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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Service Title: Transition Support Services

Service Definition (Scope):

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 outside the manageable range for the child/youth and/or their caregivers and poses a danger to self, family, and/or 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. Identification of transition 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. Development of a Wraparound Plan that includes action steps to implement strategies to address identified transition risk factors.

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

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

6. In-Home Support.

7. Identification of follow-up services that may include:
    - Evaluation to ensure the Wraparound Transition Plan is effective in the child/youth achieving and maintaining stabilization in the family home.
    - Ensure that follow-up appointments are made and kept.

WRAPAROUND TRANSITION PLAN

1. The Wraparound Transition Plan incorporates supports, a services, strategies, and goals from other service/treatment plans in place and serves as a single plan for all supports the child/youth needs to transition and maintain stabilization after out of home placement. The plan will 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 to support stabilize the individual emotionally and behaviorally and decrease the frequency and duration of future behavioral crises.
    h. Medication management and stabilization.
    i. Physical health.
    j. Identification of training needs and connection to training for family members, natural supports, and paid staff.
    k. Determination of criteria for stabilization in the family home.
    l. Identification of how the plan will fade out once child/youth has stabilized.

2. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Transition Plan. The plan 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. All service providers and supports on the Wraparound Support Team adhere to the Wraparound Plan to meet the needs of their specific focus for treatment.

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

5. 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 EVALUATION

1. Evaluation of the Wraparound Transition Plan occurs at a frequency determined by the child/youth's needs. Evaluation 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 Wrap Around Transition Plan shall be revised as needed in order to avert a crisis or crisis escalation to maintain stabilization after transition to the family home.

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 evaluation 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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. Services provided under Targeted Case Management in the State Plan shall not be reimbursed.

Service Delivery Method *(check each that applies)*:

☐ Participant-directed as specified in Appendix E

☑ Provider managed

Provider Specifications

Provider Category	Provider Type
186343 Agency	Child Placement Agency
186346 Agency	Residential Child Care Facility
195419 Agency	Medicaid Enrolled Provider

Provider Qualifications:

License:

Any agency providing this service must meet all applicable State licensing requirements

Certificate:

N/A

Other Standard:

1. Agency

    a. Certified as a Medicaid provider of In-Home Therapeutic Support services.

Wraparound Facilitator

b. 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) populations, 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

c. 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. Intellectual and developmental disabilities
        12. Mental health topics and services
        13. Substance abuse topics and services
        14. Psychotropic medications
        15. Motivational interviewing
        16. Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation

AND

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

2. Direct Support Professional

    a. Be at least 21 years of age.

AND

    b. Have the interpersonal skills needed to effectively interact with persons with developmental disabilities and the ability to:
        i. Communicate effectively, complete required forms and reports
        ii. Follow verbal and written instructions
        iii. Provide services in accordance with the Service Plan

iv. Perform the required job tasks.

AND

c. 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. Intellectual and developmental disabilities
12. Child/youth specific training

AND

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing (HCPF).

Frequency of Verification:

HCPF verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation.