COLORADO
Department of Health Care Policy & Financing

Benefits Collaborative:
Draft Service & Coverage Standards
Children's Habilitation Residential Waiver
Transition Support Services

Disclaimer: Deliberative Document

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Complex Needs Program Development and Evaluation Unit
Policy, Innovation, & Engagement Division

Clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, nutrition, counseling and behavior management. The service may include assessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the service plan.

Transition Support Services

Covered Services and Limitations

Service definition

Transition Support Services align strategies, interventions, and supports for the child/youth and family when a child/youth transitions to the family home from out of home placement.

Crisis is an event or series of events, and/or state of being greater than normal severity that become(s) outside the manageable range for the child/youth and/or their caregivers and poses a danger to self, family, community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Intensive Transition Support Services include:

1. Identification of unique strengths, abilities, preferences, desires, needs, expectations, and goals of child/youth and family.

2. Assessment of transition support needs including, but not limited to:
   a. Identification of risk factors for the transition to the family home.
   b. Physical and behavioral health supports.
   c. Education services.

d. Family dynamics.
e. Schedule and routines.
f. History of or current police involvement.
g. History of medical and behavioral health hospitalizations.
h. Identification of the causes(s) of crisis and triggers that could lead to crisis.
i. Adaptive equipment needs.
j. Past interventions and outcomes.
k. Predictive risk factors.
l. Increased risk factors.
m. Immediate need for resources.
n. Respite Services.

3. Identification and connection to services and support needs.

4. Development of a Wraparound Plan to address identified transition risk factors.

5. Coordination among family caregivers, other family members, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.

6. Dissemination of the Wraparound Transition Plan to all involved in plan implementation.

7. In-Home Support.

8. Identification of follow-up services that may include:
   - Monitoring to ensure risk/crisis mitigation plan is effective.
   - Ensure that follow-up appointments are made and kept.

WRAPAROUND TRANSITION PLAN

1. The Wraparound Transition Plan is documentation of the supports and services the child/youth needs to complete and maintain stabilization after out of home placement.

2. The Wraparound Facilitator is responsible for the development and implementation of a Wraparound Transition Plan which is guided and supported by the child/youth, their family, and their wraparound transition support team.

3. The Wraparound Transition Support Team is selected by the child/youth and their family and may be composed of case managers, residential habilitation staff, medical professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant parties involved in supporting/treating the child/youth or their family.

4. The wraparound transition support team's role is to develop and implement a Wraparound Transition Plan to address transition support needs identified in the assessment which may include, but is not limited to:
   a. Environmental Modification(s)
   b. Strategies for transition risk factors.
   c. Strategies for crisis triggers.
   d. Support needs in the family home.
   e. Respite services.
   f. Learning new adaptive or life skills.
   g. Counseling/behavioral interventions or other therapeutic interventions to further stabilize the individual emotionally and behaviorally and decrease the frequency and duration of future behavioral crises.
   h. Identification of training needs and connection to training for family members, natural supports, and paid staff.
   i. Determination of criteria for stabilization in the family home.
   j. Identification of how the plan will fade out once child/youth has stabilized.

5. The Wraparound Transition Plan shall incorporate relevant supports, services, strategies, and goals from other plans in place to support the child/youth.

6. Medication management and stabilization, medical and/or behavioral health oversight shall be an integral part of the Wraparound Transition Plan and will be coordinated with the medical and/or behavioral health provider.

7. The development and implementation of the Wraparound Transition Plan should begin while the child/youth is receiving residential services in an out of home placement.

8. Revision of strategies will be a continuous process by the wraparound support team in collaboration with the individual, until the individual is stabilized in their home.

PREVENTION AND MONITORING

1. Monitoring of the Wraparound Transition Plan occurs at a frequency determined by the child/youth's needs. Monitoring includes, but is not limited to: visits to the child/youth's home, review of documentation, and coordinator with other professionals and/or members of the team to determine progress.

2. The Wraparound Transition Plan shall be revised as needed in order to avert a crisis or crisis escalation.

3. Follow-up after completion of the Wraparound Transition Plan shall be determined on an individual basis.

4. Follow-up services post completion of the Wraparound Transition Plan include status reviews of the child/youth's stability and monitoring of predictive and increased risk factors that could indicate a return to crisis or out of home placement.

5. On-going monitoring after completion of the Wraparound Transition Plan may be provided based on individual needs to support the child/youth and their family in connecting to additional resources needed to prevent future crisis or out of home placement.

IN-HOME SUPPORT

1. Type, frequency, and duration of service is determined by the Wraparound Plan.

2. Support includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child/youth with self-care, learning self-advocacy, and protective oversight.

3. Service may be provided in the child/youth's home or community as determined by the Wraparound Transition Plan.

4. In-Home Support is provided after child/youth has transitioned to the family home from out of home placement.

Service Limits

Services covered under Medicaid EPSDT, for a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support shall not be reimbursed.

There are no limits to the amount, frequency, or duration of this service.

Provider Standards

Eligible Providers

Provider Qualifications

1. Agency
    a. Certified as a Medicaid provider of Transition Support services.
2. Wraparound Facilitator
    a. Bachelor's degree in a human behavioral science or related field of study;

    OR

    An individual who does not meet the minimum educational requirement may qualify as a Wraparound Facilitator under the following conditions: Experience working with Long-Term Services and Supports (LTSS) population, in a private or public social services agency may substitute for the required education on a year for year basis.

    When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

    AND

    b. Certification in a wraparound training program.

i. Training must encompass:
    1. Trauma informed care
    2. Youth mental health first aid
    3. Crisis supports and planning
    4. Positive Behavior Supports, behavior intervention, and de-escalation techniques
    5. Cultural and linguistic competency
    6. Family and youth servicing systems
    7. Family engagement
    8. Child and adolescent development
    9. Accessing community resources and services
    10. Conflict resolution
    11. Mental health topics and services
    12. Substance abuse topics and services
    13. Psychotropic medications
    14. Motivation interviewing
    15. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation

AND

c. Complete re-certification in wraparound training at least every other year or as dictated by the crisis prevention training course.

3. Direct Support Professional

a. Be at least 21 years of age.

AND

b. At least 40 hours of training in Crisis Prevention, De-escalation, and Intervention.
    i. Training must encompass:
        1. Trauma informed care
        2. Youth mental health first aid
        3. Positive Behavior Supports, behavior intervention, and de-escalation techniques
        4. Cultural competency
        5. Family systems and family engagement

6. Child and adolescent development
7. Mental health topics and services
8. Substance abuse topics and services
9. Psychotropic medications
10. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation
11. Child/youth specific training.

AND

c. Complete annual refresher courses on the above training topics.

Entity Responsible for Verification: The Department of Health Care Policy and Financing

Frequency of Verification: Initially and at least every 3 years.