

LAKESHORE REGIONAL ENTITY SERVICE DESCRIPTION
Wraparound Services for Children and Adolescents

This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

1. Definition or Description of Service

- a. Wraparound services for children and adolescents is a highly-individualized planning process facilitated by Wraparound facilitators. Wraparound utilizes a Child and Family Team, with team members determined by the family and often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid Mental Health State Plan, Waiver, B3 services and other community services and supports.

2. Practice Principles

- a. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound from a system level.
- b. The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community.
- c. The required organizational structure of Wraparound programs must include a Wraparound facilitator, supervisor, and Community Team; define the roles and responsibilities of those staff and the Community Team; and delineate expectations regarding child and family team capacity.
 - i. Wraparound facilitators may not have more than one provider role with any one family (i.e., may not be both the home-based therapist and Wraparound facilitator for the same child/youth and family).
 - ii. The responsibility for directing, coordinating, and supervising the staff/program shall be assigned to a specific staff position who meets the requirements of a Child Mental Health Professional (CMHP).
 - iii. Services and supports identified in the Wraparound planning process shall be available to the child/youth and family and provided as outlined in the Wraparound plan.
 - iv. The child and family team ratio shall be reflective of the needs of the individual child/youth and families being served and shall not exceed a ratio of one facilitator to ten (10) child/youth and family teams. The number of child and family teams for one facilitator may increase to a maximum of twelve (12) when two (2) child/youth and family teams are transitioning from Wraparound.
 - v. If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. For example, if a worker is a .50 FTE Wraparound facilitator, the number of teams assigned to that Wraparound facilitator shall not exceed six (6) when one team is in transition. In addition, facilitators who have other roles shall not exceed a total of fifteen (15) families across programs.

- d. The Community Team shall:
 - i. Provide a gatekeeping role that includes determination of eligibility, review of referrals, review and authorization of Wraparound Plans of Service, and Wraparound budgets.
 - ii. Provide oversight of model fidelity through the review of Wraparound Plans.
 - iii. Provide support to Wraparound staff, supervisors, and child/youth and family teams and problem-solve barriers/needs to improve outcomes for child/youth and families.
 - iv. Maintain evidence of the review and approval of Wraparound plans, budget, crisis and safety support plans, and outcomes.
 - v. Provide guidance and oversight to Wraparound staff regarding model fidelity and safety assurance.
- e. The Wraparound plan shall reflect a family-driven/youth-guided approach, and shall include the following:
 - i. Evidence that the child/youth and family team completed each step/phase of the Wraparound process, including completion of the strengths/culture discoveries, needs assessments, crisis/safety support plans, Wraparound plans, outcomes, and the development of the team mission statement.
 - ii. Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
 - iii. A strength-based, needs-driven, and culturally relevant Wraparound plan that is stated in the language of the child/youth and family.
 - iv. Evidence of regular updates as the needs of the child/youth and family change (annual updates alone are not sufficient).
 - v. Any services, supports, and interventions that are provided to the family.
 - vi. A mixture of formal and informal support and services.
 - vii. An individualized crisis/safety support plan that reflects the child's/youth's and family's strengths and culture, and seeks to build skills/competencies that reduce risk.
 - viii. Measurement of outcomes identifying when transition plans should be developed. Transition plans will address any barriers to graduation, and identify how services and supports will be maintained after Wraparound has ended.
 - ix. Evidence that the child/youth and family team review and measure outcomes at least monthly and present outcomes and measurement to the Community Team for their review at least quarterly.
- f. Amount and scope of service
 - i. All Wraparound team meetings shall be documented in the form of minutes.
 - ii. All collateral contacts shall be documented in the form of contact/progress notes.
 - iii. Meeting frequency is guided by the family's needs and level of risk. Child/youth and family teams shall meet weekly until the Wraparound plan has been developed and is being implemented.
 - iv. Exceptions to Wraparound model expectations regarding the frequency of meetings can occur to fit the family's need and availability, and must be documented in the case file.
 - v. When the Wraparound plan is successfully implemented and the child/youth and family have stabilized, meeting frequency may decrease to twice monthly.
 - vi. Wraparound child/youth and family teams begin to transition from the formal process when the outcomes identified by child/youth and family teams are met and shall not exceed three months in duration. Monthly meetings may occur during the transition phase.
 - vii. When the transition phase is successfully completed, the child/youth and family will graduate from the process.
 - viii. Upon graduation, documentation will be developed that will include the strengths and needs identified by the child/youth and family team, progress toward outcomes,

- continuing services and supports, and who will provide them. The family will receive a copy of this document.
- g. The enrolled provider with comply with the state of Michigan Wraparound evaluation requirements. Current evaluation requirements are:
 - i. Completion of the Family Status Report form at intake and every three (3) months until the family graduates from Wraparound. Upon graduation, the facilitator will complete the post-graduation/follow-up Family Status Report.
 - ii. Additional evaluation tools will be completed as identified and requested by MDHHS.
 - iii. Ensure completion of the Child and Adolescent Functional Assessment Scale (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), or the Devereux Early Childhood Assessment (DECA) at intake, quarterly, and at graduation.
 - iv. Adherence to Wraparound model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools.
 - h. Providers are encouraged to offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Providers shall assure that these practices are provided by staff that have been appropriately trained in the model(s) and are provided to the population for which the model was intended.
 - i. Provider will comply with the principles of person-centered planning as outlined in the MDHHS BHDDA Person-Centered Planning Policy.
 - j. MDHHS encourages the use of natural supports to assist in meeting an Individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the Individual's individual plan of service (IPOS).

3. Credentialing Requirements *Refer to current Medicaid Provider Manual for updated requirements.*

- a. All Wraparound services must obtain approval from MDHHS and meet the program components as outlined in the MDHHS Medicaid Provider Manual.
- b. Medicaid providers delivering Wraparound services (provided either as a 1915(b) Early and Period Screening, Diagnosis, and Treatment (EPSDT) service or an SEDW service) must request approval to provide Wraparound from MDHHS through an enrollment process defined by MDHHS, and re-enrollment must occur every three (3) years. Programs are to be re-enrolled to ensure policy and Wraparound model fidelity adherence.
- c. Provider will assure that licensed professional staff are licensed and/or registered in the State of Michigan to provide services at the level authorized by the Payor. Licensed professionals shall act within the scope of practice defined by their license.
- d. Provider shall assure that all staff providing services are qualified and trained to provide services at the level authorized by the Payor.
- e. Providers of Wraparound services must meet the staff qualifications as defined by the MDHHS Michigan PIHP/CMHSP Provider Qualification per Medicaid Services and HCPCS/CPT Codes.
- f. Provider shall maintain a copy of training records for each staff person for review if requested by the Payor, the LRE, or an external review team.
- g. Providers of services must:
 - i. Be at least 18 years of age.
 - ii. Be able to prevent transmission of any communicable disease from self to others in the environment where they are providing supports.
 - iii. Be able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed. Understanding and skill must be documented.
 - iv. Be in good standing with the law as outlined in the MDHHS/PIHP contract.

4. Service Requirements

- a. Provider's supports and services will be based upon the IPOS, and in coordination with any additional plans of the Individual (e.g. nursing, occupational therapy, physical therapy, behavior support plans). Said documents are to be present (hard copy or electronically) at the service site, and accessible to Provider's staff responsible for delivering the supports and services.
- b. Provider shall notify the Individual's care manager when the Individual's IPOS requires revision or modification.
- c. Provider shall provide services in the least restrictive and most integrated settings, unless the less restrictive levels of treatment, service or support have been unsuccessful or cannot be safely provided for that Individual.
- d. Provider shall ensure coordination of care occurs between the Individual(s) primary health care physician and Medicaid Health Plan (as appropriate). Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment, and as specified in an IPOS.
- e. Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed, and at no cost to the Individual. Provider shall be responsive to the particular needs of Individuals with sensory or mobility impairments, and provide necessary accommodations.
- f. Provider shall complete service documentation and records that meet the PIHP/CMHSP's requirements for reimbursement. Provider's services and documentation/records shall comply with the standards of the PIHP, CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third-party payers.
- g. The Individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the Individual.

5. Training Requirements

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

6. Eligibility Criteria/Access Requirements/Authorization Procedures

- a. Individuals presenting for mental health services will be engaged in a person-centered planning process through which diagnostic information and service eligibility will be determined. Eligibility tools may be used in conjunction with the person-centered planning process to determine and document medical/clinical necessity for the requested service.
- b. Waiver eligibility requires verification of no change in waiver status.
- c. The [Lakeshore Regional Entity Guide to Services](#) provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.