



**Outpatient Therapy  
as a CBHI Clinical Hub:  
Practice Guidelines**

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## Introduction

Outpatient Therapy (OP) is the one of the foundations of behavioral health treatment for children and youth. It is usually the first place that families go to when they need help, as well as the service youth return to, or step down to, after encountering a higher level of care. Many youth benefit from, and have their behavioral health treatment needs met primarily by, outpatient therapy. However, some youth require more intensive intervention and greater support than is available through outpatient therapy alone. ***For these youth, outpatient therapists play the critical role of expert helper and guide, identifying and helping families access and coordinate needed behavioral health services.***

Children’s service system reforms over the past two decades have focused especially on the children and youth with the most complex and severe needs, and on creating a true continuum of services between OP and inpatient care. In 2007, as part of the remedy in the Rosie D. class action lawsuit, the Commonwealth of Massachusetts launched the Children’s Behavioral Health Initiative (CBHI) to expand the availability of home- and community-based behavioral health services for youth enrolled in MassHealth, the state’s Medicaid program.

In 2009, CBHI implemented six new services: Intensive Care Coordination, In-Home Therapy, In-Home Behavioral Services, Family Support and Training, Therapeutic Mentoring, and Mobile Crisis Intervention. While these changes have not been directed primarily at the OP system, they have transformed the context of outpatient care, offering outpatient clinicians new options for supporting the youth and families with whom they work. In addition, these changes have created new responsibilities for outpatient clinicians to collaborate within a larger system and to educate families about their service options.

## Purpose of the Outpatient Guidelines

The Outpatient Guidelines serve three purposes: (1) to provide actionable and detailed information about the CBHI service system, its various levels of care coordination, and the responsibilities of clinical Hub providers; (2) to support and promote best practices for OP clinicians working in this expanded home- and community-based service system; and (3) to increase positive outcomes for children, youth, and families by connecting them with medically necessary behavioral health services, including Intensive Care Coordination.

These Guidelines do not attempt to describe or repeat all the requirements that may apply to the OP clinician.<sup>1</sup> Instead, they focus on key functions of OP therapy in the context of the CBHI service system—reinforcing MassHealth requirements and articulating practice standards for clinical assessment, youth and family education, referrals, care coordination, and collaboration with other home-based service providers.

Every clinician serving MassHealth children and youth under the age of 21 must understand the CBHI array of services and the role of the Hub service.<sup>2</sup> These Guidelines are designed to help develop that understanding. It is important that clinical supervisors and administrators in OP services also understand the CBHI service system and corresponding Hub responsibilities so they can continue to build and manage outpatient sites that meet the needs of families and youth. OP sites that take full advantage of, and are effectively integrated with, CBHI services can improve clinical outcomes for youth and families, while reducing the need for uncompensated care.

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<sup>1</sup> For instance, OP providers are responsible for understanding their obligations under DPH licensure regulations, MassHealth regulations, and their MCE contracts. Individual clinicians also have obligations under their licensure laws and codes of professional ethics.

<sup>2</sup> Hubs serve as the coordinator for behavioral health care for a youth. Outpatient is one of three MassHealth BH services that can function in this important role; the others are Intensive Care Coordination (ICC) and In-home Therapy (IHT).

Finally, OP programs should incorporate these Guidelines in their hiring, orientation, training, supervision, performance evaluation, and quality-improvement programs.<sup>3</sup>

When OP clinicians understand and can navigate the CBHI service system, they are able to help families make informed choices about their treatment. OP clinicians have an obligation to educate youth and families about available home-based services and their potential benefits. This education should be closely tied to an ongoing and individualized assessment of needs, and should involve thoughtful conversations with youth and families, not just disseminating brochures or web links. While the Guidelines are directed primarily to OP clinicians, supervisors, and administrators, they also may be useful to families, staff in child-serving agencies, and other service providers who wish to better understand the role of OP, and its responsibilities when serving as a CBHI clinical Hub.

Clinicians who work with young people have traditionally understood that they must be viewed, and treated, within the context of their family, school, and community. This has generally meant that OP therapy with young people has involved working with caregivers and communicating with other contacts, such as school personnel and other service providers. Communication and coordination have always been essential to good practice. With the availability of home-based services under CBHI, these principles have become even more important. Children and youth now have the opportunity to receive highly coordinated, team-based treatment interventions as well as highly flexible clinical services designed to promote and sustain their connections to home and community.

- OP clinicians have access to an expanded array of behavioral health services for children and families. For example, an OP provider serving as Hub can give the family a Family Partner, a Therapeutic Mentor, or In-Home Behavioral Services supporting the OP treatment plan.
- The OP clinician does not need to carry the weight of care coordination in working with youth who meet medical-necessity criteria for ICC or In-Home Therapy. When one of these services becomes the Hub, it assumes responsibility for tasks such as convening meetings, finding resources, and gathering updates from other providers. This allows the OP clinician to focus on therapy with the child or family while actively participating in the larger treatment plan.
- Behavioral health crises can be managed better, which may prevent unnecessary emergency room visits or inpatient admissions. Working with Mobile Crisis Intervention and community based services such as IHT and ICC that provide skilled safety planning and 24 x 7 on-call response, can reduce crises and episodes of harmful behavior. Proactive planning that takes advantage of a team working in concert helps to keep a child safe and to motivate healthy change.
- Expert help is available for working with children and youth with the most challenging behaviors. In-Home Behavioral Services can help to develop and implement effective behavioral support plans for children, youth, and their families and caregivers.

These new services, and their potential benefits for youth in outpatient care, are described in the sections that follow, as well as the role of the OP clinician in assessing, educating, and referring youth to medically necessary services. The Guidelines describe opportunities for collaboration with other CBHI service providers and best practice standards to help OP clinicians effectively integrate their service within the large home-based service network. Finally, the Guidelines reaffirm and further clarify the responsibilities that come when the OP clinician serves as the clinical Hub provider and the ways in which the provider can be compensated for these important activities.

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<sup>3</sup> We also recommend that outpatient clinicians consult Practice Guidelines for other CBHI services—not just to understand those services, but also because insights from other services may illuminate outpatient practice.

# The Children's Behavioral Health Initiative (CBHI)

## Mission

The mission of CBHI is to ensure that children with MassHealth who have significant behavioral, emotional, and mental health needs, and their families get the services they need for success in home, school, community, and throughout life. CBHI works to accomplish this mission by strengthening, expanding, and integrating Massachusetts behavioral health services into a comprehensive, community-based system of care. CBHI partners with child- and family-serving state agencies, providers, and payers to ensure that services

- meet the individual needs of the child and family;
- are easy for families to find and access; and
- make families feel welcomed and respected.

## Values<sup>4</sup>

The Systems of Care (SOC) philosophy guides the work of CBHI. The SOC framework fosters collaboration across agencies, families, and youths.

These core SOC values guide the development, delivery, and practice of CBHI services.

- **Youth-Guided and Family-Driven**  
Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.
- **Strengths-Based**  
Services are built on the strengths of the family and their community.
- **Collaborative and Integrated**  
Services are coordinated and integrated across child-serving agencies and programs.
- **Culturally Responsive**  
Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.
- **Continuously Improving**  
Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

Spurred on by these values, CBHI works to

- Increase timely access to appropriate services
- Expand the array of community-based services
- Reduce health disparities
- Promote clinical best practice and innovation
- Establish an integrated behavioral health system across state agencies
- Strengthen, expand, and diversify the workforce
- Ensure mutual accountability, transparency, and continuous quality improvement

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<sup>4</sup> CBHI values are aligned with System of Care principles, Wraparound principles, and the principles of Youth Development. For Wraparound principles, see <http://nwi.pdx.edu>; for System of Care principles, see [http://gucchdtacenter.georgetown.edu/SOC\\_Framework.html](http://gucchdtacenter.georgetown.edu/SOC_Framework.html)

For more information on the System of Care philosophy, visit the [Technical Assistance Partnership for Child and Family Mental Health](#).

## What are CBHI services? Whom do they serve?

CBHI services are the home- and community-based services for MassHealth-enrolled children and youth under the age of 21, which were newly developed around 2009. These services are now an integral part of the larger array of behavioral health services for children and youth with MassHealth. In addition, CBHI introduced changes to its existing Emergency Service Programs, with an enhanced Mobile Crisis Intervention service for members under the age of 21. In this document, these are the services that we refer to as the “CBHI array of services.”

In order to standardize assessments and give clinicians a common language, CBHI also introduced the CANS (Child and Adolescent Needs and Strengths<sup>5</sup>) tool, which must be completed by outpatient, Intensive Care Coordination, and In-Home Therapy at intake and at 90-day intervals, and which must be completed as a part of discharge planning in 24-hour levels of care. This document addresses the use of the CANS in OP for assessment, for tracking progress, and for communication and collaboration.

Additionally, CBHI requires primary care providers seeing members under the age of 21 to screen for behavioral health concerns at well-child visits, choosing from an approved menu of screening tools, and to facilitate referrals to services and supports (such as the CBHI array) as necessary. This requirement anticipated a growing national policy interest in integrating primary and behavioral health care. While primary care screening is not discussed further in these guidelines, the reader will note that the importance of communication and coordinating with all of the child’s providers, including medical providers, is emphasized throughout.

This Guide uses the term *parent* or *family* to describe person(s) who nurture and care for a child. The terms *parent* and *caregiver* are used interchangeably. A parent may be a biological, foster, or adoptive parent, a grandparent, relative, caregiver, or guardian. *Family member* may refer to caregivers, but also to the child or youth receiving services, and to other members of the family or household, such as siblings. While generally referring to how parents and families can help children and youth to access services, this publication covers MassHealth members under the age of 21, including members who do not need parental consent to obtain treatment services. Both *child* and *youth* refer here to people under age 21.

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<sup>5</sup> The CANS was developed by John S. Lyons, PhD, and the copyright is held by the Praed Foundation.

## Understanding the CBHI service array, and the support system beyond MassHealth<sup>6</sup>

This section describes a system of services and supports that includes, and extends beyond, MassHealth behavioral health services. The philosophy of CBHI is that children need more than a continuum of behavioral health services. They need, rather, a social support system that is individualized and that draws on all needed components, whether these are MassHealth services, state agency services, services or accommodations provided by local school districts, or supports developed and sustained by any number of governmental, charitable, or other sources. While OP clinicians must understand the MassHealth service options above all, they will be of greatest help to their clients when they also understand the system of support that lies beyond MassHealth services, and when they develop skills to connect families to that system.

### The Hub Services<sup>7</sup>

To help families and youth find the right service or combination of services, each child receiving CBHI services must have a Clinical Hub conduct an assessment, put appropriate services in place, and coordinate care.<sup>8</sup> Any of three services can be a Hub: outpatient therapy, In-Home Therapy (IHT), and Intensive Care Coordination (ICC).

A youth may receive one or more of the three services listed above, but at any time there is *only one* Hub.

- If the youth receives ICC, then ICC is the Hub.
- If the youth receives IHT but not ICC, then IHT is the Hub.
- If the youth is in OP, and not in ICC or IHT, then OP is the Hub.

This hierarchy is based upon the principal that when a youth participates in more than one service that could be a Hub, the service designed to provide the most intensive level of care coordination takes the lead on care coordination.<sup>9</sup>

Hub responsibilities can, and do, shift from one level to another as MassHealth members enter or leave services. As an OP provider you may, for example, initially function as a Hub, then shift that responsibility to ICC as you uncover a need for a high level of care coordination, then resume Hub responsibilities as the family meets their goals in ICC and graduates from that service.

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<sup>6</sup> Documents referenced in these Guidelines are found in the Appendices section and are also available in the Children's Behavioral Health Initiative section of the Massachusetts Behavioral Health Partnership website at [www.masspartnership.com](http://www.masspartnership.com) and on the Commonwealth's website at [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi).

These Practice Guidelines incorporate and build on the *Tip Sheet for Outpatient Clinicians* published by the Managed Care Entities (MCEs) in 2012 and updated in 2014. We welcome feedback on all of the Practice Guidelines to inform future revisions. Please address questions and comments to [cbhi@state.ma.us](mailto:cbhi@state.ma.us).

<sup>7</sup> The *Children's Behavioral Health Initiative Clinical Pathways Grid* (see Appendix D) provides a visual map of these relationships. It can be helpful to the OP clinician in understanding the service array and in helping others to understand the hub system.

<sup>8</sup> In some instances, the Hub requirement may be waived by the member's MCE. For more information, please consult the relevant guidelines for the Hub-dependent service in question, or consult with the member's MCE.

<sup>9</sup> ICC is designed as a specialty care coordination service for children, youth, and families with the greatest need for coordination; IHT provides both intensive home-based treatment and a higher level of care coordination than would be typical in OP; and OP in the Hub role is expected to provide as much coordination as the child and family need, with the expectation that this is less than would usually occur in ICC or IHT. If you as an OP provider begin to feel that the level of care coordination required for a child in your care is more than you can manage, that is one indicator that a referral to another hub (ICC or IHT, depending on other needs) may be appropriate.



The Hub is responsible for completing a comprehensive assessment of the youth's needs and developing and implementing a treatment or care plan. A critical element of this process is identifying the need for any other service(s), helping the family access the service(s), and coordinating care for the youth with the other service provider(s).

In the context of CBHI, high-quality outpatient therapy requires providers to undertake important additional activities alongside direct treatment: coordinating care between multiple services and supports; attending care-planning meetings; and consulting with other behavioral health providers, family members, or other collaterals, such as teachers, school counselors, state agency, or court staff. Though outpatient providers have always been able to bill for this kind of work, it has been reimbursed at a rate lower than that of the office visit.

MassHealth recognizes that this work, which may already be a part of your practice or something you wish you had time to do more consistently with your clients, is as important to high quality care as the therapeutic encounter. As of Oct 1, 2016, MassHealth began directing MCEs to reimburse coordination and communication activities at the same rate as the 60-minute office visit. By engaging in consultation with other providers, family members, or collaterals, you will gain more insight into your clients, which can improve your treatment plans. You will be compensated for your collaboration and communication at a rate that acknowledges the importance of this sort of work. For more definitions of these activities, see **All MCE Network Alert-Additional Changes to: Case Consultations, Family Consultations, and Collateral Contact Authorization Procedures and Parameters** in Appendix G, Additional Resources. For guidance on MCE billing procedures, please consult the individual MCE materials also linked in Appendix G.

### **Outpatient as a Hub**

Since outpatient therapy is often the first mental health service a youth or family experiences, OP often serves as the family's initial Hub. This makes the educational role of the OP provider especially important in helping youth and families learn basic concepts of behavioral health and behavioral health treatment, and of how to navigate the system successfully. Other aspects of outpatient as a Hub are discussed at length below, including best practices for OP clinicians in their referral to, and coordination with, other Hub-dependent service providers.

### **In-Home Therapy (IHT) as a Hub**

In-Home Therapy provides intensive family therapy for a youth in the home and in community settings. In this service, a clinician and a trained paraprofessional work with the family to develop and implement a treatment plan, identify community resources, set limits, establish helpful routines, problem-solve difficult situations, or change problematic patterns that interfere with the youth's development.

If an OP clinician is serving a child or youth who has IHT, but not ICC, then IHT is the Hub. IHT may convene formal team meetings, but the IHT Hub should be in frequent contact with you—the OP provider—to update you on the work being done in IHT, to learn how your work in OP is progressing, and to include you in ongoing planning with the family.

OP clinicians typically take on the Hub responsibilities when goals of IHT have been met and the service is no longer necessary for the child. This may mean continuing to support and collaborate with other Hub-dependent service providers (see below). In order to prepare for this transition in roles, the IHT hub and OP clinician should meet with the child or youth, family, and team of providers to discuss strategies for ensuring appropriate communication and continuity of care going forward.

### **Intensive Care Coordination (ICC) as a Hub**

Intensive Care Coordination provides care coordination for children and youth with serious emotional disturbance, or "SED." The service uses a team model called *Wraparound* to develop and implement a plan of care. In Wraparound, families and youth work together with behavioral health providers, develop a clear understanding of their strengths and needs, and actively guide their own care. In ICC, a team leader, called a

*Care Coordinator*, helps families convene a team of people to create a child's care plan. This *Care Planning Team* often includes therapists, teachers, social workers, and representatives of all child-serving agencies involved with the youth. It also includes "natural supports," such as family members, friends, and people from the family's neighborhood or community that the family invites to be a part of the team. Together, the team helps support the family's short- and long-term goals for the child (or the youth's goals, in the case of an older child), creating an *Individual Care Plan*. This plan also focuses on the family's strengths and respects their cultural preferences, and lists all behavioral health, social, therapeutic, or other services needed by the child and family, including informal and community resources. It will guide the youth's care and involve each provider and state agency in the integration of services.

The Care Planning Team will usually meet monthly, but sometimes more often, at the beginning or at times of particular need. At these meetings, the family, youth, and other team members chart progress, problem-solve, and make adjustments to the Individual Care Plan. The team may have less frequent formal meetings as the family approaches graduation and is preparing to manage on their own.

The ICC Care Planning Team seeks to:

- help the family obtain and coordinate services that 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 that these services are provided in a coordinated manner; and
- facilitate a collaborative relationship between the youth with SED, the family, natural supports, and involved child-serving systems to support the parent or caregiver in meeting the youth's needs, now and in the future.

When an OP clinician serves a child or youth with ICC, then ICC is the hub. OP clinicians are typically invited to participate in Care Planning meetings. Intensive Care Coordinators should be in frequent touch with you, as the OP Provider, to share information about how the child and family are progressing, to get updates on the delivery of OP therapy, and to involve you in decision-making with the team and family.

Families involved in ICC often work with a Family Partner (a provider of the hub-dependent service Family Support and Training). Family Partners can also work with an OP or IHT Hub.

If the child is not receiving IHT, and the introduction of IHT is not anticipated, the OP provider will likely need to take on Hub responsibilities when the child and family have met their goals in ICC. This may mean continuing to support and collaborate with other hub-dependent service providers, like the family partner. In order to prepare for this change in roles, the ICC will convene the team to discuss the youth's and families' prospective needs and develop a transition plan designed to ensure continuity of care. It will become the OP clinician's responsibility to work with and develop measurable treatment planning goals for any remaining Hub-dependent service providers.

## **The Hub-Dependent Services**

Hub-dependent services are those MassHealth services that are available only when coordinated through a CBHI Hub (Family Support and Training; In-Home Behavior Services; and Therapeutic Mentoring). OP providers can refer families to these services whenever they suspect that the service may be medically necessary for the child. The ultimate responsibility for determining medical necessity does not lie with the Hub, but with the provider of the Hub-dependent service. Nonetheless, it is important to be familiar with each service's medical necessity criteria (MNC). This description of the service's purpose and eligibility criteria is helpful when discussing a potential referral with the youth and family, and will assist the OP clinician in presenting the youth's and family's needs and treatment goals to the service provider.

MassHealth Hub-dependent services are described below, and again on page 19.

## **Family Support and Training (FS&T, or Family Partners)**

Family Support and Training provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver to help the parent gain hope and capacity in caring for a child with behavioral health needs. Family Partners are themselves parents or caregivers of children with special needs—they've "been there," understand what families go through, and can share their own experiences. FS&T services "do for, do with, cheer on" parents/caregivers to provide for the needs of the youth. FS&T, like all Hub-dependent services, works on accomplishing specific goals enumerated in the Hub plan. Services are provided to the parent/caregiver of a CBHI-eligible youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes) and other community settings as long as the youth meets the medical necessity criteria for this service and is receiving one of the Hub services (Intensive Care Coordination, In Home Therapy, or outpatient therapy).

FS&T is available only through Community Service Agencies, which are the same organizations that provide Intensive Care Coordination. While FS&T frequently occurs in conjunction with ICC, it can also work with other Hubs. FS&T can be extremely useful to some families working with OP Hubs, and the OP provider should be alert to the benefits that a family might derive from a referral to FS&T.

## **In-Home Behavioral Services (IHBS)**

IHBS offers valuable support to a youth with challenging behaviors that interfere with everyday life. Often, these behaviors also interfere with attempts to conduct OP therapy. There are many reasons to consider referral to IHBS. IHBS can be a valuable resource in obtaining expert help to understand the function of a child's behavior, develop a positive behavior support plan, and interrupt a cycle of disruptive behaviors that frustrated prior treatment efforts.

In IHBS, a skilled Behavioral Support Therapist conducts a Functional Behavioral Assessment to understand factors that may trigger or reinforce problematic behaviors, and, in conjunction with the family, develops a behavioral support plan that cues and reinforces more adaptive behaviors. IHBS also has a skilled paraprofessional Behavior Support Monitor who works with family members and other stakeholders to implement the Behavior Support Plan. In-Home Behavioral Services can be provided in a variety of settings, such as home, school, child care, and other community settings. IHBS can work with a child as long as needed (per medical necessity). IHBS, like all Hub-dependent services, works on accomplishing specific goals enumerated in the Hub treatment plan.

In certain situations, youth may meet the Medical Necessity Criteria for IHBS but not need or benefit from continued outpatient or other clinical Hub services. In those cases, the OP clinician may consult the member's MCE about whether a waiver of the clinical hub requirement is appropriate. You can find additional information about the waiver process on page 13 of the IHBS practice guidelines, at <http://www.mass.gov/eohhs/docs/masshealth/cbhi/practice-guidelines-ihbs.pdf>.

## **Therapeutic Mentoring (TM)**

A Therapeutic Mentor works one-on-one with a youth to support his or her community integration and personal skill development. For instance, TMs often coach youth in the development of social and self-management skills, including better ways to communicate with other youths and adults; how to deal with disagreements or peer pressure; and how to get along with others. The Therapeutic Mentor works with the child in natural settings to practice and reinforce these skills and to achieve specific clinical goals identified by the youth and family and incorporated into the treatment plan of an outpatient clinician, In-Home Therapy provider, or an Intensive Care Coordination (ICC) team. Therapeutic Mentoring can be delivered in the home, school, or community, including social and recreational settings.

## Non-Hub-Dependent Services

While the following MassHealth services can be accessed without a Hub, it is Hub's responsibility to educate the youth and family about the availability of these services and to assist them with access if needed. The Hub must communicate with and organize collaborations with the provider(s) if a child or youth is receiving one of these services. These responsibilities belong to the OP provider when OP is the Hub.

### Mobile Crisis Intervention (MCI)

MCI is the youth-serving component of an Emergency Services Program (ESP) provider, the purpose of which is to support youth and their families through psychiatric emergencies in ways that leave the family safe and emotionally stable. MCI provides an immediate, short-term, face-to-face therapeutic response to a youth experiencing a behavioral health crisis. The team is mobile, travels to where the emergency is taking place, and intervenes within one hour of contact. The MCI intervention identifies, assesses, treats, and stabilizes the situation in order to reduce immediate risk of danger to the youth or others, consistent with the youth's risk management/safety plan, if one exists. If needed, the MCI team can admit the youth to a 24-hour level of care, such as Community Based Acute Care (CBAT) or an inpatient hospital unit. The MCI team helps the family develop a risk-management/safety plan, if they do not already have one. The MCI service is available 24 hours a day, 7 days a week. Following a crisis, MCI can provide up to 7 days of crisis-stabilization services, which include face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacological intervention. The MCI team, as needed, makes referrals and builds linkages to all medically necessary behavioral health services and supports. MCI staff coordinates with the youth's Hub throughout the duration of the MCI service. MCI also coordinates with the youth's primary care physician, any other care management program, or other behavioral health providers involved with the youth.

MCI is not limited to crisis response, but can provide proactive safety-planning consultations for a child or youth while also involving other providers in the process. Not only is this a wonderful resource for the OP provider seeking assistance in safety planning, but it is also an occasion for using a non-crisis moment to build a relationship between the family and the MCI team.

To find your local MCI/ESP provider, call 1-877-382-1609 or see [www.masspartnership.com/provider/ESP.aspx](http://www.masspartnership.com/provider/ESP.aspx).

### Structured Outpatient Addictions Program (SOAP) for Adolescents<sup>10</sup>

SOAP is a short-term, clinically intensive, structured day and/or evening substance use disorder service. It provides multidisciplinary treatment to address the sub-acute needs of teens with addiction and/or co-occurring addiction and mental health conditions, while allowing them to continue to work or attend school and be part of family life.

As an OP clinician, if you refer a youth to SOAP, you will probably need to educate the youth and family, and help them clarify and maintain their motivation in advance of the SOAP admission and after discharge. Working closely with the SOAP staff as well as the family will make this process easier.

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<sup>10</sup> Substance-use problems tend to be underdiagnosed by mental health clinicians. Recent surges in opiate addiction, overdoses, and deaths serve as a reminder of the importance of assessing for substance use. One useful screening resource is called Screening, Brief Intervention and Referral to Treatment (SBIRT). You can find more Massachusetts SBIRT Training & Technical Assistance at [www.masbirt.org/](http://www.masbirt.org/). Help for substance-use problems is available through MassHealth services, including specialized outpatient and IHT services, as well as SOAP and inpatient programs. In addition, the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health provides referral and services for youth, regardless of insurance. Finally, involuntary commitment for treatment ("Section 35") is available for individuals at most imminent and severe risk.

## **Partial Hospitalization Program**

Partial Hospitalization Program is a nonresidential treatment program that may be hospital-based. The program provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance-abuse evaluation and counseling, and behavioral plans.

Partial Hospitalization is often used as a step-down from a 24-hour level of care. If you are working with a child who has been hospitalized or entered a Community Based Acute Treatment (CBAT) program, then it is important to be in touch with that program early in the admission so you can be consulted in aftercare planning. The success of Partial Hospitalization often depends on the youth agreeing to participate, and on the family having a way to transport the youth to the program on a daily basis. As an OP clinician working with a child or youth in Partial, you should work closely with the child, family, and Partial program to prepare for the next step-down to OP.

## **Other services and supports**

The responsibility for communication and collaboration does not end with behavioral health services. Children and youth often need other formal and natural supports in order to function better and to grow.

### **Formal supports**

Many children and youth with MassHealth are also involved in other formal systems of support. Almost all children and youth attend school, and many have plans for special education or for educational accommodations. Some are involved with the Department of Children and Families (DCF), receiving voluntary services, or as part of a service plan, or because DCF has custody of the child. Some youth receive services through the Department of Mental Health (DMH), or Developmental Services (DDS), and some are in unlocked residential or community settings through the Department of Youth Services (DYS). Some youth are involved with Juvenile or District Courts, the former in delinquency or Child Requiring Assistance status, the latter on criminal charges. All children and youth should be connected with a primary health care provider (if they are not, the OP provider should identify this as a need to discuss with the youth and family). Young MassHealth members may be involved in child care programs, or may receive services through Department of Public Health (DPH) Early Intervention programs. These do not exhaust the variety of formal supports that families may receive and need to navigate.

A comprehensive assessment of the child and family will allow the Hub provider to map the family's relationship to these systems, and to build needed collateral contacts into the treatment plan. If OP is the Hub, this is a particularly important task that should be integrated not only with the initial assessment and CANS, but also with the ongoing update of the assessment and CANS, and the treatment plan. If coordinating care with the full system of formal supports seems daunting, the OP provider should consider that care coordination might be better handled by ICC or IHT, and discuss these options with the family.

### **Natural supports**

In a crisis, the most important people in our lives may be the providers of formal services. Most of the time, however, our most important supports are the people we interact with every day, and the people with whom we have the deepest historical connection. Similarly, while the resources provided by educational, medical, and human-services systems can be enormously important to healthy growth and recovery from illness, most of us receive great benefit from the normal institutions of community life in which everyone partakes.

A generation ago, clinicians were trained to think that formal interventions were the primary drivers of improved functioning for people with psychological problems or chemical dependency. Now we know that the

picture is far more complex. While therapies are important, so also are opportunities to participate in the world, to connect with others, and to contribute to social life.

A thorough and insightful assessment of a child and family examines the youth's and family's social connections and informal supports. Intervention planning should in many cases incorporate natural supports as well as formal supports and behavioral health services. In some cases, developing new or stronger connections and supports should be part of the plan. When OP is the Hub, the entire team depends on the culturally informed OP assessment and plan that highlights strengths as well as needs. If the child and family present such complex needs that the OP provider would have difficulty conducting an extended and comprehensive assessment and planning process, then the provider should consider referral to another-level Hub. ICC, for example, can team with FS&T to develop a comprehensive assessment, including a Strengths Needs and Culture Discovery with the family, and can pull together a variety of formal and informal supports to develop a comprehensive plan in which OP can be more effective.

## The role of the outpatient clinician as a Hub provider

Much of what follows may appear to well-trained child clinicians to be simply good practice—the need to work with families and collateral contacts did not originate with CBHI. But the systemic context of outpatient work has changed significantly. This section describes best practices within this new context, where new opportunities arise for OP clinicians in helping children, youth, and families. Discussion of these best practices can be helpful to practitioners at all levels of proficiency, and can help to inform organizational processes in hiring, orienting, training, supervising, and evaluating staff, and in establishing priorities for quality improvement.

The key functions of the Hub provider can be broken down into five distinct steps. These steps do not fully describe the OP treatment process; instead they highlight those processes that have increased in importance under CBHI:

- Work with the family in a way that is consistent with System of Care Values.
- Engage families and youth and educate them about receiving services and about the service system.
- Complete a comprehensive initial assessment and formulation, including the CANS, and evaluate the need for care coordination and for other services and supports.
- Refer and facilitate access to other needed services, including higher levels of care coordination when needed.
- Coordinate with other services and supports.

In reality, clinical work rarely proceeds in strict sequence. Therapy is frequently iterative, periodically revisiting at a deeper levels issues and skills already addressed. Youth and families also evolve in their understanding of, and openness to, various clinical interventions. Therefore, the OP clinician should regularly reevaluate the youth and family's changing service needs, anticipate and be prepared to discuss emergent issues or concerns, and respond with additional service referral as appropriate.

### Work with the child and family in a way that is consistent with System of Care/CBHI Values

Organizational-values statements are sometimes perceived as window dressing. This is not the case with CBHI values, which are intended to strongly influence practice and to positively affect youth and families experience as participants in their care.

OP providers should understand that CBHI values describe MassHealth's understanding of, and expectations for, the delivery of behavioral health services. For this reason, it is important for OP clinicians, supervisors, and managers to consider implications of CBHI values in their own practice.

- **Child-Centered and Family-Driven:** Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.

Practices that express this value include sharing documentation such as all assessments, treatment plans, and progress notes with families and youth; having protocols to refer families to peer supports such as (depending on their needs) family organizations or FS&T at a CSA; having regular family input into your organization's governance, program planning, and quality-improvement processes; and having special skills and supports to engage and support teens and young adults transitioning to adult roles and adult systems.

- **Strengths-Based:** Services are built on the strengths of the family and their community.

Practices that express this value include training and supervision on how to identify actionable strengths with children, youth, and families, and how to use actionable strengths in treatment planning. Strengths-based practice should be evident in the language used both when family members are present and when they are not, and in documentation including the assessment, treatment plan, and progress notes.

- **Culturally Responsive:** Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.

Practices that express this value include hiring staff who reflect the people served in terms of race, language, and ethnicity; providing staff training and supervision on how to open conversations about race and culture in the treatment process; making your facility feel physically welcoming and familiar to the population you serve; and frequently rating the CANS culture items at a level higher than 0, reflecting awareness of cultural issues that should be considered when providing treatment.

- **Collaborative and Integrated:** Services are integrated across child-serving agencies and programs.

Practices that express this CBHI value are described throughout these Guidelines.

- **Continuously Improving:** Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

Practices that express this value include frequent discussions with youth and families about their assessment of progress and of appropriateness of their plan; providing clinical training and supervision around how to measure outcomes and use them in ongoing treatment; and providing supervision that focuses on clinical goals and outcomes, including use of the CANS to track progress toward goals.

Resources are available to assist OP providers in putting CBHI/System of Care values into practice. Materials can be found at [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi), the DMH Youth's Behavioral Health Knowledge Center at [www.cbhknowledge.center](http://www.cbhknowledge.center), or by consulting with the CBHI office at MassHealth, which has access to other materials and resources ([cbhi@state.ma.us](mailto:cbhi@state.ma.us)). The National Wraparound Initiative (<http://nwi.pdx.edu>) is an excellent source of practical examples of how the components of a System of Care can work together.

## **Engage families and youth, and educate them about receiving services and about the service system**

Education is more than providing information. It requires an assessment of what the child and family know, what they believe is relevant, and how they learn best. And it is an ongoing process, throughout the time that the OP clinician works with the child and family.

Nonetheless, providing information is an essential component of education. The best single source, aside from what you tell families in conversation, is the appropriate regional version of the CBHI brochure, *Worried about the way your child is acting or feeling?* These brochures can be downloaded in PDF format or ordered in bulk for free from the Commonwealth's CBHI website ([www.mass.gov/masshealth/CBHI](http://www.mass.gov/masshealth/CBHI)). Click on *CBHI Brochures*. Other resources and information about the CBHI service system can be found in the Appendix of these Guidelines.

*Note: MassHealth requires you, as an OP provider, to share this brochure with the caregiver (or the youth legally permitted to make own medical decisions) as part of your intake procedure. But families and youth have a lot to absorb and decide during the intake phase of treatment; be prepared to offer the brochure again at any later point when consumers are prepared to use the information.*



## Complete a comprehensive initial assessment

### The initial assessment with CANS

Assessment is a clinically complex process. MassHealth's MCEs allow OP providers to bill two units (sessions) of diagnostic assessment, CPT 90791, recognizing that gathering data for an initial assessment often takes more than one outpatient meeting.

The procedure code for a psychodiagnostic interview pays more than the procedure code for a standard OP treatment hour. It must be accompanied by the HA modifier signifying that the CANS was done as part of the assessment, otherwise the claim will be rejected. If the caregiver or member declines consent to enter the full CANS into the MassHealth CBHI system on the Virtual Gateway (VG), the OP provider must still enter the demographic data and information on Serious Emotional Disturbance (SED) into the system, and must complete the rest of the CANS on paper and retain it in the medical record.

*The clinician should, of course, never enter CANS information about which he or she is uncertain, simply to complete the CANS. This is unacceptable practice, and it is not necessary from the point of view of the CANS requirement or the use of the HA modifier. If the provider is unable to gather all the information needed to complete the full CANS, it is acceptable to enter all the information that is available, and then to finalize the CANS in the system as "incomplete but final."*

**Important note about consent!** If the child has had other CANS records entered into the CBHI system on the VG by another provider organization, and the caregiver has currently consented to both the other provider organization and your provider organization to enter the full CANS into the VG, then you as an OP clinician will be able to view and copy the CANS entered by that other provider. Similarly, other providers with consent for this child will be able to view and copy the CANS that you enter. This has several implications, reflecting both the benefits and the responsibilities of collaboration:

- If someone else has assessed the child and entered a CANS, you can have immediate access to that record without having to mail or fax a consent form, or await a return mailing or fax. You have immediate information about how the provider saw the child. The reverse is also true: Another provider with consent can see, immediately and at any time, the CANS you entered.
- Furthermore, you can edit a copy of the CANS entered by the other provider; the new version has your name on it, and defaults to today's date as date of assessment. *You are responsible for editing the copy to make sure the information in it is up to date and reflects your own assessment*, but you are saved significant time and effort in data entry.
- Any CANS you enter (including your CANS based on copies from other providers) can be seen and copied by other providers with consent. Other providers rely upon the accuracy of your assessment and their work can be affected by any erroneous information on your part. The quality of your work is, in this way, visible and relied upon within the circle of providers working with this child.

For further information about the CANS see the CANS page at the CBHI website, [www.mass.gov/masshealth/cans](http://www.mass.gov/masshealth/cans). For further information about billing or about compliance with the CANS requirement, consult the MCE paying for the care of the child or youth. (See Appendix G for contact information.)

Assessment is rarely finished after two sessions. Clinicians and families continue to learn and redefine needs and strengths as they work together. The client medical record should reflect the OP clinician's continuing update of assessment information, as should the CANS update every 90 days or less. And since the purpose of assessment is to shape the intervention, treatment plans should also reflect the continual learning that occurs as you work with the child and family.

When OP is the Hub, it is the OP assessment and treatment plan that form the basis for the work of any Hub-dependent services. It is the responsibility of the OP Hub to provide, with member consent, the assessment (including the CANS) and treatment plan as part of the referral to any Hub-dependent service. It is also the responsibility of the OP hub to stay in frequent contact with the Hub-dependent services, to inform them of any updates to the assessment and plan, and to obtain updates from them on their progress and any other information that could inform the overall plan. In this way, the OP clinician can modify or add new treatment goals in accordance with the youth and families progress over time.

### **What level of care coordination is needed?**

At the start of services, and whenever the youth's condition or situation changes, the OP clinician, in partnership with the family, assesses the family's need for care coordination.

Most children, youth, and families have external contacts, or might develop them, who could provide some assistance and support, and with whom some coordination is warranted. Thus, some level of communication and coordination with OP will almost always be needed, particularly when OP is the clinical Hub. In some situations, much higher levels of communication and coordination will be needed to deliver consistent and effective care. In these instances it is the responsibility of the OP provider to assess whether a more intensive Hub service is indicated and to discuss this service option with the youth and family.

**Intensive Care Coordination (ICC)**, and its Wraparound model of care planning and delivery, should be considered when any of the following are present:

- One or more state agency is working with the family (or needs to be)
- New state agency involvement begins
- Two or more treatment providers are involved (or need to be)
- Special-education services need to be integrated into the treatment plan
- Treatment of complex physical health issues need to be integrated into the treatment plan
- Two or more plans of care are duplicative or conflicting
- The family is confused by multiple treatment or "service" plans
- Existing providers are struggling to coordinate, and stay informed about, each other's efforts.

ICC is delivered by one of 32 CSAs across the Commonwealth. Because of the great potential value of ICC in serving children and youth with serious emotional disturbance, it is especially important that our system ensure that families are well-educated about ICC, and that they are offered referrals to explore the service whenever appropriate. To this end, OP clinicians are required by their contracted MCEs to assess every six months whether a child and family meets medical necessity for ICC. Especially when families have multiple providers or state agency involvement, OP clinicians must regularly reevaluate the need for more intensive care coordination.

If the child and family appear to meet medical necessity for ICC, the OP clinician should discuss the potential benefits of the service with the family, including the OP clinician's ability to continue as a treater and a member of the care planning team. If the youth and family wish to meet with an ICC provider to learn more about the service, the OP provider should make a referral for that purpose. With appropriate consent, the OP clinician is responsible for communicating with the potential service provider, informing the intake process, and facilitating access to CSA services (ICC and FS&T).

*This process must be documented in the medical record within 30 days of the first visit and every six months thereafter using the Assessment of Need for ICC form (Appendix G). MassHealth's MCEs will audit outpatient charts to assess compliance with this requirement.*

**In-Home Therapy** should be considered when the youth is not eligible for ICC but would benefit from more intensive care coordination; when the number of parties working with the family is more limited, or when home dynamics are affected by and intertwined with the youth's behavioral health needs. IHT can help the family learn new ways to relate to one another and solve problems and set limits, while developing clinical goals and strategies designed to promote healthy emotional regulation skills. Consider IHT, for example, when any of the following present.

- Treatment would benefit from a team approach (both MA and BA-level staff).<sup>11</sup>
- The entire family or family subsystem would benefit from coordinated therapy.
- The child and family require a higher level of treatment intensity and frequency, including the availability of clinical supports seven days per week.
- A higher level of care coordination needs to occur in school, hospital, community, etc.

After consultation with the family, if the OP clinician makes a referral to an IHT program, the OP clinician is responsible for facilitating access to IHT. There may be a choice of local IHT provider agencies. The OP clinician should help the family obtain and weigh information about any distinctive characteristics of the various agencies including proximity, language capacity, specialization, and waitlists. Once a decision is made, the OP clinician must ensure that the request for services is received and the intake is process underway.

It is not uncommon for youth to need and receive both ICC and IHT. In this instance, ICC assumes responsibility for care coordination and Wraparound team formation while IHT delivers its clinical service as a member of the Care Planning Team. The majority of youth in ICC also retain the services of their individual outpatient clinician as an important member of the team.

### **Which Hub-dependent services are needed?**

In the Wraparound community, there is a saying: "A service is not a need." The implication is that a need can be met in a variety of ways (not always through formal services), and that we serve children and families best by carefully exploring many ways to meet each of their needs. In ICC, following the Wraparound process, the Care Planning Team brainstorms multiple interventions before deciding upon a next step for meeting a need. This leads to more creative and individualized interventions, and also gives the team flexibility to move to Plan B when Plan A does not work.

Treatment planning in all levels of care, including outpatient, should follow this principle, and should be careful to define child and family needs first, before matching those needs with appropriate clinical interventions. The OP provider should consider all available interventions, including those relying on natural supports, and should not become rigidly locked into any specific service as the solution for a child or youth. It is not necessary to have a Wraparound team to brainstorm interventions; this is an appropriate activity for OP clinicians to undertake with families and collaterals, and in supervision.

Having considered various alternatives, and thoroughly understanding the Hub-dependent CBHI services, the OP clinician and family will often decide that one or more of the Hub-dependent CBHI services should be included in the child's plan.

In order to refer to a Hub-Dependent service, the OP clinician's treatment plan for the youth must include one or more clinical goals that the Hub-Dependent Service will address.

OP clinicians can use a referral to Family Support and Training (FS&T) to accomplish a variety of goals which benefit the youth and family, including the following.

- Promoting productive collaborations between families and providers

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<sup>11</sup> IHT always involves a master's-level clinician and often a bachelor's-level staff person, too. Whether a two-person team is required, however, will be determined upon individual clinical need.

- Educating parents/caregivers about services and interventions
- Assisting in the navigation of child-serving systems (DCF, education, mental health, juvenile justice, etc.)
- Fostering empowerment through linkages to peer/parent support and self-help groups
- Identifying formal and informal community resources (e.g., after-school programs, food assistance, housing resources, summer camps, etc.)
- Providing support and coaching for the parent/caregiver

In-Home Behavioral Services (IHBS) often work extremely well for children or youth receiving OP, analyzing situations where a child's behavior has been difficult to change through other therapeutic interventions. OP treatment goals for IHBS may include the following.

- Informing family's/caregivers' understanding of the triggers and functions of youth's challenging behavior
- Reducing specific negative behaviors by teaching positive replacement skills
- Providing support, coaching, and training for the parent/caregiver in the use of behavior-support strategies
- Developing consistent behavior-support plans that allow for generalization of self-regulation skills across settings

Therapeutic Mentors (TM) can be a wonderful "extender" of OP therapy, because the TM can provide as much intervention as clinically appropriate, and can work with the child or youth in natural community settings. Through a therapeutic 1:1 relationship, TM can help to address clinical goals such as the following.

- Supporting the development of age-appropriate social skills
- Fostering greater community connections by facilitating participation in community, social, and recreational events
- Developing and practicing self-regulation and self-management skills
- Building successful peer and adult relationships

### **What other services and supports are needed?**

A thorough and thoughtful assessment will typically result in identification of a number of needs experienced by the child or youth, as well as perhaps family needs that affect the child's ability to make progress in treatment. As explained in the preceding section, there may be many possible ways to address a need. Effective treatment planning considers many alternative pathways and leads to flexible plans that can change in response to setbacks.

While it is important to refer to CBHI and other BH services whenever appropriate, the OP clinician, in collaboration with the family, should entertain a full range of services and supports. These include formal services mentioned previously, including federal and state entitlements, services provided by local educational authorities (school systems, including both special educational services and accommodations within regular educational programs), services available through state agencies, charitable resources, and community resources and supports. Informal supports can also include extended family and community activities and

assistance. As Hub provider, it is necessary to consider a full range of services and supports in treatment planning.

While outpatient clinicians are often well-informed about community services and creative in devising individualized interventions to meet child and family needs, it is difficult to be expert in a wide variety of external services and supports, and it can be challenging to explore many possible alternatives for meeting numerous needs, especially when working with multiple collaterals. When this task appears daunting within the framework of OP therapy, the OP clinician should discuss with the family a referral to ICC to manage the planning process with the OP provider as a key participant.

## **Refer and facilitate access to needed services and supports**

Referral should always occur with the informed consent of the family (or young person able to consent for him or herself), and with appropriate releases.

Referral involves more than a phone call or faxing a referral form. It also involves follow-up to ensure that the referral information was received, and to monitor the provider's capacity to respond in a timely way. Some family members are quite comfortable making the referral themselves; in this case the OP clinician should follow up with the family to see if the connection has been successfully made, and should be prepared to assist if it has not. The OP clinician should also be prepared to contact the other service provider to share additional information that will help the other party to contact the family, if needed, and that will help with issues such as assignment of staff, and to initiate collaboration.

### **Referral to ICC or IHT**

As the OP provider, if you think the youth and family could benefit from ICC (due to a need for more intensive care coordination) or IHT (due to a need for an intensive in-home therapy team that provides care coordination) you should:

- Review the medical necessity criteria (MNC) for ICC. If the youth appears to meet the criteria for ICC, explain the service to the youth and the family and discuss their interest in seeking ICC. You can share this short [video](#) with the youth and family to explain how ICC works. If they are interested, obtain consent from the family to contact the local Community Service Agency (CSA) for ICC on their behalf. Encourage the family to set up a visit to the CSA, or to have CSA staff visit the home, if the family wishes. OP clinicians may be able to bill a joint meeting with CSA staff using a consultation code.
- If the youth does not meet MNC for ICC, or if the youth or family is not interested in pursuing ICC, explain the IHT service to the youth and family and discuss their interest in seeking IHT. As appropriate, obtain consent from the family to contact the preferred IHT provider (see below). Encourage the family to set up a visit to the IHT site, or to have IHT staff visit the home, if family wishes. (OP clinicians are able to bill collateral contact codes for conversations with the IHT provider.)
- Go to the Massachusetts Behavioral Health Access (MABHA) website, [www.mabhaccess.com](http://www.mabhaccess.com), where you can search for ICC and IHT providers by zip code and see which ones have available service capacity. Any person can log into the site as a guest. (Alternately, the current CBHI Brochure for your region has a listing of ICC or IHT providers—see Appendix G. However, provider listings are subject to change, so you can find the most current listings on the MABHA website.)
- Contact the identified ICC or IHT provider, with the consent of the family, to initiate referral and share your client's assessment, including the CANS, and treatment/action plan.
- Participate as part of the youth's ICC Care Planning Team or IHT treatment team upon the youth's successful enrollment in either Hub.

## Referral to Hub-Dependent services

- Referral to a Hub-dependent service is made directly to the program that the youth/family accepts.
- OP Clinicians and families can use the MABHA website, [www.mabhaccess.com](http://www.mabhaccess.com), to search for Hub-dependent service providers by zip code and identify providers with available service capacity. Any person can log into the site as a guest. (Alternately, the current CBHI Brochure for your region—see Appendix G—has a listing of TM and IHBS providers. For Family Support and Training, refer to the CSA listings in the brochure. Since provider listings are subject to change, you can find the most current listings on the MABHA website.)

Reminder: Hub-dependent services must address a goal (or goals) identified in the OP clinician’s treatment or action plan for the youth. (See Appendix B for the medical necessity criteria.)

## Referral to other BH services

### *Mobile Crisis Intervention (MCI)*

Many OP clinicians expend a large amount of their time and energy, sometimes uncompensated, on a subset of their caseloads whose families are frequently in crisis. Worries about their clients in crisis can also occupy the thoughts and disturb the sleep of clinicians away from work. Since crisis is a condition of life for many children, youth, and families in the public behavioral health system, it is essential for OP clinicians to understand how to work with MCI to manage crises as safely as possible, or to avert them altogether. OP programs should ensure that all clinicians understand how MCI functions, where the local MCI/ESP program is located in the community, and how to contact MCI to alert the team to a child who may need MCI services, or to arrange a safety-planning intervention. Every OP clinician should have an orientation of how MCI operates. This will better allow clinicians to orient families to MCI.

OP Clinicians should explain the MCI program to youth and families and describe the benefits of working with an MCI program instead of calling 911 or taking their child to a hospital emergency department (ED).

- For example, ambulance services often require that children be strapped to a gurney, which can exacerbate children’s distress and lack of control, especially if they have a history of physical or sexual trauma.
- Some police officers may be skilled at deescalating a dysregulated youth, while others may instigate a control struggle that ends in a physical confrontation.
- EDs typically deal with patients of all ages of and all types of medical and psychological trauma, and waits in EDs can be very long; in the end, the ED must call the MCI team to come to the ED to perform the crisis evaluation.
- Except when a medical setting is truly necessary, the hospital ED is rarely the best place to resolve a child’s psychological crisis. With MCI, by contrast, planning can be done in advance; the team can come wherever they are needed; they are trained to work with young people; and they can continue to intervene with the family for up to seven days.

If a child is likely to need MCI services at some time, it is wise to get consent from the family to contact the MCI team and place an individualized safety plan on file with the provider. This allows the MCI team to respond with advanced knowledge of the youth and family, including potential triggers and useful de-escalation strategies. MassHealth safety-planning resources are available at the MBHP website at [www.masspartnership.com/provider/CrisisPlanning.aspx](http://www.masspartnership.com/provider/CrisisPlanning.aspx). OP clinicians should generally obtain in advance a release of information that would allow them to contact the MCI team and share information if needed (without having to worry about whether an emergency constitutes an exception to usual confidentiality practices).

Outpatient Clinicians can help families identify their local ESP/MCI Program by either going to <https://www.masspartnership.com/provider/ESP.aspx> or by calling the statewide ESP/MCI toll-free number (877-382-1609) and entering the family's zip code. These contact numbers should also appear in the family's own individual crisis/safety plan.

#### *Structured Outpatient Addictions Program*

Outpatient Clinicians should contact the MassHealth Member's health plan to find out about the availability of SOAP services and contact information for nearby service providers.

#### *Partial Hospitalization Program*

Outpatient clinicians should contact the MassHealth Member's health plan to find out about the availability of partial hospital services and contact information for nearby service providers.

### **Referral to state agencies and other services and supports**

Behavioral health services do not satisfy every human need. Other services and supports may be beneficial to youth and support their ability to engage in more traditional behavioral health services. A thorough clinical assessment should identify other formal and informal support needs that a youth and family may have, so that the OP clinician can work to connect them with available resources. Some families require a summer camp program, a therapeutic after-school program, or respite in order to meet their child's needs throughout the year. Others may need special medical care, legal or housing assistance, special education advocacy, or access to subsidized recreational opportunities. The OP clinician need not know every system or community resource, but must know where to look for help when needed.

Many state agencies offer a rich menu of activities and supports, as well as connections to other community-based resources. OP clinicians' knowledge of relevant child serving agencies and their eligibility criteria is critical to connecting youth with other services and supports, both now and into adulthood. As needed, and with appropriate consent, OP clinicians are expected to coordinate with other state agency providers, as well as case-management/service-coordination staff to help secure access to these resources. Youth whose effective treatment requires more frequent contact and ongoing collaboration with responsible state agencies should be considered for referral to a higher level of care coordination.

Family organizations in Massachusetts, such as the Parent Professional Advocacy League (PPAL), the Parent Information Network (PIN), Parents Helping Parents, the Federation for Children with Special Needs, and the Asperger/Autism Network (AANE), can be a terrific resource for parents and caregivers seeking individual advocacy and other formal and informal supports on half of their children.

OP clinicians should be generally knowledgeable about special education and educational accommodations in Massachusetts, and of the scope of services and workings of child-serving state agencies. Clinicians should be capable of obtaining more information as needed and making referrals or assisting in completing applications to these entities or requesting educational evaluations. For children and youth involved with special education or with state agency services, it is essential that OP clinicians communicate and collaborate (with member consent) with those agencies. Youth whose effective treatment requires more frequent communication with school staff, including ongoing collateral contact and participation in IEP development and implementation, should be considered for referral to a higher level of care coordination. Remember that MassHealth will reimburse for collateral contact. See Performance Specifications for Outpatient services in Appendix G and the individual MCE billing guidelines listed there as well.

A family with many needs may benefit from a Family Partner to help them find supports and learn to navigate the service systems relevant to their child. A family with multiple system involvement may benefit from ICC to develop an individualized team that can coordinate multiple interventions from a single plan.

## Coordinate care with other service providers

### OP as the Hub and primary coordinator of care

Having identified and made referrals to other services and supports, the next step for the OP clinician, if OP is the Hub, is to coordinate care. If IHT or ICC is the Hub, then the next step for the OP clinician will be to collaborate and communicate with the Hub as needed. As a reminder, the communication and coordination necessary for a Hub provider to perform are reimbursable activities. For clarification, refer to the All-MCE Network Alert, *Additional Changes to: Case Consultations, Family Consultations, and Collateral Contact Authorization Procedures and Parameters* included in Appendix G, as well as links to the MCE websites.

In the CBHI context, care coordination includes at least the following specific activities.

- Obtaining consent, if needed, to communicate with other formal and informal supports identified by the youth and family
- Sending needed documentation (assessment and CANS) to each Hub-dependent service so that they can organize their work and obtain needed authorization
- Regularly connecting with Hub-dependent service provider(s) to obtain and provide updates on the youth's progress. Note: For Family Support and Training (Family Partner) and for Therapeutic Mentoring, the performance specifications require *weekly contact* with the Hub; For In-Home Behavioral Services, performance specifications require "regular, frequent" contact with the Hub to report updates on progress on the identified behavioral goal(s)
- Ensuring that the OP treatment plan includes one or more concrete, measurable, and individualized goals to be addressed by the Hub-Dependent Service
- Coordinating care and collaborating with other service providers
- Sharing important information, such as changes in youth status or service goals, and addressing these changes through modifications to the treatment plan
- Continually assessing and identifying any need for other Hub-dependent services and/or other services/supports (informed by the comprehensive assessment and CANS) and making those referrals and linkages, as appropriate
- Documenting care coordination activities in the youth's health record
- Ensuring adequate transition planning as the youth and family prepare to graduate from a service or support, including a reassessment of prospective needs and the identification of alternative services or service providers for continuity of care

Within the MassHealth system, Hub-dependent providers are literally dependent on the Hub to do their work and will usually understand the need to work together. Other MassHealth providers, such as 24-hour levels of care, may be less aware of the Hub system, but they too have a responsibility to collaborate and are accountable to the MCEs that hold their contracts. It is reasonable and appropriate for the OP clinician to call the member's MCE if another MassHealth provider fails to collaborate appropriately. Child-serving state agencies are not accountable to MassHealth or the MCEs, but each agency has committed to collaborating with CBHI as spelled out in each agency's CBHI protocol (available on the CBHI website, [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi)). If an OP clinician feels that an agency staff person is not collaborating in a way that is consistent with the agency's protocol, the OP clinician should bring the situation to the attention of his or her supervisor, for consultation and for assistance in escalating the concern within the state agency, if needed.

That said, conflicts are best resolved through mutual understanding and respect, rather than through invoking protocols and filing complaints. A good care coordinator uses leadership skills to help others understand why



the OP clinician is taking a lead role, what the rationale is for requests being made, and how other team members (even if there are just one or two) have a voice in the process. When OP providers elicit cooperation by sharing information, showing respect for others' knowledge and autonomy, and above all by demonstrating that the needs of the child and family come first, formal complaints will be rare. Nonetheless, clinicians should know and use written protocols and grievance procedures when necessary.

### *Coordinating with MCI*

The level of coordination with MCI obviously depends upon the needs of the youth and family. For youth and families at moderate-to-high risk of a behavioral health crisis, the OP Clinician should develop a safety plan with the youth and family. (See Additional Resources, below.) Best practice indicates that the OP clinician should also act *proactively* to alert the local MCI provider to situations in which a child/family may be at imminent risk of a crisis and to provide a copy of the safety plan ahead of time. (See also Referral to other BH services above for a discussion of proactive coordination with MCI.)

Communication is required between the OP Clinician and the MCI team whenever a child experiences a crisis that results in an emergency MCI contact. In general, the MCI team will initiate contact with the OP clinician, but it is equally the responsibility of the OP clinician to follow up.

The OP clinician must discuss with both family and the MCI provider the nature and outcome of the contact; the precipitants to the MCI contact; the youth and caregivers' responses to MCI; and the MCI assessment of current and future safety for the family, and recommendations for changes to the existing safety plan. By understanding the episode from both the MCI and family perspectives, the OP clinician and family can make practical changes to the safety plan and better understand what will prevent an emergency in the future.

### **When ICC is the Hub**

When youth is receiving ICC, best practice is for the OP clinician, with consent of the family, to become a member of the youth's Care Planning Team (CPT). (See below for billing for care coordination.)

- By participating in CPT meetings, the OP clinician is an active participant in the decision-making and consensus-building that supports a family's engagement in clinical interventions and other activities on the Care Plan.
- The OP clinician, as part of the CPT, assists the family in identifying goals and developing and implementing the Individual Care Plan (ICP; see below).
- The OP clinician provides input to the CPT to describe the goals of outpatient therapy for inclusion in the ICP and provides updates on the youth's progress toward goals. The outpatient clinician ensures that he or she coordinates the outpatient therapy treatment goals with the youth's needs as identified by the CPT.
- The OP clinician maintains a sufficient level of contact with the ICC Care Coordinator to successfully carry out his or her responsibilities as noted above.
- The OP clinician documents all ICC-related activities in the youth's health record.

The ICC/Wraparound process generates several documents that may be useful to the OP clinician:

- *The Individual Care Plan (ICP)* specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. The plan is developed by the CPT, and incorporates the strengths and needs of the youth and family. The ICP is the primary coordination tool for behavioral health and informal interventions.
- *Strengths, Needs, and Culture Discovery* is part of the *Wraparound* process and is documented in the comprehensive assessment form or in a separate document. It contains salient information that can

help inform OP clinicians about the family's unique strengths, needs, and culture, and it has the potential to inform more effective approaches to care and disposition planning.

- *CBHI Crisis Planning Tools (Appendix E)* comprise a set of resources that is available for families to use in preventing, planning for, and navigating crisis situations. Families decide how to use any of the tools.
  - *Safety Plan*—This is a flexible tool developed by youth and families that describes an individualized plan that the youth/family finds meaningful to use when a crisis situation arises. With the family's consent and participation, the safety plan should be reviewed and updated after a MCI episode, at the time of discharge from a 24-hour facility, and when circumstances change or otherwise impact the youth's safety. It is reviewed periodically during CPT meetings.
  - *Advance Communication to Treatment Provider document (Advance Communication)*—This document provides a method for the youth and/or parents to communicate potential crisis support or intervention in advance and in writing to future providers. In essence, it communicates the following: "If you see me/my child in crisis, here is how I/we would like to be treated, here are the types of interventions I/we prefer, and here is what is important to me/our family." The Advance Communication tool promotes the consideration of personal/family voice and choice and the practice of "Shared Decision-Making." The completion and dissemination of the document is determined by the young adult/parent. The Advance Communication is most likely to be useful when a youth has used crisis services before and expects to use the services again.

### **When IHT is the Hub**

IHT serves youth with a wide range of needs. The OP clinician, the youth, family, and the IHT clinician, along with other appropriate team members, will together determine how best to coordinate care between OP Therapy and IHT.

Some aspects of the coordination can be effectively accomplished by regular telephone and HIPAA-compliant electronic communications (e-mail, texting). However, there is no effective substitute for face-to-face team meetings in which all the significant, concerned individuals take part. At minimum, best practice indicates a full, in-person meeting early in treatment to ensure that everyone understands the purpose of treatment, the family's goals, the planned intervention, and the roles of each service or support. Regularly planned meetings during the course of intervention are highly recommended as the most robust coordination tool to ensure proactive, valuable responses to changing circumstances, including timely, coordinated responses to any unexpected crisis situation.

The OP clinician documents all collateral contacts with IHT and IHT-related treatment-planning activities in the youth's health record.

### **Work to anticipate and manage transitions**

Children, youth, families, and service systems often function reactively, responding to events without prior awareness or planning. As service providers we need to model a more proactive stance, helping families and their support systems to anticipate and prepare for change.

Transitions are stressful but also inevitable. OP Clinicians can help families learn to manage transitions, however, by planning for natural transitions as they arise. Such transitions include those that are developmental, such as moving up a level in school; experiencing the physical, physiological, and psychological changes of puberty; assuming the risks and responsibilities of a driver's license; or arriving at the age of making one's own medical decisions. The "transition to adulthood" is really many transitions over many years, and should be a recurrent focus of planning for adolescents and young adults. Many transitions are forced by external circumstances, such as family moves, and may entail a degree of loss. Transitions associated with the end of the school year, the

summer hiatus, and the beginning of the next year affect all children and frequently require forethought and planning from the treatment team.

Separating from a formal service or support is another common transition, but one that can be challenging for youth and families to accept. When these transitions are anticipated, OP providers should proactively plan for and assist the youth and family in considering how this change will affect them and what can be done to manage it. By collaborating directly with the exiting service provider, the OP clinician can help to ensure a smooth transition and avoid unnecessary disruptions in continuity of care. When transitions are unplanned, the OP provider plays an important role in supporting the youth and family while promptly securing alternative services and supports.

OP clinicians can support youth and families in identifying and managing the kinds of changes that affect their ongoing care and treatment by:

- scanning for transitions as part of the ongoing assessment process;
- working with youth and families to anticipate future transitions and their significance;
- making transitions a part of conversations and planning with families; and
- helping families develop, rehearse, and master strategies that will allow them to successfully weather transitions in their lives and the lives of their children.

Since stress may cause “regression”—people may temporarily forget the skills they have learned, or lose confidence in their ability to use them—it may be important to review past work and to help your clients and their families reinforce their gains. Transitions can also make other team members anxious. The Hub’s obligation to communicate is never greater than during transitions.

## **Master the administrative imperatives; billing issues**

Clinical work is heavily interspersed with administrative imperatives: documentation, completion of administrative forms, billing, obtaining authorizations, and much more.<sup>12</sup> Yet all of these tasks are necessary to the work of helping people. And if the clinician does not develop a discipline for managing these tasks, he or she will end up perpetually reacting to administrative imperatives, which can interfere with the primary goal of focusing on the needs of children, youth, and families. While these tasks are generally beyond the scope of these guidelines, it is appropriate to offer some information about billing for OP services, since this drives many other administrative imperatives, which should not overshadow clinical work and supervision.

In addition to the traditional face-to-face treatment services (i.e., individual, couples, family, and group therapy), OP clinicians can bill for time spent engaged in case consultations, family consultations, and collateral phone contacts. This includes time spent with youths and/or with their parents (face-to-face); when participating in treatment team/care planning team (CPT) meetings (phone and face-to-face); collaborating with treatment-/care- planning teams (phone and face-to-face); and engaging in coordination and/or collaboration activities (phone, e-mail, and face-to-face), as these are all reimbursable activities. As noted earlier, MassHealth has directed MCEs to reimburse this work at the same rate as the 60-minute office visit. Together, the MCEs have aligned definitions and billing guidelines for these services. For more detail, refer to the all-MCE Network Alert, *Additional Changes to: Case Consultations, Family Consultations, and Collateral Contact Authorization Procedures and Parameters*, included in Appendix G, Additional Resources. For definitions of these kinds of services, see “Performance Specifications for the Outpatient Services” also listed in Appendix G.

Outpatient managers should contact each MCE and/or go to their websites (see Appendix G) for clarification regarding utilization of collateral contacts, case consultations, and family consultations.

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<sup>12</sup> For MCE documentation standards, see Appendix C.

When a youth is covered both by commercial insurance and MassHealth, MassHealth is required to be the payer of last resort. This means that MassHealth, in order to pay for a service, must have documentation that the commercial payer denied the claim. Therefore, the OP provider must submit a denial from the primary insurer along with the claim for case consultation/collateral contact activities to the appropriate MassHealth MCE. Clinicians who work in organizations or who contract with billing agencies should contact their billing specialist for assistance.

## APPENDICES

### Appendix A: Definition of Terms

*Care Planning Team (CPT):* A Care Planning Team is convened by an Intensive Care Coordinator, working with a family to bring order, purpose, and possibility to complex system involvement that centers on the behavioral health of a youth. The CPT incorporates the principles and phases of Wraparound. The team consists of a youth and parent/caregiver along with both formal and natural support persons, which include treatment providers, professionals such as representatives of child-serving state agencies, school personnel, advocates, and family supports. The purpose is to work together as a team, driven by the family and guided by the youth, to ensure collaboration and good sense in identifying goals, creating an Individual Care Plan, and progressing toward the youth/family goals. A Care Planning Team must include more than the youth, parent/caregiver, and care coordinator.

*Child and Adolescent Needs and Strengths (CANS):* The CANS is a tool that provides a standardized way to organize information about a child's needs and strengths as part of a behavioral health diagnostic assessment. Massachusetts has two versions, for youth aged birth to four and five to 20. The CANS is intended to be used as a treatment decision-support tool in family-focused, collaborative practice by behavioral health practitioners serving MassHealth members under the age of 21.

*Community Service Agency (CSA):* A Community Service Agency is an entity under contract with the MassHealth Managed Care Entities to deliver two of the Children's Behavioral Health Initiative (CBHI) services in a high-fidelity Wraparound framework to eligible children and their families. The two services are Intensive Care Coordination and Family Support and Training. Each CSA serves a specific geographic area, or a defined population. The 29 geographic Community Service Agencies in the Commonwealth are conterminous with Department of Children and Families Areas. Three CSAs serve defined populations (Hispanic in the Springfield/Holyoke area, African American in Boston, and deaf and hard of hearing in the whole state).

*Comprehensive Assessment:* A Comprehensive Assessment is a gathering of information, developed by a clinician in collaboration with a youth and the youth's family, which serves to understand the youth's needs and direct the youth's treatment. An Assessment includes the youth's strengths and current concerns, organized with sufficient detail of medical, psychiatric, and substance-use history, relevant developmental history, current treatment and medications, and risk factors, to provide a substantive picture of the youth's mental status and functioning and a cogent clinical formulation and DSM V diagnosis. The Assessment includes a review of the child's need for care coordination and the adequacy of current care coordination services to meet this need. The Assessment includes the CANS. The CANS is not a replacement or substitute for the complete Comprehensive Assessment but is a tool to organize the information gathered through the Comprehensive Assessment. The CANS supports communication among service providers and ensures that the child's and family's strengths and needs are identified across life domains. Providers of Hub-dependent CBHI services are expected to obtain and use the most recent completed Comprehensive Assessment for the youth they serve. *(Please note that Assessment with a capital A is used throughout this document to refer to this specific document in contrast to other forms of assessment or the general activity of making an assessment.)*

*Family Partner:* A Family Partner is an individual who delivers Family Support and Training services that are intended to help families to navigate the complex state, educational, and behavioral health systems and to instill hope in a positive future for their children with special needs. A Family Partner has lived experience as a caregiver in a parental role of a youth with mental health and/or other special needs. Family Partners may choose to share their story or other personal information in line with the intent and purpose of Family Support and Training.

*Family Support and Training Services (FS&T):* FS&T provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver to help the parent gain hope and capacity in caring for a child with behavioral health needs. Family Support and Training services “do for, do with, cheer on” parents/caregivers to provide for the needs of the youth. Services are provided to the parent/caregiver of a CBHI-eligible youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes) and other community settings as long as the youth meets the medical necessity criteria for this service and is receiving one of the Hub services (Intensive Care Coordination, In Home Therapy, or outpatient therapy).

*Hub Service:* Hub services are outpatient therapy, In Home Therapy, and Intensive Care Coordination. Hubs serve as the primary behavioral health care provider for a youth. The Hub service clinician, in concert with youth and family, assesses the youth’s clinical need for services, including the youth’s need for care coordination and Hub-dependent services, and then links youth to appropriate services to meet those needs, including Hub services providing greater levels of care coordination. Hubs collaborate with collateral supports and services to integrate interventions across treatment plans. Hubs facilitate treatment/care planning meetings as needed for coordination of care. The Hub service with the highest level of intensity takes primary responsibility for care coordination.

*Hub-Dependent Service:* Hub-dependent services include Therapeutic Mentoring, In Home Behavioral Services (except when circumstances warrant a waiver of the Hub referral), and Family Support and Training. They provide a specialty service that augments the interventions of the Hub provider. Referrals for Hub-dependent services are made by one of the Hub services.

*Individual Care Plan (ICP):* An Individual Care Plan is developed according to Wraparound principles in the context of a Care Planning Team with youth enrolled in Intensive Care Coordination. The Care Plan specifies the goals and actions to address the medical, educational, social, therapeutic, or other needs of the youth and family. It incorporates the strengths and needs of the youth and family. The ICP unifies multiple treatment plans into an overarching plan and serves as the primary coordination tool for behavioral health interventions, informal supports, and *Wraparound* care planning.

*Individualized Action Plan (IAP):* An Individualized Action Plan, also known as a treatment plan<sup>13</sup>, is a detailed, individualized plan that is developed through collaboration between the IHT clinical team and the youth and family. It states the youth and family goals and, using understanding gleaned from the Comprehensive Assessment, the IAP identifies the “prescription” for therapeutic activities for both Hub and Hub-dependent services that will help the youth move towards his or her goals. Hub-dependent providers work on one or more IAP goals. The youth, parent/caregiver, and Hub clinician all influence and concur with the final IAP. The plan is written in nontechnical language that is understandable to the youth and family. The IAP indicates who was involved in the development of the plan and who is responsible for carrying out each action in the plan.

*In Home Behavioral Services (IHBS):* In Home Behavioral Services is a Hub-dependent service (except when the situation warrants waiver of the Hub requirement) that addresses a youth’s behaviors that interfere with successful functioning in the community. Services are delivered by one or more members of a team consisting of professional clinicians and qualified support staff via a combination of Behavior Management Therapy and Behavior Management Monitoring.

*Behavior Management Therapy*, a component of IHBS, includes a behavioral assessment (observing the youth’s behavior, antecedents of behaviors, and identification of motivators) and the development of a highly specific behavior plan with interventions that are designed to diminish, extinguish, or improve specific behaviors related

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<sup>13</sup> Some providers distinguish an Individual Action Plan as a plan dependent upon a treatment plan and carried out by an individual who is not required to have clinical training or licensure. However, the terms are used interchangeably in this document in reference to In Home Therapy, as both are in general use by providers and others.

to the youth's behavioral health condition(s). Both the assessment and the plan are created in collaboration with the youth and family. Supervision of interventions and training for other practitioners to address specific behavioral objectives are provided.

*Behavior Management Monitoring*, the other primary component of IHBS, includes implementation of the behavior plan developed by the Behavior Management Therapist and the family as well as monitoring of the youth's behavior and reinforcing implementation of the behavior plan by the parent/caregiver. Also included is reporting back to the Behavior Management Therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals, so that the behavior plan may be modified as needed.

*In Home Therapy (IHT)*: In Home Therapy is a structured, consistent, strength-based, collaborative, therapeutic relationship between a licensed clinician and a youth and family for the purpose of treating the youth's behavioral health needs. Treatment may include improving the family's ability to provide effective support for the youth, promoting his or her healthy functioning within the family and community, and preventing an emergency admission to an inpatient hospital or other out-of-home treatment setting. IHT has **both a clinical and a care coordination function**. Expectations for IHT providers serving as clinical hubs are described in detail in the IHT Service Description and IHT Operations: E. Care Coordination sections below. The IHT clinician develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, working with the entire family or a subset of the family, to implement focused interventions that enhance problem-solving, limit-setting, risk management/safety planning, and communication. IHT may include Therapeutic Training & Support with a supporting staff person who assists the IHT clinician to coordinate care across domains of the child's life, such as school, physical health, and community. Together they may assist in building specific life skills to strengthen the family, identify and utilize community resources, or help to develop and maintain natural supports for the youth and parent/caregiver in order to promote sustainability of treatment gains.

*Intensive Care Coordination (ICC)*: An Intensive Care Coordinator implements high fidelity Wraparound consistent with Systems of Care philosophy. The ICC service facilitates care planning and coordination of services for youth with serious emotional disturbance who are enrolled in MassHealth Standard or CommonHealth and who meet the age range and medical necessity criteria for this service. The Intensive Care Coordinator works with the youth, parent/caregiver, natural supports, treatment providers, schools, state agencies, and others who play a key role in the youth's life to develop a Care Planning Team for the youth. Using Wraparound principles, this team composes an Individual Care Plan to address the youth's strengths and needs and support the goals identified by the youth and parent/caregiver. As the youth and family move toward accomplishment of goals and demonstrate ability to sustain gains, the team supports the transition out of ICC with appropriate follow-up services and supports.

*Managed Care Entity (MCE)*: An MCE is an organization that contracts with the Commonwealth to provide MassHealth insurance products to Massachusetts residents. The term MCE is used by EOHHS to refer to a broad category of health plans, including specialized plans that deliver particular benefits, such as Behavioral Health services only.

*Mobile Crisis Intervention (MCI)*: MCI is the youth-serving component of an Emergency Services Program provider, the purpose of which is to support youth and their families through psychiatric emergencies in ways that leave the family safe and emotionally stable. MCI provides an immediate, short-term, face-to-face therapeutic response to a youth experiencing a behavioral health crisis. The team is mobile, travels to where the emergency is taking place, and intervenes within one hour of contact. The MCI intervention identifies, assesses, treats, and stabilizes the situation in order to reduce immediate risk of danger to the youth or others, consistent with the youth's risk management/safety plan, if one exists. The MCI team helps the family develop a risk management/safety plan, if they do not already have one. The MCI service is available 24 hours a day, seven days a week. Following a crisis, MCI can provide up to seven days of crisis-stabilization services, which include face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention. The

MCI team, as needed, makes referrals and builds linkages to all medically necessary behavioral health services and supports. For youth who are receiving ICC or IHT, MCI staff coordinates with the youth's Care Coordinator or In Home Therapist throughout the duration of the MCI service. If IHT is acting as the clinical Hub, they must be available to coordinate with the MCI team before, during, and after the crisis event. MCI also coordinates with the youth's primary care physician, any other care management program, or other behavioral health providers involved with the youth.

*Natural Supports:* Natural supports consist of individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as extended family members, friends, neighbors, members of faith communities, contacts at day care, school, camp, or other community contexts that are accessible in families' daily environments. The purpose of joining with natural supports is to find sustainable, affirmative resources that will help children and families move forward in their lives long after professional involvement ends.

*Parent/Caregiver:* Parent/caregiver refers to any biological, kinship, foster, and/or adoptive family/caregiver responsible for a parental role in the care of a youth.

*System of Care (SOC):* 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 in the context of their culture, environment, and family situation. For a full discussion of System of Care, see: *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families*, Edited by Beth A. Stroul, M.Ed. & Gary M. Blau, Ph.D. and [www.samhsa.gov](http://www.samhsa.gov) resources.

*Therapeutic Mentoring:* Therapeutic Mentoring is a Hub-dependent service that offers structured, one-to-one, strengths-based support services between a Therapeutic Mentor and a youth, dependent on the referring Hub service and guided by the Hub's Individualized Action Plan, for the purpose of addressing daily living, social, and communication needs.

*Therapeutic Training & Support (TT&S):* Therapeutic Training & Support is one dimension of the In Home Therapy service, which is available to families to assist in achieving treatment goals and therapeutic objectives. The TT&S staff may coach, teach, or otherwise support the youth to develop, practice and generalize skills to understand and manage emotional responses to family situations. He or she may assist the family in understanding the youth's emotional and mental health needs. The TT&S staff may engage in skill-building activities to strengthen the youth's functioning in the family, support family members in practicing concrete skills for dealing with the youth's episodes of disturbance, and assist in enhancing networks of natural support. TT&S are not required to have clinical credentials for their supporting role.

*Wraparound:* Wraparound is a well-defined planning process driven by 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. CBHI services are designed to align with Wraparound principles. See the National Wraparound Initiative website for a full description.



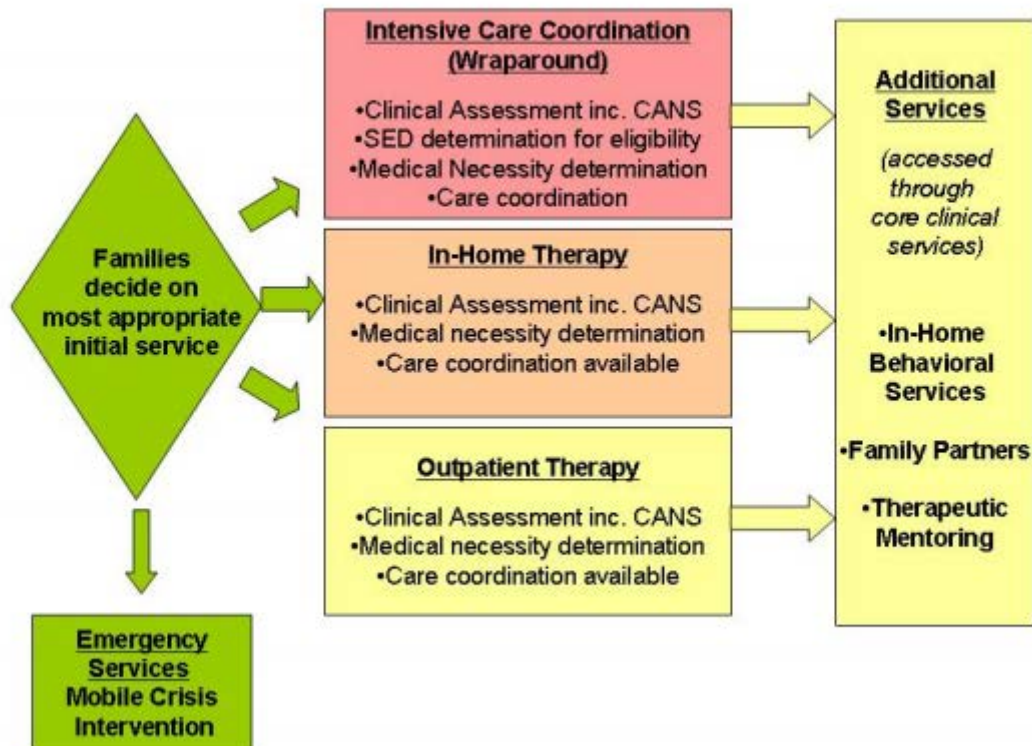
## Appendix B: Medical Necessity Criteria, Service Definitions, and Performance Specifications for CBHI services:

[www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx](http://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx)

## Appendix C: Managed Care Entity CBHI Health Record Documentation Standards

[www.masspartnership.com/pdf/MCE%20CBHI%20Health%20Record%20Doc%20Standards%20March%202013.pdf](http://www.masspartnership.com/pdf/MCE%20CBHI%20Health%20Record%20Doc%20Standards%20March%202013.pdf)

## Appendix D: Children's Behavioral Health Initiative Clinical Pathways Grid



## Appendix E: Crisis-Planning Tools

[www.masspartnership.com/provider/index.aspx?InkId=CrisisPlanningTool.ascx](http://www.masspartnership.com/provider/index.aspx?InkId=CrisisPlanningTool.ascx)

## Appendix F: Availability of CBHI Services to Members in Various MassHealth Benefit Plans

Youth must be under 21 years of age, have the correct MassHealth Category type, and meet Medical Necessity Criteria to be eligible for each of the Children’s Behavioral Health Initiative services. Verification of the appropriate benefit plan/category type is a critical step to ensure that children and families receive the appropriate needed services. Providers must routinely refer to the MassHealth Eligibility Verification System (EVS) to check each child’s category of eligibility. It is expected that all providers routinely verify insurance eligibility. For enrollment or assistance with EVS, contact MassHealth Customer Service.

CBHI Services	Covered Benefit by MassHealth Category Type			
	Standard	CommonHealth	Family Assistance	MassHealth Limited
Mobile Crisis Intervention (MCI)	YES	YES	YES	YES
In Home Therapy (IHT)	YES	YES	YES	NO
Intensive Care Coordination (ICC)	YES	YES	NO	NO
Family Support and Training (FS&T) <i>(Also called Family Partner)</i>	YES	YES	NO	NO
Therapeutic Mentoring (TM)	YES	YES	NO	NO
In Home Behavioral Services (IHBS)	YES	YES	NO	NO

## Appendix G: Additional Resources for Outpatient Clinicians

### CBHI Brochure

MassHealth regional *CBHI brochures* provide family-friendly descriptions of CBHI services available to certain MassHealth-enrolled children and youth through age 20. The brochures also include regional contact information for Mobile Crisis Intervention, In-Home Therapy, and Intensive Care Coordination providers. Outpatient providers can order the brochures free of charge for dissemination to parents/caregivers at <http://www.mass.gov/eohhs/consumer/insurance/cbhi/cbhi-brochures-and-companion-guide.html>

### CBHI Companion Guide for Professionals

CBHI has developed a guide, *MassHealth Behavioral Health Services for Children and Youth Aged 20 and Younger: A Guide for Staff Who Work with Children, Youths, and Families*. This guide contains an abundance of information and can be accessed by visiting [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi) and clicking on CBHI Brochures.

### CBHI Websites

The CBHI website, [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi), contains a wealth of information and resources for providers and family members, including the brochure and companion guide referenced above.

The CBHI section of the MBHP website, [www.masspartnership.com/provider/index.aspx?InkID=CBHI.ascx](http://www.masspartnership.com/provider/index.aspx?InkID=CBHI.ascx), is a resource maintained by MBHP, on behalf of the MCEs, that provides an abundance of information pertaining to CBHI. Examples of the kinds of information found here include, but are not limited to the following.

- Commonly asked questions from the CBHI Outpatient Forums sponsored by the MCEs
- An overview of CBHI community-based services
- Medical-necessity criteria, performance specifications, and service definitions for the services
- Listings, and referral contact numbers for the services
- The CANS tool and other CANS resources
- Materials from CBHI meetings sponsored by the MCEs
- Resources for Systems of Care Committees
- *Wraparound* resources
- Crisis-planning tools and other resources
- Guidelines for ensuring timely access to the CBHI services
- Questions and answers about information that is common across all MCEs

### Massachusetts Behavioral Health Access (MABHA)

The MABHA website, [www.mabhaccess.com](http://www.mabhaccess.com), is a resource designed to enable behavioral health and other health care providers to locate potential openings in mental health, substance-use disorder, and CBHI services (ICC, FS&T, IHT, TM, and IHBS) for the purpose of referring individuals to those available services. The MABHA website allows providers and families to enter their zip code and find the CBHI provider nearest to their home, as well as the Emergency Services Provider (ESP) that covers their area. Additionally, youth, families, and providers of any type are welcome to use the website to locate these services, which they can access directly from the community, as well as other stakeholders, such as advocates, state agency personnel, primary care clinicians, and school personnel, who may refer youth and families to CBHI services.

## MassHealth Managed Care Entities

Given that the processes and parameters for obtaining authorizations (initial and ongoing) and authorization extensions for Hub-dependent services differ across each of the MCEs, outpatient clinicians should refer to the MCEs' websites for this specific information or contact their designated MCE representative. Note: Obtaining authorization for Hub-dependent services is not required of outpatient clinicians among *all* the MCEs.

- Beacon Health Options<sup>14</sup>: [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com)
- BMC HealthNet Plan: [www.bmchp.org](http://www.bmchp.org)
- Fallon Community Health Plan: [www.fchp.org](http://www.fchp.org)
- Neighborhood Health Plan: [www.nhp.org](http://www.nhp.org)
- Network Health: [www.network-health.org](http://www.network-health.org)
- Massachusetts Behavioral Health Partnership<sup>15</sup>: [www.masspartnership.com](http://www.masspartnership.com)
- Health New England<sup>16</sup>: [www.healthnewengland.org](http://www.healthnewengland.org)

## Tip Sheet for Outpatient Providers

The Tip Sheet provides a quick reference to many of the issues discussed in these Guidelines. See the CBHI website, at [www.mass.gov/eohhs/docs/masshealth/cbhi/op-cbhi-tip-sheet.pdf](http://www.mass.gov/eohhs/docs/masshealth/cbhi/op-cbhi-tip-sheet.pdf).

## Assessment of Need for ICC form

MassHealth MCEs require OP providers periodically assess their clients' need for ICC using this form <http://www.mass.gov/eohhs/docs/masshealth/cbhi/icc-evaluation-of-need.pdf>.

## What is Intensive Care Coordination?

MassHealth and the Children's Behavioral Health Knowledge Center teamed up to produce this educational video about Intensive Care Coordination to help Outpatient providers and other referral sources explain ICC to families who may benefit from it. Find the video on the CBHI homepage, at [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi).

## Contacting your local Mobile Crisis Intervention (MCI) team

To find your local provider, call 1-877-382-1609 or see [www.masspartnership.com/provider/ESP.aspx](http://www.masspartnership.com/provider/ESP.aspx).

**All MCE Network Alert: Additional Changes to Case Consultations, Family Consultations, and Collateral Contact Authorization Procedures and Parameters.** The MassHealth MCEs jointly developed this provider alert. Each MCE distributed the same alert under their individual logos. We have attached MBHP's provider alert (see following page) as an example. Please contact your MCE for a copy.

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<sup>14</sup> BMCHP, NHP and FCHP have contracted with Beacon Health Strategies (Beacon) to manage the delivery of mental health and substance-use disorder services for each of these plans' respective members.

<sup>15</sup> MBHP manages the mental health and substance-use disorder services for members of the Primary Care Clinician (PCC) Plan within MassHealth.

<sup>16</sup> MBHP is also the behavioral health contractor 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-use disorder services for members of the HNE Be Healthy plan.

**ALERT #168**

**Date: September 1, 2016**

## **ADDITIONAL CHANGES TO:**

### **CASE CONSULTATIONS, FAMILY CONSULTATIONS, AND COLLATERAL CONTACT AUTHORIZATION PROCEDURES AND PARAMETERS**

*The following information should be noted immediately by your chief executive officer, chief medical officer, chief operating officer, chief financial officer, program director, quality management director, compliance officer, billing director, and staff.*

The Massachusetts Behavioral Health Partnership (MBHP) has long recognized the importance of active and effective coordination of care between behavioral health, medical, and other treating providers for our Members. To that end, Members (adult and child) have the benefit of case consultations and family consultations. In recognition of the special needs that children and adolescents under the age of 21 require, providers may also access collateral contacts for this segment of the Member population.

In an effort to better meet the needs of our Members and to facilitate coordinating services and communicating appropriately with those involved in the Member's care, the MassHealth Managed Care Entities (MCEs) have worked together to align the program specifications of these codes.

Outpatient Services providers are to utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for Members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with Member consent and as applicable, Outpatient Services providers are to utilize case consultation and collateral contacts in order to involve the collaterals identified within the Care Coordination section of the General performance specifications in the planning, assessment, and treatment for Members. All such activities are to be documented in the Member's health record and releases of information obtained, as required.

Please read this information carefully and be sure that it is communicated to all clinicians and billing staff in your agency. This information can also be found in the Outpatient Services Performance Specifications on the MBHP website at [www.masspartnership.com](http://www.masspartnership.com). Questions should be directed to our Community Relations Department at 1-800-495-0086.

## Case Consultation, Service Code 90882

*(Please see your outpatient fee schedules for use of modifiers and descriptions.)*

**Definition:** a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physician, concerning a Member who is a client of the BH provider

Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual's progress, and revise the treatment plan, as required.

The scope of required service components provided includes, but is not limited to the following:

- Treatment coordination
- Treatment planning
- Assessment of the appropriateness of additional or alternative treatment
- Clinical consultation (which does not include supervision)
- Second clinical opinion
- Aftercare planning
- Termination planning

### Requirements:

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether the consultation was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.
- The meeting is either between two outpatient providers who do not share the same provider number or between the outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, or residential provider.
- Multiple providers with different provider numbers may bill for the same case consultation if more than one provider is present or on a phone conference.

### Limitations:

- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP in order to be reimbursed for these services.

## **Family Consultation, Service Code 90887**

*(Please see your outpatient fee schedules for the use of modifiers and descriptions.)*

**Definition:** a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and with family members or others who are significant to the Member and clinically relevant to a Member's treatment

Goals of family consultation are to educate, identify, and plan for additional services or resources, coordinate a treatment plan, review the individual's progress, or revise the treatment plan, as required.

The scope of required service components provided includes, but is not limited to, the following

- Treatment coordination
- Treatment planning with the Member's family or identified supports
- Assessment of the appropriateness of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the Member's care

### **Requirements:**

- The provider who submits the claim must maintain appropriate documentation, including the date and time of the consultation, names of all parties involved, purpose of consultation, and whether it was in-person or telephonic. Documentation should also include what actions will occur as a result of the consultation.
- Multiple providers with different provider numbers may bill for the same family consultation if more than one provider is present or on a phone conference.

### **Limitations:**

- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP in order to be reimbursed for these services.

## **Collateral Contact, Service Code H0046**

*(please see your outpatient fee schedules for the use of modifiers and descriptions)*

**Definition:** a documented communication of at least 15 minutes' duration, either in-person, by telephone (including voice mails), or by email. These contacts are between a provider and individuals who are involved in the care or treatment of a Member under the age of 21. This would include, but is not limited to: school and day care personnel, state agency staff, human services agency staff, court-appointed personnel, religious or spiritual advisers, and/or other community resources.

The scope of required service components provided includes, but is not limited to, the following

- Treatment coordination
- Treatment planning with the Member's family or identified supports
- Implementation of additional or alternative treatment
- Aftercare planning
- Termination planning
- Supporting or reinforcing treatment objectives for the Member's care

### **Requirements:**

- The provider who submits the claim must obtain appropriate documentation, including the date and time of the contact, names of all parties involved, purpose of contact, and whether the contact was in-person, telephonic, or by email.
- Multiple providers with different provider numbers may bill for the same collateral contact if more than one provider is present or is part of a phone conference.

### **Limitations:**

- One unit equals 15 minutes. There is no maximum unit restriction/day.
- Consultations are authorization free.
- The provider must be contracted with MBHP in order to be reimbursed for these services.



## **Periodic Record Audits**

To ensure quality of the consultations and per state requirements, MBHP will schedule periodic record audits with providers who receive reimbursement for any of the services contained in this *Alert*. Reimbursement for these services is contingent upon appropriate documentation within the medical record. During the audit, records corresponding to a list of paid claims and dates of service will be reviewed to verify that all required documentation is present.

Payment will be subject to recoupment if any of the required medical necessity criteria, documentation, parameter or exclusion requirements, as noted above, have not been met.