Community Service Agency

Intensive Care Coordination and Family Support and Training

Program Description and Operations Manual

Version 3

TABLE OF CONTENTS

Definition of Terms

Care Coordinator: A care coordinator is an individual who provides intensive care coordination to small numbers of youth and families and does not have other simultaneous (non-ICC related) job responsibilities; facilitates the development of a Care Planning Team (CPT); convenes CPT meetings; coordinates and communicates with the members of the CPT to ensure the development and implementation of the ICP; works directly with the youth and family to implement elements of the ICP; coordinates the delivery of available services; and monitors and reviews progress toward ICP goals and updates the ICP in concert with the CPT.

Care Planning Team (CPT): A CPT is comprised of both formal and natural support persons, which includes the youth and caregiver(s), professionals including representatives of child-serving state agencies and school personnel, advocates, and family supports who assist the family in identifying goals and developing and implementing an Individual Care Plan (ICP). A CPT must include more than the youth, caregiver, and care coordinator.

Child and Adolescent Needs and Strengths (CANS): The CANS is a tool that provides a standardized way to organize information gathered during behavioral health diagnostic assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision-support tool for behavioral health providers serving MassHealth members under the age of 21.

Community Service Agency (CSA): A CSA is an entity that is under contract with the MassHealth Managed Care Entity (MCE) to be a Community Service Agency.

Family/Caregiver: Family/caregiver refers to any biological, kinship, foster, and/or adoptive family/caregiver responsible for the care of a youth.

Family Support and Training Services (FS&T): This is a service provided to the parent/caregiver of a youth (under the age of 21) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes) and other community settings. The service provides a structured, one-to-one, strength-based relationship between a family partner and a parent/caregiver. FS&T services enable caregivers/family members to provide for the needs of the youth. FS&T services are available to parents/caregivers of youth who meet the medical necessity criteria for this service, AND who are receiving one of the hub services, i.e., ICC, In-Home Therapy (IHT), or Outpatient services.

Family Partner: A Family Partner is an individual who delivers FS&T services. This individual has experience as a caregiver of a youth with special needs and preferably a youth with mental health needs.

Individual Care Plan (ICP): An ICP is a care plan that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family, that is developed by the CPT as defined above, and incorporates the strengths and needs of the youth and family. The ICP is the primary coordination tool for behavioral health and informal interventions and *Wraparound* care planning.

Intensive Care Coordination (ICC): ICC is a service that facilitates care planning and coordination of services for MassHealth youth, with serious emotional disturbance (SED), under the age of 21, and enrolled in MassHealth Standard or CommonHealth who meet the medical necessity criteria for this service. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

Program Director: This individual is responsible for the overall supervision of the intensive care coordination and family partner staff and is the overall clinical director of the operations of the CSA.

Senior Care Coordinator: This individual must be a master's-level clinician with at least three years of experience in providing outpatient behavioral health services to youth and families. Experience with home-based or *Wraparound* models is preferred.

Senior Family Partner: This individual must be an adult who has experience as a caregiver of a youth with special needs and preferably a youth with mental health needs. He/she must have a minimum of two years experience working collaboratively with state agencies, consumer advocacy groups, and/or behavioral health outpatient facilities.

System of Care: A *System of Care* is a cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families.

Wraparound: *Wraparound* is a definable planning process involving the youth and family that results in a unique set of community services and natural supports individualized for that youth and family to achieve a positive set of outcomes.

Community Service Agencies (CSA)

A CSA is a community-based organization whose function is to facilitate access to, and ensure coordination of, care for youth with serious emotional disturbance (SED) who require or are already utilizing multiple services or who require or are involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health) and their families. In total, there are 32 CSAs: 29 that provide services in the geographic region consistent with the current 29 service areas for the Department of Children and Families (DCF) (previously known as Department of Social Services) and three culturally and linguistically specialized CSAs to address the needs of specific cultural or linguistic groups in Massachusetts. These culturally or linguistically specialized CSAs have demonstrated expertise at providing behavioral health services to one or more cultural or linguistic populations. Specialized CSAs were selected for their demonstrated ability to reach deeply into specific cultural or linguistic communities and tailor their services to engage and serve their specialized populations. It is important to note that all CSAs are expected to be culturally relevant and respond to the individualized needs of the youth and families they serve in accordance with *Wraparound* principles. Geographic CSAs and specialized CSAs working in overlapping areas are expected to collaborate and partner in ways that strengthen services to families.

The roles and responsibilities of the Community Service Agencies include:

- Actively engaging youth and families seeking Intensive Care Coordination services and Family Support and Training services using the *Wraparound* care planning process
- Providing intensive care coordination, using dedicated care coordinators trained in *Wraparound* principles and practices
- Providing infrastructure support for Intensive Care Coordination and Family Support and Training services
- Actively participating in a quality improvement process to identify the "lessons learned" from youth, families, providers, and others. These "lessons learned" will continually shape the vision and functions of the CSA.
- Developing and supporting a local *Systems of Care Committee* that will be charged with supporting the service area's efforts to create and sustain collaborative partnerships among families, parent/family organizations, traditional and non-traditional service providers, community organizations, state agencies, faith-based groups, local schools, and other stakeholders
- Supporting referrals to other behavioral health resources and services
- Creating and sustaining linkages to local school districts, juvenile courts, and local human service providers

Intensive Care Coordination Services

The Intensive Care Coordination (ICC) service is to support youth with serious emotional disturbance by building upon youth and family strengths and available support systems in order to maintain and improve the youth's ability to experience successful outcomes at home, in school, and in the community. ICC is not traditional case management that typically is provided by clinicians or others as part of other job responsibilities. ICC assigns one dedicated care coordinator to work intensively with youth and their families as the locus of accountability for ensuring that services and supports are coordinated across systems and providers. ICC facilitates care planning and coordination of services for MassHealth youth, with serious emotional disturbance (SED), under the age of 21, and enrolled in MassHealth Standard or CommonHealth who meet the medical necessity criteria for this service. Care planning is driven by the needs of the youth and

developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

Additionally the ICC service seeks to:

- Secure and/or coordinate services the youth needs and/or receives from providers, state agencies, special education, or a combination thereof
- Assist with access to medically necessary services and ensure these services are provided in a coordinated manner
- Facilitate a collaborative relationship among a youth with SED, his/her family, natural supports, and involved child-serving systems to support the parent/caregiver in meeting their youth's needs

ICC services are delivered to the youth and family through the *Wraparound* planning process that adheres to the four phases and the "Ten Principles of *Wraparound*":

The Four Phases of *Wraparound*

- Engagement and team preparation
- Initial plan development
- Implementation
- Transition

For additional information about the phases and activities of the *Wraparound* process refer to: http://www.rtc.pdx.edu/PDF/PhaseActivWAProcess.pdf

The Ten Principles of *Wraparound*

- **Individualized**: To achieve the goals laid out in the in the *Wraparound* plan, the team develops and implements a customized set of strategies, supports, and services.
- **Family voice and choice**: Family and youth perspectives are intentionally elicited and prioritized during all phases of the *Wraparound* process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- **Community-based**: The *Wraparound* team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote child and family integration into home and community life.
- **Collaboration**: Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single *Wraparound* plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
- **Culturally relevant:** The *Wraparound* process demonstrates respect for, and builds on, the values, preferences, beliefs, culture, and identity of the youth and family and their community.
- **Team-based**: The *Wraparound* team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The *Wraparound* plan reflects activities and interventions that draw on sources of natural support.

- **Strengths-based**: The *Wraparound* process and the *Wraparound* plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Unconditional**: A *Wraparound* team does not give up on, blame, or reject youth and their families. When faced with challenges or setbacks, the team continues to work towards meeting the needs of the youth and family and towards achieving the goals in the *Wraparound* plan until the team reached agreement that a formal *Wraparound* process is no longer necessary.
- **Outcome-based**: The team ties the goals and strategies of the *Wraparound* plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

In addition to NWI principles, other values that provide the framework for ICC include:

- Families are the most important caregivers.
- All youth and families/caregivers have strengths that must be identified and emphasized.
- Service system professionals have knowledge, skills, and strengths that are helpful to youth and families.

Intensive Care Coordination (ICC) and Family Support and Training (FS&T) Services

Delivery of ICC may require care coordinators to team with Family Partners. When a Family Partner is involved at the same time as the ICC service, the care coordinator and Family Partner will work in concert with one another while maintaining their discrete functions. The Family Partner works one-on-one and maintains regular frequent contact with the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Partner educates parents/caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them and facilitates the parent's/caregiver's access to these resources.

ICC and FS&T services link youth and their parent(s)/caregiver(s) with community resources and help youth and their parent(s)/caregiver(s) to cope with and manage situational events that might otherwise disrupt the stability of the youth in the home and community. It is expected that Care Coordinators and Family Partners will have <u>weekly</u> contact (phone or face-to-face) with the family of each enrolled youth they support.

The roles and responsibilities of the Care Coordinator include but are not limited to:

- Conducting a comprehensive, home-based assessment inclusive of the CANS and other tools as determined necessary, which occurs in the youth's home or another location of the family's choice
- Identifying with the youth and family-appropriate members of the CPT
- Facilitating the development and implementation of a youth- and family-centered ICP in collaboration with the family and collaterals
- Developing a Safety Plan, and/or other Crisis Planning Tool, in collaboration with the youth and family and collaterals
- Maintaining regular contact with the family, youth (where appropriate), and other relevant persons in the youth's life (collaterals)
- Facilitating CPT meetings

- Maintaining face-to-face contact with the youth and family, as determined by the youth and family and members of the CPT
- Making referrals and linkages to appropriate supports as identified in the ICP
- Identifying and developing natural supports with the youth and family
- Assisting with system navigation
- Providing family education, advocacy, and support
- Identifying and actively assisting the youth and family to obtain and monitor the delivery of available services including medical, educational, social, therapeutic, or other services
- Monitoring, reviewing, and updating the ICP to reflect the changing needs of the youth and family

The roles and responsibilities of the Family Partner include but are not limited to:

- Engaging the parent/caregiver in activities in the home and community. These activities are designed to address one or more goals on the youth's ICP for youth enrolled in ICC.
- Assisting the parent/caregiver with meeting the needs of the youth and meet one or more of the following purposes:
    - Educating
    - Supporting
    - Coaching
    - Modeling
    - Guiding
- and may include:
    - Educating
    - Teaching the parent/caregiver how to navigate the child-serving systems and processes
    - Fostering empowerment, including linkages to peer/parent support and self-help groups
    - Teaching the parent/caregiver how to identify formal and community-based resources (e.g., after-school programs, food assistance, housing resources, etc.)

Medical Necessity Criteria for Intensive Care Coordination Service (ICC)

The Medical Necessity Criteria for ICC are:

1. The youth meets criteria for serious emotional disturbance (SED) as defined by either Part I or Part II of the criteria below.

   Part I:
   The youth currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM–IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

   The diagnosable disorder identified above has resulted in functional impairment that substantially

interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

OR

Part II:
The youth exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.

The emotional impairment is not solely the result of autism, developmental delay, intellectual impairment, hearing impairment, vision impairment, deaf-blind impairment, specific learning disability, traumatic brain injury, speech or language impairment, health impairment, or a combination thereof.

2. The youth:

   a. needs or receives multiple services other than ICC from the same or multiple provider(s)

   OR

   b. needs or receives services from, state agencies, special education, or a combination thereof;

   AND

   c. needs a care planning team to coordinate services the youth needs from multiple providers or state agencies, special education, or a combination thereof.

3. The person(s) with authority to consent to medical treatment for the youth voluntarily agrees to participate in ICC. The assent of a youth who is not authorized under applicable law to consent to medical treatment is desirable but not required.

4. For youth in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting who meet the above criteria, the admission to ICC may occur no more than 180 days prior to discharge from the above settings.

Referrals

All ICC referrals are made to the CSA. Anyone may refer to a CSA (e.g., parents/caregivers and youth, schools, state agencies, providers, etc.) with the consent of the family or guardian. A staff person at the CSA will determine if the referred youth meets basic criteria for enrollment in ICC which includes:

- The referred youth has MassHealth Standard or MassHealth CommonHealth.
- The referred youth is under age 21.
- The family is willing to meet/consider the service.

Telephone contact must be 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. When someone other than the custodial parent/caregiver makes a referral for ICC, the parent/caregiver is contacted regarding the referral to ascertain the interest in the ICC service. If the parent/caregiver is interested and the member meets the basic enrollment criteria (see above), the ICC provider offers an appointment to meet with the youth and family within three (3) calendar days of the referral to begin the comprehensive, home-based assessment inclusive of the CANS.

Some youth and families may be referred to the CSA for ICC services, and through the comprehensive, home-based assessment inclusive of the CANS, it is determined that the youth does not meet medical necessity criteria for ICC services. ICC providers are required to provide linkage to other services for these youth and families.

See Appendix A for the ICC Referral Process Flow Chart. See Appendix B for Guidelines for Managing Referrals to ICC, which was drafted collaboratively between the CSAs and the MCEs. See Appendix C for Guidelines for Ensuring Timely Access to CBHI Services, which describes the use of the Massachusetts Behavioral Health Access (MABHA) website (http://www.mabhaccess.com/) to identify availability for the ICC service as well as for the other CBHI services. The MABHA website, as described on the website, is designed to enable behavioral health and health care providers to locate potential openings in mental health and substance use services for the purpose of referring individuals to those available services. Youth, families, and other stakeholders such as state agency staff are welcome to utilize the website to locate those services that they can access directly from the community. Currently two groups of services are available on this website: CBHI services and 24-hour levels of care. There are details on the website about who can search for openings in these services and how to do so.

All FS&T referrals are made to the CSA. Any of the three hubs – ICC, IHT, or outpatient – may refer the parent/caregiver for this service with their consent. A staff person at the CSA will determine if the referred parent/caregiver meets basic criteria for enrollment in FS&T which includes:

- The youth of the referred parent/caregiver has MassHealth Standard or MassHealth CommonHealth.
- The youth of the referred parent/caregiver is under age 21*.
- The parent/caregiver is willing to meet/consider the service.

* Reminder: Individuals do not age out of FS&T services at age 18. FS&T is a service provided to caregivers of any eligible youth under 21 years of age. As such, parents/caregivers of youth between the ages of 18 -20 are eligible to receive FS&T, per the FS&T Medical Necessity Criteria, if that youth resides with or has a current plan to return to the identified parent/caregiver.

Telephone contact must be made with the parent/caregiver to initiate services within three (3) business days of receipt of the referral. When someone other than the parent/caregiver makes a referral for FS&T, the parent/caregiver is contacted regarding the referral to ascertain their interest in the FS&T service. If the parent/caregiver is interested and meets the basic enrollment criteria (see above), an appointment is offered to meet with the parent/caregiver. See the FS&T Performance Specifications for additional information regarding the provision of the FS&T service. Note: FS&T is a hub-dependent service, and, as such, must be provided alongside one of the hub services – ICC, IHT, or outpatient. If a referral is made to the CSA for FS&T services and the parent/caregiver is not currently connected with one of the hub services, the CSA will educate the referral source regarding this requirement and will connect the parent/caregiver to one of the hub services, with agreement and consent from the parent/caregiver and as appropriate.

Referrals for DYS/DCF-involved Youth

In most instances, youth who are committed to DYS, or who are in the care and/or custody of DCF, will be referred by the state agency. In instances when a DYS/DCF-involved youth is referred by someone other than the family or the state agency caseworker, the ICC provider will contact the appropriate DYS or DCF office (with proper consent as required by law) to discuss the referral before scheduling the comprehensive, home-based assessment inclusive of the CANS.

Enrolling More Than One Family Member in ICC

When a sibling of the referred youth is a MassHealth member and may need ICC, the sibling may be referred to ICC. All siblings will be enrolled in ICC with the same care coordinator when possible, based on the care coordinator's capacity to provide services to additional youth. The ICP developed for that youth will include coordination with the sibling's ICP.

ICC Service Components

The care coordinator is responsible for coordinating all services and supports identified in the ICP. The referred youth is the recipient of the ICC Services in the ICP.

It is expected that the ICC program be available at times that are convenient to families. This will include evening and weekend availability.

The following are components of the program:

Comprehensive, Home-based Assessment

The services and supports provided by the care coordinator to the youth and family begin with a comprehensive, home-based assessment inclusive of the CANS and emphasize the life domains of school/work, cultural and spiritual, social, living, safety and legal, medical and health, emotional/psychological, and recreational. The assessment identifies the youth's and family's strengths and needs, and also includes any risk management/safety planning. The ICC care coordinators will complete a comprehensive, home-based assessment inclusive of the CANS for all ICC-referred youth within 10 days of consent for participation in ICC. While this is referred to as a home-based assessment, the completion of the comprehensive assessment should always be in a location of the parent/caregiver choice.

The assessment must be reviewed and signed by a master's-level clinician (or above) who is a licensed at the independent level. Additionally, the care coordinator will complete an initial Safety Plan, and/or other Crisis Planning Tool, with a youth and parent/caregiver immediately upon consent for participation within ICC.

The ICC comprehensive home-based assessment will be used to gather information about the youth and caregiver/family necessary to evaluate each of the criteria. Components of the assessment include:

- The youth and caregiver's willingness to participate in the program
- Face-to-face interview(s) with the parent/caregiver and the youth
- Identifying the strengths, needs, and culture of the youth and family, inclusive of the strengths of the community
- Signed permissions for the release of information for appropriate collaterals, including the MassHealth-contracted MCE, school, primary care clinician, and other providers and caregivers

- Phone and/or face-to-face interviews with other family members, other people identified by the family, state agency representatives, school representatives, and other involved organizations as indicated
- Information regarding current needs and services and previous services for the youth in areas of health, psychiatric, social/peer, and school
- Completion of the CANS
- Working with the family to identify potential CPT members
- With proper consent and release of information, gathering of relevant records from behavioral health and other providers, schools, and any involved child-serving agencies
- The strengths, needs and culture discovery (SNCD)

Safety Planning

A family centered Safety Plan must be created for each youth, with the consent of and in collaboration with the youth and family, and others as identified by the family in accordance with the ICC Performance Specifications and the *Crisis Planning Tools for Families: A Companion Guide for Providers* (dated March 29, 2011). The Safety Plan details the family's chosen approach to crises. The Safety Plan is reflective of action the family believes may be beneficial. The goal of the Safety Plan is to support and promote families' competencies in reducing risk in a manner that is authentic and individualized to a given youth/family. The Safety Plan is consistent with a family/youth's readiness for change, insight into behavior, and self-defined priorities, and incorporates their interest and comfort with the use of natural and formal supports. The Safety Plan is a tool used by families to reduce or manage worsening symptoms, promote wanted behaviors, prevent or reduce the risk of harm or diffuse dangerous situations. Each youth must have a Safety Plan completed immediately upon gaining consent for participation in ICC. Prior to this, the ICC provider assesses the safety needs of the youth and family and engages them in the safety planning process, including a review and use of the set of Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements, and Companion Guide for Providers) where appropriate and in accordance with the Companion Guide for Providers. The care coordinator reassesses the safety needs of youth and family as clinically indicated. The care coordinator documents these processes within the youth's health record. If a family, after engaging in the safety planning process, chooses not to complete a Safety Plan, the care coordinator must document this in the Safety Plan form and file it within the youth's health record. It is expected that the Safety Plan or set of Crisis Planning Tools will be reviewed periodically during CPT meetings or more frequently as needed. The Safety Plan must be reviewed and updated with the family after an encounter with the ESP/Mobile Crisis Intervention (MCI) Team, at the time of discharge from a 24-hour facility, or when any circumstances change that impact risk and safety. The ICC provider ensures that the Safety Plan is updated at the time of discharge/graduation from ICC. The purpose of this plan is to reduce risk by building on family members' strengths, focusing on what works and incorporating family informed strategies that are natural and sustainable to the family. It strengthens bridges within the family, the informal support network, and the formal treatment network as appropriate to each family. For youth transitioning to a new hub service and/or transitioning from youth-based services to the adult service system, this plan will be inclusive of the new hub services and any adult services when applicable. See Appendix D for the Safety Plan to be used for all youth newly enrolled in ICC, MCI, and IHT, as well as for the other Crisis Planning Tools (Advance Communication to Treatment Provider, Supplements, and the Companion Guide for Providers).

Care Planning Team (CPT) Meetings

The care coordinator has the overall responsibility for the implementation and management of the ICP. The care coordinator will work with the family to determine the composition of their CPT and convene that team within 28 calendar days of the youth/family's consent to treatment.

Members of the CPT must include the youth when appropriate and parent(s)/caregiver(s), the care coordinator, the family partner, and all behavioral health providers involved with the youth. The CPT may include other family members, 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. CPT membership should reflect a balance of natural and formal support persons.

For youth enrolled in ICC who are in foster care or kinship care settings, the ICC provider will work with DCF to determine the appropriateness of engaging the biological family in the CPT based on the DCF disposition plan.

The ICP is developed through shared decision making by all members of the CPT, recognizing that each member has a significant contribution to offer. During the CPT process, every team member will commit to the plan, and the responsibilities for each team member will be clearly identified. Each CPT should strive for consensus in the provisions of the ICP. The *Wraparound* process includes mechanisms for resolving disagreements between team members and requires consensus on the final plan.

It is expected that the CPT will generally meet monthly. For youth with more complex and/or intense needs, 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. Every quarter, progress in meeting the goals of the ICP shall be comprehensively reviewed by the CPT, and every 90 days the CANS will be updated.

During the initial engagement of the family and care plan team members, it is expected that the care coordinator convenes the second CPT meeting within 30 calendar days of the first CPT meeting. This initial frequency of CPT meetings will support the formation of that CPT and the individualized goal planning.

Prior to discharge from ICC, the ICC conducts an assessment that utilizes the CANS to assist in identifying the youth's strengths and needs according to life domains and appropriate level-of-care recommendations. A CPT meeting is convened to develop an aftercare/transition plan for the family that is inclusive but not limited to ongoing strategies, supports, resources, and services in place at the time of discharge. The transition plan should denote a new hub provider when applicable. For youth turning 21, the provision of age-appropriate services and supports as well as the provision of supports and services relevant to the transition from the youth service system to the adult service system, when applicable, will be outlined.

The ICC provider will ensure that an attendance sheet with names and contact information for each care plan team member is signed by all attendees at every CPT meeting. The attendance sheet should review the expectations related to member participation and confidentiality. The ICP should be revised at each meeting to reflect changes or progress made since the last care plan meeting and updates any safety planning needs. Changes to the ICP cannot be made when only a youth, care coordinator, and caregiver have met. This would not be considered a CPT but rather a meeting with the youth and family.

If a member of the CPT cannot participate in the scheduled ICP meeting, his/her input into the plan should be solicited prior to the CPT meeting and before finalization of the plan. All members of the team should sign the ICP. The written ICP will be completed and distributed to the CPT members within <u>seven calendar days</u> of the care plan team meeting.

See Appendices E and F for the authorization parameters and processes, respectively, for use by the CPT. However, it is the behavioral health provider of the recommended service who must obtain an authorization from the youth's MCE for the service that provider will deliver to a youth.

<u>Please see Appendix G for the Conflict Resolution Process for Care Planning Teams in Intensive Care</u>

Coordination.

Individual Care Plan (ICP)

The primary tool for ICC care planning is an Individual Care Plan (ICP). The youth and parent/caregiver (biological, adoptive, foster, guardian, kinship) have the lead role in the development of the ICP supported by the care coordinator and CPT members.

Information gathered through the comprehensive, home-based assessment inclusive of the CANS, the SNCD, and the goals prioritized by the youth and parent/caregiver will guide the plan. ICP will include both formal and informal services and supports from the family's natural support system and local community. As the team process evolves, caregivers and CPT members will work together to identify and increase the availability of natural and community resources, with the expectation that 50 percent of supports and services will ultimately be derived from these informal sources.

An ICP specifies:

- Youth and family strengths
- Youth and family vision
- Life domain area addressed
- Needs identified as priorities by the family and youth
- Strengths of the team used to address needs
- Specific goals/tasks, timeline, and responsible parties
- Care coordination and support needs of the youth and parents/caregivers
- Role of other providers and supports, including state agency services as applicable
- Beneficial community resources
- Coordination of physical and behavioral health, including medication management

The ICP is standardized and must be used by all ICC providers. See Appendix H for the ICP document. The written ICP will be completed and distributed to the CPT members within seven calendar days of the CPT meeting.

Coordination of the ICP with Other Care Plans

For youth receiving services from state agencies or other organizations, the *Wraparound* care planning process must ensure that the ICP demonstrates coordination with other provider or state agency plans or individual education plans.

24/7 Availability of the ICC Team

ICC staff will be available 24 hours a day, seven days a week by pager to triage and resolve crises occurring for the youth and family. It is expected that each youth will have a Safety Plan and that youth and parent(s)/caregiver(s) will be given written information on how to contact the ICC provider after hours.

Coordination with Mobile Crisis Intervention (MCI)

If the youth enrolled in ICC experiences a crisis, during business hours (M-F, 8 a.m. - 8 p.m.), the ICC provider provides phone and face-to-face contact to work with the family, and as necessary engages the CPT, to

implement the Safety Plan to address the crisis. If the ICC provider determines the need for ESP/MCI or emergency services, the ICC provider will assist the family in accessing that service. While a family should be encouraged to contact the ICC provider before engaging the MCI team, a family may contact and/or engage the MCI team at their discretion.

After hours (i.e., between 8 p.m. and 8 a.m. and on weekends), a care coordinator provides phone contact to work with the family to implement the Safety Plan. If, based upon the ICC provider's clinical assessment of the youth's needs MCI is required, or in the event of an emergency, the ICC provider shall engage the ESP/MCI. While a family should be encouraged to contact the ICC provider before engaging the MCI team, a family may contact and/or engage the MCI team at their discretion.

It is expected that the care coordinator will work closely with the MCI clinician to provide information and take part in the disposition decisions and after-care planning. ICC will participate by phone and/or be present with the youth and parent/caregiver during the MCI. ICC will remain involved throughout the intervention to provide information and to assist in the development of a disposition plan.

It is expected that the CSA will have ongoing communication with the designated ESP/MCI provider in its area regarding ICC, the role ICC is expected to have when an ICC-enrolled youth is referred for a Mobile Crisis Intervention, and how to reach the ICC provider after business hours. ICC staff should proactively supply any additional information such as the Safety Plan, or other Crisis Planning Tool, to the MCI on youth for whom there is heightened concern or safety risk with the permission of the parent/caregiver of the enrolled youth.

If a youth is seen by the MCI team and NOT admitted to a 24-hour facility, the care coordinator must conduct a face-to-face visit with the family within 24 hours of the end of the MCI in order to review the Safety Plan and update it if necessary. The ICP should also be reviewed with the family to identify any changes that might be needed.

In situations in which the ICC provider learns of an MCI after it has occurred, the ICC provider will contact the MCI provider to gather necessary information to coordinate care and plan a face-to-face visit with the family. During the face-to-face visit which occurs within 24 hours of learning of the MCI, there will be a review and update of the Safety Plan.

Coordination with 24-hour Facilities

If a youth is admitted to a 24-hour level of care (e.g., inpatient, CBAT), the care coordinator will contact that facility within 24-hours and schedule a team meeting at the facility within two business days for care coordination and disposition planning. There should be ongoing communication and collaboration between ICC and the facility staff throughout the youth's admission. The care coordinator will continue to have weekly contact with the youth and parent/caregiver throughout the youth's admission. If there are any difficulties coordinating care with a 24-hour facility, ICC staff should contact the identified representative at the Managed Care Entity and alert them to the need for immediate assistance in resolving the matter.

The care coordinator must participate in the hospital/CBAT discharge planning meeting to review/revise the Safety Plan and assist in aftercare planning. ICC staff will conduct a face-to-face visit with the family within 48 hours of the youth's discharge from a 24-hour level of care.

Coordination with Child-serving State Agencies

The care coordinator will ask the parent/caregiver to provide a release of information authorizing the exchange of service information between the ICC provider and any state agency personnel that are working with the youth and family. 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.

Coordination with Local Education Authorities (LEAs)

The care coordinator will ask the parent/caregiver to provide a release of information authorizing the exchange of service information between the ICC provider and school personnel that are working with the youth and family. 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. In accordance with laws and regulations governing the School-Based Medicaid program (formerly known as the Municipal Medicaid Program), school systems are mandated by the Individuals with Disabilities Education Act (IDEA) to provide health-related services to their special education student populations. Local education authorities (LEAs) are permitted to file claims for partial federal reimbursement of Medicaid covered services that are listed in the student's IEP. It is the responsibility of the care coordinator to ensure that MassHealth-covered services listed in a youth's IEP are not duplicative of MassHealth covered services listed in the ICP.

Coordination with Temporary Foster Placement

In the event that DCF places a youth who is receiving ICC in a temporary foster care setting, it is expected that ICC will schedule a team meeting for care coordination and disposition planning. If the placement is outside of the CSA service area, the ICC provider may consider working with DCF and the CPT to transfer ICC services to the youth's closest CSA. This transition of care should include the youth and parent/caregiver, the DCF caseworker, and the existing CPT. If it is determined through the care planning process that it is appropriate for the youth to receive services from a CSA in the youth's new community, a meeting should occur between the current (or referring) CSA provider and the receiving CSA. The receiving CSA should contact the MCE for the youth to notify of involvement with the new CSA.

Coordination with Other Providers of Behavioral Health Services

The ICC provider is responsible for assisting the MassHealth-enrolled youth to access to medically necessary covered services. It is required that the providers of behavioral health services providing services to ICC-enrolled youth participate in CPT meetings on a regular basis. The care coordinator will ask the parent/caregiver to provide a release of information authorizing the care coordinator to contact these providers via phone shortly after the youth is enrolled to explain the role of ICC and to request a copy of the most recent treatment plans. If the provider does not respond to telephone outreach, the care coordinator or ICC program director should contact the supervisor/program/clinic director of the behavioral health provider. If there is no response to these attempts, a letter should be sent to the provider and his/her supervisor explaining ICC and requesting participation in CPT meetings and assistance in coordinating care. A copy should be placed in the youth's chart. In addition, the ICC provider should contact the identified representative at the MCE and request assistance with engaging the provider.

Coordination with Primary Care

The care coordinator will ask the parent/caregiver to provide a release of information authorizing the exchange of service information between the primary care provider (PCP), ICC provider, and any other relevant service provider, as appropriate. The care coordinator will invite the PCP to participate in all CPT meetings. It is required that the ICC provider will coordinate care with the youth's PCP. Any identified medical needs should be documented in the ICP, and the youth's PCP should be apprised of the youth's progress. With consent and in collaboration with the family, the care coordinator is encouraged to utilize the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form (found at http://www.masspartnership.com/pcc/pdf/Combined_MCE_BH_ProviderTwo-wayForm101610.pdf). This

"Two Way" Communication Form was collaboratively created by the MCEs and intended to be used by all MassHealth providers to facilitate communication. Behavioral health providers and PCPs can use the form when communicating with one another about a MassHealth Member. The primary purpose of this quality improvement initiative is to increase the frequency and the quality of the content of communication between behavioral health providers and primary care clinicians.

Continuing Care and Graduation/Discharge Criteria

Continuing Care Criteria

Continued enrollment in ICC is based on the youth meeting the following medical necessity criteria:

1. The clinical conditions continue to warrant ICC services in order to coordinate the youth's involvement with state agencies and special education or multiple service providers; AND
2. Progress toward ICP identified goals is evident and has been documented based upon the objectives defined for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with *Wraparound* and Systems of Care principles; OR
3. Progress has not been made, and the CPT has identified and implemented changes and decisions to the ICP to support the goals of the youth and family.

Process for Authorization and Continuing Care Reviews

If upon assessment and initial work with the family and the CPT, continued involvement with the ICC service is needed, the provider will follow the authorization process for the Member's MCE. See Appendix E for authorization parameters for the Managed Care Entities (MCEs). See Appendix F for the authorization processes for the MCEs. See Appendices I and J for the Service Definitions for both ICC and FS&T, respectively.

Note that the MCE will not authorize services if a CPT has not occurred, absent exceptional circumstances.

Graduation/Discharge Criteria

There is no time limit for involvement with the program. Length of enrollment is based on the youth continuing to meet medical necessity criteria and an assessment by the CPT that the ICC program is continuing to support progress towards meeting the identified goals. Youth will graduate from the program/be discharged from the program when:

1. The youth no longer meets the criteria for SED.
2. The CPT determines that the youth's documented ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. Consent for treatment is withdrawn.
4. The youth and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
5. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or a community setting with community-based supports or ICC.

6. The youth turns 21.

Process for Discharge Reviews

Following the completion of the final CANS and CPT meeting, the care coordinator will follow the discharge process identified for the MCE that is insuring the Member. See Appendix F for the discharge processes for the MCEs.

At the time of discharge from ICC, the parent/caregiver of the youth may choose to continue receiving (and meets the continued criteria for) the FS&T service. Per the ICC Performance Specifications, prior to discharge from ICC, a CPT meeting is convened to develop an aftercare/transition plan for the family. The care coordinator conducts an assessment that utilizes the CANS, to assist in identifying the youth's strengths and needs and making appropriate level of care recommendations. These recommendations may include continued participation by the parent/caregiver in the FS&T service to assist the youth/family in sustaining gains, as long as there is a referral to, or current service provision by, another hub, i.e., IHT or outpatient. The MCEs support this practice, as it contributes to the goal of improving the parent/caregiver's capacity to ameliorate or resolve the youth's emotional or behavioral needs and strengthen their capacity to parent. According to the FS&T Performance Specifications, the Family Partner works closely with the family and any existing/referring behavioral health provider(s), to implement the objectives and goals identified in the referring provider's [or existing provider's] treatment plan.

Staffing

Each CSA has at least a program director, senior care coordinator(s), senior family partner(s), care coordinators, and family partners. Additionally, there is expectation of an administrative support staff to the program and a child/adolescent-trained psychiatrist or psychiatric nurse mental health clinical specialist who is available during normal business hours.

Given the range of needs of youth with SED who will meet ICC medical necessity criteria, a CSA will be expected to provide care coordination services with a range of intensity and staffing. The CSA must assign, manage, supervise, and monitor care coordinators so that its staff provides the appropriate intensity of care coordination services to meet the youth needs.

In order to perform the required ICC activities, a CSA is likely to need one care coordinator for every 8-10 youth, for those youth and families with the most intensive needs. In order to perform the required ICC activities, a CSA is likely to need one care coordinator for every 18 children, for those children and families with the less intensive needs. It is suggested that caseloads should not exceed an overall provider-level average of one care coordinator for every 14 youth across the population of youth that it serves.

Each CSA has the following staff to support ICC and Family Support and Training:

- Program director, full-time, who has administrative and clinical responsibility for the program and supervises the senior care coordinator(s) and the senior family partner(s)
- Under the supervision and direction of the program director, the senior care coordinator(s) and senior family partner(s) serve as supervisors to the care coordinators and family partners respectively as well as provide some direct service to families.
- Clinician(s) licensed at the independent practice level to support supervision requirements for care coordinators and family partners

- Child or adolescent psychiatrist or psychiatric nurse mental health clinical specialist who provides consultation to the staff and program

Staffing Supervision Requirements

Care coordinators and family partners must be supervised by a behavioral health clinician licensed at the independent practice level. The clinician may be the senior care coordinator, program director, or senior family partner as long as s/he is licensed at the independent practice level. This supervision requirement may be met through individual, group, or dyad (e.g., care coordinator and Family Partner together) supervision. The CSA will ensure that this requirement is met.

Additionally, the CSA will ensure that a behavioral health clinician licensed at the independent practice level signs off on the comprehensive home-based assessment.

Program Director

The minimum staff qualifications for a program director include:

- Must be a master's-level (or above) clinician with at least three (3) years of supervisory and/or management experience. Experience managing a home-based or *Wraparound* program is preferred.
- Must have at least five (5) years post-graduate experience providing behavioral health services to youth and families
- Must meet the credentialing criteria for master's-level clinicians as outlined in the MCE's most current Provider Manual for master's-level clinicians
- Must be certified in the Massachusetts CANS

Senior Care Coordinator

The minimum staff qualifications for a senior care coordinator include:

- Must be a master's-level clinician with at least three (3) years of experience in providing outpatient behavioral health services to youth and families. Experience with home-based or *Wraparound* models is preferred. Must have supervisory experience
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and/or behavioral health outpatient facilities
- Must meet the credentialing criteria for master's-level clinicians as outlined in the MCE's most current Provider Manual
- Must be certified in the Massachusetts CANS

The senior care coordinator must meet with the program director on a weekly basis for supervision. All supervision must be documented in files accessible for review by the MCE during the site review process or upon request. Supervision notes must contain, at a minimum, information regarding frequency of supervision, format of supervision, supervisor's signature, and general content of supervision sessions.

Care Coordinator

Minimum staff qualifications for a care coordinator include:

- Master's-level: a master's or doctoral degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university;

- Bachelor's-level: a bachelor's degree in a human services field from an accredited academic institution and one year of relevant experience working with families or youth. If the bachelor's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree; or
- An associate's degree or high school diploma and a minimum of five (5) years of experience working with the target population pursuant to MCE credentialing criteria
- Experience in navigating any of the child/family-serving systems and experience advocating for family members who are involved with behavioral health systems
- Must have a valid Massachusetts driver's license and automobile
- Must be certified in the Massachusetts CANS

The care coordinator must meet with the senior care coordinator on a weekly basis for supervision. All care coordinators must participate in weekly supervision with a clinician licensed at the independent practice level. All supervision must be documented in files accessible for review by the MCE during the site review process or upon request. Supervision notes must contain, at a minimum, information regarding frequency of supervision, format of supervision, supervisor's signature, and general content of supervision sessions.

Senior Family Partner

Minimum staff qualifications for a senior family partner include:

- Experience as a caregiver of a youth with special needs and preferably a youth with mental health needs
- Bachelor's degree in a human services field from an accredited university and one (1) year of experience working with the target population; or
- Associate's degree in a human service field from an accredited school and one (1) year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum of two (2) years of experience working with children/adolescents/transition age youth; and
- Must have a minimum of two (2) years supervisory experience
- Must have experience working collaboratively with state agencies, consumer advocacy groups, and/or behavioral health outpatient facilities
- Must have a valid Massachusetts driver's license and automobile with proof of auto insurance.

The senior family partner must meet with the program director on a weekly basis for individual supervision. All supervision must be documented in files accessible for review by the MCE during the site review process or upon request. Supervision notes must contain, at a minimum, information regarding frequency of supervision, format of supervision, supervisor's signature and credentials, and general content of supervision sessions.

Family Partner

Minimum staff qualifications for a family partner include:

- Experience as a caregiver of a youth with special needs and preferably a youth with mental health needs
- Bachelor's degree in a human services field from an accredited university and one (1) year of experience working with the target population; or
- Associate's degree in a human service field from an accredited school and one (1) year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum

of two (2) years of experience working with children/adolescents/transition age youth; and

- Experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems
- Must have a valid Massachusetts driver's license and automobile with proof of auto insurance.

With regard to the experience a family partner must have working with children/adolescents/ transition age youth, the MCEs have determined that the definition of experience, as noted within the Performance Specifications, can be either paid or volunteer in nature.

The family partner must meet with a senior family partner on a weekly basis for supervision. Additionally, all family partners must participate in weekly supervision with a clinician licensed at the independent practice level. All supervision must be documented in files accessible for review by the MCE during the site review process or upon request.

Child/Adolescent Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist

The ICC provider ensures that a board-certified child psychiatrist or a child-trained psychiatric nurse mental health clinical specialist is available during normal business hours to provide consultation services. If an individual is scheduled to sit for the board, a waiver may be granted (the ICC provider should contact the MCEs).

Interns

See Appendix K for the MCEs' Use of Interns for All the CBHI Services.

Waivers

At times CSAs may have staff they are considering for the position of a care coordinator or family partner. The staff may not meet all of the staffing requirements, as noted within that service's Performance Specifications, however, the CSA may have determined that the staff meets a particular need within their CSA, i.e., language, race/ethnicity, culture, other. In these instances, CSAs may submit a waiver request to the MCEs. All waiver requests must be submitted electronically via the MBHP-CSA@valueoptions.com mailbox and must contain the required documentation for consideration. See Appendix L for the MCE CBHI Waiver Request Form that must accompany all waiver requests.

Training

In addition to the required training and coaching that will be provided by the training and coaching vendor, each provider for ICC and Family Support and Training services will need to develop a training/orientation program to be used for new staff. The training must be reviewed annually by all staff.

- *Systems of Care* philosophy
- The four phases of *Wraparound* and the 10 principles of *Wraparound*
- Family systems
- Peer support
- Partnering with parents/caregivers/guardians
- Psychotropic medications and possible side effects

- Child and adolescent development
- Related core clinical issues/topics
- Overview of the clinical and psychosocial needs of the target population
- Available community mental health and substance-specific services within their natural service area, the levels of care, and relevant laws and regulations
- Introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.)
- Individual Care Plans
- Safety Plans
- Family-driven crisis planning/management
- Ethnic, cultural, and linguistic considerations of the community
- Community resources and services
- Family-centered practice
- Behavior management coaching
- Mandated reporting
- Social skills training
- Basic IEP and special education information

Additionally, all care coordinators must complete the approved CANS training and be credentialed to administer the CANS prior to completing the CANS. The MCEs may request, as appropriate, documentation from CSAs illustrating these training requirements are met.

Culturally Relevant Practice

Culturally relevant services include respectful recognition of differing values and culture of the youth, family, school, and other providers. This includes, but is not limited to, recognition of economic status, gender, sexual orientation, ethnicity, race, language, and the unique values and goals of each youth and family. It utilizes the strengths of all in order to provide comprehensive care to families. To ensure that effective care is provided, agency staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers impacting the delivery of care. Providers will make every effort to recruit ICC and Family Support and Training staff that represent the diversity of the youth and caregivers/families served and deliver services in the primary language of the youth and caregivers/families served.

Culturally relevant practice is an ongoing learning process that should be viewed as a goal that agencies can strive towards, and there will always be room for growth. It accepts and respects differences, emphasizes the dynamics and challenges arising from cultural and linguistic differences in planning and delivering services to diverse populations, and is committed to acknowledging and incorporating the following:

- Importance of cultural awareness
- Sensitivity to cultural diversity brought by a variety of factors including ethnicity, language, lifestyle, age, sexual preference, and society status
- Bridging linguistic differences in appropriate ways

- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific cultural needs of the consumers
- Access to non-traditional services

CSAs will utilize the strengths of all in order to provide comprehensive care to youth and their caregivers/families. To ensure that effective care is provided, providers will seek consultation and additional services when necessary to overcome barriers impacting the delivery of care.

The following language describes provider responsibilities regarding cultural competence (the same responsibilities as for outpatient providers):

1. The program provides services that accommodate the Member, consider the Member's family and community contexts, and build on the Member's strengths to meet his or her behavioral health, social, and physical needs.
2. The program staff will have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.
3. The provider ensures access to qualified clinicians able to meet the cultural and linguistic needs of all Members served in their local community.
    a. Providers ask Members' language of choice.
    b. Because clinical staff with linguistic capacity is preferable to translators, providers offer the Member a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so.
    c. The provider has access to qualified interpreters/translators and translation services, experienced in behavioral health care, appropriate to the needs of the local population served. In case the program must seek translation services outside of the agency, it must maintain a list of qualified translators to provide this service. Interpreter/translator services are provided at a level which enables a Member to participate fully in the provider's clinical program.
4. Any written documentation should be available in the Member's primary language when requested, including discharge documents.
5. Programs will provide ongoing, in-service training that will include cultural competency issues pertaining directly to the client population served.
6. Programs will include cultural competence in their ongoing quality assessment and improvement activities.

Coordination and Conflict Resolution Process with State Agencies Protocols

Department of Children and Families (DCF)

Department of Developmental Services (DDS)

Department of Youth Services (DYS)

Department of Transitional Assistance (DTA)

Department of Mental Health (DMH)

Department of Public Health (DPH)

See Appendix M for the state agency protocols for DCF, DDS, DYS, DTA, DMH, and DPH. These protocols provide details regarding the coordination efforts and processes in place for resolving conflict for state agency-involved youth.

Reporting and Monitoring

Reporting: Referrals, Waitlist and Staffing in the CSA Monthly Workbook

Complete and submit CSA Monthly Workbooks to MBHP, on behalf of the MCEs, no later than the 8th of the month, to the CSAmonthlydata@valueoptions.com mailbox using the submission macro embedded in the Excel spreadsheet. Referral status should be accurate as of the 7th day of the month of submission. CSAs that have not submitted data on time will be contacted by MBHP's Youth Network Manager (YNM) or designee. CSAs are expected to have a plan in place to ensure this data is submitted to MBHP on time every month. It is imperative that all data is correct, especially the data on the Member worksheet tab. CSA Program Directors must review, at a minimum, the Member worksheet **prior to** the workbook submission in order to ensure the CSA Program Director 1) submits accurate data, 2) is aware of the number of youth and length of wait the CSA is reporting to the MCEs and MassHealth, and 3) is actively addressing access to care issues at the youth and system level. It is also strongly advised that any CSA staff that enters data into the CSA monthly workbook reacquaint themselves with the instructions and definitions located on the first two tabs of the CSA workbook.

CSAs use the CSA Monthly Workbook to track and report referral, waitlist and staffing information that includes but is not limited to youth referred to ICC, referral date, referral source, first available ICC appointment offered, referral/youth status, and discharges, as well as staffing information. The CSA Monthly Workbook consists of two data submission worksheets which a CSA must complete. The first data worksheet (Member List) is for entering/tracking a listing of referrals for ICC within a CSA. The second data worksheet (Staff) is for entering/tracking a listing of staff within a CSA. There are additional data worksheets contained within the CSA Monthly Workbook that are useful to CSA staff, i.e., staff summary, referrals, active-discharged, disposition, etc. Providers should refer to Appendix N for an explanation of CSA Monthly Workbook definitions and instructions that are intended to clarify and guide CSA staff in completing these worksheets.

Enter data (please refer to CSA Monthly Workbook Definitions and Instructions in Appendix N) into the first worksheet (Member List) for the following youth and situations:

- Youth for whom service has started;
- Youth who are not MH-eligible;
- The youth/family has not yet been reached;
- An initial appointment has been scheduled;
- The youth/family is waiting to schedule a first appointment;

- The youth/family is choosing to wait for a preferred staff;
- During the referral process, the youth/family is referred outside; or
- The youth/family declines the service.

The following youth/families should be excluded:

- The youth/family was not calling for ICC.

The data fields on the Member List worksheet requiring entry include:

- Youth name
- MassHealth number
- Referral date
- Referral source
- Date family requests ICC
- Date initial appointment (1st available appointment) offered
- Date service started
- Referral/Member status
- ICC staff number
- FP staff number
- Discharge date
- Discharge reason

Data entered into the second worksheet (Staff) should include the following (please refer to CSA Monthly Workbook Definitions and Instructions in Appendix N that clarify specifically what to enter for these categories):

- Staff name
- FTE
- Position
- Start date
- End date
- Date of Team Observation Measure (TOM) #1 for the current fidelity data collection year
- Date of TOM #2for the current fidelity data collection year

Note: As the CSA Monthly Workbook Definitions and Instructions indicate for both spreadsheets, additional fields with grey background are automatically system-generated, based on what is entered.

Maintaining Integrity of the Data

There is logic/code built into the workbook to remove all youth and staff names during the transmission process from sender's e-mail box. The data arrives to MBHP with all protected health information removed. The youth

and staff are then tracked by a unique number. In order to assure the integrity of this data, CSAs are advised of the following:

- do not overwrite rows and re-assign youth numbers to more than one Member;
- do not overwrite or delete staff from the workbook;
- do not attempt to archive your records in any way;
- if a youth re-enrolls, please keep the historical data on the Member, and enter the name into a new row in the Member List worksheet; and
- if a staff person leaves or is terminated, please indicate the date of departure on the Staff List, and keep this staff person listed to keep historical data intact.

Monitoring: Referrals, Waitlist and Staffing in the CSA Monthly Workbook

Criteria for identifying CSAs that are outliers relative to ICC wait time
CSAs will be considered outliers relative to access to care when they meet one or both of the following "outlier targets:"

(I) Outlier Target #1: A CSA has <u>any number</u> of youth waiting over the target number of days for ICC. Beginning in November, using the October 2011 data, CSAs with youth waiting over 30 days will be the considered outliers. In December, using the November 2011 data, any CSA with youth waiting over 20 days will be considered outliers. In January, using the December 2011 data, any CSA with youth waiting over 10 days will be considered outliers.

(II) Outlier Target #2: A CSA's average time to offer families an appointment is greater than three (3) calendar days.

The following network management and Member outreach activities will be implemented with any CSA that meets the criteria for outlier target #1:
CSAs that have Members waiting for ICC services beyond the targeted number of days in Outlier Target # 1 are asked to provide to MBHP in their monthly reporting process the rationale as well as a plan to provide access for every youth waiting over the target number of days. When a CSA reports that any youth is "Waiting because there is no provider with availability nearby," the following Network Management Action occurs:

MBHP's Youth Regional Network Manager (YRNM) contacts the CSA Program Director within three (3) days of data submission to verify that the CSA is:

- Screening to be sure the youth is waiting for ICC;
- Offering to refer the family to another CSA that is within proximity for the family;
- Triaging referrals to other behavioral health services on a timely basis; and
- Ensuring ICC caseload and staffing pattern promotes access and quality of care.

If after the follow-up regarding data submission with the CSA Program Director, youth are still found to be waiting over the targeted # of days for services, the YRNM will notify the Member's MCE with the blinded identification number. The MCE will outreach the CSA to get the Member's identifying information and then outreach the Member to ensure access to other behavioral health services when indicated.

The following network management activities will be implemented with any CSA that meets the criteria for outlier target #1 and/or outlier target #2.

On a monthly basis, the TA team examines the Monthly CSA Access Report by Provider and looks at trends in the average days waiting (of youth currently waiting) and average ICC caseload, and the number of youth waiting. The TA team also receives information that the MBHP YRNM gathered in following up on the number of Members who were waiting. The TA team identifies all outlier CSAs based on both outlier indicators. These outlier CSAs are then engaged in the following network management and technical assistance activities:

1. TA team requests that the CSA submit within five (5) days of notification by the MCE, an updated Development Plan that includes tasks and a timeline to address screening, referral and triage processes, as well as staffing and hiring patterns as well as any other necessary action items to ensure timely access to care.
2. The TA team reviews the tasks and timelines in the revised Development Plans and provides technical assistance as needed. Some examples of TA may include:
    - Linkage with CSAs who have had success in developing agency infrastructure to support timely access to care,
    - Review of MCE Guidelines for Managing Referrals to ICC,
    - Review of MCE Guidelines for Timely Access to Care, and
    - Review of Tip Sheet compiled from CSAs identified as having success in the provision of timely access to care.
3. On a monthly basis, the TA team examines the member level list of youth waiting over the target number of days. The TA team identifies persistent CSAs outliers that continue to have <u>any number of youth</u> waiting for ICC over the target number of days.
4. The TA team contacts persistent CSAs outliers to review progress on access to care related tasks and timelines that were added to their Development Plan in the previous month(s).
5. In the event that a CSA has not reached the targeted goal for that month, the TA team determines the next course of action based on such factors as the severity and/or chronicity of the problem, the history of agency responsiveness to TA/NM interventions, etc. Interventions may include:
    - Urgent phone or in person conference between TA team and CSA Director, which may result in a revised CSA Development Plan
    - Urgent in person conference between TA team CSA Director and one or more of the following:
        I. CSA agency CEO or other senior staff, MBHP Statewide Youth Network Manager (YNM)
        II. MBHP Regional Director
        III. MCE Behavioral Health Directors
    - Formal written corrective action plan
6. On a monthly basis, TA teams update the MCE BH Directors and CBHI managers and MassHealth Office of Behavioral Health in writing on all CSAs who are outliers relative to access, noting progress on Development Plan tasks and timelines, as well as the impact of TA interventions. The MCE BH Directors and CBHI managers provide feedback and guidance to TA teams aimed at strengthening the network management activities and interventions used with CSAs. The TA teams will contact the MCE BH Directors on a weekly basis on any urgent matters around access.

Process for Submission of the Separate Spreadsheet on Youth Waiting Over the Target Number of Days: MBHP, on behalf of the MCEs, will contact every CSA with youth waiting over the target number of days (30 days for the October 2011 workbook submission) between the 8th and the 20th of the month.

- MBHP will send the CSA Program Director a copy of the Wait List Follow-up Report, which lists all youth (by ID #) waiting over the target number of days. (Note: This report is also shared with MassHealth, Judge Ponsor, and the Rosie D. plaintiffs.)
- The CSA will fill in the Wait List Follow-up Report and return it via the MBHP-CSA@valueoptions.com mailbox.
- Please note that this 30 day target will be lowered in increments of 10 days. That is, for the November 2011 report due in December this outlier target will be set at 20 days, and for the December 2011 Report due in January 2012, the target will be set at 10 days.

Fidelity Monitoring

The ICC provider will be completing or participating in a range of data collection on quality, outcomes, and fidelity. Currently, two instruments will be used:

Team Observation Measure (TOM)

Wraparound Fidelity Index version 4 (WFI-4)

The fidelity instruments will gather information regarding the provider's fidelity to the *Wraparound* model and assess the quality of individualized care planning and care coordination for children and youth with complex needs and their families. The results from these instruments provide useful information for program management, training, and coaching in order to improve the fidelity to the *Wraparound* model. It is encouraged that the results be shared with the family and the CPT if the family concurs.

The TOM can be administered by any senior care coordinator, senior family partner, program director, or Quality Department staff member who has been trained in how to administer the TOM and who has a strong *Wraparound* foundation. Please refer to Chapter 3 in the TOM manual for qualifications for use. It is required that the ICC provider use the TOM for fidelity and quality improvement purposes at the CSA. The cost of use of the TOM is not one that will be incurred by the provider. Using the *Wraparound* Online Data Entry and Reporting System (WONDERS), the CSA will enter the results of the TOM and will be able to generate reports that can be used in the following ways:

1. In programmatic development and training with the staff person who was observed to promote skill-based supervision. A discussion about the results of the observation(s) should focus and help identify areas for continued growth and skill development in the area of care plan meeting facilitation.
2. Aggregate data across all observations at the CSA should be used to assist the CSA in planning internal trainings and identifying and prioritizing group supervision needs for CSA staff members.
3. Data should be shared with the assigned VVDB coach to help inform CSA site specific coaching plan.

Every CSA will conduct two observations on every facilitator of Care Planning Teams twice yearly from the date of hire for existing staff and two times between months four and six for new hires. The information will be entered online in the *Wraparound* Online Data Entry Reporting System (WONDERS) by trained CSA staff on a rolling basis as the TOMs are administered. CSAs will be able to generate fidelity, strengths, and needs reports based on the information entered into WONDERS.

The WFI-4 will be completed by Consumer Quality Initiatives (CQI), a vendor contracted by MBHP. CSA Family Partners and ICC providers will explain the WFI-4 interview process that CQI conducts to every caregiver of enrolled youth (up to and including youth age 17) and obtain signed consent (that notes the

caregiver agrees or does not agree to be contacted) (see WFI Talking Points at www.masspartnership.com under the Fidelity heading). Each CSA will continue to have a target of twenty (20) completed interviews which will be conducted by CQI. Providers will obtain caregiver consents and fax the information to CQI until twenty (20) interviews have been completed. CSAs will need to fax consents to CQI beginning July 1, 2011, for those youth enrolled between January 1, 2011 and November 1, 2011. CSAs fax consents on a rolling basis to the attention of Melissa Goodman at (617) 445-5846. CQI will conduct interviews between July 1, 2011 and February 20, 2012.

ICC providers must comply with these fidelity and quality management requirements. The MCEs will share WFI data with the ICC providers and with CQI and will use that data in quality improvement activities. See Appendix O for the consent forms used with the WFI-4 (Evaluation Summary and Acknowledgement of Consent for Caregivers), both English and Spanish.

The MCEs will share data from fidelity reports generated from TOM, WFI-4, and any other fidelity instrument that may be used with the ICC providers at monthly CSA TA meetings and will use that data in quality improvement activities.

Incident Reporting

Please refer to your contract with each MCE regarding incident reporting for its members.

Insurance Eligibility Monitoring

It is the responsibility of all CSA providers is to monitor the MassHealth eligibility of youth enrolled in ICC. Critical activities include:

- Checking the youth's MassHealth eligibility via the Eligibility Verification System (EVS) on a **daily** basis
- Ensuring that the youth and family's address in the EVS system matches the current mailing address of the family so that all MassHealth materials are sent to the family's current address
- Assisting youth and families with completing required eligibility verification paperwork. At least annually the youth and family must complete eligibility paperwork. Other sentinel events that will trigger a verification of eligibility or re-determination may include (but are not limited to):
    - Prior to a youth turning 19
    - Upon expiration of SSI or Transitional Aid to Families with Dependent Children (TAFDC) benefits
    - The youth or parent becoming eligible for employee sponsored health insurance
- For youth with MassHealth coverage through the Department of Children and Families (DCF) it is critical to coordinate with the youth's DCF worker and the family regarding transitioning insurance coverage prior to the termination of MassHealth coverage through DCF.

When assisting youth who have been identified as having a serious emotional disturbance (SED) with completing the Medical Benefit Request (MBR), it is important to ensure that the disability segment of the application is completed. For additional information regarding state disability evaluation for MassHealth child reviews, contact Disability Evaluation Services at the University of Massachusetts Medical School, Commonwealth Medicine. For more details, CSAs can also access the secure web site at www.masspartnership.com < CSA Working Documents < CSA Meetings < December 18.

For questions regarding the status of a Medical Benefit Request (MBR) or member eligibility the youth or family should contact the MassHealth Enrollment Center (MCE) at 1-888-665-9993 (TTY: 1-888-665-9997). For general MassHealth eligibility questions, assistance in selecting a health plan, or for questions about MassHealth benefits contact MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648).

Program Governance

Local Systems of Care Steering Committee

National experience with *Wraparound* shows that the supportiveness of the implementation environment contributes powerfully to successful implementation. The Community Service Agency (CSA) needs to maximize the changes for effective *Wraparound* implementation by nurturing formal and informal community processes that will support Care Planning Teams in their work. Convening and nurturing the local Systems of Care Committee is one mechanism for accomplishing this. Every local committee will reflect the needs and strengths of the community and the CSA in its charter, membership, process, and focus. Furthermore, each local committee will have developmental tasks to accomplish, and its work will evolve over time.

Each CSA is responsible for the development and coordination of a local Systems of Care Committee intended to support the CSA's efforts in the local geographic area to establish and sustain collaborative partnerships among families, parent/family organizations, traditional and non-traditional service providers, community organizations, state agencies, faith-based groups, local schools, MassHealth and its contracted Managed Care Entities (MCEs), and other community stakeholders. The local Systems of Care Committee ensures that the CSA's ICC program is well coordinated with other elements of the service delivery system, with state agency services, and with informal helpers and community resources. The committee must meet monthly on an ongoing basis.

The specialized CSAs and the geographic CSAs may form a joint local Systems of Care Committee. If they choose to form separate committees, both the geographic and specialized CSAs must collaborate to attend the other's committee meetings as needed to address resource and community needs.

The membership in the local Systems of Care Committee should include, to extent possible, but is not limited to:

- Parents/caregivers
- Transition-age youth (TAY)
- CSA provider
- Department of Mental Health (DMH)
- Department of Children and Families (DCF)
- Department of Youth Services (DYS)
- Department of Developmental Services (DDS)
- Department of Public Health (DPH)
- School departments or Local Education Authorities (LEAs)
- Community services organizations
- Parent/Professional Advocacy League (PAL) and or a representative of a PAL-affiliated parent support group

- Representative from one of the judicial authorities
- Local Mobile Crisis Intervention (MCI)
- Faith community
- Business community
- Representative from the local specialized CSA
- If the ICC is subcontracted to a provider by the CSA, the ICC provider must also be represented on the local Systems of Care Committee.

Parents/caregivers and/or transition-age youth who are actively enrolled in ICC can participate as members of a local Systems of Care Committee (SOC). A family member and/or TAY who participates on an ongoing basis should be someone who can manage the dual role of committee attendee and service recipient. The facilitator of the SOC is responsible for exploring this question with the family member in a transparent way.

Additionally, it is the role of the facilitator to ensure that the family/caregiver and/or TAY youth is oriented to the purpose of the committee and support them in speaking about system issues from the point of view of the family and/or youth. They are not there to be helped or advised. Since telling one's own story is one of the ways that a family member can help committee members understand their point of view, they may share details from their personal experience. Meeting facilitators should be prepared to redirect discussion that veers in the direction of clinical questioning or problem solving. Family members or TAY should be made aware that they need not speak, if they do not wish to.

The committee is co-chaired by the CSA provider, another local Systems of Care Committee member, and/or a community member representative agreed to by the committee. It is strongly recommended that a parent or youth co-chair the committee. A subcontracted ICC provider may not co-chair the local Systems of Care Committee.

The local committee serves as an advisory committee to the CSA. The activities and functions of the local committee do not supersede the leadership or responsibilities of the provider organization. In this role, the local committee assists with:

- Quality management processes that address opportunities to improve the delivery of the CSA services including review of systemic barriers and the identification and fostering of community resources and relationships to promote sustainability,
- Community resource monitoring and development, including identifying and monitoring gaps in services, conducting community asset mapping, building capacity of resources and supports, and improving linkages with the schools and other natural supports in the community, and
- Issues or themes related to the delivery of ICC services that arise from program data that indicate access and coordination barriers. The local Systems of Care Committee provides assistance in navigating access to address needs of youth and families served by ICC. The local Systems of Care Committee does *not* engage in individual level review or management of families engaged in ICC.

Youth/family-specific information may not be discussed at local Systems of Care Committee meetings. However, in the event that a youth/caregiver is asked to participate, the ICC provider is responsible for ensuring that appropriate informed consent is obtained and documented in the medical record.

The CSA is responsible for documenting and maintaining minutes of each local Systems of Care Committee meeting, as well as those in attendance. There is no expectation that the CSA provide the MCEs with this

documentation, although CSAs are expected to provide it upon request as needed.

CSAs should review the Systems of Care Committee Resources that are being developed and are available at www.masspartnership.com < Systems of Care Committee Resources.

Appendix A

ICC
Referral
Process Flow

This document can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < ICC Referral Flow Chart

Appendix B

Guidelines for Managing Referrals To ICC

This document can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < ICC Referral Guidelines

Appendix C

Guidelines for Ensuring Timely Access to CBHI Services

This document can be accessed in the following location:

www.masspartnership.com < CBHI < CBHI Overview

Appendix D

ICC/MCI/IHT
Safety Plan

This document, and the other Crisis Planning Tools, can be accessed in the following location:

www.masspartnership.com < CBHI < Crisis Planning Tools

Appendix E

MCE Authorization Parameters for CBHI Services

This document can be accessed in the following location:

www.masspartnership.com < CBHI < MCE Documents and Resources

Appendix F

MCE Authorization Processes (Initial, Concurrent, and Discharge)

These documents can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < MCE Authorization Processes

Appendix G

Conflict Resolution Processes for Care Planning Teams in Intensive Care Coordination

This document can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < Conflict Resolution Process for Care Planning Teams in Intensive Care Coordination

Appendix H

Individual Care Plan (ICP)

This document, as well as the ICP manual and other ICP resources, can be accessed in the following location (and saved accordingly):

www.masspartnership.com < CSA Working Documents < ICP

Appendix I

ICC Service Definition

This document can be accessed in the following location:

www.masspartnership.com < CBHI < Service Definitions for CBHI Services

Appendix J

FS&T Service Definition

This document can be accessed in the following location:

www.masspartnership.com < CBHI < Service Definitions for CBHI Services

Appendix K

MCE Use of Interns for CBHI Services

This document can be accessed in the following location:

www.masspartnership.com < CBHI < MCE Documents and Resources

Appendix L

MCE CBHI Waiver Request Form

This document can be accessed in the following location:

www.masspartnership.com < CBHI < MCE Documents and Resources

Appendix M

State Agency Protocols: DCF, DDS, DMH, DPH, DTA, and DYS

These documents can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < State Agency Protocols

Appendix N

CSA Monthly Reporting: CSA Monthly Workbook Definitions and Instructions

CSA Monthly Workbook Definitions

MBHP is collecting this data on behalf of all the MCEs and MassHealth. Therefore, numbers submitted should reflect all activity regardless of insurer. The CSA Monthly Workbook is used to generate a report providing information on all youth who are members of any of the six MassHealth Managed Care Entities and served by a CSA.

General Acronyms:

CSA: Community Service Agency
ICC: Intensive Care Coordination
FP: Family Partner
FTE: Full Time Equivalent
YTD: Year to Date
LOS: Length of Stay
MCE: Managed Care Entity

Referrals:

Referrals are defined as calls to the CSA requesting ICC services on behalf of a member, where the referral source (if not the family themselves) has spoken with the family and believes the youth is appropriate for and interested in the ICC service. Referrals exclude calls regarding people who are out of the age range for the service, or who do not have MassHealth Standard or CommonHealth. Date for referral is considered date referral made, even if just a message. All dates may be entered either m/d/yy or m/d/yyyy.

Keys to Referral Sources:

Family/Youth: This is a self referral by family or youth
DCF: Department of Children and Families
DMH: Department of Mental Health
DYS: Department of Youth Services
Probation
DDS: Department of Developmental Services
School: Includes pre-school or Headstart
MCI: Mobile Crisis Intervention Services
In-Home: In-Home Therapy Services
Outpatient: Includes any outpatient behavioral health provider
PCP: Primary Care Provider
Hospital: Only psychiatric hospitals
TCU/CBAT: Transitional Care Units and Community Based Acute Treatment facilities

Referral Status (Based on status at end of month):

Service Started: Youth/family has provided written consent to participate and has met with a care coordinator, not a family partner. This date is used in calculating the number of new members receiving the service in the month.

Initial Appointment Offered: This is the date of the first available ICC appointment offered to the youth/family regardless of the date the family chooses to meet with the ICC This includes appointments offered via voicemail, post mail, outreach letter left at the family's residence, etc.

Family Not Yet Reached: Youth for whom a referral has been made, but an initial appointment has not yet been offered due to CSA staff that are still attempting to reach the youth/family to offer an appointment.

Not MassHealth Eligible: Youth who is no longer eligible for MassHealth Standard or CommonHealth.

Referred to Other Service: Youth/family who is referred to more clinically appropriate service, such as MCI, IHT, or outpatient, and who is not interested in ICC at this time. This includes youth who chooses to go to another ICC provider or another service and who is not added to the wait list for ICC.

Family Declines Service: Youth/family indicates that they are not interested in ICC services at this time, either verbally or in writing to the CSA, OR by not responding to outreach attempts.

Waiting for Preferred Staff: Youth/family who chooses to wait to schedule a first appointment in order to work with a particular care coordinator for reasons other than linguistic capacity. Date of first available appointment offered with first available care coordinator should be noted as the date of Initial Appointment Offered.

Waiting to Schedule 1st Appointment: Youth/family is waiting for future appointment that is not yet scheduled, due to CSA capacity.

Discharge Reasons:

Goals Met: Youth who no longer meets medical necessity criteria because goals have been met and continued services are not required in preventing worsening of behavioral health condition.

Consent withdrawn: Youth/family who indicates they no longer want services, either by formally withdrawing consent, or by no longer engaging in or participating in services.

Not SED: Youth who no longer meets medical necessity criteria due to SED criteria no longer being met.

Family Moved: Includes youth/family who moves too far away for the current CSA or moves out of the CSA area because of a change in caregiver.

Disenrolled MH: Includes youth disenrolled from MassHealth and youth still enrolled in MassHealth but disenrolled from an ICC eligible benefit category. Does not include youth changing to a different MCE.

Out of home: Includes youth who is placed out of home and unable to return to community even with ICC supports.

Youth 21: Youth who has aged out because he/she is now 21.

Additional Definitions

Youth #	This is a system generated number that is not changeable.
Youth Name	Youth name as known to CSA. Please note, if referral does not become a request for Intensive Care Coordination, and the Member is referred to outside service, or the family declines the service, the name may be left blank. However record the referral and member status for reporting purposes. Column with names will be automatically removed when the data is submitted to MBHP.
MH #	Youth's MassHealth identification number. Please note, if referral does not become a request for Intensive Care Coordination, and the Member is referred to outside service, or family declines the service, the MassHealth number may be left blank. This column will be automatically removed when the data is submitted to MBHP.
Date Family or Youth Requests ICC	This is the date that the family or youth directly talks to the CSA and says they are interested in ICC. If it is a case that is self-referred, this will be the same as a referral date. In reporting wait times, this is the date from which a wait for a service begins.
Discharge Date	Date Member is discharged from ICC. Used for report on discharges.
Active Status	System calculated field allowing referrals to be filtered into groups depending on whether referral is: 1) YES (Active); 2) D/C (Discharged); 3) New (Referral in Process), OLD (Completed Referral without ICC), or Blank (Referral for Next Month).
LOS	System calculated field showing length of time in months for active or discharged youth and in days for referrals in process.
Staff Number	This is a system generated number that is not changeable.
Staff Name	Enter the staff name, last name first. If a staff member leaves employment and then returns, start a new line with the same name. This column will be automatically removed when the data is submitted to MBHP.
FTE	Put the current FTE amount for this staff member up to 1. This number should be current for all active staff as of the end of the reporting month.
Position	Use the drop down menu to pick the appropriate staff category. Use "ICC-Other" for program director or other administrative staff who may have a caseload.
Start Date	Date staff member eligible to begin accepting referrals. All dates may be entered either m/d/yy or m/d/yyyy.
End Date	Last date staff member available to see youth. Leave cell blank for all active staff. All dates may be entered either m/d/yy or m/d/yyyy.
Active	System generated field with "YES" for active and "NO" for inactive during reporting month.
Staff Type	System generated field with value of either "ICC" or "FP" for type of staff.

Caseload	System generated field with the current caseload for this staff member for the reporting month based on staff designation on member list.

CSA Monthly Workbook Instructions

For questions, e-mail: MBHP-CSA@valueoptions.com or call your MBHP TA manager/Youth Regional Network Manager (YRNM).

Macro Instructions

1	This Excel workbook uses buttons that you can click on that start what are called "macros" which perform a set of operations such as to "insert a new row." When you use a version of Excel before Windows 2007, a pop up box will ask you to enable the macro. For Windows 2007, when you open the file you will get a security warning. Click on the options box and "enable the content".

General Instructions

2	If you want to past information into the "Member List" or "Staff" tables, please use "Paste Special," click on "Values" so that formatting is not disturbed.
3	When saving this file, you may change the name but please remove any "COPY OF" wordage that Word sometimes adds.
4	On SetMonth sheet enter, month, year, and CSA number. Month and year should always be month and year corresponding to reporting month and year. Initially be sure that the month is "7" and year is "2010."
5	Enter all currently active staff.
6	Enter members on member list sheet with all appropriate fields completed. Enter only ongoing youth and referrals that are active as of July 1, 2010. For ongoing youth enrolled before 7/1, referral information (columns "D" through "G") does not need to be completed.
7	On Member list sheet, cells will become colored if not all data is entered.
8	If more rows are needed, click on "insert rows/fix row error" button and insert the preferred number of rows in the dialog box. If your computer happens to crash during the insertion of rows, reopen the workbook, click on the "insert rows/fix row error" button, and insert new row(s). This will fix any row error that might have occurred.
9	When ready to send data for month to MBHP, click on "Send file without PHI to MHBP" button on SetMonth sheet. Please send file between the 7th and the 13th of following month. The code in the "Send" macro will save your file for you and will tell you where the file with and the file without the PHI will be saved. Some CSAs have special computer security protection that will not allow an email to be sent via code. These CSAs must use the "Special Send" workbook template. If you have the "Special Send", you still must click "Send" in order to save the files and remove the PHI, but you must manually send your workbook to CSAmonthlydata@valueoptions.com.
10	Before sending data, use filters to check that all data is completed. For example, click on filter for "Active Status' column to check if all cells are completed for "NEW" referrals.
11	Use filters to create a printout of various categories of youth. For example, filtering on "YES" in "Active Status" column will allow you to printout all active cases.
12	To print out staff, filter so that you will not get to long a printout. Suggest filtering on "YES" in "Active Status" column.

13	Plan a regular schedule to create a back up with a different name.

Pivot Table Worksheets

14	The four pivot table sheets are designed to help you track youth and staff listed in the data sheets. Feel free to change them as they are only for your use and will not be used by the MCEs.
15	Pivot tables will only update (refresh) after you have saved the worksheet and opened it again or clicked on the "refresh pivot table" button.
16	After refreshing the pivot tables, you may want to change the column widths to allow easier reading.
15	Because the initial staff and Member list data sheets are blank, the initial pivot tables have blank or default values in the filter fields. Use the values in the box to update the filter fields.

CSA Specific Worksheets

16	For additional information that a CSA would like to maintain on either Members or staff, use the "CSA Member Worksheet" or the "CSA Staff Worksheet."
17	Both of these worksheets mirror the names on the primary Member and staff worksheets and those columns are protected and insure that the two worksheets stay in sync.
18	You may add any information or formulas to any of the columns (other than "A" and "B" as needed. Please e-mail any questions on the use of these worksheets.
19	These worksheets will not be forwarded to MBHP when you click on the "Send to MBHP" button.

Using the "Send file without PHI to MBHP" Button (Macro)

20	When you click on the "Send file without PHI to MBHP" button, you will get a number of pop up boxes. Please click as directed in the following instructions.
21	Any pop up box that asks you whether it is "ok", click on "ok."
22	You may get a "file already exists" pop up box. Click on "Yes."
23	You may get a pop up box to allow you to send an e-mail. Click on "allow."

For questions regarding monthly data submission, please send an e-mail to the MBHP-CSA@valueoptions.com mailbox.

Appendix O

Evaluation Summary and Acknowledgement of Consent For Caregivers for WFI-4 (English and Spanish)

These documents can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < Fidelity

Appendix P

Children's Behavioral Health Initiative (CBHI) Mission and Values

Mission

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care and to ensure that families and their children with significant emotional and behavioral health needs obtain the services they need for success in home, school, and community.

Values

1. Services are driven by the needs and preferences of the youth and family, using a strengths-based perspective.
2. Services are relevant to the culture, values, beliefs, and norms of the family and its community.
3. Services are delivered in an individualized, flexible, coordinated manner.
4. Services are integrated across child-serving agencies and programs.
5. Families are involved in service planning and monitoring.

Appendix Q

MCE Web Sites

Beacon Health Strategies[1]: www.beaconhealthstrategies.com

BMC HealthNet Plan: www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: www.nhp.org

Network Health: www.network-health.org

Massachusetts Behavioral Health Partnership[2]: www.masspartnership.com

Health New England[3]: www.healthnewengland.com/

[1] BMCHP, NHP, and FCHP have contracted with Beacon Health Strategies (Beacon) to manage the delivery of mental health and substance abuse services for each of these plans respective members.

[2] MBHP manages the mental health and substance abuse services for members of the Primary Care Clinician (PCC) plan within MassHealth.

[3] MBHP is also the behavioral health subcontractor for Health New England's (HNE) Managed Care Organization (MCO) contract with MassHealth, HNE Be Healthy. In this role, MBHP manages the mental health and substance abuse services for members of the HNE Be Healthy plan.