Saginaw County Community Mental Health Authority

Wraparound- An Overview

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Objectives

- **Introduction to the Wraparound Model**-*What is Wraparound?*
- **Eligibility Criteria**- *For whom and when do we recommend Wraparound?*
- **Referral Process**-*How do we refer consumers to Wraparound?*
- **Maintenance/Exit Criteria**-*How/when do consumers leave Wraparound?*
- **SEDW (Serious Emotional Disturbance) Waiver-** *What is SEDW and what does it have to do with Wraparound?*

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Overview- What is Wraparound?

- 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 often representing multiple agencies and informal supports.
- The **Wraparound Plan** may also consist of other non-mental health services and supports that are secured from, and funded by, other agencies in the community. 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.

Michigan Department of Health and Human Services. Michigan Medicaid Provider Manual, Sec. 3.29-Wraparound Services for Children and Adolescents Pg. 24

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Wraparound Eligibility Criteria

Children/youth and families served in Wraparound shall meet ***two*** or more of the following criteria:

- Children/youth who are involved in multiple child/youth serving systems.
- Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children/youth who have received other mental health services with minimal improvement in functioning.
- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are working with multiple children/youth in a family and the identified outcomes are not being met.

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Wraparound Plans

3.29.C. Plans of Service Pg. 27-

The Wraparound plan shall reflect a family-driven/youth-guided approach, and shall include the following:

- 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.
- Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
- A strength-based, needs-driven, and culturally-relevant Wraparound plan that is stated in the language of the child/youth and family.
- Evidence of regular updates as the needs of the child/youth and family change (annual updates alone are not sufficient).
- Any services, supports, and interventions that are provided to the family.
- A mixture of formal and informal support and services.
- 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.
- 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.
- 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.

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The Michigan Medicaid Provider Manual requirements

Maintenance/Transition/Graduation

Pg. 27-28

- **3.29.D. AMOUNT AND SCOPE OF SERVICE**
- All Wraparound team meetings shall be documented in the form of minutes.
- All collateral contacts shall be documented in the form of contact/progress notes.
- 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.
- 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.
- When the Wraparound plan is successfully implemented and the child/youth and family have stabilized, meeting frequency may decrease to twice monthly.
- 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.
- When the transition phase is successfully completed, the child/youth and family will graduate from the process. 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.

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Wraparound referral process

INTAKE

*Family Request for Service (CAI) or

*internal-Level of Care Change (LOCC) request

CARE MANAGEMENT-> COMMUNITY TEAM

*Case presentation

*Recommendations

*Accept/Deny

CLINICAL ASSESSMENT/ORIENTATION

*Consider/Complete SEDW

*OTM and Safety/Support Plan

ENGAGEMENT-

*Build Team

*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.

MAINTENANCE/TRANSITION

*When the Wraparound plan is successfully implemented and the child/youth and family have stabilized, meeting frequency may decrease to twice monthly.

*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.

GRADUATION

*Transition Plan identifies any ongoing services and supports, and are reviewed and approved by Community Team.

*When the transition plan is successfully completed, the child/youth and family will graduate from the process. A Graduation Summary will be completed by Wraparound Facilitator and will be presented and approved by Community Team.

Community Team

~ The Community Team shall:

- ❖ Provide a gate-keeping role that includes determination of eligibility, review of referrals, review and authorization of Wraparound Plans of Service, and Wraparound budgets.
- ❖ Provide oversight of model fidelity through the review of Wraparound Plans.
- ❖ Provide support to Wraparound staff, supervisors, and child/youth and family teams and problem-solve barriers/needs to improve outcomes for children/youth and families.
- ❖ Maintain evidence of the review and approval of Wraparound plans, budget, crisis and safety support plans, and outcomes.
- ❖ Provide guidance and oversight to Wraparound staff regarding model fidelity and safety assurance.

EVALUATION AND OUTCOMES MEASUREMENT

The enrolled provider will comply with the State of Michigan Wraparound evaluation requirements. Current evaluation requirements are:

- Completion of the Family Status Report form at intake and every three months until the family graduates from Wraparound. Upon graduation, the facilitator will complete the post-graduation/follow-up Family Status Report.
- Additional evaluation tools will be completed as identified and requested by MDHHS.
- 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.
- 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.

Pg. 27- **3.29.E. EVALUATION AND OUTCOMES MEASUREMENT**

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Children's Serious Emotional Disturbance Home and Community Based Services Waiver (SEDW)

- **General Information-**
- The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW.
- MDHHS operates the SEDW through contracts with the CMHSPs.
- The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMSHP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.

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SEDW Eligibility Criteria

1.2 Eligibility- To be eligible for this waiver, the child must meet all of the following criteria.

- Live in a participating county OR;
- Live in foster care in a non-participating county pursuant to placement by MDHHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP; AND Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR;
- Reside with a legal guardian; OR
- Reside in a foster home with a permanency plan; OR
- Be age 18 or age 19 and live independently with supports; AND
- Meet current MDHHS criteria for the state psychiatric hospital for children; AND
- Medicaid eligibility criteria and become a Medicaid beneficiary; AND
- Demonstrate serious functional limitations that impair the ability to function in the community.
- As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
- CAFAS® score of 90 or greater for children age 7 to 12; OR
- CAFAS® score of 120 or greater for children age 13 to 18; OR
- For children age 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND
- Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.

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SEDW Provisions

- **Key Provisions-**
- ~The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services.
- The CMHSP is responsible for assessment of potential waiver candidates.
- Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services.
- The Wraparound Facilitator, the child and his family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services.
- All services and supports must be included in an IPOS.
- A SEDW beneficiary must receive at least one SED waiver service per month in order to retain eligibility.

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A Few Considerations to Remember

- Presenting a case to Community Team does not guarantee approval, they may request additional services be attempted or further areas explored before accepting a case.
- Siblings are not automatically accepted to Wraparound. Two siblings may both have services, but they are not guaranteed to be accepted to Wraparound. Each child must be presented to Community Team and meet eligibility requirements.
- Wraparound is for cases where multiples attempts at different services have been attempted with minimal success and risk of removal is high.

CASE MANAGEMENT vs WRAPAROUND FACILITATOR

- Wraparound Facilitators are NOT case managers, though some functions remain the same. A Wraparound Facilitator links and coordinates to arrange for everyone to get in the same room at the same time and organizes the content of the meetings, but is not responsible for all of the tasks that are identified in meetings.
- A Wraparound Facilitator's emphasis is on the team versus only the child. For example, a WF may assist a mother in appointment reminders or arrangements for their individual needs in addition to the child's needs, if that will improve the outcomes listed in the plan.
- A Wraparound Facilitator is responsible for all documentation, and for ensuring that all services that have been discussed are being delivered.

Saginaw County Community Mental Health Authority

Wraparound is located at the Towerline Office

1040 N. Towerline Rd, Saginaw, Michigan 48601

Phone: (989) 797-3400

24 Hour Mental Health Emergency Services

(989) 792-9732

Toll Free: 1-800-233-0022

www.sccmha.org