, shampoo, conditioner, feminine hygiene products, deodorant, razor and shaving cream, socks, underwear, laundry soap, and fees associated with ordering a birth certificate.</p>
Communication <i>(Requests are limited to \$100 per 12-month period)</i>	<p>Communication expenses include: cell phone, cell phone minutes/cards (may be utilized for phone minutes while the participant is incarcerated to contact the CC).</p>
Clinical Services	<p>Clinical expenses include: one clinical assessment per year when other opportunities for funding support have been exhausted</p>

Gap funding may not be utilized to fulfill criminal sanctions/court orders.

A participants 12-month period starts when they are referred to the program. This 12-month period resets after 12 months and a new 12-month period starts and ends when discharged. It is the responsibility of the provider to track and verify that the request falls within the number of requests allowed yearly.

Participant Transfers

Transfer Process

When a participant requests to transfer from one provider to another, the PO will assist in signing the new ROI and submitting for transfer. If the participant is off supervision, the ROI's will be initiated by the assigned FTR Administrator. During the transfer process, the assigned CC is still responsible for providing FTR services and should not stop engaging until the transfer officially goes through and the participant is longer with that provider. All chronos should be updated before a transfer takes place as once the participant transfers to another provider, the previous provider will no longer have access to the participant's chronos. All transfers must be staffed with the care team before a transfer takes place.

Transfer Timeline

A participant should stay with their provider for at least 3 months before a transfer will be considered. There are some expectations to this and will be determined by a case by case basis.

Transfer Due to Location

If a participant moves to another region, it's best practice to transfer the participant to a CC in that region. The participant does have a choice if they want to continue to work with their CC regardless of the new location. In that case, the CC will determine if they are able to provide the level of service in that region, and if so, will be responsible for maintaining engagement standards including face-to-face services.

Gap Funding

Please refer to the "Transfer" section of the gap funding guidance for more information on when a participant transfers to another provider.

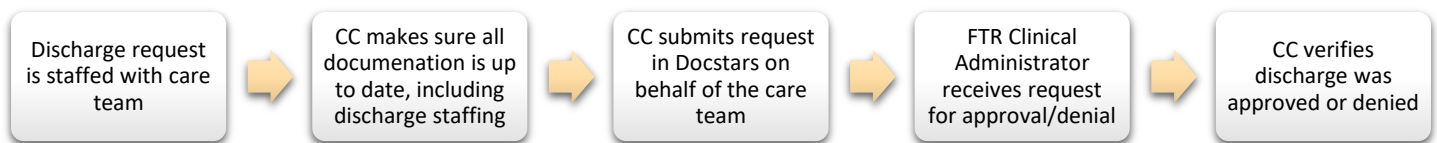
Discharges

The following guidance will outline the expectations of discharge requests and provide a description of each discharge type.

Discharge Process

All discharges must be staffed with the care team before a discharge is officially requested. FTR is “by choice”, therefore a participant may choose on their own volition to opt out of FTR. Once the decision is made by the participant or the care team to discharge from FTR, the CC will submit the discharge request in Docstars on behalf of the care team. The request will then be sent to the FTR Clinical Administrator to approve or deny the request. Once the discharge is requested, there will be a “Discharge” tab in Docstars that will note the status of the discharge. This will show if the discharge was accepted or denied. Once the discharge is approved, it will automatically make a note in Chronos. The CC must have all documentation entered before a discharge request is made as once the discharge goes through, the CC will no longer have access to that participant’s Chronos.

It is the responsibility of the CC to follow through with all discharge requests. A discharge could be denied for multiple reasons such as more information is needed, the discharge was filed under the wrong discharge type, or the discharge request was determined to be requested prematurely and services should continue.



Transition

FTR does not have a set length of time for each participant. It’s specific to each participant’s needs. If the participant is doing well, has multiple months of positive outcomes and feels like they have accomplished their goals, they may be ready to change levels or discharge. A conversation should take place between the CC and the participant to start entering a transition phase to ensure the participant has supports and long-term services established in the community.

Discharge Types

Declined/stopped participating

Participant asks to be discharged from FTR OR they stop communicating with CC but remain in good standing with their PO.

No contact/absconded

Participant has absconded from supervision or is in active revocation and is no longer communicating with CC as well as PO.

Completed program/transferred to long-term community services/staff approved

Participant is no longer in need of FTR services and has long-term services established in the community. Both PO and CC agree that participant has successfully completed FTR.

Reincarceration

Participant returns to jail or prison.

Moved out of region

Participant moves out of the state.

When a participant moves to another region of the state, they can continue working with FTR. Therefore when provider selects this discharge category because their participant moved from the eastern part of the state to the western part of the state (for example), it often times is denied because the participant was able to transfer providers without being discharged from FTR. If the participant moves from one region of the state to another and declines to continue FTR, the provider would select 'declined/stopped participating' as the discharge category.

Transfer provider

Participant transfers from one FTR provider to another.

Often times a participant does not need to discharge in order to transfer providers. Therefore, when a provider selects this discharge category, it may often be denied because the participant was transferred to another provider without needing to discharge.

Adverse program termination

Participant is removed from FTR for reasons such as death, inappropriate or dangerous behavior towards CC, etc.

Documentation Reviews

As part of our efforts to improve the documentation and services provided in FTR, we will be conducting documentation reviews approximately every 6 months or as needed. These reviews will be led by the FTR Clinical Administrator and/or FTR Lead Admin. Your assigned FTR Administrator will be arranging the meetings to summarize these reviews and will be attending in order to identify what areas of training support and technical assistance that may be beneficial.

At least five participant files, or 20% of the provider's total caseload in the selected region, whichever is more, will be selected for a documentation review. A random selection process was designed to ensure that each care coordinator has at least once case pulled for the review, depending on agency size and region. If the provider in this region only has one care coordinator, then only 3 cases will be selected for review.

A documentation review summary will be completed to record the strengths and areas of needed improvement. An action plan for any needed improvements will be agreed upon at the end of the meeting and then 60 days will be given to complete this plan.

60 Day Action Plan

If areas of immediate growth are identified during a documentation review or at anytime by the FTR Administrator, a meeting will be setup to communicate about the areas of concern and work collaboratively to develop a 60-day action plan. This plan will summarize areas of growth, training and technical assistance needed, and the timeline for completion.

A provider may be moved to a status of "not in good standing" if the provider is not fulfilling requirements as outlined in the Provider Agreement or guidance and does not remedy identified deficiencies within 60 days. When a provider is "not in good standing", additional referrals may be paused.

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Free Through Recovery

Website: www.behavioralhealth.nd.gov/addiction/FTR

ND Department of Corrections and Rehabilitation

Website: www.docr.nd.gov