"People helping people help themselves"

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Community-Based Options for Youth and Families
Intensive Home and Community-Based Wraparound Services

MFP-PRTF Demonstration Grant Service Definitions

The Money Follows the Person - Psychiatric Residential Treatment Facility (MFP-PRTF) Demonstration Grant service definitions provided below are approved by the Centers for Medicare and Medicaid Services (CMS), the Office of Medicaid Policy and Planning (OMPP), The Division of Aging (DA) and the Indiana Division of Mental Health and Addiction (DMHA).

The MFP-PRTF services provided for this program are the same as the ones provided under the PRTF Transition Waiver. Additional information regarding the scope, exclusions, billing and limitations associated with the wraparound services may be found in the PRTF Transition Waiver Provider Policy and Procedure Manual.

Wraparound Facilitation
Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and Activities designed to carry-out the wraparound process. Children/youth who participate in the PRTF Waiver must receive WF. Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care. The individual who facilitates and supervises this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (grant, local system of care, etc.). The WF is responsible for:

1) Completing a comprehensive re-assessment of the individual at least annually;
2) Working in full partnership with team members to develop a revised and annual plans of care;
3) Overseeing implementation of the revised plan;
4) Identifying providers of services or family based resources; facilitating Child and Family Team meetings; and
5) Monitoring all services authorized for a child's care.

PRTF Waiver services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values. The WF:

1) Offers consultation and education to all providers regarding the values and principles of the model;
2) Monitors progress toward treatment goals;
3) Ensures that necessary data for quality evaluation is gathered and recorded; and
4) Ensures that all PRTF Waiver related documentation is gathered and reported to DMHA as per requirements.

The wraparound model involves 4 stages (Miles, Brunes, Osher & Walker, 2006):

1) Engagement: The family meets the WF. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the wraparound process. The WF engages other team members identified by the family and prepares for the first child/family team meeting.
2) Planning: The WF informs the team members about the family's strengths, needs, and vision for the future. The wraparound team does not meet without the family present. The team decides what to work on, how the work will be accomplished, and who is responsible for each task. Plan of Care (POC)

development is facilitated by the WF and the WF is responsible to write the POC and obtain approval of the POC from DMHA. The WF also facilitates a plan to manage crises that may occur.

3) Implementation: Family and team members meet regularly (at least monthly). Meetings are facilitated by the Wraparound Facilitator who also assures that the family guides the family/team meetings. The team reviews accomplishments and progress toward goals and makes adjustments. Family and team members work together to implement plan.
4) Transition: As the family team nears the goals, preparations are made for the family to transition out of formal wraparound and MFP-PRTF services. The family and team decide how the family will continue to get support when needed and how wraparound can be re-started if necessary.

The Wraparound Facilitator:

1) Completes CANS Reassessments every six months to monitor progress.
2) If the WF is not an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d), he/she arranges for a OBHP to complete the annual PRTF LOC re-evaluations with active involvement of the Child and Family Wraparound Team;
3) Guides the engagement process by exploring and assessing strengths and needs;
4) Facilitates, coordinates, and attends family and team meetings;
5) Guides the planning process by informing the team of the family vision (no team meeting without family);
6) Guides the crisis plan development, monitors the implementation and may intervene during a crisis;
7) Authorizes and manages Flex Funding as identified in the Plan of Care;
8) Assures that the work to be done is identified and assigned to a team member;
9) Assures that the written Plan of Care that was developed, written and approved by the Division of Aging;
10) Reassesses, amends, and secures on-going approval of Plan of Care;
11) Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status;
12) Monitors cost-effectiveness of Medicaid services;
13) Monitors and supervises the Wraparound Technician; and,
14) Guides the transition of the youth from MFP-PRTF services.

Wraparound Facilitation does not duplicate Wraparound Technician services or any other Grant or state plan Medicaid service. Every child/family will have a WF. The WF may perform the tasks identified for a Wraparound Technician. This will occur when the caseload does not warrant an added person to perform all the duties of the Wraparound Technician. Both WF and Wraparound Technician services include assistance to participants in gaining access to services (MFP-PRTF, medical, social, educational and other needed services). The difference between these two services is related to the complexity of the activities. The WF manages the entire wraparound process and ensures that all reassessments are completed; ensures that the plan of care is completed (including a crisis plan) and is approved; guides all team members to ensure that the family vision is central to all services; manages the flex fund; and supervises the Wraparound Technician.

Wraparound Technician

The Wraparound Technician applies the theories and concepts of the wraparound process and the resulting Plan of Care to the child/youth's day to day activities. Wraparound Technicians are guided and supervised by the Wraparound Facilitator. They discuss progress with other team members, providers, and family and make recommendations to the Wraparound Facilitator and team.

1) Participate in Child and Family Team meetings;
2) Monitor progress by communicating with the family and child, as well other team members and the Wraparound Facilitator. The timetable for and the mode of communication should be determined with the family;

3) Assist the family and child with gaining access to services and assure that families are aware of available community-based services and other resources such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs;
4) Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services;
5) Monitor health and welfare of the child/youth;
6) May provide crisis intervention;
7) May facilitate Medicaid certification and enrollment of potential providers identified by the family to provide demonstration project services.

Wraparound Technician may not duplicate Wraparound Facilitation or any other Grant or state plan Medicaid service. However, the Wraparound Technician functions may be provided by the same individual who provides Wraparound Facilitation services.

Habilitation
Habilitation services enhance participant functioning, life and social skills; prevent or reduce substance use/abuse; increase client competencies and build child and family's strengths and resilience, and positive outcomes. This is accomplished through developing skills in identification of feelings; anger and emotional management; how to give and receive feedback; criticism and praise; problem-solving; decision making; assertive behavior; learning to resist negative peer pressure and develop pro-social peer interactions; improve communication skills; optimize developmental potential; address substance abuse and use issues; build and promote positive coping skills; learn how to have positive interactions with peers and adults, encourage therapeutic/positive play with or without parents/guardians, encourage positive community connections, and develop non-paid, natural supports for child and family . Activities are to be conducted face-to-face with the client and address the needs of the participant. Habilitation services do not include services that are mandated under Individuals with Disabilities Education Act (IDEA) or covered under the Rehabilitation Act of 1973.

Respite Care
Respite Care services are provided to participants unable to care for themselves and are furnished on a short term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care may be provided on an hourly basis or a daily basis. The service may be planned and provided on a routine basis (such as daily, weekly, monthly, or semi-annually), or may be unplanned when a caregiver has an unexpected situation requiring assistance in caring for the participant. Respite Care may also be provided as an emergency in response to a crisis situation in the family. A crisis situation is one where the individual's health and welfare would be seriously impacted in the absence of the Crisis Respite Care. Respite Care services may be provided in the participant's home or private place of residence, or any facility licensed by the Indiana Family and Social Services Administration, Division of Family Resources or by the Indiana Department of Child Services as specified in the provider specifications found in Appendix C-1/C-3 of this document. Respite services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A participant who needs consistent 24-hour supervision with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her profession in the state of Indiana.

Respite Care may be provided on an hourly basis (billable in 15-minute units) for less than 7 hours in any one day; or at the daily rate for 7 to 24-hours in any one day. Crisis Respite Care is provided for a minimum of 8 to 24 hours billable at a daily rate. Twenty-four hour Respite Care cannot exceed 14 consecutive days. Respite cannot be provided as a substitute for regular childcare to allow the parent/guardian to hold a job or attend school.

Respite Services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite providers who are relatives must meet the following:

1) Approved by DMHA as a MFP-PRTF provider;
2) Selected by the family/child to provide the service; and
3) Maintain the qualifications required for Respite service.

Respite Care may not be provided by parents for a participant who is a minor child, or by any relative who is the primary caregiver of the participant. When relatives provide Respite Services, the Wraparound Technician will verify that the services were provided by making an unannounced visit to the respite site during the time the respite service is scheduled.

Consultative Clinical and Therapeutic Service
Consultative Clinical and Therapeutic Services that are not covered by the State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community based consultation activities are provided by professionals in psychology, social work, counseling and behavior management. The service includes assessment, development of a home treatment/support plan, training and technical assistance to carry out the plan, monitoring of the participant and other providers in the implementation of the plan. Crisis counseling and family counseling may be provided. This service may be delivered in the participant's home, in the school, or in the community as described in the Plan of Care to improve consistency across service systems.

This service may coordinate intervention planning in the school setting, but would not duplicate services that would be provided through an Individualized Education Plan (IEP) for children in special education.

Flex Funds
Flex funds are utilized to purchase any of a variety of one-time or occasional goods and/or services needed for participants when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled child's Plan of Care. Flex fund services and/or supports must be described in the person's Plan of Care. The use of Flex Funds on expenditure must be tied directly to a specified need documented on the Plan of Care, supported by the rationale as to how that expenditure will assist the participant to remain in the home and/or community. The service rationale must also be related to one or more of the following outcomes: success in school; living at the person's own home or with family; development and maintenance of personally satisfying relationships; prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or becoming or remaining a stable and productive member of the community. Flex Funds may be used to purchase bus passes or alternate methods of public transportation to enable participants and their families to gain access to approved MFP-PRTF services and other community services, activities and resources. The purchase of bus passes or alternate methods of transportation will not duplicate services delivered under Transportation services in the MFP-PRTF service program and/or Medicaid State Plan services. All uses of flex funds must be specified in the Plan of Care and approved prior to being incurred.

Claims for flex funds will be submitted through the regular claims process. Documentation must also be included in the clinical record regarding the unavailability of any other funding source for the goods and/or services, the necessity of the expenditure and the outcomes affected by the expenditure. The documentation must also include the wraparound team determination that the expenditure is appropriate and needed in order to achieve the treatment goals and that the expenditure will not supplant normal family obligations. Flex funds may not be used for purely diversional or recreational activities or items, or for room and board.

Non-Medical Transportation
Transportation services are available to enable participants and their families to gain access to MFP-PRTF services and other community services, activities, and resources as specified in the Plan of Care. Transportation may be provided to/from school if the school does not provide transportation; to an approved after school or week-end therapeutic activity; to an approved summer camp; and, other similar services or activities. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State

Plan, defined at 42 CFR 440.170(a) and does not replace them. Transportation services under the MFP-PRTF service program are offered in accordance with the participant's Plan of Care. Federal financial participation is available for the cost of transportation to a training event or conference. Whenever possible, family, friends, neighbors, or community agencies which can provide this service at no charge are utilized. Transportation services may not be provided for purely recreational or diversional activities or for any reason not directly tied to the child's plan of care.

Non-Medical Transportation Services may be provided by a custodial parent, foster parent, or legal guardian if the Treatment Team determines that no other providers or resources are available for this service. When custodial parents/foster parent/legal guardians are utilized for Non-Medical Transportation, that individual must:

1) Be approved by DMHA as a MFP-PRTF provider;
2) Be selected by the family/child to provide the service; and
3) Maintain the qualifications required for this service.

All Non-Medical Transportation Service provided by a custodial parent, foster parent or legal guardian must be documented by date, time, duration, purpose and the documentation must be submitted to the Wraparound Facilitator. The Wraparound Facilitator and/or Wraparound Technician verifies monthly reports submitted against the approved Non-Medical Transportation amount listed in the Notice of Action.

Training and Support for the Unpaid Caregiver

Training and Support for Unpaid Caregivers is an activity or service that educates, supports, and preserves the family and caregiver unit. Training and Support activities and the providers of these activities are based on the family/caregiver's unique needs and are identified in the plan of care. Activities may include, but are not limited to the following: teaching practical living skills; parenting skills; home management skills; use of community resources; child development; record-keeping skills to assist all caregivers; development of informal support; decision-making skills; conflict resolution; and, coping skills; as well as assistance with gaining knowledge, insight, and empathy in regard to the participant's illness, and increasing confidence, stamina and empowerment. Training and Support for Unpaid Caregivers may be delivered by the following types of resources: non-profit, civic, faith-based, professional, commercial, and government agencies and organizations; community colleges, vocational schools, universities, lecture series, workshops, conferences, seminars, on-line training programs; Community Mental Health Centers, and other qualified community service agencies.
For purposes of this service, "Unpaid Caregiver" is defined as any person, family member, neighbor, friend, coworker, or companion who provides uncompensated care, training, guidance, companionship, or support to a MFP-PRTF participant.

Reimbursement is available for non-hourly Training and Support for Unpaid Caregivers for the costs of registration/conference training fees, books and supplies associated with the training and support needs outlined in the plan of care. Hourly reimbursement is available for one-on-one training by providers of this service as specified in the plan of care including the individual provider's attendance at the child-family team meeting. Reimbursement is not available for the costs of travel, meals, and overnight lodging.

Policy/Procedure Approval		
Revised: May 2013	MFP-PRTF Service Definitions	
DA Approval:		**Date:**
DMHA Approval:		**Date:**
OMPP Approval:		**Date:**