OVERVIEW

Every reasonable effort must be made to maintain the stability of a child in community placements. When that is not possible due to the severity of mental or behavioral health needs, residential services may be necessary. Residential services are a short-term intervention with a primary focus on engaging and supporting youth and families in their homes and communities, using a range of culturally and linguistically competent family-driven and youth-guided, trauma-informed, evidence-based and evidence informed practices to address their needs and strengths. Residential service providers must follow the requirements outlined in this policy when the child's needs cannot be met in a less restrictive setting.

RESIDENTIAL PROGRAM TYPES

Based on the recommendation from the independent assessment, which includes the child's needs and strengths as well as short- and long-term treatment goals, the Regional Placement Unit (RPU) will refer a child for intervention under one of the following residential program types.

Qualified Residential Treatment Program (QRTP)

A Qualified Residential Treatment Program (QRTP) provides services following a child's removal from their own home or on-going out of home placement. This program has a trauma-informed treatment model that is designed to address the emotional or behavioral needs of children and provide clinical treatment as appropriate.

Program Types

The following residential program types follow the QRTP requirements:

- General Residential.
- Mental Health and Behavior Stabilization.
- Youth with Problematic Sexual Behaviors.
- Developmentally Disabled and Cognitively Impaired.
- Substance Abuse Rehabilitation.
- Parent/Baby.

- Specialized Developmental Disability (SDD).
- Intensive Stabilization.
- Human Trafficking Survivor.

Emergency Shelter Services

Emergency shelter services are provided on a short-term basis following a child's removal from their own home or on-going out of home placement. Services must include a written behavioral assessment of the child, an assessment of the family and family alternatives, and recommendations for needed services in the least restrictive setting; see FOM 722-03, Placement Selection and Standards.

QUALIFIED RESIDENTIAL TREATMENT PROGRAM REQUIREMENTS

A residential care program must be certified as a QRTP to contract with the Michigan Department of Health and Human Services (MDHHS) for residential services. To be certified as a QRTP the residential care program must apply by submitting the DHS-5336, Contracting with the Children's Services Agency for Foster Care, Adoption, and Residential Services. The requirements for a QRTP are:

- Uses a trauma-informed approach.
- Has licensed or registered nursing staff and other licensed clinical staff on-site and/or available 24/7.
- Is licensed in accordance with title IV-E requirements and nationally accredited.
- Involves the child's family members in the child's treatment plan.
- Provide outreach to family members, fictive kin and document in the service plan. This includes siblings, how those family members are integrated into the treatment process, how those family members are involved in post-discharge, and how sibling connections are maintained throughout.

- Provide discharge planning and family-based aftercare support for at least six months post discharge.
- Incorporate the short-and long-term goals identified by the independent assessment into the youth's treatment.

REFERRAL AND ACCEPTANCE

The following must be completed by the residential service provider:

- Submit the signed DHS-3600, Individual Service Agreement, to the RPU.
- Submit a new DHS-3600 when a child will remain with the same provider, but the child would be best served in a different program with that provider including change of security level.

The residential service provider must only accept a child for admission after receiving a fully executed DHS-3600. In an event of an emergency, the DHS-3600 must be fully executed no later than the first working day following admission for residential services.

The residential service provider must only admit MDHHS supervised abuse/neglect children who are referred by the RPU.

Requests for Change in Program Type

A child must not be moved from one residential program to another including within the same campus or area without going through the RPU. The assigned provider must continue to deliver residential services to the child and their family until RPU, or the primary caseworker/agency arrange for discharge.

All children admitted for residential services must be assessed by the independent assessor. This must occur prior to referral and admission to residential services. In emergency situations a child may be referred and admitted to a residential care program prior to the completion of the independent assessment; in these cases, the assessment must occur within 30 calendar days of admission. The residential service provider is not responsible for conducting or securing the assessment; the referral for assessment will be made by the RPU.

See FOM 912, Residential Services: Caseworker Responsibilities for more information about the independent assessment.

SERVICES TO BE PROVIDED

The residential service provider must maintain the capability to provide services 24 hours a day, 365 days a year.

The residential service provider must engage family members, caregivers, and any identified support person and connect them with resources to ensure a child can live in the community successfully.

In collaboration with the primary caseworker/agency, the residential service provider must work to identify and engage appropriate family members, caregivers, and permanent connections for children. The residential service provider is responsible for collaborating with the caseworker to establish permanence for the child as soon as possible.

Residential services must be provided based on the assessed needs of the child and the family.

Basic Residential Care

Residential services must be trauma informed and evidence-based, evidence-informed or identify as a promising practice to effect optimal outcomes.

Residential service providers must consistently deliver all of the following:

- Food.
- Shelter.
- Ongoing clothing needs.
- Incidental expenses such as:
  - Personal allowances.
  - School supplies.
  - Personal hygiene supplies.
- Routine health, medical and dental care.

- Services within the framework of Michigan's Child Welfare Practice Model (MiTEAM) must be provided.
- Treatment planning that is family driven, with a child guided perspective. For children without identified family, treatment planning must include engaging supportive adults involved with the child.

The residential service provider must allow the assigned primary caseworker/agency provider responsible for case management, or another staff designated by the primary caseworker/agency to have contact upon request with the child, this includes by phone, virtual contact, in person, and must provide a place for them to meet privately if requested; see FOM 722-06H, Case Contacts.

Psychological Services

The residential service provider must provide psychological services to a child according to the child's treatment plan. Psychological testing must occur as necessary for treatment planning, as well as psychological consultation with family and staff as necessary to assist in understanding the child's needs, test results, implications for treatment and interventions most appropriate for the child and family.

Note: Only licensed professionals trained to administer and interpret psychological tests will be allowed to provide psychological testing to children.

Individual or Group Therapy

The residential service provider must provide at a minimum, weekly direct therapy services to each child individually; group therapy can be used as an adjunct treatment. Individual and/or group therapy must be provided in accordance with the child’s treatment needs as identified in the child’s service plan.

Psychiatric Services

The residential service provider must provide psychiatric services to an individual child according to the child's treatment plan. This includes consultation with the family, medical and educational staff, and any other relevant individuals involved in the child's treatment

as necessary to assist in understanding the results of the psychiatric evaluation and implications for the child's treatment and identification of treatment interventions that are most appropriate for the child.

Prescribing Clinician

The residential service provider must follow requirements regarding the prescribing clinician in FOM 802-1, Psychotropic Medication in Foster Care.

Informed Consent

The residential service provider must follow the requirements regarding informed consent in FOM 802-1, Psychotropic Medication in Foster Care.

Educational Services

The residential service provider must ensure that every child is provided appropriate educational services. The residential service provider must:

- Collaborate with the child's identified school to screen for possible educational disabilities. If a disability is suspected, refer the child for an Individual Educational Program Team (IEPT) evaluation within the first 30 calendar days to assess, plan and place the child in the most appropriate educational/vocational program.
- Request prior educational assessments within 30 calendar days of admission to assess the current educational needs.
- Initiate an exit review of the educational plan at least 30 calendar days prior to discharge and forwarded to the primary caseworker/agency responsible for case management.
- Ensure that program staff are available to assist during school hours in case of a crisis.
- Notify, in writing, to the school administration where the child is enrolled, the name of the person who is supervising the child's foster care case, and who is responsible for attending IEPT meetings. This notification should be contained in the education section of the child's foster care case record.

- Provide or arrange structured educational and/or vocational activities for children who are suspended from or expelled from school, or who have passed their General Education Development (GED) test. These activities include, but are not limited to:

  - Structured homework time.
  - Additional reading and/or writing activities.
  - Online educational programming.
  - Independent study assignments.
  - Independent living skills.

- Monitor and maintain school progress, including documenting a minimum of weekly contact with the school. Monitoring and maintaining school progress may look like:

  - Obtaining school assignments.
  - Completion of homework.
  - Supporting test preparation.
  - Capturing and reporting grades and test scores.
  - Additional tutor services.

- Provide tutorial services to a child, as necessary, based on the child's Individualized Education Plan (IEP) or treatment plan. Those individuals providing tutorial services must have appropriate educational credentials.

- Provide advocacy and service planning for children that are expelled or suspended, including actively engaging the child's family in the advocacy and planning process.

- Comply with Michigan's Department of Education rules and requirements if operation of a school is taking place on the residential's grounds.

- Maintain enrollment in the child's school of origin, whenever possible.

- Assess the family's educational background and capacity to support the child's education service needs and coordinate with the primary caseworker/agency to refer family members to relevant adult education programming as indicated, when appropriate.

Transportation

The residential service provider is responsible for routine transportation (defined as any travel, including family visitation) that is required by the child and family for treatment purposes which may not reasonably be provided by the parents or other funding source. The residential service provider must coordinate with the primary caseworker/agency responsible for foster care case management to resolve transportation and location barriers.

Independent Living Preparation

Independent living preparation is a comprehensive and coordinated set of activities that will assist children in preparing for independence or self-sufficiency in areas of housing, employment, financial and personal care.

The residential service provider must provide independent living activities for all children aged 14 and older which will include, but are not limited to:

- Budgeting and money management.
- Employment seeking skills.
- Communication skills.
- Relationship building.
- Establishing health and hygiene.
- Household maintenance and upkeep.
- Educational assistance.
- Preventive health services.
- Parenting skills.
- Accessing community services.

The residential service provider must identify independent living activities in the child's ISP and USP regularly, following the child's 14th birthday; see FOM 722-03C, Older Youth: Preparation, Placement and Discharge.

The residential service provider must provide relevant self-care, daily living skills, community engagement, and mobility skills according to the child's ability.

Trauma Responsive Services

The residential service provider must screen the child for trauma and refer or provide clinical trauma assessments, as necessary. The residential service provider must collaborate with mental health providers to link the child to evidence-based services and develop strength-based case plans.

The residential service provider must complete the CWL 4607, Chief Administrative Tool, to document how they are practicing and achieving a trauma informed environment and submit it to the Division of Child Welfare Licensing (DCWL) annually for evaluation.

Medical and Dental Care

The residential service provider must ensure that each child receives routine and non-routine medical and dental care as required; see FOM 801, Health Services for Children in Foster Care. In addition to the policy requirements outlined in FOM 801, the residential service provider must ensure the child has access to the following:

- Rehabilitative, physical, or dental procedures by medical personnel, as necessary.
- Utilization of enrolled Medicaid providers or a board-certified physician or dentist volunteering their time for health procedures.
- Provision of medication as prescribed by a treating physician. The residential must have a standard operating procedure for dispensing and storage of medication.
- Special diets provided as needed and regularly reassessed utilizing appropriate specialized personnel. Any child who is determined to be obese/underweight must have a plan to address their weight, health, and well-being.
- Registered or licensing nursing staff on site and/or available 24 hours a day, 7 days a week. The nursing staff must be available, within 60 minutes, to the residential care program at all times.

Wardrobe/ Personal Possessions

The residential service provider must ensure that each child has an adequate wardrobe as defined by and documented on the DHS-3377, Clothing Inventory Checklist, while receiving services and upon discharge; see FOM 903-04, Purchased Care Payment Procedures.

Legal or Court Related Services

The primary caseworker/agency must ensure that the residential service provider is informed of all court hearings and court orders relevant to the child's care.

The residential service provider must coordinate with the primary caseworker/agency responsible for placement of a child in matters relating to any legal or court activities that concern the child. The residential service provider is required to:

- Provide court testimony, recommendations, and reports as requested by the court.
- Ensure all directives and services ordered by the court are completed to the satisfaction of the court within the timeframes ordered.
- Attend court hearings, when necessary.

The residential service provider may be required to provide:

- Transportation of the child to and from court hearings.
- Supervision of the child during transport or while present at the hearing.

If a child cannot be safely transported to a court hearing, the residential service provider must immediately notify the child’s Lawyer Guardian ad Litem (LGAL) and the primary caseworker/agency responsible for the child’s case management.

See SRM 131, Confidentiality- Children's Services.

Assessments

The residential service provider must utilize the following assessment tools:

- Child Assessment of Needs and Strengths (CANS), Child and Adolescent Needs and Strengths (CANS), or Child and Adolescent Functional Assessment Scale (CAFAS), and
- Casey Life Skills Assessment (CLSA) or Daniel Memorial Assessment (for children 14 years of age and older).
- Additional standardized and reliable assessment tools to assess overall progress in functioning may also be used.

In addition to the assessment tools above, the following assessments are required by program type:

Youth with Problematic Sexual Behaviors

CANS-Sexually Aggressive Behavior Module (CANS-SAB).

Parent/Baby

Adult-Adolescent Parenting Inventory (AAPI) to assess parenting skill progress.

Specialized Developmental Disability (SDD)

The residential program must utilize one or more of the following assessment tools within 21 calendar days of admission:

- Autism Diagnostic Observation Schedule (ADOS).
- Pearson's Expressive Vocabulary Test (PEVT).
- Assessment of Functional Living Skills (AFLS).

Intensive Stabilization

- Biopsychosocial Assessment to be completed within 3 calendar days of admission.
- Psychiatric Assessment to be completed within 72 hours of admission.
- Nursing Assessment to be completed within 24 hours of admission.

Human Trafficking Survivor

- Biopsychosocial Assessment.
- Psychiatric Assessment.
- Nursing Assessment.
- Integrated Behavioral Health Team Assessment.

Unless otherwise specified, the residential service provider must administer all assessments within 30 calendar days of admission and quarterly thereafter until discharge.

Exception: The initial assessment completed by the independent assessor will satisfy the requirement of the CANS or CAFAS within the first 30 calendar days of placement.

The assessments must be completed by a professional trained in the identified tool.

Bio-psychosocial Evaluation

Within the first 30 days of a child's admission, the residential service provider must complete a bio-psychosocial evaluation as part of the initial assessment. If a bio-psychosocial evaluation was completed within the last year, that evaluation must be reviewed and can be used to meet the requirement. The evaluation must include:

- Strengths, skills, and special interests.
- Permanency history.
- Social history for the child, parents, and family.
- History of maltreatment and trauma.
- Mental status examination.
- Trauma screening and assessment results.
- Trauma-responsive support plan that is:
    - Individualized to meet the child's strengths and needs.
    - Culturally and linguistically competent.
    - Child-guided and strength-based, including the following elements:

- Ensuring clear rights and expectations/responsibilities.
- Promoting collaboration and empowerment with the child.
- Skill building to teach the child how to regulate their emotions and behaviors.

- Intelligence and projective tests, as indicated.
- Behavioral assessment.
- Family, environmental, cultural, and religious or spiritual preferences.
- Educational and vocational goals and needs.
- Psychiatric history, as necessary.
- Specific behaviors and frequency of those behaviors that would necessitate a more intensive treatment setting.
- Develop a strength-based plan that focuses on daily living skills.

Service Plans

Initial Service Plan

The residential service provider must complete the Children's Foster Care Residential Initial Service Plan, DHS 365 (4-9 years), DHS-365-A (10-13 years), or DHS-365-B (14 years and older) and submit it to the caseworker within 30 days of the child's admission for residential services.

Updated Service Plan

The residential service provider must complete the Children's Foster Care Residential Updated Service Plan, DHS-366 (4-9 years), DHS-366-A (10-13 years), or DHS-366-B (14 years and older) and submit it to the caseworker within 60 days following the ISP and every subsequent 90 days.

Treatment Planning

The residential service provider must develop an assessment-based treatment plan within 30 calendar days of the child's admission unless otherwise specified by program type in the contract.

Treatment plans must be developed based on CANS. The residential service provider must include the child's short- and long-term goals identified by the qualified assessor in the initial treatment plan.

The residential service provider must submit the child's treatment plans to the caseworker within the child's first 60 days of placement and every subsequent 90 days.

STAFFING REQUIREMENTS

The residential service provider must maintain sufficient well-trained staff to provide effective child engagement that encourages the child's goals while creating a safe environment. The residential service provider will recruit and employ a diverse staff reflective of the client population.

Reasonable and Prudent Parent Standard

The residential service provider must designate individual(s) trained in making decisions using the reasonable and prudent parent standard as well as those who are authorized to consent to the child's participation in activities.

The designated individual(s) must be onsite and authorized to apply the standard to decisions involving the child's participation in age or developmentally appropriate activities. The individual(s) should consult with the child's family and treatment team who are most familiar with the child at the residential care program when applying and using the reasonable and prudent parent standard.

Staff will be trained and familiar with the Prudent Parent Standard; see FOM 722-11, Prudent Parent Standard and Delegation of Parental Consent.

Staff Education, Experience and Qualifications

All residential services staff must possess the following minimum qualifications before working with children:

- A non-judgmental, positive attitude towards children and their families.
- Training in positive engagement and interactions when working with children and families.
- Training in working with children and families who have experienced trauma.
- Cultural and ethnic sensitivity, cultural humility, as well as diverse competency; see SRM 403, Non-Discrimination in Foster Care and Adoption Placements.
- Knowledge of mental health, substance use disorder, child sexual behavior and child development.
- Training in crisis prevention and intervention, assessment of potentially violent situations and effective de-escalation techniques.

Therapeutic interventions must be provided by one of the following professionals who is trained/certified in evidence-based and trauma informed treatment:

- Licensed Master's Level Social Worker.
- Licensed Master's Level Counselor.
- Limited Licensed Master's Level Psychologist.
- Licensed Psychologist, Ph.D.
- Limited Licensed Master's Level Counselor or Limited License Master's Level Social Worker under the supervision of a Licensed Counselor or a Licensed Master's Level Social Worker, Licensed Psychologist, Ph.D., or Psychiatrist.
- Psychiatrist trained to work with children and families. Preferably Board Certified in Child/Adolescent Psychiatry.

Note: If the residential service provider subcontracts for therapy services, the residential service provider must ensure the subcontracted provider has the appropriate credentials outlined above.

Staff Training Requirements

The residential service provider must use a training practice model that operationalizes the values of family-driven, child-guided, trauma-informed, permanency, involvement in the community, culturally and linguistically competent care. The training model must have an urgent focus on permanency practices, engaging, and working with families in their community towards successful and sustainable reunification.

The residential service provider must provide 50 hours of training for a new hire during the first year of employment. A minimum of 40 hours of training must be completed within the first 30 calendar days of the new hire's employment and the new hire must complete 16 of the 40 hours of training prior to providing direct care services. The remaining hours must be completed prior to the end of the employee's first year of employment.

The residential service provider must ensure all residential staff are trained to serve as a role model for appropriate social skills, prioritizing needs, negotiation skills, accessing local resources, hygiene and grooming preparation, food preparation and anger management.

The residential service provider must provide residential staff with quarterly trauma-focused training to maintain a trauma-informed milieu and treatment environment. Trauma-focused programming must be based on an evidence-based, evidence-informed, or promising practice treatment model.

INVOLVEMENT OF THE CHILD'S FAMILY

The residential service provider must include the child's family (including incarcerated parents) and placement caregiver(s) as extensively as possible from the beginning of the admission process through discharge, transition, and aftercare. Families and caregiver(s) must be supported and involved in all aspects of the child's/family's treatment and transitional/discharge planning.

Family and caregiver(s) involvement must remain the center of the child's programming. All services must be provided in a manner that ensures that the child, families, and placement caregiver(s) receive comprehensive, culturally competent interventions.

The residential service provider, in accordance with each child's individual treatment plan, must:

- Include the family (birth, relative, identified adult support and/or permanent caregiver) in the development of the treatment plan and document the family's involvement in the service plan.
- Ensure the opportunity for daily contact between family and the child, when safe and therapeutically indicated for the child to have contact with their family.
- Provide transportation and flexible hours to meet the family's schedule to facilitate the family's treatment goals. If the distance of a family from the agency is identified as a barrier, describe the agency's plan to reduce the barrier to ensure ongoing family contact; see FOM 722-06I, Maintaining Connections: Parenting Time, Sibling Visitations, and Contact.
- Provide an identifiable area for family to spend time together at the residential facility which offers privacy and comfort when it is safe and in the best interest of the child to do so.
- In collaboration with the primary caseworker/agency responsible for case management, ensure weekly sibling involvement and visitation and other required sibling interaction is occurring; see FOM 722-06I, Maintaining Connections: Parenting Time, Sibling Visitations, and Contact.
- Provide supported intervention based on the child's treatment needs to encourage and strengthen sibling relationships unless the primary caseworker/agency indicates it should not occur.
- Include a specific plan to address the family's needs that will assist the family in meeting the needs of the child.
- The residential service provider must coordinate with the primary caseworker/agency responsible for case management to identify, recruit and prepare any identified family for placement with the child.

- Prohibit the withholding of family contact (in any form) as a method of discipline.
- Ensure the child is present for identified special recruitment activities for children who are available for adoption. In addition, the residential service provider must aggressively pursue family finding/family search and engagement practices for every child receiving residential services for whom there is no identified family. The residential service provider must involve the child in adoption recruitment and planning activities. If there are any safety concerns or other identified treatment concerns, the residential service provider will consult with the assigned primary caseworker/agency responsible for case management.

Family Team Meetings (FTM)

Family team meetings (FTM) are an essential component of MiTEAM case practice model and serve as the primary forum for collaborative case planning for the child and family.

FTMs are used to plan and review for the child and to ensure the child receives an appropriate array and quantity of services that are necessary to stabilize the child, help them heal and achieve permanency as soon as possible. Services are to prepare the child to succeed in a less restrictive community-based setting after discharge. The residential service provider, child, and the child's family must participate in quarterly FTMs.

The residential care provider must incorporate goals and action steps regarding the child from previous FTMs into the initial treatment plan.

The residential care provider will coordinate with the primary caseworker/agency to participate in a pre-meeting discussion with the child at least 24 hours prior to the FTM. The residential care provider will participate with the child in person or via phone conference for all FTMs when appropriate for the child to participate.

The residential will work with the child, family, treatment team, primary caseworker/agency, and local Community Mental Health (CMH) provider to assist the child in developing meaningful connections to the child's family, community, and other non-family resources.

See FOM 722-06B, Family Team Meeting.

DISCHARGE PLANNING

Discharge planning must begin at the time of admission to residential services. The residential service provider must develop an initial discharge plan within 30 days of the child's admission. A review of the discharge plan must be completed quarterly and no more than 30 days prior to discharge. The discharge plan must be created in collaboration with the child, parent(s) or guardian(s), agency with case management responsibility, foster parent(s), relative caregiver(s), local CMH providers, Permanency Resource Monitor (PRM), and the residential staff.

The child's discharge plan along with the child's projected discharge date must be included in each child's/family's service plan. The child's/family's discharge plan must include the level of care projected to be needed at discharge. The discharge plan must include services that are recommended after discharge, such as mental health, behavioral health, and family support services.

The residential service provider must ensure the child's/family's discharge plan is reviewed and updated during quarterly FTMs.

Planned Discharge

The residential service provider must provide the following transitional services to children when a planned discharge occurs:

- Submit a discharge service plan to the primary caseworker/agency responsible for case management.
- Residential service provider must coordinate with CMH directly or the primary caseworker/agency for the referral and any identified services until discharge. A referral to CMH for assessment and case management services can be made 180 days prior to discharge.

The residential service provider must also provide aftercare requirements outlined in this item, and medical and mental health requirements outlined in this item.

Unplanned Discharge

All children being moved to another residential provider must be referred to the RPU for the placement process. The residential service provider must continue residential services until the child is admitted to a new residential provider.

The residential service provider can request the discharge of a child from the program, within 30 days, prior to the child successfully achieving the treatment goals due to one of the following:

- A child is no longer receiving benefit from services or has reached maximum benefit of the residential provider's services.
- Significant safety concerns exist for the child, peers, and/or staff.

Note: If the child poses a threat or harm to self or others, the residential service provider may request and be approved to provide a one-to-one staffing ratio.

When the residential service provider is requesting a child's discharge from a residential program due to one of the outlined reasons, a request must be submitted in writing to the RPU and the child's primary caseworker/agency and must include the following:

- Child's identifying information.
- A detailed explanation of the safety concerns.
- A detailed explanation of the circumstances that exist that prevents the residential service provider from meeting the child's needs.
- Actions taken by the residential service provider to address child’s treatment needs.
- Evidence that a FTM was held with the foster care caseworker, Supervisor, RPU, and parent or involved family member within 30 days of the request to explore alternatives to replacement which might include:
    - Explore options to change milieu (unit, peers).

- Changes in staffing ratio (including request for 1:1 – dependent on staff availability and expedited approval from DCWL).
- Modifications of the treatment/behavior plan or program structure.
- Additional psychiatric consults/screening.
- Access to additional outside services if indicated which might include inpatient or partial hospitalization, occupational therapy, Primary Care Physician (PCP) or dietician consults, speech, and language services.
- Exploration of IEP amendments for additional services or change in school setting.
- Exploration of reunification or placement with a fit and willing relative.

A request for discharge cannot be based on the child's diagnosis, acuity, criminal or sexual offender status, race, color, religion, national origins, sexual orientation, gender identity, linguistic or cultural needs, or previous negative outcomes or experiences with this child.

The residential service provider must continue with services to the child for up to 30 calendar days following the written request for discharge.

Medical and Mental Health Requirements at Discharge

For both planned and unplanned discharge from the residential care program, the residential service provider must provide health packet five days prior to the child's discharge. The health packet must include:

- A complete list of the child’s medications including those used routinely and on an as needed basis. This list must be generated from the medication administration record used to administer medications and must be reviewed and reconciled by the residential service provider's nurse. This list must be

generated and reconciled no more than 48 hours before discharge.

- A list of the medications supplied on discharge including (as applicable):
  - Prescriptions for medications sent with the child (minimum 30-day supply).
  - Prescription refills (minimum 30-day supply) available for transfer from the pharmacy at discharge.
  - Medications supplied in packaging (minimum 30-day supply).
  - If a child is taking Clozapine and the pharmacy will not dispense a 30-day supply, the prescription should include refills sufficient to provide a 30-day supply once Clozapine Risk Evaluation and Mitigation Strategy (REMS) required lab work is obtained/documented.
- Copies of psychiatric care documentation including the initial psychiatric evaluation, all medication review documents and any related documents (e.g., documented correspondence about psychiatric care).
- Copies of medical examinations including comprehensive (annual) health examinations, and acute care visits.
- Copies of laboratory and all other diagnostic studies conducted while the child was in the residential care program's care.
- Assessment documents including those conducted as part of the intake process, and any assessments conducted for the purposes of treatment planning.
- Initial and two most recent updated treatment planning documents from the residential intervention program.
- A statement for each child receiving psychotropic medication, including the name of the child’s next treating psychiatrist/primary care physician, date of last medication review, date of last signed informed consent, date of medication review following discharge (within five days of discharge), and date the psychiatric information was provided to the next psychiatrist/primary care physician.

- The packet may be sent by fax to the appropriate recipients, or paper copies may be transferred by the caseworker or other person transporting the youth from the residential provider. Document the transmission of the packet.

- When a child transitions from one residential service provider to another, within 24 hours of discharge, a telephone call between the nursing staff of the accepting and referring programs (residential or hospital) is to be held to discuss the transfer.

- When a child transitions from the residential provider to a hospital (general medical or psychiatric), the residential service provider's nurse will contact the hospital nursing staff (emergency department or floor/unit to which the youth is admitted) to coordinate care. This conversation must include:

  - A review and reconciliation of all medications.

  - The overall health status of the youth, including current treatment and any diagnostic work up in progress at the time of transition.

  - A list of ongoing laboratory or other monitoring required because of current treatment; for example, complete blood counts required for individuals taking clozapine.

- The residential care program's nursing staff will communicate with consulting physicians/health care providers (general health and psychiatric) within one business day of any of the following transition events:

  - From inpatient medical or psychiatric care to the residential program.

  - From the residential program to an emergency department for potential admission for medical or inpatient psychiatric care.

  - From another clinical site to the residential program.

- The communication between the residential service provider's nursing staff and consulting physicians/health care providers must include:

  - A summary of the nurse-to-nurse consultation.

- Status of the youth, including any concerns, such as level of alertness, side effects, ongoing diagnosis or treatment that will need attention/orders prior to psychiatric evaluation.
- Review of current medication supply/needs prior to scheduled psychiatric evaluation.

- The communication between the residential service provider's nurse and the consulting physician/health care provider can occur via direct phone call, voicemail to the consulting physician/health care provider, fax, or HIPAA-compliant email. The manner of communication will be documented in the nursing note, as will any subsequent communication between the nurse and the consulting physician/health care provider.
- The residential service provider must ensure the communication is documented as a nursing note and will be co-signed by the physician/health care provider within five business days, either by fax transmission of a paper health record, or by electronic signature within an electronic health record. The document must be kept in the child's health record.

Note: If the child is hospitalized in a psychiatric hospital, once stabilized it is expected that the child is to return to their residential care program if it is in the child's best interest.

AFTERCARE

The residential service provider must provide aftercare services for each child discharged from residential services contracted by MDHHS. Aftercare services must continue for a duration of six months post discharge and must be provided to children who are discharged into a community setting.

Exception: Discharge to another child caring institution (CCI), adult foster care, shelter, hospital, detention, or jail.

The residential service provider is not required to provide aftercare services if a child was in the program for 14 days or less, or if the independent assessment determines that the child should be serviced in the community and that the child is discharged from the residential program within 30 days of entry.

For families living outside of the 90-mile radius from the residential program, the residential service provider may subcontract or

partner with another residential provider who is in the family's community to provide any direct care services required under level two. If the family is living outside of the 90-mile radius and services are subcontracted, the Families Transition Coordinator (FTC) is responsible for ensuring the required services are being provided and the aftercare residential report is completed and submitted.

Out of State

Aftercare is not required for children who are discharged to a community placement out of state or move to a community placement out of state during the six-month aftercare period. Services or activities to ensure a smooth transition are encouraged and providers can bill for the associated aftercare level while providing those services.

Services to be Provided

Level One

Level one aftercare services are provided when the child has services being provided in the home by CMH, a Prepaid Inpatient Health Plan (PIHP), or another provider approved by program office. When providing level one aftercare services, the residential provider must:

- Assess the child and family for any needs that are not being covered by community-based services and coordinating with the primary caseworker to ensure the appropriate referrals are made.
- Participate in CMH Wraparound meetings or other treatment team meetings, if appropriate.
- Maintain regular, minimum of monthly, contact with the CMH or other service provider for updates on the child.
- Ensure initial contact with the youth/family is completed within five business days of discharge from the program.
    - Two contacts must be made within the first 30 days post discharge.
    - One contact per month must be made for the remaining months.

Level Two

Level two aftercare services are provided by the residential provider when the child is not receiving services from CMH, a PIHP, or a service approved by program office. When providing level two aftercare services, the residential service provider must:

- Assess the child and family for needs that are not being covered through community-based services and coordinating with the caseworker to ensure the appropriate referrals are made.
- Provide crisis on-call.
- Provide therapeutic/psychiatric services as identified by the child's treatment plan.
- Offer activities, classes, or other programs for the child and the family to participate in.
- Assess the need for CMH or other community-based services and assisting with facilitating services.
- Complete the initial face to face contact with the youth/family within five business days of discharge from the intervention.
    - In-person contact must be made weekly for the first 30 days post discharge.
    - In-person contact must be made twice per month for the second month post discharge.
    - In-person contact must be made monthly for the remaining months.
    - In-person contacts may be made by the FTC or therapist.

Assessments and Reports

The residential service provider must complete the MDHHS-5931, Residential Aftercare Report, at 30, 90, and 180 days after discharge from the residential program. All reports must include any clinical assessments and treatment goals. The residential service provider must submit the reports to the primary caseworker/agency no later than 15 days after completion.

CONCERNS/ GRIEVANCE PROCESS

If the residential service provider has concerns about specific actions or inactions of a child's caseworker, the residential provider may take the following steps:

- Discuss the issues with the caseworker's supervisor.
- If the concerns are not resolved, escalate to the program manager or county director.
- If the concerns are not resolved program manager or county director, escalate to the Business Service Center (BSC) Director.

CRITICAL INCIDENTS

The residential service provider must document any incidents in MiSACWIS, including, but not limited to:

- Child death or suicide.
- Attempted suicide.
- Serious child injury or illness requiring inpatient hospitalization.
- Contact with law enforcement.
- Corporal punishment of a child.
- Physical restraint of a child.
- Mechanical restraint of a child.
- Seclusion of a child.
- AWOL and/or escape of a child.
- Allegations of child sexual abuse or sexual harassment.

Residential staff who has reasonable cause to suspect child abuse or neglect must file a report with the MDHHS Centralized Intake Unit; see FOM 722-13, Referrals to Children's Protective Services (CPS).

Restraints and Seclusion

Positive peer culture, peer-on-peer restraint, chemical restraint, prone restraints, a restraint chair, noxious substances, instruments causing temporary incapacitation, other restraints that may constrict

a child's breathing, or any form of corporal punishment is prohibited.

Restraints may only be used after less restrictive techniques have been exhausted and the restraint is still necessary to prevent serious injury to the child, self-injury, injury to others, or as a precaution against escape where the child may be at risk of injury to self or others.

Residential service providers must follow requirements regarding restraint and seclusion; see FOM 722-02B, Guidance for Restraints in Child Caring Institutions.

Absent Without Legal Permission (AWOLP)

See FOM 722-03A, Absent Without Legal Permission (AWOLP), for more information.

CHILD FATALITY

The death of a child must be reported; see SRM 172, Child/Ward Death Alert Procedures and Timeframes.

RATE CHART LOCATION

The rates for CCI and placement agency foster care (PAFC) providers have been relocated to the public website.

The rates can be accessed at the hyperlink below:

http://www.michigan.gov/documents/mdhhs/Residential_Foster_Care_Adoption_Combo_Spreadsheet_516066_7.xls

LEGAL AUTHORITY

State

Child Care Organizations Act 116 of 1973, MCL 722.123a

Placement of a child in foster care into a qualified residential treatment program. Includes requirements, assessment of qualified

individual, duties of court or administrative body, dispositional review, approval for continued placement, and definitions.

Probate Code of 1939 Act 288 of 1939, MCL 712A.19

Determination as to placement in a residential care program.

The Social Security Act, MCL 400.14-400.122

Federal

Family First Prevention Services Act, PL 115-123

The purpose of this is to enable States to use Federal funds of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-Welfare-Policy@michigan.gov).