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CHILDREN DIAGNOSTIC TREATMENT SERVICES PROGRAM

~~POLICY~~POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) that the Provider Network and any subcontractors, and direct contractors that provide services to children, adolescents, and their families will meet the standards for the Children's Diagnostic and Treatment Services Program.

~~PURPOSE~~PURPOSE

The purpose of this policy is to provide direction to DWIHN contractors, subcontractors, and direct contractors in assuring that a comprehensive array of services is available for children and their families.

~~APPLICATION~~APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism
3. This policy impacts the following ~~contracts/service lines~~contracts/service lines: Medicaid, SUD, Autism, Grants, General Fund

~~KEYWORDS~~KEYWORDS

1. Additional Mental Health Services (B3S)
2. Applied Behavioral Analysis (ABA)
3. Best Practice

4. Central Registry Clearance
5. Child Mental Health Professional (CMHP)
6. Coordination of Care
7. Devereux Early Childhood Assessment (DECA)
8. Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT):
9. Evidence-Based Practice (EBP)
10. Family Member
11. Home Based Services
12. Individual Plan of Service (IPOS)
13. Maintenance of Certification (MOC)
14. Medical Necessity
15. Prevention Services
16. Promising Practice
17. Referral
18. Respite
19. Serious Emotional Disturbance (SED)
20. System of Care (SOC)
21. Waiver Support Application (WSA)
22. Wraparound

~~STANDARDS~~STANDARDS

1. DWIHN Network of Providers and their subcontractors must ensure that, at a minimum, the following occurs:
    a. Develop and implement policies, procedures, practices and monitoring activities that comply with the Department of Community Health Administrative Rules (subpart 6), and DWIHN policies and procedures for Children's Diagnostic and Treatment Program.
    b. Provide initial screening, intake evaluations, and emergency evaluations to ascertain the mental health needs of minors.
    c. Provide referrals to the appropriate Authority to meet immediate needs, protection and security for those minor's located in Wayne County who are residents of another county. Describe how services not directly provided can be accessed.
    d. Have written agreements/arrangements that clarify the respective responsibilities for coordination and provision of services with public and private human service agencies which provide for the educational, judicial and child welfare and other health services agencies.
    e. Maintain a resource listing that identifies programs to which the minors and their families are referred. The listing indicates the types of services provided, eligibility

criteria and names and location of the referral sources.

f. Provide an array of services specifically oriented to meet the needs of minors and their families that include:
    1. Diagnostic Services sufficient to develop a Plan of ~~Services~~Service; including Screening, Evaluation, Emergency services, Emergency evaluations and Referrals.
    2. Case management for the development, coordination, implementation, and monitoring of the plan of service.
    3. Crisis Stabilization and responses that reduce acute emotional disabilities and their physical and social manifestation ~~in order~~ to ensure safety of the minor, his or her family and others.
    4. Out of home treatment ~~that~~ includes both inpatient treatment and community residential treatment.
    5. Traditional outpatient mental health treatments for children and their families.
    6. Clinical therapies are provided for individuals, groups and families.
    7. Prevention services and other treatments that provide opportunities to learn, improve and demonstrate specific skills that are appropriate to the child's needs, which may include problem-solving skills, communication skills and acceptable social skills.
    8. Home-based services that can be provided in the minor's home and/or other community settings.
    9. Respite ~~Services~~services providing temporary relief to the caregiver supporting the goal of maintaining the minor in the home and community.
    10. Applied Behavioral Analysis (ABA) services for children from birth to age 21 with an ~~Autism Spectrum Disorder~~autism spectrum disorder diagnosis.
    11. Aftercare services including follow-up services to assist individuals/ families after discharge from a hospital, residential facility, or who have received community mental health services.

g. Provide services in locations that are to be accessible through publicly available transportation and in a barrier-free environment.

h. 1915 (i)SPA services:

i. (i)SPA include Serious Emotional Disturbance, Serious Mental Illness and Intellectual/Developmental Disability.

To be eligible the individual must meet the needs-based criteria:

- Must have a substantial functional limitation in one or more of the following areas of major life activity (self-care, communication, learning, mobility, self-direction, economic self-sufficiency, capacity of independent living) and
- Without 1915(i)SPA services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence,

recovery, productivity, or community inclusion and participation.

1915 (i)SPA services include; Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Financial Management Services/Fiscal Intermediary, Housing Assistance, Respite, Skill Building, Specialized Medical Equipment and Supplies, Supported/ Integrated Employment and Vehicle Modification (Assistive Tech)

a. Develop a Family-Centered Plan that addresses the expressed desires and needs of the identified consumer and their family after they have participated in a pre-planning process and a comprehensive evaluation/assessment has been developed. Ensure that the actual provision of each service is documented on an individual basis in the case record according to Person/ Family Centered Planning process. Each plan must include the amount, scope and duration of services. The plans will be reviewed according to services provided, as requested by the consumers, but no less than annually.

b. The Family Centered Plan (or IPOS) is the fundamental document in the individual's record~~,~~ and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient, and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan and/or a support plan, and may be further characterized as follows:

    1. It must satisfy Michigan Department of Health and Human Services (MDHHS) guidelines demonstrating adherence to the Person-Centered Planning (PCP) process and principles.
    2. It includes pertinent information from assessments necessary to address the expressed desires and needs prioritized by the recipient, and may include general physical, psychiatric (i.e., mental/psychological, emotional and behavioral) and social examinations. For persons under 26 years of age who have developmental disabilities, the mental examination includes psychometric and educational evaluations as well as assessment of adaptive behavior.
    3. It addresses as either desired or required by the consumer/family, his or her need for housing, clothing, health care, employment opportunities, legal services, transportation, and recreation.
    4. It is reviewed and updated at intervals specified in the plan which reflect the level of care and intensity of service needs and when requested by the consumer~~,~~ or required as a result of identified health and safety conditions, but no less than annually. The documented reviews shall contain an analysis of progress regarding objectives and goals that were developed using the PCP process. Updates and the indicated changes are authenticated by the signature of the consumer/authorized representative and the dated legible signature of the person named in the plan as responsible for managing it.
    5. It includes any Behavioral Treatment Committee that approved restrictions or limitations of rights placed on the recipient only when these limitations or restrictions are essential to safeguarding the health and safety needs of the individual. All clinically appropriate attempts shall be made to limit or avoid such restrictions or limitations. Actions taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future shall be documented and include specific intermediate and long-range goals, developed with the individual/authorized

representative, that specifies the manner in which the facility can improve the consumer's condition and the projected timetable for attainment of such goals.

6. The person/authorized representative shall receive a copy within 15-business days of the IPOS meeting. Includes, but is not limited to, core demographic and clinical elements.

c. Ensure that families are provided information about accessing respite services and community living supports during the Person/Family Centered Planning process as deemed medically necessary. It should be documented on the pre-planning form, dated and initialed by the families, that they have been offered these services.

d. Shall ensure that all families of children and youth that are Medicaid eligible have information regarding their right to Early Periodic Screening, Diagnostic and Treatment Services (EPSDT). There must be documentation in the case record that is signed by family/guardians that they have been informed of this service, and if requested, assist with accessing this service. If families have accessed this service, clinicians should request copies to be included in the case record.

e. Standardized assessments tools will be utilized to determine level of function and level of care. All Child Mental Health Professionals who provide direct clinical services or supervise clinical Child Mental Health Professionals must be certified to administer the assessment tools specific to their service population. All tools must be administered baseline (14 days of intake), quarterly and discharge.

1. The Level of Care Utilization Services (LOCUS) is a required assessment tool for all individuals in the Community Mental Health Service Programs (CMHSP) system over the age of 18. The LOCUS is to be completed at intake and at reassessment intervals for individuals over the age of 18 receiving adult services.

    i. The LOCUS is not required for youth ages 18-21 receiving SED services. If youth transitions to adult services, the LOCUS is required.

2. The Child Adolescent Functional Assessment Scale (CAFAS) is a required assessment tool for all children in the CMHSP system, ages 7 through 21 years. The CAFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health services.

    i. For youth, ages 18-21, that are involved in the SED Waiver and Wraparound, the CAFAS is required. If youth is I/DD and receiving Wraparound, the CAFAS is not a requirement.

    ii. For youth ages 18-21 qualifying for services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) the CAFAS is required.

1. The Pre School and Early Childhood Functional Assessment Scale (PECFAS) is a required assessment tool for all children in the CMHSP system ages 4 up until the 7th birthday. The PECFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.

2. Devereaux Early Childhood Assessment (DECA): DECA-I, DECA-T, DECA-C; is used for assessing the social and emotional needs of infants, toddlers and children ages 0 - 47 months.

    a. Infants (DECA I) 0 to 18 months of age

b. Toddlers: (DECA-T) 18 to 36 months of age

c. Children: (DECA-C) 37 to 47 months of age.

d. The DECA is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.

3. Modified Checklist for Autism in Toddler-Revised (M-Chat-R) ~~or~~is a questionnaire for individuals 16 months to 30 months of age. The Social Communication Questionnaire (SCQ) is ~~used for~~an autism spectrum disorder screening ~~children from birth to~~instrument for individuals ages 4 years and up, with a mental age ~~21~~over 2 years ~~for Applied Behavior Analysis services~~.

    a. Coordinate with other entities that serve the youth and their families, i.e., primary care physicians, schools, child welfare, public health, substance use providers, and the juvenile justice system once a signed release has been obtained and placed in the case record. There should also be documentation in progress notes indicating when coordination and attempts have occurred to get information from other human service entities including primary care physicians.

    b. Maintain formalized workforce development program that assures professional development and training in identifying and treating the needs of minors and their families. Regular review of training requirements and recommendations will occur to ensure special emphasis is made on new and emerging material and practices and outdated material is removed.

    c. Certified programs shall be clinically supervised by a Child Mental Health Professional who has at least a master's degree in a mental health related field with 3 years of clinical experience working with minors and their families.

    d. Employ clinicians that are qualified by certified training and have supervised experience to diagnose and treat children with serious emotional disturbance and/or intellectual/developmental disabilities, and who meet the requirements for Child Mental Health Professional Credentials, Criminal Background Check and Central Registry. Clearance of the applicants shall be reviewed and verified by the service provider prior to the Clinician providing services to children and their families.

    e. Ensure that Child Mental Health Professionals ~~that~~(CMHP) and Qualified Behavioral Health Professionals (QBHP) are contractual staff are held to the same credentialing standards and have the same supporting documentation in their credentialing files of their employers as non-contractual staff.

    f. ~~Have Maintenance of Certification documentation in the credential's files of Board-Certified Child Psychiatrists.~~Have maintenance of certification and licensure documentation in the credentialed employees' files of Board Certified Behavior Analyst.

    g. Include toll free, TTY, and TDD telephone numbers on all publicly distributed publications that are distributed to the public.

4. Array of services

    a. Home Based Services: Services are provided in the family home or community. Any contacts that do not occur in the home or community must be clearly explained in case record documentation, the expected duration and the plan to address issues

that are preventing the services from being provided in the home and community. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports. The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:

1. Enrolled home-based service providers are available and sufficient to ensure home-based services meet the need across the community.
2. Responsibility for directing, coordinating, and supervising the staff/ program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience.
3. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families.
4. The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/ 3 transitioning).
5. If providers wish to utilize clinicians who serve mixed caseloads (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services cases assigned to each partial position cannot exceed the same percentage of the maximum active home-based services caseload. For example, a 50% home-based position could serve no more than 6 home-based cases. The total maximum caseload, including home-based and other services cases, for a full-time clinician serving a mixed caseload is 20 cases.
6. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services.
7. Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies ~~supports~~support and resources.
8. Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis

intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family.

9. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning for individuals, couples, or families.
10. Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign–in sheets, or other methods of documentation. Supervision is provided by a Qualified Mental Health Professional and is a child mental health professional with three years of clinical experience.
11. The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings.
12. Home-based providers shall participate in local meetings and adhere to DWIHN reporting protocol.
13. There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.
14. A minimum of 4 hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc. will be provided to implement the plan of service.
15. The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to case closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed 3 months.
16. Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or DWIHN Crisis Center. If after hours crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provides the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.

b. Infant Mental Health (IMH) services and Early Childhood Mental Health Services (ECMHS) A Home-

Based Services that is a best practice model that focuses on the caregiver-child dyad. The target population served:

- Women exhibiting psychosocial or medical risk during pregnancy (and their infants, toddlers, preschoolers, or young children).
- Adolescent parents and their infants, toddlers, preschoolers, or young children.
- Parents/legal guardian engaged in suspected or substantiated child abuse and neglect and their infants, toddlers, preschoolers, or young children.
- Mentally ill or emotionally disordered parents/legal guardian and their infants, toddlers, preschoolers, or young children.
- Parents/legal guardian with developmental disabilities and their infants, toddlers, preschoolers, or young children.
- Infants discharged from neonatal intensive care units and their parents/legal guardian; toddlers, preschoolers, or young children who are medically fragile and their parents/legal guardian.
- Infants, toddlers, preschoolers, or young children with developmental delays.
- Infants, toddlers, preschoolers, or young children who are in situations that place them and their parents/legal guardian at risk (Refer to Medicaid Chapter III, Section 7.2.B).
- Infants, toddlers, preschoolers, or young children who have a diagnosable behavioral or emotional disorder.
- Infant, toddlers, preschoolers, or young children who may be at risk of being excluded from school/~~child care~~childcare due to functional impairment(s).

1. Characteristics of intervention occur through the modality of home visits, home and office visits, school/~~child care~~childcare observations and group sessions with structured intervention activities. Home visits are a necessary component of all Early Childhood Services. All Early Childhood mental health interventions have the following components:
    a. The focus of assessment and intervention is the parent-infant (or toddler, preschooler, or young child) dyad in the context of the family system.
    b. Intervention is designed to support and nurture the parent as the primary caregiver, including attention to parental needs; increasing parental self-esteem; and reinforcement of appropriate parent-infant, toddler, preschooler, or young child interactions; and parental capacity to empathize with the child's needs.
    c. Provision of developmental guidance and information about infant, toddler, preschooler or young child behavior and corresponding child caring practices.
    d. Facilitate and promote management of real-life problems including crisis resolution, linkage to community resources, advocacy, facilitation of problem-solving skills, and linkage to informal support systems.
    e. Resolution of intrapsychic and family system issues impeding attachment, self-regulation, and exploration.

2. Infant Mental Health services clinicians must:
    a. Meet the qualifications of a child mental health professional, AND
    b. Must have, at a minimum, a Level II Endorsement, OR
    c. Must request a Provisional Endorsement, and be in the process of applying for "Endorsement" through the Michigan Association for Infant Mental Health (MI-AIMH)
    d. Must obtain Level II Endorsement within two years of requesting a Provisional Endorsement, AND
    e. Comply with the Endorsement requirements as outlined by MI-AIMH.
3. Early Childhood Mental Health Services Clinicians must:
    a. Meet the qualifications of a Child Mental Health Professional, AND
    b. Attend any relevant ~~trainings~~training courses specific to this age group ~~that the sponsors~~.
4. ~~The Autism Benefit is a benefit under the Behavioral Health Treatment Services (BHT) which provides access to evidence-based Applied Behavior Analysis (ABA) Services to children covered by Medicaid ages birth to twenty-one with an Autism Spectrum Disorder (ASD) Diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnostic Evaluations, Psychological Testing, Neuropsychological Testing, Adaptive Testing, Behavior Assessments, Behavior Intervention Plans, Functional Analysis of Severe Maladaptive Behaviors, ABA Direct Services, Technician Direction and Observation (Supervision), Group Behavior Therapy, and Parent/Guardian Training. Individuals receiving the Medicaid Autism Benefit also have access to any other medically necessary services covered by DWIHN.~~
5. ~~To access Behavioral Health Treatment Services a child must complete the Person-Centered Process (PCP) to develop an Individual Plan of Service (IPOS) to coordinate service delivery. This process starts by the family calling the DWIHN Access Department to determine I/DD or SED designation. From there, the family receives an appointment and is scheduled with either a Support Coordinator or Case Manager to assist in the Person-Centered Process (PCP).~~
6. ~~To access the Medicaid Autism Benefit, a validated and standardized screening tool must be administered before the child is referred for further evaluation. The screening tool may be administered as either part of the well child visit by a physician during the medical and physical examination OR by contacting DWIHN Access Department directly. The DWIHN Access Department will review the screening results or physician referral form to determine if further evaluation may be needed then contact the family to finalize enrollment and other screening processes. During this call, the family is offered a choice of three Diagnostic Evaluators to obtain a Comprehensive Diagnostic Evaluation for further evaluation. The Diagnostic Evaluator in receipt of the referral receives an automatic authorization for the evaluation, cognitive, and adaptive testing. The practitioner provides a comprehensive review of evaluation results, feedback, recommendations for behavioral management, and behavioral health service eligibility. The behavioral intervention should be provided at an appropriate level of intensity which will vary for~~

~~each member and should reflect general focus areas for treatment, specific needs of the individual and response to treatment.~~

7. ~~Families new to DWIHN are connected to a general Developmental Disability Intake Interview, which begins the Person-Centered Planning (PCP) process to begin the pre-plan and Individualized Plan of Service (IPOS). This plan includes the ASD services along with all other medically necessary services for the individual. Existing Families that are already enrolled with an active Clinically Responsible Service Provider (CRSP) and have an IPOS will not need to complete another Intake Interview.~~

- The Autism Benefit is a benefit under the Behavioral Health Treatment Services (BHT) which provides access to evidence-based Applied Behavior Analysis (ABA) Services to eligible individuals covered by Medicaid ages birth to twenty-one with an autism spectrum disorder (ASD) diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnostic Evaluations, Psychological Testing, Adaptive Testing, Behavior Assessments, Behavior Plans of Care, ABA Direct Services, Technician Direction and Observation (Supervision), group training and Parent/ Guardian Training. Individuals receiving the Autism Benefit have access to other services deemed medically necessary that are covered by Medicaid and provided by DWIHN.
- DWIHN is the initial point of access for members who have been referred and require a screening to be completed for a comprehensive diagnostic evaluation and behavioral assessment of ASD. To access the BHT services, a validated and standardized ASD screening tool must be administered before the individual is referred for further evaluation. The ASD screening tool may be administered through a variety of means (i.e., PCP, DWIHN Access Department, other medical professionals, etc.).
- The DWIHN Access Department will review the ASD screening results or physician referral form to determine if further evaluation may be needed. If the ASD screening is positive, then the family is offered a choice of three Diagnostic Evaluators to receive a Comprehensive Diagnostic Evaluation to determine diagnosis. The Diagnostic Evaluator in receipt of the referral receives an automatic authorization for the evaluation, cognitive, and adaptive testing. The practitioner provides a comprehensive review of evaluation results, feedback, recommendations for behavioral management, and medical necessity for behavioral health service eligibility.
- The comprehensive diagnostic evaluation must be performed before the individual receives the BHT services array of applied behavior analysis (ABA) services, occupational therapy (OT), and speech language therapy (SLT).
- In cases of transfer between PIHPs or CMHSPs for individuals who were deemed to meet medical necessity criteria for ABA, the initial diagnostic evaluation from the transferring region should be deemed valid and accepted unless there are clearly extenuating and clinically relevant circumstances (e.g., caregiver or provider recommending/seeking re-evaluation). DWIHN will accept these evaluations completed outside of DWIHN contracted provider network which meet requirement of MDHHS Autism Policy. The procedure steps of submission are detailed in the Comprehensive ASD Evaluations Procedure.

a. Parent Management Training Oregon Model (PMTO): PMTO is an evidence-based best practice approach that recognizes the vital role parents play as being the primary change agents within their family. PMTO is tailored for serious behavior problems for youth from preschool through

adolescence. In addition, PMTO can be applied to families with complex needs and challenges, e.g. mental health issues, poverty, divorce, etc. Parents are supported and encouraged as they learn skills they can utilize to provide appropriate care, instruction and supervision for their children. Clinicians utilize role-play and problem solving to promote the development of parents' skills. There are five core components to the PMTO model. They are:

1. encouragement,
2. limit-setting,
3. problem-solving,
4. monitoring, and
5. positive involvement.
   PMTO is implemented either individually basis or in a group setting. However, when in a group setting, the term Parenting Through Change (PTC) is used.

b. Serious Emotional Disturbance Waiver (SEDW) provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with a SED who are enrolled in the SEDW. MDHHS operates the SEDW through contracts with the CMHSPs.

   1. The SEDW provides a community mental health service array to those actively enrolled in the waiver, in attempts to avoid hospitalization or removal from the home and/or community.
   2. Services are provided in the community using the Wraparound process to service coordination. If a child/youth is placed on "Inactive Status" due to their removal from the community, the assigned Community Mental Health Provider along with the DWIHN Children's Initiative Coordinator will monitor the child/youth for no more than 90 days, developing a plan to return the child/youth to the community. If the child/youth is out of the community longer than 90 days, the youth will be terminated from the SEDW and will have to reapply upon their return to the community.
   3. Referrals are coordinated by the DWIHN Children's Initiative Coordinator along with Child Welfare, MDHHS, other counties, parents/guardians and service providers~~. The referral includes; Waiver Certification Form, Family Choice Assurance, Demographic Data Form, CAFAS/PECFAS/DECA.~~
   4. The DWIHN Coordinator shall:
      i. Review all referrals for appropriateness in collaboration with the referral source and the SEDW provider.
      ii. Provide oversight to the application process, ensuring all documentation is compiled and complete for submission to MDHHS.
      iii. ~~Process, submit and track~~Track all referrals.
      iv. Coordinate the SEDW for all eligible children residing in Wayne County.
      v. Assist with coordinating transfers when a youth moves out of Wayne County or into Wayne County.
      vi. Review all documentation that has been submitted by the ~~Clinically Responsible Service~~SEDW Provider ~~(CRSP) for entry~~ into the Waiver Support Application (WSA).

vii. Submit the SEDW packet to MDHHS via the WSA.

5. DWIHN Finance shall conduct monthly Medicaid reviews to ensure all youth enrolled in SEDW have active Medicaid.
6. Service providers shall:
    i. Submitted billing through CHAMPS (via MH-WIN) ~~using the SEDW Medicaid Fee Screen~~.
    ii. Submit all ~~requests to renew/terminate~~ SEDW ~~youth~~renewals into the WSA, one month prior to ~~actual~~the due date.
    iii. Submit all SEDW completed packets into the WSA for DWIHN Coordinator to review and approve.
    iv. Ensure the correct CPT code is utilized when a youth transitions from CMH Wraparound services (H2021) to SEDW Wraparound services (H2022). This will be reflected in both billing documents and in the IPOS.
    v. Participate in quarterly SEDW provider meetings with DWIHN Coordinator.
    vi. Participate in monthly meeting with DWIHN Coordinator to review each youth that is active in the SEDW.
    vii. Send SEDW Informational Letter to youth and family once a referral is received.
    viii. Send SEDW Transitional Letter to the family three (3) months prior to the youth's renewal/termination date from the SEDW.
    ix. Send the DWIHN Coordinator the SEDW Renewal Checklist, when completing an annual SEDW renewal.

c. Trauma Focused Cognitive Behavioral Therapy: TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques.

~~Wraparound is a team-driven and family-led process involving the family, child, natural supports, agencies and community services. Individual services and supports build on strengths to meet the needs of children and families across life domains, promoting success, safety and permanence in the home, school and community. Wraparound is a culturally competent process, building on the unique values, preferences and strengths of children and families, and their communities. Plans are developed and implemented based on a collaborative planning process that includes a balance of formal and informal services and supports.~~

1. ~~The Wraparound process, facilitated by a Qualified Child Mental Health Professional, encourages the involvement of all service systems and natural supports in children and family life.~~
2. ~~Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, systems and informal supports.~~
3. ~~As a team planning process, Wraparound takes a holistic view of the lives of children, youth~~

~~and families. The Wraparound model affirms that the best way to assist families is to listen to what they identify as their needs.~~

4. ~~The planning process provides families with a structure that builds upon their unique strengths and abilities as a means to meet those needs. The planning process identifies the child's strengths and needs, as well as strategies and outcomes.~~
5. ~~The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community.~~
6. ~~The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child and family and is developed in partnership with other community agencies.~~
7. ~~The Wraparound Community Team:~~
    i. ~~Include representation from system partners, other child serving agencies and local community agencies.~~
    ii. ~~Provide support to Wraparound staff, supervisors and child/youth and family teams to problem-solve barriers/needs to improve outcomes for children, youth and families.~~
    iii. ~~Work as a collaborative body to improve community service delivery to children, youth and families~~
    iv. ~~Provide support to other child serving community agencies who are experiencing challenges meeting the needs of children, youth and families with complex needs~~
    v. ~~Implement additional activities and responsibilities that reflect the individual needs of the community.~~

a. Youth in Transition: Services for youth supportive to the specific needs of young people ages 15-21 transitioning to adulthood. Youth in Transition services include:
    1. Group curriculum focused on development and mastery of practical life skills.
    2. Inclusion of Youth Peer Support Services in treatment plan
    3. Community-based learning opportunities
    4. Individual clinical outpatient services with a therapist trained in transitional age youth service models.

b. Youth Peer Support Services: Youth Peer Support (YPS) peer-delivered service for youth and young adults. It is designed to support youth and young adults with serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of direct support, information sharing, and skill building. Youth Peer Support Services can be provided to youth and young adults up to 26 years of age, depending on the individual's developmental and life stage needs. YPS services are provided by trained Youth Peer Support Specialists and primarily provided in a home or community setting.

c. The Parent Support Partner (PSP) service is an intervention that supports families whose children receive services through a community mental health service provider. The purpose of the service is to increase family involvement, voice and engagement within the mental health treatment process and to equip parents with the skills necessary to address the challenges of raising a youth with special needs thus improving outcomes for youth with serious emotional

disturbance and/or intellectual/developmental disabilities, including autism involved with the public mental health system. The service is provided by parents or primary caregivers with first-hand experience navigating public child serving agencies and raising a child with mental health or developmental challenges. Support provided to a family by a PSP will focus on increasing confidence as they find their voice when partnering with service providers, and will empower the parent to develop sustainable, natural support networks after formal service delivery has ended. PSPs, serving as an equal member of the treatment team, assist in identifying goals in the individualized plan of service that will support the parent to find their voice and confidence in parenting a child with serious emotional disturbance (SED) and/or intellectual developmental disabilities (I/DD), including autism. They enhance the therapeutic process by increasing engagement, expanding and increasing skills. There is an expectation that the service will be an intervention-based service and attached to a treatment goal.

~~QUALITY ASSURANCE/ IMPROVEMENT~~QUALITY ASSURANCE/ IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of DWIHN network of providers and their subcontractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

~~COMPLIANCE WITH ALL APPLICABLE LAWS~~COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN network of providers and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

~~EXHIBITS~~EXHIBITS

1. MDHHS Family Driven-Youth Guide Policy (March 2021)
2. ~~Relax. Take a Break: A Family Guide to Respite for Children in Michigan~~
3. Department of Community Health, Mental Health and Substance Abuse, Administrative Rules Subpart 6, R 330.1205 – 330.2135 Children's Diagnostic and Treatment Services.
4. Michigan Department of Health and Human Services Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) March 2018
5. Michigan Department of Health and Human Services Devereux Early Childhood Assessment (Infant, Toddler, Clinical Versions) March 2018

6. MDHHS Technical Requirement for Children (December 2020)

~~LEGAL AUTHORITY~~LEGAL AUTHORITY

All of the following Authority policies refer to the most recent policy:

1. Department of Community Health, Mental Health and Substance Abuse, Administrative Rules Subpart 6, R 330.1205 – 330.2135 Children's Diagnostic and Treatment Services.
2. Michigan Compiled Laws, Mental Health Code Act 258 of 1974: Sec.330.1206. Sec. 330.1208
3. Department of Human Services Central (Perpetrator) Registry.
4. MDHHS Family Driven-Youth Guide Policy (March 2021)
5. SED WAIVER (A Home and Community-based Services Waiver for Children with Serious Emotional Disturbance) TECHNICAL ASSISTANCE MANUAL
6. PECFAS - CAFAS Guidance (March 2021)

~~RELATED POLICIES~~RELATED POLICIES

1. Assessment Policy
2. CAFAS-PECFAS-DECA Procedure
3. Clinical Practice Guidelines
4. Coordination of Care
5. Credentialing/Re-Credentialing.
6. Individualized Plan of Service.
7. Early Childhood Mental Health Services
8. Services to Minor Children
9. Parent Management Training Oregon Model
10. Respite
11. Wraparound

~~CLINICAL POLICY~~CLINICAL POLICY

~~YES~~

~~INTERNAL/EXTERNAL POLICY~~

~~EXTERNAL~~

Yes

Attachments

DCH MH Admin R330 2105.pdf

DHHS 17 Family-Driven_and_Youth-Guided_Policy_and_Practice_Guideline - Clean (1).docx

MDHHS 12 TECHNICAL REQUIREMENT FOR SED CHILDREN.docx

Michigan Department of Health and Human Services Devereux Early Childhood Assessment (Infant, Toddler, Clinical Versions) March 2018

PECFAS-CAFAS Guidance March 2021 (1).doc

Relax Take a break Family Guide to Respite

Approval Signatures

Step Description	Approver	Date
Stakeholder Feedback	Allison Smith: Project Manager	Pending
Compliance/Administrative Review	Yolanda Turner: VP of Legal Affairs	02/2024
Compliance/Administrative Review	Tiffany Devon: Director of Communications	02/2024
Compliance/Administrative Review	Sheree Jackson: Vice President of Compliance	02/2024
Compliance/Administrative Review	Stacie Durant: VP of Finance	02/2024
Compliance/Administrative Review	Manny Singla: Executive VP of Operations	02/2024
Clinical Review Committee	Ebony Reynolds: Clinical Officer	02/2024
Clinical Review Committee	Judy Davis: Director of Substance Abuse Disorders	01/2024
Clinical Review Committee	Jacquelyn Davis: Clinical Officer	01/2024
Clinical Review Committee	Daniel West: Director of Crisis Services	12/2023
Clinical Review Committee	Kathryn Mancani: Interim Director of Residential Assessments	12/2023
Clinical Review Committee	Shama Faheem: Chief Medical Officer	12/2023

Clinical Review Committee	Melissa Moody: VP of Clinical Operations	12/2023
Clinical Review Committee	April Siebert: Director of Quality Improvement	12/2023
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	12/2023
Clinical Review Committee	Leigh Wayna: Director of Utilization Management	12/2023
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	12/2023
NCQA Committee	Tania Greason: Quality Administrator	12/2023
NCQA Committee	Allison Smith: Project Manager	12/2023
NCQA Committee	Shana Norfolk: Strategic Planning Administrator	12/2023
NCQA Committee	Maria Stanfield: Director of Strategic Operations	12/2023
Unit Review and Approval	Cassandra Phipps: Director of Children's Initiatives	12/2023
Unit Review and Approval	monica Hampton: Clinical Specialist	12/2023