Targeted Case Management Services: Intensive Care Coordination

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications.

Intensive Care Coordination (ICC) is a service that provides MassHealth youth, with serious emotional disturbance (SED), under the age of 21, and enrolled in MassHealth Standard or CommonHealth, services and supports are driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

ICC is defined as follows:

Assessment: The care coordinator facilitates the development of the Care Planning Team (CPT), who utilize multiple tools, including a strength-based assessment inclusive of the Child and Adolescent Needs and Strengths (CANS-MA version), in conjunction with a comprehensive assessment and other clinical information to organize and guide the development of an Individual Care Plan (ICP) and a risk management/safety plan. The CPT is a source for information needed to form a complete assessment of the youth and family. The CPT includes, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving state agencies, and natural supports, such as family members, neighbors, friends, and clergy. Assessment activities include without limitation the care coordinator

- assisting the family to identify appropriate members of the CPT;
- facilitating the CPT to identify strengths and needs of the youth and family in meeting their needs; and
- collecting background information and plans from other agencies.

The assessment process determines the needs of the youth for any medical, educational, social, therapeutic, or other services. Further assessments will be provided as medically necessary.

Development of an Individual Care Plan: Using the information collected through an assessment, the care coordinator convenes and facilitates the CPT meetings and the CPT develops a child- and family-centered Individual Care Plan (ICP) that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. The care coordinator works directly with the youth, the family (or the authorized healthcare decision maker), and others to identify strengths and needs of the youth and family, and strategies for meeting their needs.

Referral and related activities: Using the ICP, the care coordinator

- convenes the CPT which develops the ICP;

- works directly with the youth and family to implement elements of the ICP;
- prepares, monitors, and modifies the ICP in concert with the CPT;
- will identify, actively assist the youth and family to obtain, and monitor the delivery of available services including medical, educational, social, therapeutic, or other services;
- develops with the CPT a transition plan when the youth has achieved goals of the ICP; and
- collaborates with the other service providers and state agencies (if involved) on the behalf of the youth and family.

Monitoring and follow-up activities: The care coordinator will facilitate reviews of the ICP, convening the CPT as needed to update the plan of care to reflect the changing needs of the youth and family. The care coordinator working with the CPT perform such reviews and include

- whether services are being provided in accordance with the ICP;
- whether services in the ICP are adequate; and
- whether these are changes in the needs or status of the youth and if so, adjusting the plan of care as necessary.

Components of Service

1. ICC services are delivered by a service provider that is contracted as a CSA.
2. ICC services must be delivered by a provider with demonstrated infrastructure to support and ensure
    a. Quality Management /Assurance
    b. Utilization Management
    c. Electronic Data Collection / IT
    d. Clinical and Psychiatric Expertise
    e. Cultural and Linguistic Competence.
3. ICC services include, but are not limited to:
    a. A comprehensive home-based assessment inclusive of the CANS and other tools as determined necessary that occurs in the youth's home or another location of the family's choice
    b. Family-driven identification of appropriate members of the CPT

	c. Development and implementation of a youth- and family-centered ICP in collaboration with the family and collaterals d. Development of a risk management/safety plan in collaboration with the family and collaterals e. Regular contact by the care coordinator with the family, youth (where appropriate) and other relevant persons in the youth's life (collaterals) f. Facilitation of CPT meetings g. Face-to-face contact with the youth and family, as determined by the youth and family and members of the CPT h. Referrals and linkages to appropriate services along the continuum of care i. Identification and development of natural supports j. Assistance with system navigation k. Family education, advocacy, and support l. Monitoring, reviewing, and updating the ICP to reflect the changing needs of the youth and family m. Psychiatric consultation to the care coordinator regarding the youth's behavioral health treatment needs 4. The ICC provider must be available by phone and staff on-call pagers to monitor the need for ESP/Mobile Crisis Intervention services and assist with access to those services for the youth and their families 24 hours a day, 365 days a year. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not acceptable. 5. The ICC provider offers and delivers services in the youth's home or community and participates in CPT meetings and other activities in schools, day care, foster homes, and other community settings. 6. With required consent, when the ICC provider is responsible for scheduling the meeting, CPT meetings are scheduled at a time and location when at least one family member can be available to attend in person. The ICC provider will not convene CPT meetings with collaterals without the youth, parent/guardian/caregiver unless the youth and/or parent/guardian/caregiver agree to the CPT meeting occurring. ICC providers will encourage other providers to arrange meetings in a similar manner.

	7. ICC is delivered in a manner that is consistent with *Systems of Care* philosophy and *Wraparound* planning principles and adheres to the four phases of *Wraparound.* 8. The ICC provider addresses a variety of complex treatment and system issues. The care coordinator is skilled in providing education and planning regarding treatment access and service needs, parenting skills, conflict resolution, mediation, risk management/safety planning and intervention, and family advocacy and support. 9. The ICC provider assists the youth to access medical, educational, social, therapeutic, and other services identified in his/her ICP, and is responsible for developing a plan to initiate and guide those service interventions.
Staffing Requirements	
	1. The ICC provider is staffed with care coordinators who have successfully completed skill- and competency-based training in the delivery of ICC consistent with *Systems of Care* philosophy and the *Wraparound* planning process and have experience working with youth with SED and their families. 2. The ICC provider employs both bachelor's level and master's level care coordinators who work with a range of youth and their families who present with varying degrees of complexity and needs. 3. The ICC provider ensures adequate staffing of master's level care coordinators and bachelor's level care coordinators or an associate's degree or high school diploma and a minimum of five (5) years of experience working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems. 4. The ICC provider is responsible for ensuring that the number of youth assigned to each care coordinator (youth to care coordinator ratio) allows for the care coordinator to appropriately and effectively provide the ICC services

	each youth requires. 5. The ICC provider ensures that a licensed, master's level senior care coordinator provides adequate supervision to each care coordinator on a weekly basis. 6. The ICC provider ensures that a board-certified or board-eligible child psychiatrist or a child-trained mental health APRN is available during normal business hours to provide consultation services to the care coordinator. The psychiatric clinician is available to provide phone or face-to-face consultation within one day of a request. 7. The ICC provider participates in, and successfully completes, all required training. 8. The ICC provider ensures that all senior care coordinators complete the state required training program for ICC and have successfully completed skill- and competency-based training to supervise care coordinators. 9. The ICC provider ensures that all care coordinators complete the state required training program for ICC and have successfully completed skill- and competency-based training to provide ICC services. 10. The ICC provider's training program for all care coordinators, upon employment and annually thereafter, minimally includes the following: a) *Systems of Care* philosophy b) Psychotropic medications and possible side effects c) Family systems d) Peer support e) Partnering with parents/guardians/caregivers f) Child and adolescent development g) Related core clinical issues/topics h) Overview of the clinical and psychosocial needs of the target population i) Available community mental health and substance-specific services within their natural service area, the levels of care, and relevant laws and regulations j) The four phases of *Wraparound* and the 10 principles of *Wraparound* k) Ethnic, cultural, and linguistic considerations of the community l) Community resources and services m) Family-centered practice n) Behavior management coaching

	o) Mandated Reporting p) Social skills training q) Psychotropic medications and possible side effects r) Risk management/safety plans s) Crisis Management t) First aid/CPR u) Introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.) v) Basic IEP and special education information w) Managed Care Entities' performance specifications and medical necessity criteria x) Child/adolescent development including sexuality y) Conflict resolution
Service, Community, and Collateral Linkages	
	1. The ICC care coordinator facilitates the development of a CPT that is comprised of formal and natural supports of the youth and /or family's preference. The CPT includes, as appropriate, but is not limited to, the youth and family, the care coordinator, the Caregiver Peer to Peer Support staff, therapist, school personnel, relatives, primary care physician or clinician, clergy, other professionals providing services, state agency representatives, juvenile justice representatives, and others identified by the family. For youth enrolled in ICC who are in foster care or kinship care settings, the ICC provider works with DCF to determine the appropriateness of engaging the biological family in the ICC CPT based on the DCF permanency plan. 2. The youth is a core member and an integral part of the CPT. The youth is invited and supported to participate in every CPT in an age appropriate manner. The ICC provider ensures the youth's participation to the greatest extent possible in developing and setting goals for ICC. 3. Using the information collected through the home-based assessment inclusive of the CANS, the care coordinator convenes and facilitates the CPT, which develops a youth- and family-centered ICP that specifies the goals and actions to address the medical, social, therapeutic, educational, and other needs of the youth. As part of the care planning process, the care coordinator works directly with the youth, the family and others to identify the strengths, needs, and strategies of the youth and family in meeting their needs.

	4. With consent, if required under applicable law, the care coordinator communicates and collaborates with other necessary individuals involved with the youth and his/her family, such as behavioral health providers including outpatient/In-Home Therapy Services staff, DCF, DMH, DYS, and DDS workers, probation officers, guardians ad litem, attorneys and advocates, teachers, special education administrators, primary care physicians and other physicians, and others. The care coordinator frequently contacts these collaterals by telephone, invites them with adequate notice to CPT meetings and, with consent, if required under applicable law, provides them with copies of the completed ICP. 5. The care coordinator assists the family in identifying and including formal and natural supports and community-based agencies, services, and organizations, such as after-school programs, Big Brother/Sister, clergy, neighbors, and cultural organizations, in the care planning process. The care coordinator frequently contacts these key people by telephone and invites them to CPT meetings and with consent, provides them with copies of the completed ICP. 6. The ICC provider maintains linkages and a working relationship with local providers of all services in their service area in order to facilitate referrals from these providers and to ensure care is properly coordinated for youth and families served by both ICC and these providers. 7. The ICC provider maintains linkages and working relationships with the local ESP/Mobile Crisis Intervention provider in their service area in order to facilitate referrals from the Mobile Crisis Intervention provider and to ensure care is properly coordinated for youth and families served by ICC and ESP/ Mobile Crisis Intervention. With consent from the parent/guardian/caregiver, if required, when a youth and family involved in ICC is in need of intervention from ESP/Mobile Crisis Intervention, as determined by the ICC provider, family and the ESP provider, the care coordinator is in contact with the ESP/Mobile Crisis Intervention staff at the time of referral (or if not, the referral source immediately upon learning of referral to ESP/Mobile Crisis Intervention) to provide relevant information, assistance, and recommendation for

	how ESP can best intervene to the ESP/Mobile Crisis Intervention staff. 8. The ICC provider maintains linkages and working relationships with the local Crisis Stabilization provider in their service area in order to facilitate referrals from the Crisis Stabilization provider and to ensure care is properly coordinated for youth and families served by both ICC and Crisis Stabilization. 9. With consent, if a youth is admitted to a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP), the care coordinator contacts the facility at the time of referral and provides preliminary treatment recommendations to initiate and guide treatment, and schedules a CPT meeting at the facility within two (2) days for care coordination and disposition planning. The CPT meeting includes the participation of the family and facility staff. The ICC provider and facility staff communicates and collaborate on a youth's treatment throughout his/her admission to develop, in concert with the family, a disposition plan that is consistent with his/her ICP. With consent, if required by applicable law, the care coordinator is required to participate in all meetings that occur during the youth's tenure in the facility as appropriate.
Quality Management (QM)	
	1. The ICC provider participates in all network management, utilization management, and quality management initiatives and meetings. 2. The ICC provider participates in all fidelity-monitoring activities required by EOHHS and the payers.
Process Specifications	
	1. The ICC provider will adhere to a standard Operations Manual (and all subsequent revisions), that includes requirements related to successful completion of skill- and competency-based training, care management provision and supervision requirements, care planning requirements, including a process for resolving disputes between team members, reporting of adverse incidents, and consent

	requirements. The Operations Manual will incorporate statewide interagency agreements concerning the role and responsibilities of representatives of each child-serving agency. 2. The ICC provider must comply with all requirements and standards in the ICC Operations Manual 3. The ICC provider develops and maintains policies and procedures relating to all components of the ICC service that are consistent with the guidelines and standards in the ICC Operations Manual. 4. The ICC provider ensures all new and existing staff will be trained according to the guidelines and standards identified in the ICC Operations Manual. 5. The ICC provider ensures that all services are provided in a professional manner, ensuring privacy, safety and respecting the youth and family's dignity and right to choose.
Treatment Planning and Documentation	1. Telephone contact is made with the family within 24 hours of referral, including self-referral, for ICC to offer a face-to-face interview with the family, which shall occur within three (3) calendar days to assess their interest in participation and gain consent for service. 2. The ICC provider will obtain voluntary consent required to participate in ICC. 3. Immediately upon gaining consent for participation, the ICC provider will complete, with the family, an initial risk management/safety plan that will be confirmed and/or expanded as necessary at the first CPT meeting. 4. The care coordinator for each youth reviews and updates the risk management/safety plan. The risk management/safety plan details a response plan for the family to provide stability in crisis situations and to prevent the need for out-of-home services, such as hospitalization, whenever possible. The youth and family's CPT will review this plan periodically during CPT meetings. The risk management/safety plan is reviewed and updated as needed but at a minimum after an encounter with the ESP/Mobile Crisis Intervention Team staff and at the time of discharge from a 24-hour facility. The ICC provider ensures that, for each youth, a written copy of the current risk management/safety plan is sent to and maintained by the local ESP/Mobile Crisis

	Intervention Team. 5. The care coordinator completes a comprehensive, strength-based assessment, consistent with *Wraparound* planning process and fidelity measures, in the home unless the youth and/or family choose another location. The comprehensive, home-based (whenever permitted) assessment includes interviews with the youth, parent/caregiver, family and other relevant persons, observations of the youth and the family, and use of the age appropriate version of the Massachusetts CANS within ten (10) calendar days of the date on which the family consented to ICC. 6. The care coordinator works with the family to determine the composition of their CPT. 7. The CPT identifies strategies to meet the needs of the youth including the services the youth needs and coordinates with the service plans of child serving agencies. The CPT's determinations are incorporated into the ICP. The CPT is responsible for assisting the youth to access the needed medical, educational, social, and other services identified in the ICP. 8. The CPT generally meets <u>monthly, although for youth with more complex and/or intense needs</u> the CPT will meet more frequently, and for youth with less complex and/or intense needs, the CPT may meet less frequently, but no less than quarterly. Each ICP must be reviewed <u>at least quarterly</u>. 9. The first CPT meeting and the development of the ICP occur within 28 calendar days of the family's consent to services. The care coordinator, together with the CPT, develops a youth- and family-centered ICP that specifies the goals and actions to address medical, social, educational, therapeutic, and other services that may be needed by the youth and family. The ICP is subsequently revised at each CPT meeting to reflect changes or progress made since the last CPT meeting. 10. The care coordinator, in consultation with the CPT coordinates the implementation of the ICP, monitors the ICP, and modifies the ICP as needed. The care coordinator convenes the team as needed to reflect the changing needs of the youth and family. The care coordinator and the team perform such reviews and include whether services are being provided in accordance with the ICP, whether the services in the ICP are adequate, and whether there are changes in the youth's needs or

	status, and if so, adjust the ICP as necessary 11. Depending on the complexity and intensity of the youth and family's needs, the care coordinator, in collaboration with the family and CPT, make a determination regarding the frequency of face-to-face contact with the youth and his/her family. Families presenting with higher intensity and/or more complex needs are anticipated to have more frequent meetings with their care coordinator than families presenting with lower intensity and/or less complex needs. The care coordinator documents the rationale for the frequency of visits for each family, including any missed visits and attempts to reschedule those visits in the youth's medical record. Visits/contacts are necessary in order to coordinate, communicate about, and monitor activities related to goals and services identified in the ICP and in order to assess and address changes in the child's needs. 12. When situations arise in which more than one MassHealth Standard- or CommonHealth-enrolled youth in a family requires ICC, the same care coordinator is assigned to both/all youth in order to ensure that services are coordinated and to minimize the number of individuals with whom the family/guardian/caregiver needs to communicate/work, unless the family/guardian/caregiver specifically requests a different care coordinator for the subsequently enrolled youth. 13. The ICC provider is available to provide support by phone or staff on-call pager to the youth and the family 24 hours a day, 365 days a year. During business hours (M-F, 8 a.m. - 8 p.m.), the ICC provider provides phone and face-to-face assessment of the need for ESP/Mobile Crisis Intervention or emergency services and assistance with access to such services, including mobilizing to the home or community settings (e.g., school) to assess the youth's needs and coordinate responses to emergency situations. After hours (i.e., between 8 p.m. and 8 a.m. and on weekends), the ICC assesses the youth's need for crisis services and provides crisis support by phone. If, based upon the ICC's clinical assessment of the youth's needs, Mobile Crisis Intervention is required, or in the event of an emergency, the ICC provider shall engage the ESP/Mobile Crisis Intervention. ICC providers shall remain actively involved in monitoring and assessing the youth's need for services during the course of Mobile Crisis Intervention. An answering machine or answering service directing

	callers to call 911 or the ESP, or to go to a hospital emergency department (ED), is not acceptable.
Discharge Planning and Documentation	1. The duration of ICC services is dependent on the youth continuing to meet medical necessity criteria for this service including an assessment by the CPT that ICC is continuing to support progress towards meeting the identified goals and the youth's age. 2. Prior to discharge from ICC, a CPT meeting is convened to develop an aftercare/transition plan for the family. The ICC conducts an assess ment that utilizes the CANS to assist in identifying the youth's strengths and needs and making appropriate level of care recommendations. The aftercare/transition plan includes at a minimum: a) documentation of ongoing strategies, supports, and resources to assist the child/adolescent and family in sustaining gains; b) identification of the child/adolescent's needs according to life domains; c) a list of services that are in place post-discharge and providers arranged to deliver each service; d) a list of prescribed medications, dosages, and possible side effects; and e) treatment/care recommendations consistent with the service plan of the relevant state agency for children/adolescents who are also DMH clients or children/adolescents in the care and/or custody of DCF, and for DDS, DYS, and uninsured DMH clients. 3. Prior to discharge, the care coordinator, in conjunction with the youth, family members, significant others, and all providers of care, develop an updated risk management/safety plan. The purpose of this plan is to communicate and expedite a youth-focused disposition to other levels of care when clinically indicated and to ensure ongoing supports within the community. 4. The ICC provider ensures that the written risk management/safety plan and aftercare/transition plan are both provided at the time of discharge from ICC services to the youth and parent/guardian/caregiver, and, with consent, to significant others, In-Home Therapy Services provider, outpatient or other community-based providers, ESP/Mobile Crisis

	Intervention, the primary care physician/clinician, school, and other entities, and/or agencies engaged with, or significant to, the youth's aftercare.