Community Service Agency

Intensive Care Coordination and Family Support and Training

Program Description and Operations Manual

Version 2

TABLE OF CONTENTS

Definition of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Service Agencies (CSA)

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

The roles and responsibilities of the Community Service Agencies include:

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

Intensive Care Coordination Services

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

meet the medical necessity criteria for this service. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

Additionally the ICC service seeks to:

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

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

The Four Phases of *Wraparound*

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

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

The Ten Principles of *Wraparound*

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

- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The *Wraparound* plan reflects activities and interventions that draw on sources of natural support.
- **Strengths-based**: The *Wraparound* process and the *Wraparound* plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Unconditional**: A *Wraparound* team does not give up on, blame, or reject youth and their families. When faced with challenges or setbacks, the team continues to work towards meeting the needs of the youth and family and towards achieving the goals in the *Wraparound* plan until the team reached agreement that a formal *Wraparound* process is no longer necessary.
- **Outcome-based**: The team ties the goals and strategies of the *Wraparound* plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

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

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

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

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

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

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

- Conducting a comprehensive, home-based assessment inclusive of the CANS and other tools as determined necessary, which occurs in the youth's home or another location of the family's choice
- Identifying with the youth and family-appropriate members of the CPT
- Facilitating the development and implementation of a youth- and family-centered ICP in collaboration with the family and collaterals
- Developing a risk management/safety plan in collaboration with the youth and family and collaterals

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

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

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

Medical Necessity Criteria for Intensive Care Coordination Service (ICC)

The Medical Necessity Criteria for ICC are:

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

   Part I:
   The youth currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD-10 or DSM–IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another

diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

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

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

OR

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

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

2. The youth:

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

   OR

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

   AND

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

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

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

Referrals

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

- The referred youth has MassHealth Standard or MassHealth CommonHealth.

- The referred youth is under age 21.
- The family is willing to meet/consider the service.

Telephone contact must be made with the family within 24 hours of referral, including self-referral, for ICC to offer a face-to-face interview with the family, which shall occur within three (3) calendar days to assess their interest in participation and gain consent for service. When someone other than the custodial parent/caregiver makes a referral for ICC, the parent/caregiver is contacted regarding the referral to ascertain the interest in the ICC service. If the parent/caregiver is interested and the member meets the basic enrollment criteria (see above), the ICC provider offers an appointment to meet with the youth and family within three (3) calendar days of the referral to begin the comprehensive, home-based assessment.

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

See Appendix A for the ICC Referral Process Flow Chart. See Appendix B for Guidelines for Managing Referrals to ICC, which was drafted collaboratively between the CSAs and the MCEs.

Referrals for DYS/DCF-involved Youth

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

Enrolling More Than One Family Member in ICC

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

ICC Service Components

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

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

The following are components of the program:

Comprehensive, Home-based Assessment

The services and supports provided by the care coordinator to the youth and family begins with a comprehensive, home-based assessment inclusive of the CANS and emphasizes the life domains of school/work, cultural and spiritual, social, living, safety and legal, medical and health, emotional/psychological, and recreational. The assessment identifies the youth's and family's strengths and needs, and also includes any

risk management/safety planning. The ICC care coordinators will complete a comprehensive, home-based assessment inclusive of the CANS for all ICC-referred youth within 10 days of consent for participation in ICC. While this is referred to as a home-based assessment, the completion of the comprehensive assessment should always be in a location of the parent/caregiver choice.

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

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

- The youth and caregiver's willingness to participate in the program
- Face-to-face interview(s) with the parent/caregiver and the youth
- Identifying the strengths, needs, and culture of the youth and family, inclusive of the strengths of the community
- Signed permissions for the release of information for appropriate collaterals, including the MassHealth-contracted MCE, school, primary care clinician, and other providers and caregivers
- Phone and/or face-to-face interviews with other family members, other people identified by the family, state agency representatives, school representatives, and other involved organizations as indicated
- Information regarding current needs and services and previous services for the youth in areas of health, psychiatric, social/peer, and school
- Completion of the CANS
- Working with the family to identify potential CPT members
- With proper consent and release of information, gathering of relevant records from behavioral health and other providers, schools, and any involved child-serving agencies

Risk Management/Safety Planning

A risk management/safety plan must be created for each youth. The risk management/safety plan details a response plan for the family to use when crisis situations arise and gives suggestions for how to prevent the need for out-of-home services whenever possible. Each youth must have a risk management/safety plan completed immediately upon gaining consent for participation in ICC. It is expected that this plan will be reviewed at the beginning of each CPT meeting or more frequently as needed. The risk management/safety plan must be reviewed and updated after a Mobile Crisis Intervention (MCI), at the time of discharge from a 24-hour facility, or when any circumstances change that impact risk and safety. The ICC provider ensures that the risk management/safety plan is updated at the time of discharge/graduation from ICC. The purpose of this plan is to communicate and expedite a youth-focused disposition to other levels of care when clinically indicated and to ensure ongoing supports within the community. For youth transitioning to a new hub service and/or transitioning from youth-based services to the adult service system, this plan will be inclusive of the new hub services and any adult services when applicable. See Appendix C for ICC/MCI risk management/safety plan to be used for all youth enrolled in ICC.

Care Planning Team (CPT) Meetings

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

Members of the CPT must include the youth when appropriate and parent(s)/caregiver(s), the care coordinator, the family partner, and all behavioral health providers involved with the youth. The CPT may include other family members, school personnel, relatives, primary care physician or clinician, clergy, other professionals providing services, state agency representatives, juvenile justice representatives, and others identified by the family. CPT membership should reflect a balance of natural and formal support persons.

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

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

It is expected that the CPT will generally meet monthly. For youth with more complex and/or intense needs, the CPT will meet more frequently, and for youth with less complex and/or intense needs, the CPT may meet less frequently, but no less than quarterly. Every quarter, progress in meeting the goals of the ICP shall be comprehensively reviewed by the CPT, and every 90 days the CANS will be updated.

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

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

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

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

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

Please see Appendix F for the Conflict Resolution Process for Care Planning Teams in Intensive Care Coordination.

Individual Care Plan (ICP)

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

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

An ICP specifies:

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

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

Coordination of the ICP with Other Care Plans

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

24/7 Availability of the ICC Team

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

Coordination with Mobile Crisis Intervention (MCI)

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

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

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

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

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

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

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

Coordination with 24-hour Facility

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

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

Coordination with Child-serving State Agencies

The care coordinator will ask the parent/caregiver to provide a release of information authorizing the exchange of service information between the ICC provider and any state agency personnel that are working with the youth and family. The care coordinator frequently contacts these collaterals by telephone, invites them with

adequate notice to CPT meetings and, with consent, if required under applicable law, provides them with copies of the completed ICP.

Coordination with Local Education Authorities (LEAs)

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

Coordination with Temporary Foster Placement

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

Coordination with Other Providers of Behavioral Health Services

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

Coordination with Primary Care

The care coordinator will ask the parent/caregiver to provide a release of information authorizing the exchange of service information between the primary care provider (PCP), ICC provider, and any other relevant service provider, as appropriate. The care coordinator will invite the PCP to participate in all CPT meetings. It is required that the ICC provider will coordinate care with the youth's PCP. Any identified medical needs should be documented in the ICP, and the youth's PCP should be apprised of the youth's progress.

Continuing Care and Graduation/Discharge Criteria

Continuing Care Criteria

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

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

Process for Authorization and Continuing Care Reviews

If upon assessment and initial work with the family and the CPT, continued involvement with the ICC service is needed, the provider will follow the authorization process for the Member's MCE. See Appendix D for authorization parameters for the Managed Care Entities (MCEs). See Appendix E for the authorization processes for the MCEs. See Appendix H for the MCE Common ICC Clinical Review Questions, which are the standardized questions that are part of the MCEs' authorization processes. See Appendices I and J for the Service Definitions for both ICC and FS&T, respectively.

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

Graduation/Discharge Criteria

There is no time limit for involvement with the program. However, based on experience in other states and communities, average length of stay in similar programs for youth in or at high risk for out-of-home placement (i.e., youth with the most intensive needs) is about 16 months. Because the population served in Massachusetts is somewhat broader, the length of stay, on average, may actually be less. Length of enrollment is based on the youth continuing to meet medical necessity criteria and an assessment by the CPT that the ICC program is continuing to support progress towards meeting the identified goals. Youth will graduate from the program/be discharged from the program when:

1. The youth no longer meets the criteria for SED.
2. The CPT determines that the youth's documented ICP goals and objectives have been substantially met, and continued services are not necessary to prevent worsening of the youth's behavioral health condition.
3. Consent for treatment is withdrawn.
4. The youth and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
5. The youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or a community setting with community-based supports or ICC.
6. The youth turns 21.

Process for Discharge Reviews

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

Staffing

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

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

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

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

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

Staffing Supervision Requirements

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

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

Program Director

The minimum staff qualifications for a program director include:

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

Senior Care Coordinator

The minimum staff qualifications for a senior care coordinator include:

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

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

Care Coordinator

Minimum staff qualifications for a care coordinator include:

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

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

Senior Family Partner

Minimum staff qualifications for a senior family partner include:

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

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

Family Partner

Minimum staff qualifications for a family partner include:

- Experience as a caregiver of a youth with special needs and preferably a youth with mental health needs
- Bachelor's degree in a human services field from an accredited university and one (1) year of experience working with the target population; or
- Associate's degree in a human service field from an accredited school and one (1) year of experience working with children/adolescents/transition age youth; or high school diploma or GED and a minimum of two (2) years of experience working with children/adolescents/transition age youth; and
- Experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems
- Must have a valid Massachusetts driver's license and automobile

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

Child/Adolescent Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist

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

Interns

CSAs that intend to utilize interns who will be working in any direct capacity with youth and families need to submit an "MCE Intern Training Plan" to their respective MCE Network Management Team. Requests for interns must be in addition to a CSA's core team, not in place of them. See Appendix K for the MCE Intern Request Process. See Appendix L for the MCEs' Use of Interns for All the CBHI Services.

Training

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

- *Systems of Care* philosophy
- The four phases of *Wraparound* and the 10 principles of *Wraparound*
- Family systems
- Peer support
- Partnering with parents/caregivers/guardians
- Psychotropic medications and possible side effects
- Child and adolescent development
- Related core clinical issues/topics
- Overview of the clinical and psychosocial needs of the target population
- Available community mental health and substance-specific services within their natural service area, the levels of care, and relevant laws and regulations
- Introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.)
- Individual Care Plans
- Risk management/safety plans
- Crisis Management
- Ethnic, cultural, and linguistic considerations of the community
- Community resources and services
- Family-centered practice
- Behavior management coaching
- Mandated reporting
- Social skills training

- Basic IEP and special education information

Additionally, all care coordinators must complete the approved CANS training and be credentialed to administer the CANS prior to completing the CANS.

Culturally Relevant Practice

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

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

- Importance of cultural awareness
- Sensitivity to cultural diversity brought by a variety of factors including ethnicity, language, lifestyle, age, sexual preference, and society status
- Bridging linguistic differences in appropriate ways
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific cultural needs of the consumers
- Access to non-traditional services

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

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

1. The program provides services that accommodate the Member, consider the Member's family and community contexts, and build on the Member's strengths to meet his or her behavioral health, social, and physical needs.
2. The program staff will have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.

3. The provider ensures access to qualified clinicians able to meet the cultural and linguistic needs of all Members served in their local community.
    a. Providers ask Members' language of choice.
    b. Because clinical staff with linguistic capacity is preferable to translators, providers offer the Member a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so.
    c. The provider has access to qualified interpreters/translators and translation services, experienced in behavioral health care, appropriate to the needs of the local population served. In case the program must seek translation services outside of the agency, it must maintain a list of qualified translators to provide this service. Interpreter/translator services are provided at a level which enables a Member to participate fully in the provider's clinical program.
4. Any written documentation should be available in the Member's primary language when requested, including discharge documents.
5. Programs will provide ongoing, in-service training that will include cultural competency issues pertaining directly to the client population served.
6. Programs will include cultural competence in their ongoing quality assessment and improvement activities.

Coordination and Conflict Resolution Process with State Agencies Protocols

Department of Children and Families (DCF)

Department of Youth Services (DYS)

Department of Mental Health (DMH)

Department of Public Health (DPH)

See Appendix M for the state agency protocols for DCF, DYS, DMH, and DPH. These protocols provide details regarding the coordination efforts and processes in place for resolving conflict for state agency-involved youth. The protocols can also be found in the secure CSA Working Documents section of the MBHP web site (www.masspartnership.com).

Reporting and Monitoring

Referrals and Staffing

On a monthly basis, the provider will track and report referral information that includes but is not limited to youth referred, referral date, referral source, certain dates in referral process, referral/youth status, and discharges, as well as staffing information. Include youth for all MassHealth MCEs. The data must be submitted to MBHP via an Excel spreadsheet by the 13th of the month for the month prior. The Excel spreadsheet consists of two data submission worksheets. The first data worksheet (Member List) is for entering/tracking a listing of referrals for CSA youth within a CSA. The second data worksheet (Staff) is for entering/tracking a listing of staff within a CSA. Providers should refer to Appendix N for a list of definitions and instructions that are intended to clarify and guide CSA staff in completing these worksheets. Complete and submit worksheets to MBHP, on behalf of the MCEs, on a monthly basis, to the MBHP-CSA@valueoptions.com mailbox using the submission macro embedded in the Excel spreadsheet. Referral status should be accurate as of the 7th day of the month of submission. The first data submission to MBHP using this new spreadsheet system will be by August 13th.

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

- Youth for whom service has started;
- Youth who are not MH-eligible;
- The youth/family has not yet been reached;
- An initial appointment has been scheduled;
- The youth/family is waiting to schedule a first appointment;
- The youth/family is choosing to wait for a preferred staff;
- During the referral process, the youth/family is referred outside; or
- The youth/family declines the service.

The following youth/families should be excluded:

- Referrals completed or youth discharged prior to July 1st or
- The youth/family was not calling for ICC.

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

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

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

- Staff name
- FTE
- Position
- Start date
- End date

Note: As the definitions sheet indicates for both spreadsheets, additional fields with grey background are automatically system-generated, based on what is entered.

Fidelity Monitoring

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

Team Observation Measure (TOM)
Wraparound Fidelity Index version 4 (WFI-4)
Massachusetts Document Review Measure (MA-DRM)

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

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

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

Every CSA will conduct two observations on every facilitator of Care Planning Teams twice yearly from the date of hire for existing staff and two times between months four and six for new hires. The information will be entered online in the *Wraparound* Online Data Entry Reporting System (WONDERS) by trained CSA staff. CSAs will be able to generate fidelity, strengths, and needs reports based on the information entered into WONDERS. See Appendix O for the letter that was disseminated to CSAs on June 14, 2010 regarding the fidelity monitoring plan for FY11.

The WFI-4 will be completed by Consumer Quality Initiatives (CQI), a vendor contracted by MBHP. CSA Family Partners and ICC providers will explain the WFI-4 project to enrolled families and obtain signed consent for caregiver participation in an interview with CQI. Each CSA will continue to have a target of twenty

(20) completed interviews which will be conducted by CQI. Providers will obtain caregiver consents and fax the information to CQI until twenty (20) interviews have been completed. CSAs will need to fax consents to CQI beginning October 1st, 2010, for those youth enrolled in ICC for at least a three-month period of time. Please fax consents to the attention of Melissa Goodman at (617) 445-5846. CQI will conduct interviews between January and June of 2011.

The Massachusetts Document Review Measure (MA-DRM) is a 30-item instrument that is used to assess wraparound fidelity through review of documentation typically used in wraparound implementation. The MA-DRM is administered by a trained evaluator who uses the tool to rate conformance to the principles of wraparound in materials such as the child and family's wraparound plan, crisis and safety plans, transition plans and meeting notes. Like the other fidelity tools, items on the MA-DRM link to the ten principles of the wraparound process and result in scores for individual items, the 10 principles of wraparound and a total score for the instrument.

Trained evaluators from the Managed Care Entities will use the MA-DRM in FY11 to rate conformance to the principles of Wraparound as evidenced by documentation in youth medical records.

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

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

Incident Reporting

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

Insurance Eligibility Monitoring

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

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

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

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

Program Governance

Local Systems of Care Steering Committee

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

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

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

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

- Parents/caregivers
- Transition-age youth (TAY)
- CSA provider
- Department of Mental Health (DMH)
- Department of Children and Families (DCF)
- Department of Youth Services (DYS)
- Department of Developmental Services (DDS)

- Department of Public Health (DPH)
- School departments or Local Education Authorities (LEAs)
- Community services organizations
- Parent/Professional Advocacy League (PAL) and or a representative of a PAL-affiliated parent support group
- Representative from one of the judicial authorities
- Local Mobile Crisis Intervention (MCI)
- Faith community
- Business community
- Representative from the local specialized CSA
- If the ICC is subcontracted to a provider by the CSA, the ICC provider must also be represented on the local Systems of Care Committee.

Parents/caregivers and/or transition-age youth who are actively enrolled in ICC can participate as members of a local Systems of Care Committee (SOC). A family member and/or TAY who participates on an ongoing basis should be someone who can manage the dual role of committee attendee and service recipient. The facilitator of the SOC is responsible for exploring this question with the family member in a transparent way. Additionally, it is the role of the facilitator to ensure that the family/caregiver and/or TAY youth is oriented to the purpose of the committee and support them in speaking about system issues from the point of view of the family and/or youth. They are not there to be helped or advised. Since telling one's own story is one of the ways that a family member can help committee members understand their point of view, they may share details from their personal experience. Meeting facilitators should be prepared to redirect discussion that veers in the direction of clinical questioning or problem solving. Family members or TAY should be made aware that they need not speak, if they do not wish to.

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

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

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

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

The CSA is responsible for documenting and maintaining minutes of each local Systems of Care Committee meeting, as well as those in attendance. There is no expectation that the CSA provide the MCEs with this documentation, although CSAs are expected to provide it upon request as needed.

Appendix A

ICC
Referral
Process Flow

This document can be accessed in the following location:

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

Appendix B

Guidelines for Managing Referrals To ICC

Guidelines for Managing Referrals to ICC

Referral/Intake Screening:

- Within 24 hrs. of receipt of referral, the CSA screens referral for appropriateness of service (via referral source and/or direct youth/family contact).
- If the youth/family is appropriate for, and in need of a behavioral health intervention, the CSA refers the youth/family to the most appropriate behavioral health service (including but not limited to OP/IHT/CSP)***** or MCE Care Management such as ICM (OP and IHT can co-occur with MCE Care Management).
- If the youth/family and CSA agree that the needs can be met by IHT or OP Hub, the CSA helps the family connect to one of those Hub providers. The youth/family is provided a comprehensive list of agencies that provide Hub services (consisting of complete regional list and neighboring cities and towns - reflective of lists posted on MCE web site) from which the family can choose.
- The provider of IHT or OP* and the youth/family are informed that if youth needs ICC at a later date, the Hub will refer the youth/family to the CSA.
- The family and youth are removed from the ICC referral list.
- If the youth/family and ICC agree that ICC is needed, the family is informed that an immediate appointment is not available and is given the option to either:
    1. be connected with an alternate CSA and informed of all nearby CSAs that have immediate appointments available; or
    2. make an appointment for a specified date in the future that the CSA reasonably believes that it will be able to begin delivering ICC services to the referred youth ; or
    3. be placed on a waitlist to be contacted by the CSA when it can begin delivering ICC services.

  If the youth/family chooses option number three:
    1. The Family Partner or ICC makes contact with the youth/family and provides the family with information regarding community resources, services, and providers. (When the FP is identified as contact, s/he will consult with a senior care coordinator or program director to consider whether further assessment or immediate services are necessary.)*
    2. The Family Partner or ICC maintains regular telephone contact with the family to assess safety concerns and the family's continued interest in remaining on the waitlist.

**** MCI can be accessed at any time for assessment of acute crisis.***

Additional Considerations:

For an ICC-enrolled youth in acute/other 24-hour LOC with no foreseeable disposition back to the community –consider closing ICC and refer to MCE ICM Program.
For DCF referrals of non-emancipated youth with no family/or other person in the community to return to – refer to MCE ICM Program.

Appendix C

ICC/MCI
Risk Management/Safety Plan

This document can be accessed in the following location:

www.masspartnership.com < CBHI < Risk Management Safety Plan

Appendix D

MCE Authorization Parameters

Managed Care Entity (MCE) Authorization Parameters for CBHI Services

Note: All authorization parameters below are floors not ceilings. If a provider uses up the units authorized in a given time parameter prior to the end of the end date of the authorization, the provider can contact the MCE for a clinical review to request additional units.

INITIAL AUTHORIZATION PERIOD FOR ICC AND FS&T

Service	Authorization Parameter
Intensive Care Coordination (ICC)	1 unit = 15 minutes 192 total units for ICC and FS&T combined, with no maximum units for either
Family Support and Training (FS&T)	

EVERY 90 DAYS FOLLOWING INITIAL AUTHORIZATION

Service	Authorization Parameter
Intensive Care Coordination (ICC)	208 units/90 days (13 weeks) 1 unit = 15 minutes
Family Support and Training (FS&T)[1]	208 units/90 days (13 weeks) 1 unit = 15 minutes

AUTHORIZATION PARAMETERS FOR OTHER CBHI SERVICES

Service	Authorization Parameter
Therapeutic Mentoring	208 units/90 days (13 weeks) 1 unit = 15 minutes
In-Home Therapy (IHT)	360 units/90 days (13 weeks) 1 unit = 15 minutes
In-Home Behavioral Services	120 units/30 days 1 unit = 15 minutes

[1] When FS&T is authorized **without** ICC (e.g., when a youth has IHT or outpatient) this will be the initial authorization parameter.

Appendix E

MCE Authorization Processes (Initial, Concurrent, and Discharge)

These documents can be accessed in the following location:

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

Appendix F

Conflict Resolution Processes for Care Planning Teams in Intensive Care Coordination

Conflict Resolution Process
for Care Planning Teams in Intensive Care Coordination

Introduction

Community Service Agencies (CSA) will encourage processes that build on existing relationships based on trust and respect to create needs identification-resolution-feedback loops that join family member(s) and child/youth, child-serving agency representatives, direct care, supervisor, administrative, clinical, support, and executive personnel. Effective processes must invite needs and strengths discovery at the Care Planning Team (here on referred to as the Team) level, and analysis and action at successive levels as may be necessary to resolve identified challenges.

The processes within each Team should start with the fundamental question "What can be done to address impediments to youth and families meeting their objectives and achieving their goals?" The Care Coordinator will work directly with the youth, family, and other members of the Care Planning Team to identify the strengths and needs of the youth and family and to develop a plan for meeting the identified needs and goals with concrete interventions and strategies and identified responsible persons. **It is expected that the Team, facilitated by the Care Coordinator, will make every attempt to resolve disagreements within the Team before seeking the assistance of the conflict resolution process.**

The Conflict Resolution Process

The conflict resolution process is available to assist the Team to address disputes concerning the youth's Individualized Care Plan (ICP) arising within the Care Planning Team, that the Team has not been able to resolve at the Team level. There are two types of disputes, each with its own procedure.

1. **Disputes Not Involving State Agencies**

   If a dispute not involving a state agency has not been resolved at the Team level, the youth's parent or guardian, or the emancipated minor, may seek resolution by asking the Care Coordinator to initiate the conflict resolution process. The Care Coordinator will inform the other members of the team that the process has been initiated.

   Within five business days, to the extent practical, the Care Coordinator will convene a consultation meeting. The meeting will include the family and youth, any other members of the team who are parties to the conflict, and the Senior Care Coordinator. If the family and youth attend the meeting, the Care Coordinator will assist the family and youth in presenting their views.

   If no resolution is reached, a second consultation meeting will be convened within five days, to the extent practical, that includes the family and youth, any other members of the team who are parties to the conflict, and the CSA Program Director.

   If a proposed resolution is reached, the Care Coordinator will determine, based upon individual circumstances, whether it can be implemented without further action by the CPT or whether it is necessary to convene a CPT meeting to review the proposed resolution. Any CPT meeting will be held within 10 business days of the proposed resolution, to the extent practicable.

If the family or youth is dissatisfied with the resolution, or if the Team does not accept the proposed resolution, the matter shall be referred to the CEO or designee for final decision.

2. Disputes involving state agencies

If a dispute involving one or more state agencies has not been resolved at the Team level, the child or youth's parent or guardian, the emancipated minor, or the Care Coordinator acting on behalf of and in the interests of the youth, may seek resolution by asking the Care Coordinator to initiate the conflict resolution process. The Care Coordinator will inform the other members of the team that the process has been initiated.

Within five business days, to the extent practicable, the Care Coordinator will convene a consultation meeting. The meeting will include the family and youth, the CSA Program Director, and the senior Area Manager of any state agency of the Executive Office of Health and Human Services (EOHHS) involved in the conflict. If the family and youth attend the meeting, the Care Coordinator will assist the family and youth in presenting their views.

If the Program Director and Area Manager are not able to resolve the dispute, the dispute shall be referred to and resolved pursuant to the EOHHS interagency process required by G.L. c. 6A, § 16R. The final resolution and an explanation of the decision reached will be communicated to the Team within a reasonable period of time or within the time prescribed by regulation when such regulations are promulgated.

This process does not establish any entitlement to services from any state agency nor does it replace or invalidate grievance or appeals processes established by provider agency policy or state agency statutes or regulations.

Information and Assistance

The Care Coordinator will inform all Team members about the Conflict Resolution Process and shall help family members on the Team initiate this process if they disagree with positions or decisions of Team members.

The Local System of Care Committee

- The Local System of Care Committee is NOT a venue for resolving disputes in individual Care Planning Teams; however, systemic or policy issues may be brought to the Local Committee.
- Issues involving EOHHS state agency policy that cannot be resolved on a local level will be referred by EOHHS agency staff attending Local Committee meetings to their managers and, as appropriate, to their Regional or Area Directors and agency representative on the CBHI Interagency Implementation Team at the state level.

Appendix G

Individual Care Plan (ICP)

This document can be accessed in the following location (and saved accordingly):

www.masspartnership.com < CSA Working Documents < ICP

Appendix H

MCE Common ICC Clinical Review Questions

MCE Common ICC Clinical Review Questions

- Has the youth been enrolled in ICC previously?

- Frequency of CPT meetings
  - Greater than monthly
  - Monthly
  - Every other month
  - Quarterly

- What was the date of the last CPT meeting?
  - Note: *CPT meetings must occur at least quarterly.*

- What was the date of the last update/review of the risk management/safety plan?
  - Safety issues?
    - Narrative

- List goals and the options selected to meet goal.
  - Narrative section for priority goals, options selected to meet those goals, and progress on goals

- What state agencies are involved? *(Can select more than one)*
  - DCF
  - DMH
  - DDS
  - DYS
  - None

- Does the youth have a signed IEP?
  - Yes
    - Date of most recent IEP meeting
    - Did the care coordinator and/or supervisor and/or family partner attend the meeting?
  - No
    - If no, is the youth on a 504?
      - Yes
      - No
  - The IEP is in process

- Who are the members of the care plan team? *(Can select more than one)*

	Team member	**Do they attend the CPT meetings regularly?**
	Youth	Yes No *(If no, why?)*
	Parent/caregivers	Yes No *(note: No CPT mtg should occur without the parent/caregiver present.)*
	Family Partner	Yes No

	Relatives	Yes No
	State agency staff	Yes No
	Outpatient therapist	Yes No
	Therapeutic mentor	Yes No
	Behavior management therapist	Yes No
	Behavior management monitor	Yes No
	In-home therapy staff	Yes No
	School staff	Yes No
	Natural supports *(Include narrative section identifying natural supports e.g., clergy, neighbor, friend of youth, etc.).*	Yes No

Note: A care planning team should include more than the youth and parents/caregivers. For youth with behavioral health services (e.g., outpatient, therapeutic mentoring, etc.), it is expected that those staff persons regularly participate in care planning team meetings.

- Has the youth had an encounter with the Mobile Crisis Intervention team in the past 6 months (or since enrollment if length of enrollment has been less than 6 months)?
  - No
  - Yes
    - What role did ICC play in the referral and intervention process?

- Is the youth currently in an out of home placement?
  - No
  - Yes
    - Where?
      - Inpatient/CBAT
        - What is the disposition plan for this youth?
        - Describe the role ICC is playing in facilitating return to the community?
      - Crisis stabilization
        - What is the disposition plan for this youth?
        - Describe the role ICC is playing in facilitating return to the community?
      - DCF STARR program
        - What is the disposition plan for this youth?
        - Describe the role ICC is playing in facilitating return to the community?
      - Group home
        - What is the disposition plan for this youth?
        - Describe the role ICC is playing in facilitating return to the community?
      - DYS detention
        - What is the disposition plan for this youth?
        - Describe the role ICC is playing in facilitating return to the community?
      - Foster care
        - Is the DCF plan currently for reunification with birth/biological family?

    - If yes, describe the role ICC is playing in facilitating return to birth/biological family.
- Residential/IRTP
    - What is the disposition plan for this youth?
    - Describe the role ICC is playing in facilitating return to the community?
        - *Note: There is a 180 day limit on youth in residential being enrolled concurrently in ICC.*
- Other
    - What is the disposition plan for this youth?
    - Describe the role ICC is playing in facilitating return to the community?

- Date of most recent CANS *(Note: The CANS must be updated quarterly at a minimum.)*
- Conclusion from CANS *(Note: This should be provided in narrative form.)*
- **Diagnosis**
    - Axis I:
    - Axis II:
    - Axis III:
    - Axis IV:
    - Axis V:

- Explanation of SED Determination *(Note: narrative of why youth continues to meet definition criteria)*

Appendix I

ICC Service Definition

This document can be accessed in the following location:

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

Appendix J

FS&T Service Definition

This document can be accessed in the following location:

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

Appendix K

MCE Intern Request Process for CSAs

This document can be accessed in the following location:

www.masspartnership.com < CSA Working Documents < MCE Intern Request Process

Appendix L

MCE Use of Interns for All the CBHI Services

This document can be accessed in the following location:

www.masspartnership.com < CBHI < MCE Use of Interns for CBHI Services

Appendix M

State Agency Protocols for DCF, DYS, DMH, and DPH

DEPARTMENT OF CHILDREN AND FAMILIES

Children's Behavioral Health Protocols

Process and Procedures for Accessing MassHealth Behavioral Health Services on Behalf of DCF Children and Families

6/18/09

I. Strategic Opportunities for DCF to Focus on Children's Behavioral Health:

The Department of Children and Families is one of five Executive Office of Health and Human Services agencies leading the development and implementation of the Children's Behavioral Health Initiative (CBHI). With its commitment to bringing multiple systems together to best meet the needs of children and families, the CBHI is an integral component of the Department's strategic effort to advance effective child welfare practice. The Department is committed to improving the safety, permanence, and well-being of children through family centered, strengths based and community connected practice. This commitment is reflected in the CBHI's focus on engaging families as true partners in the development of a meaningful plan of action that best meets their child's needs for success. When families are actively involved with helping professionals and participate in team decision processes to enhance their strengths and needs children are safer.

The shared commitments of the Department and the CBHI are leverage points for improving the child welfare system along three priority objectives:

1. Safely stabilizing and preserving families
2. Safely reunifying families
3. Safely creating new families through adoption, kinship or guardianship.

These priority objectives challenge the Department to align child welfare policy, practices and resources to organize the local delivery of services around the sustained safety of children and families. With an improved systems of care approach, targeted and effective services, and community focused services, the CBHI will play a critical role in the Department's strategy for making our child welfare system among the best in the nation. The overarching expectations that the Department has for the new Children's Behavioral Health system are:

1. To increase timely access to needed and relevant behavioral health services
2. To increase coordination of services to those children who need behavioral health services and whose parents/guardians need support
3. To continue the trend in decreased utilization of Congregate Care and other out of home services
4. To have shorter lengths of stay for children who are in Congregate Care and other out of home settings

CBHI and the DCF Integrated Casework Practice Model

The Department is currently implementing a new child welfare practice model. The DCF Integrated Casework Practice Model emerged from a four year dialog including a broad range of DCF staff, community providers, family members and national experts. The essential practices of this model are founded on the principles of family centered, safety organized frameworks and are based in the traditions of strength based wraparound approaches. Realizing that child and family safety are a matter of community importance, the Integrated Practice Model relies on collective and community centered approaches to decision making.

The implementation of the CBHI in the context of the Department's Integrated Practice Model will challenge the Department to increase the knowledge and skills of social workers, supervisors and managers related to Children's Protective Services and Children's Behavioral Health in the following practice areas:

1. Strengthen our capacity to assess indicators of safety, risk and parenting capacity
2. Strengthen our capacity to identify children's behavioral health needs as early as possible.

With the new array of behavioral health services now available, families will have access to resources that will complement the community support services that the Department can offer. In some instances the new MassHealth services will be sufficient to support the parent/guardian's care of the child at home and no DCF involvement will be necessary.

The Department has identified four priority populations for referral to CBHI services for fiscal year 2010:

1. Voluntary applications or CHINS referrals received after July 1, 2009 where the primary presenting issue is the child's behavioral health needs. In these cases the differential response will be to refer to a CBHI service for assessment and treatment of those needs.
2. Active Placement Referrals where behavioral health wraparound services may serve to prevent the need for placement, or shorten the duration of that placement.
3. Youth in Congregate Care Placements who are Discharge Ready, where CBHI services can help support the transition to community based care.
4. Open cases where there are significant unmet behavioral health needs of a child or children.

CBHI and the DCF Family Networks System of Care

For several years the Department has organized access to and management of its purchased service system through a Lead Agency structure called Family Networks. The Community Service Agencies (CSA's) are aligned with the Lead Agency catchment areas. Both systems use systems of care approaches, including intensive service coordination, family team decision making, utilization management procedures that ensure that services are effective in meeting the goals of the service plan, and the development of community based services that create sustainable supports to families following their involvement with the Department. The Department and the families it serves have realized significant benefits as a direct impact of this system. Families have a true voice in the development of their service plan, fewer children are being placed in residential settings and more are receiving services in their community, and the savings that have accrued from efficient management of the service system has led to an increased investment in community based services. The Department is committed to the continued operation and evolution of Family Networks, and will continue to utilize this system to address the protective concerns of families that come to our attention.

Most of the families served by the Department have protective needs, and the majority of those families have children under the age of 11. The focus of DCF's work with these families is to increase the capacity of the parents/guardians to provide a safe and nurturing environment for raising children. Most of these families remain intact while this work is carried out, and the services that have been developed to support them are focused on building parental capacity. In a relatively small percentage of these families children require some period of out of home care while

these capacities are strengthened, as well as to provide a safe and therapeutic environment for children with extraordinary behavioral health needs.

When the family's primary needs are protective, and the service goal is strengthening parental capacities, DCF accesses the Family Networks system to provide services to these families. Through Family Networks, a Family Team is convened by the Area Lead Agency and providers of outpatient or in-home behavioral health services to the family are invited to participate on the team.

Some families have both protective needs and significant behavioral health needs for one or more child. If Intensive Care Coordination is the appropriate behavioral health service and if the family simultaneously needs Family Networks services, a decision will be made with family input to decide whether the Family Team is convened through the Community Service Agency (providing Intensive Care Coordination for CBHI) or through the Family Networks Lead Agency. The following protocols provide guidance to DCF social workers and supervisors on how to make this decision. Regardless of who convenes the Team, it is expected that representatives of each agency will participate as necessary and appropriate.

Other families served come to the attention of the Department through the CHINS process or through a voluntary application for services in order to receive assistance in caring for a child with significant behavioral health needs. A significant proportion of the congregate care population is comprised of CHINS involved adolescents who have behavioral health needs that have not been adequately met through intensive community based services. These youth who are at home, at risk of placement, or already in placement can be a prime beneficiary of the new MassHealth behavioral health services. For eligible youth with significant behavioral health needs, Intensive Care Coordination offered through a Community Service Agency may be an appropriate service. In those cases the Intensive Care Coordinator will convene the Team and coordinate care.

These broad areas of practice represent the conceptual framework for the convergence and integration of the Department's Integrated Practice Model, the Family Networks service management structure, and the Children's Behavioral Health Initiative. What follows are the practice guidance and protocols for the implementation of CBHI within Department casework.

II. DCF Protocols for the Children's Behavioral Health Initiative

Primary Care Behavioral Health Screens

⇒ DCF social workers are responsible for ensuring that children receive Medical Screening Examinations and Comprehensive Examinations when a child enters a DCF out-of-home placement or enters DCF custody and remains at home.

⇒ DCF is required to seek an appointment for a Medical Screening Examination within 7 calendar days and a Comprehensive Medical Examination within 30 calendar days after the child enters DCF out-of-home placement or custody. A comprehensive medical examination is a visit which includes the components required by current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocols and Periodicity Schedule, appropriate to the child's age and focuses on the presence of any acute or chronic medical or behavioral issues that may require treatment, additional evaluation or referral to other medical practitioners.

⇒ Every child must have access to primary care. Whenever possible, the comprehensive medical exam should be completed by the child's primary care provider or another medical practitioner in the same practice. MassHealth does not pay for primary care delivered in Emergency Departments. Emergency Departments should not be used for the medical screening examinations for MassHealth Members. When a child under CHINS custody remains at home, the DCF social worker works with the child's parent/guardian to ensure that an EPSDT screen is conducted if needed.

⇒ In some cases, the circumstances warranting the transfer of a child's custody to DCF may indicate the need for additional consultation with medical specialists such as child protection teams.

DCF Role in Identifying Children With Behavioral Health Needs

Families come to DCF through several paths, including 51A, court custody, CHINS and voluntary requests for services. Regardless of the path to DCF, the process for identifying possible behavioral health needs for children on MassHealth is the same.

⇒ DCF will identify possible behavioral health needs as a structured part of its primary case management decision points:

1. Throughout the DCF Intake, Assessment and Ongoing Casework Process
2. Prior to Referring a Child to Congregate Care
3. Prior to a Child Leaving Congregate Care
4. Prior to Case Closing

⇒ The DCF Social Worker will decide whether a referral for a behavioral health diagnostic assessment (including CANS) and treatment might be appropriate by asking the parent / guardian or other collateral contacts whether any of the following conditions apply to a child or children in the family.

- Does the child appear to be depressed?

- Does the child have outbursts of angry or violent behavior?
- Does the child engage in risky behavior that could result in injury or death?
- Does the child use or abuse substances?
- Does the child have poor interpersonal relationships?
- Does the child have school difficulties that could potentially be related to a possible mental, behavioral or emotional disorder?
- Is anyone concerned that the child may have emotional or psychological problems?
- Is the child currently receiving behavioral health services for any of these conditions?
- If the child is autistic, or developmentally disabled or mentally retarded, does the child also appear to others to have emotional or psychological problems?

⇒ The DCF Social Worker will consult with the Supervisor if there is any reason to be concerned that a child may have behavioral health needs that require services. The supervisor will provide direction to the Social Worker on how to assist the family in determining what services may be most appropriate in accordance with these protocols.

Identifying The Most Appropriate Behavioral Health Service For a Referral

DCF Referral Goals: DCF's goal in making referrals is to try to ensure that the service meets the child and family's needs and minimizes the number of clinical transitions by helping the family identify what is potentially the most appropriate behavioral health service. DCF will seek to have the behavioral health assessment conducted by the provider most likely to be an appropriate service provider (i.e. Outpatient Therapy, Substance Abuse Treatment, In-Home Therapy, or Intensive Care Coordination through the CSA.) The custodial parent or legal guardian has the right to seek behavioral health treatment including pre treatment assessments from any provider of any service in the child's managed care network.

- **Role of DCF Social worker:** The DCF social worker, in consultation with his or her supervisor will help the parent/guardian to identify the service most likely to be appropriate, based on the information available. In instances where DCF has care or custody of the child, the DCF will identify the service most likely to be appropriate, consulting with the parents/guardians, in accordance with current practice.

- **Role of DCF Supervisor:** DCF supervisors will be trained in the differences between the various behavioral health core services offered by MassHealth (i.e. Outpatient Therapy, In-Home Therapy, ICC) and to provide guidance to the social worker regarding the most appropriate service level to refer to for diagnostic assessment and treatment.

Referring MassHealth Children To A Behavioral Health Assessment

Upon identifying a child in potential need of behavioral health services, the DCF social worker will provide a MassHealth child and family with a referral to an outpatient clinician, in-home therapy or

intensive care coordination where they will receive a comprehensive behavioral health diagnostic assessment, followed by behavioral health services as clinically indicated.

⇒ **If the child already has an outpatient clinician or psychiatrist**, the social worker and parent/guardian (depending upon custody) will confer with the child's clinician before making a referral for an assessment.

⇒ **If a child has a history of significant behavioral health needs or significant trauma, but is not currently seeing an outpatient clinician or psychiatrist,** the DCF social worker will share information with the family about the array of MassHealth behavioral health services to help the family determine the most appropriate service and will provide the family with assistance in accessing that service in accordance with these protocols.

⇒ **If a family is interested in receiving Intensive Care Coordination or In-Home Therapy services**, the family may go directly to a local Community Service Agency for Intensive Care Coordination or an In-home Therapy provider to receive a behavioral health assessment and determination of medical need for the service. The Social Worker will assist the family in identifying the service provider in their area.

⇒ **If a child is in an acute psychiatric crisis,** the parent/guardian or caregiver will be directed to immediately call the Emergency Service Provider (ESP) for mobile crisis intervention (described below). The social worker may assist the family in making the call, and will follow up to ensure that emergency services were received.

Providing Referrals

The referral process for all behavioral health services is as follows:

1. If possible behavioral health needs are identified, the social worker consults with the supervisor as needed to determine which behavioral health service may be most appropriate.
2. Social Worker discusses behavioral health service options and the Department's recommendation with the parent/guardian.
3. DCF social worker obtains the parent/guardian's consent to share and obtain information about themselves and any child under 18 with the service provider. The standard DCF Medical consent form found on the DCF intranet may be used. If the child is in DCF custody, written consent is not required to make the referral for the child.
    - **Youth over 18** must themselves consent to services and to release information unless the court has appointed a Legally Authorized Representative with the authority to make treatment decisions. Youth over 18 may choose to have their family involved in decisions, but family members or other individuals cannot be involved in any manner without the explicit consent of the youth.
4. The Social Worker makes the referral to the agreed upon behavior health service, or assists the parent in making the referral.
5. The Social Worker contacts parent/guardian to confirm that the referral has been made and that the intake process is underway.
6. The Social Worker documents these activities in Family Net

For Referrals to Mobile Crisis Intervention Service

For Youth Living in the Community

- If the youth is in a behavioral health crisis, the family will be urged to call the ESP/ Mobile Crisis Intervention service in their area. The DCF social worker will have the number of their local Mobile Crisis Intervention service available, and will assist the family in making this call if s/he is requested to do so. The family will be informed that Mobile Crisis Intervention service will come to any location in the community where the youth is located, including home, school or other community setting. The social worker will follow up with the family to make sure that the service was received.

For Youth in Placement (Including congregate care and foster care)

- Mobile Crisis should be called by the caregiver or social worker in the event of a behavioral health crisis.

Expected Response to Referrals

- **For Referrals to Intensive Care Coordination**

1. Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the parent or guardian to offer a face-to-face interview.
2. A face-to-face interview with the youth and/or family will be offered within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
3. The comprehensive home-based assessment must be completed within 10 calendar days of the date on which consent for ICC was obtained. Eligibility for ICC services is determined as part of the comprehensive home-based assessment.
4. In instances when a youth in DCF custody is referred by someone other than the family or the state agency caseworker, the ICC provider will contact the appropriate DCF office (with proper consent as required by law) to discuss the referral before scheduling the comprehensive home-based assessment inclusive of the CANS. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure parent or guardian authorization and to convey it by fax, mail or hand delivery to DCF and the providers with whom they want to speak.
5. The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the parent/guardians consent to treatment.

- **For Referrals to In-Home Therapy**

1. The In-Home Therapy provider responds telephonically to the parent / guardian within one business day of receiving a referral.
2. During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.

- **General**

  - If the child or youth does not meet the requirements of the service, or if the youth and family do not wish to participate, behavioral health provider is expected to provide a referral to other services, as appropriate.

Ensuring Continuity of Care During Transitions from Congregate Care

As part of the discharge process from a DCF congregate care to a community setting, the DCF-contracted congregate care provider, DCF social worker, Lead Agency and family will review the youth's needs and options for behavioral health services. In order to ensure a smooth transition to the community and continuity of clinical care, a referral to **ICC only** will be made no later than three months prior to a planned discharge and no more than 180 days prior to planned discharge. The ICC provider may provide services for eligible youth during this transition period. These services do not supplant services provided through the out of home provider, but rather augment and complement those services. For ICC, the Care Coordinator may convene the first Care Planning Team at the congregate care setting.

Once the family and provider agree on a specific community-based behavioral health service, the DCF Service Plan will be updated. The DCF social worker will note any added behavioral health services in the DCF Service Plan as the treatment plan evolves.

DCF Participation In ICC Care Planning Team

- **DCF Goal for ICC:** DCF's goal in the Care Planning Team is to ensure that services support the sustained safety and well-being of children and families. DCF social workers will represent DCF in achieving this goal through collaboration, engagement, partnerships and communication to maximize the formal and informal resources that can help children with behavioral health needs.
- **DCF Representation on Care Planning Team:** For children in the care or custody of the agency, the DCF social worker will participate in the Care Planning Team for the children in their case load. For children not in DCF custody the social worker will participate in the Care Planning Team when requested by the family or youth.
- **Consent for DCF Social Worker To Share Confidential Family Information within Care Planning Team:** In all cases where DCF does not have care or custody, the DCF social worker will receive written consent before sharing confidential family information in the Care Planning Team. The medical release form on the intranet is sufficient.
- **DCF Social worker Role:** The DCF social worker is an active participant in the Care Planning team and is expected to regularly attend Care Planning meetings. The DCF social worker is expected to function as part of the Care Planning team with the twin objectives of supporting family-driven behavioral health care and child protective services mandates. The DCF social worker is responsible for bringing the concerns of DCF to the Care Planning Team so that a collaborative effort can be made by the Team to adequately address all DCF protective concerns and permanency goals and to try to come to a shared plan of action.
- **Integrated Care Planning:** The ICC Care Planning Team will develop an Individual Care Plan, along with a risk management/safety plan. **DCF's Service Plan** will be updated.
    - The primary tool for ICC care planning is an **Individual Care Plan (ICP).** The youth and parent/caregiver (biological, adoptive, foster, guardian, kinship) have the

lead role in the development of the ICP supported by the care coordinator and CPT members. Information gathered through the comprehensive home-based assessment and the goals prioritized by the youth and parent/caregiver will guide the plan. The ICP will include both formal services and supports and informal services and supports from the family's natural support system and local community. It is developed by the CPT and specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family and incorporates the strengths and needs of the youth and family.

- The ICC's **risk management/safety plan** details a response plan for the family to use when crisis situations arise and gives suggestions for how to prevent the need for out-of-home services whenever possible. Each youth must have a risk management/safety plan completed immediately upon gaining consent for participation in ICC. It is expected that this plan will be reviewed at the beginning of each Care Planning Team meeting or more frequently as needed. The risk management/safety plan must be reviewed and updated after a Mobile Crisis Intervention (MCI), at the time of discharge from a 24-hour facility, or when any circumstances change that impact risk and safety

- **DCF Services to Support Community-based Care:** As a member of the CPT team the DCF social worker for the referred child will participate in the development of the ICP. Prior to attending the team meeting, the social worker, supervisor and a Lead Agency service coordinator will hold an administrative meeting to discuss what DCF services, if any, may be offered as options to meet goals identified by the CPT. The DCF social worker will then have the authority to approve the inclusion of these services during the team meeting. If community-based services other than those for which prior approval has been given are recommended by the team, the social worker will consult with the supervisor and Lead Agency service coordinator and will inform the Intensive Care Coordinator of services DCF is able to offer in support of the ICP within five business days of the team meeting.

- **DCF Placement Providers** (including congregate care and foster care) serving a family receiving ICC are expected to participate on the ICC Care Planning Team meetings.

Coordination Between ICC and the DCF Lead Agency

The DCF Lead Agency provides the utilization management function for all DCF-purchased services (including service identification, referral, and utilization review). In addition, the Lead Agency convenes a Family Team to coordinate services for a DCF-involved family. However, if a child is receiving Intensive Care Coordination services, the ICC will convene the Team and coordinate services. **The Lead Agency will not convene a separate Family Team**, but will authorize and review utilization of DCF-purchased services for the family. With the family's approval (except when DCF has custody), the DCF supervisor may, at their discretion, ask the lead agency coordinator to attend the ICC Team, if they determine that it might be beneficial.

How Custodial Issues Impact The Care Planning Process

- **In The Decision to Access ICC Services**: 1.) When DCF has no custody the custodial parent/guardian will determine whether a referral to Intensive Care Coordination should be made. 2.) When DCF has non-CHINS custody the social worker will seek the support and

participation of the parent(s)/guardians (when appropriate /available) in the care planning teams. Family Partners can be helpful in engaging parents/guardians in these circumstances. 3.) When DCF has CHINS custody or a voluntary placement agreement has been signed, the social worker may defer to the wishes of the parent/guardian regarding a referral to and their participation in the care planning team, or alternatively after consulting with the supervisor, proceed with the referral in the absence of parent/guardian support.

- **When DCF has custody and the goal is Permanency through Family Reunification**, the ICC Care Coordinator's goal is to facilitate the development of a family driven plan which supports the reunification process while recognizing DCF permanency planning obligations. In this instance, the CPT process should simultaneously respect the department's mandate to ensure the child's safety and welfare and engage the family and build on their strengths and capacity to meet the child's needs. The care planning team process is intended to build common ground and address the concerns of all parties through the Wraparound Team process.
- **If DCF has custody and the goal is to achieve Permanency through Adoption, Guardianship, Kin or Alternative Planned Permanent Living Arrangement,** the ICC care planning process can enhance permanency if the child has a stable team that will be with the child for the coming year. If the plan is to discharge the child to a kinship placement, pre-adoptive placement or intensive foster care agency it is expected that the receiving parent/guardians will participate in the development of the Care Planning Team and fully support the implementation of the Individual Care Plan.

  In the event that DCF places a youth receiving ICC in a temporary foster care setting, it is expected that ICC will schedule a team meeting for care coordination and disposition planning at the earliest possible date. If the placement is outside the CSA service area, the ICC provider will work with DCF and the Care Planning Team to consider whether transfer of ICC services to the closest Community Service Agency (CSA) would be in the child's interest. This transition of care should include the youth and parent/caregiver, the DCF social worker, and the full Care Planning Team.
- ICC can also support youth who are working toward living independently. ICC will work with DCF social worker and the youth to convene a team that will support the youth through the transition to young adulthood. Family members may be included in the team, even if the youth will not return to the family. If DCF has custody, the youth's voice and viewpoint should be an important aspect in determining the composition of the team.

Partnering With Community Service Agencies (CSAs) Providing Intensive Care Coordination (ICC)

Establishing a DCF/CSA Collaborative Relationship:

The Area Director and the Lead Agency Program Director of each DCF Area Office will establish a working relationship with the director of the Community Service Agency (CSA) and the ESP/Mobile Crisis Intervention provider in their area to facilitate collaboration for families served by both agencies. If a Specialized CSA also serves their area, the Area Director and Lead Agency Director will also establish a working relationship with the Specialized CSA. Area Directors will confer at least quarterly or more frequently if needed with CSA and ESP directors in order to ensure issues are addressed as they arise in the implementation and ongoing operations of this new system.

DCF Participation in Local System of Care Committees

- Each DCF Area Director will assign an Area Program Manager to represent the Department at each Local Systems of Care committee.
- When issues arise within the Local System of Care committee meetings that are of concern to the DCF Area Program Manager, these issues will be referred to the DCF Area Director and, as appropriate, to DCF Regional Director and the representative on the CBHI Interagency Team at the State level.
- Each DCF Area Director will invite the CSA Director to sit on Area Board. (During the first year of start-up, this may not be possible for the CSA.)

Trainings To Ensure Coordination Between DCF and ICC

- **DCF Staff Training:** All DCF Regional Directors, Regional Clinical Directors, Area Directors, Area Program Managers, Supervisors and Social Workers will receive training in Wraparound, these protocols, and the CBHI service system. The purpose of the Wraparound training is to understand the process of collaborative care planning and the various roles of DCF social workers, supervisors and area directors in the process.
- **CSA Staff Training:** Care coordinators and family partners will receive training in collaborative approaches to working with DCF, including DCF's protective mandate and how the array of custody arrangements may impact the care planning team process. DCF staff will help deliver this aspect of the CSA training.

Summary Roles and Responsibilities of DCF Staff

Role of the DCF Social Worker

1. Obtains information from parent/guardian and collaterals regarding the behavioral health needs of children
2. Consults with supervisor to determine what services may be most appropriate and discusses service options with the parent/guardian
3. Assists in accessing the agreed upon service (s).
4. Participates in ICC Team
5. Documents activities in FamilyNet
6. Updates DCF Service Plan as needed

Role of the DCF Supervisor

1. Supervisor provides supervision to the Social Worker to assist in determining the most appropriate behavioral health service.
2. Supervisor seeks additional advice, if needed, on the appropriate level of service from the Area Program Manager.
3. Supervisor follows up with Social Worker to learn the outcome of the referral.

4. Supervisor prepares Social Worker for participation on Care Planning Team if Intensive Care Coordination services are to be provided.

Role of the DCF Area Program Manger

1. Area Program Manager assures referral of MassHealth-eligible children and youth with behavioral health needs to MassHealth Behavioral Health services is covered in supervision with their assigned supervisors.
2. The Area Program Manager provides consultation to the supervisor regarding the most appropriate level of behavioral health service for a child and family.
3. The Area Program Manager monitors/manages the smooth flow of shared cases between DCF, the area lead agencies and the Community Service Agencies.
4. The Area Program Manager represents the Area Director on Local Systems of Care Committee.

Role of the Area Director

1. The Area Director is the primary liaison to the Community Service Agency. The Area Director and the CSA Director develop a collaborative working relationship in order to ensure the successful integration of Children's Protective Services mandates with the Wraparound care planning process.
2. The AD ensures that all area office staff are knowledgeable about the local behavioral health system, including service definitions, service locations, referral procedures, the Wraparound Principles of Care, and the process and procedures of Intensive Care Coordination care planning teams.
3. The Area Director convenes monthly meetings with the Director of the CSA to identify and resolve issues related to the integration of the CPS and behavioral health service systems.

DYS Strategic Direction on Children's Behavioral Health

The Department of Youth Services is one of five Executive Office of Health and Human Services agencies leading the development and implementation of the Children's Behavioral Health Initiative (CBHI). With its goal of bringing multiple systems together to best meet the needs of children and families, the CBHI is an integral component of the Department's strategic effort to promote positive change in the lives of youth committed to our custody.

Positive Youth Development, an approach that emphasizes and builds on the strengths of an individual and their family, provides the framework for all DYS services.

DYS is in the process of redesigning its community service delivery system. The overarching goal of the new Community Services Model is to go beyond accountability and recidivism reduction and to help DYS youth thrive as adolescents and young adults. The model places the emphasis on serving and supervising youth on an individualized basis in the context of their families and their community. This commitment is reflected in the CBHI's focus on engaging families as true partners in the development of a meaningful plan of action that best meets their child's needs for success. When families are actively involved with professionals and collaborate as a team to discover their strengths, positive youth development can emerge.

At its core, the new Community Services Model calls for a framework to support a case management team by adding clinical, family, resource, site support and clerical elements to the casework team. While clients are assigned to a primary caseworker responsible for all of the coordination and delivery of services, the community case management team will work in a coordinated fashion to insure that the array of service needs are met and maintained. This array may include service connections in the areas of behavioral health, medical care, education and employment. It may also include connecting youths and their families to mentoring, recreation, civic engagement activities, housing and family supports. And, finally, it will include accountability, supervision and attention to personal safety issues of the client.

The Community Services Model envisioned builds on the community supervision model employed successfully by DYS over the past ten years and represents a further evolution of that model. The core features of the model - increased contact and engagement with DYS youth by caring, responsible adults, emphasis on pro social development, building life skills and social competencies, community connectedness, service access, support and supervision - are maintained. The changes build on improved Departmental practices in assessment and residential treatment and programming. They represent a merging of valuable insight and input from our juvenile justice service providers, our staff, and experts from the field of juvenile justice with lessons learned from the past model and an emerging body of promising practices in directly related and relevant fields.

The goal is a team that delivers high quality, culturally responsive services and supports; that build on the strengths and compensates for the deficits of the youth and families served by the Department; and in a manner that produces positive results for DYS youth, their families, and their communities.

DYS Protocols for the Children's Behavioral Health Initiative

Identifying Behavioral Health Needs Among Its Committed Juveniles

Background

When the Juvenile Court adjudicates juveniles for commitment to DYS custody, DYS performs a comprehensive 30-45 day assessment of all committed youth, in a DYS Assessment program. As part of the comprehensive 30-45 day assessment of care needs, the DYS Clinician conducts a comprehensive behavioral health assessment, using an array of standard assessment tools and conducts a full case history including home visits, meetings with the family, information-gathering on trauma history, early neurological development, and educational testing to perform a risk-needs analysis for among other areas, substance abuse, psychological function, and offense behavior.

The Child and Adolescent Needs and Strengths tool (CANS) is a standard part of the 30-45 DYS assessment process for newly committed youth. All DYS clinicians are trained in the use of the CANS and all licensed clinicians will be required to be certified in the use of the CANS. Only licensed DYS clinicians can administer CANS. License-eligible clinicians who are trained and certified in CANS may assist in completing the CANS during a DYS assessment and prior to community placement under the direction of a licensed clinician.

Prior to release to the community, a DYS clinician updates the CANS as part of the DYS pre-release care planning process, to ensure continuity of care with MassHealth providers.

Accessing MassHealth for Committed Juveniles

Each newly committed juvenile is enrolled in MassHealth and may choose to enroll in MassHealth's Primary Care Clinician Plan or one of MassHealth's Managed Care Health Plans. If the youth or their Legally Authorized Representative does not make a choice, the juvenile will automatically be enrolled in the Massachusetts Behavioral Health Partnership for their behavioral health care and will receive medical services through MassHealth's fee-for-service network.

Identifying the Most Appropriate Community Based Behavioral Health Service

- During the DYS pre-release process, the DYS Clinician will draw on the results of the updated clinical assessment (including CANS). The DYS Caseworker and DYS Clinician will talk with the parent or legal guardian and the youth about the relevant options for behavioral health services, and which service(s) might best fit the behavioral health needs of the youth and family, and help support the youth to reside safely in the community.
- With appropriate consent, the DYS Caseworker and clinician will then arrange for a referral to the local provider, providing additional follow-up as needed to ensure an initial intake and service assessment occurs.
- DYS does not have legal custody over its committed population. The parent or legal guardian decides which behavioral health services best meet the needs of their child.

  However, DYS is statutorily authorized to determine and establish the conditions under which a youth is released to the community, to enforce compliance with those conditions and to revoke the grant of liberty afforded the youth based on non compliance with those

conditions of release. The Department does this with the welfare and safety of the youth and the community in mind. DYS does currently and will continue to make every effort to actively engage the youth and their family in the determination of those conditions of release.

For example, DYS often mandates treatment participation as a "condition" of release to the community. This is recorded on the youth's "Grant of Conditional Liberty (GCL)". For example, DYS may require a youth to continue substance abuse treatment begun in residential programs in the community, as one of the conditions for release to the community.

Providing Referrals

Background

After a stay in a hardware secure or staff secure residential treatment facility, typically for 8 months to 1 ½ years, youth return to the community with a Grant of Conditional Liberty and ongoing supervision and support through a Community Re-entry Center. The Community Re-entry Center does not provide any direct treatment services but maintains relationships with local service providers and the regional CSA. The DYS Case Worker draws on the services provided by community-based providers to support the youth. Once the youth has returned to the community, the DYS Case Worker at the Community Re-Entry Center is responsible to support the youth and family's participation in behavioral health services. For MassHealth-eligible children:

- During the pre-release process, the DYS Caseworker, in collaboration with the DYS Clinician, is responsible for identifying and making referrals to appropriate behavioral health services. Youth whose updated CANs identifies the presence of a serious emotional disturbance should be considered for ICC.
- The referral process for all behavioral health services is as follows:
    1. Share information about the service with the parent or guardian and the youth (especially for youth making his or her own treatment decisions).
    2. With appropriate consent, support the parent (or youth) in seeking services. This can be accomplished by offering provider contact information, or actively facilitating a phone call or meeting with the provider.
- **For referrals to Intensive Care Coordination,** the DYS Caseworker and DYS clinician will help the family identify the Community Service Agency (CSA) in the geographic area to which the child is returning, and also inform the family of any specialized CSAs serving their region. (See attached list.) A family may request Family Support and Training (through a Family Partner) in conjunction with the referral. The family may make this request to the provider independently, or the DYS caseworker or casework manager may assist them by facilitating a phone call or meeting with the treatment provider.
- **For referrals to In-Home Therapy** and all other MassHealth Behavioral Health services, the Caseworker and DYS clinician will help the family identify providers in their community. For more information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the managed care plan directly. A list of the plans and contact numbers and websites are Attached in Appendix A.

- If a youth is living apart from his parents or guardian, the youth may obtain Intensive Care Coordination services without parental consent under the following circumstances. Massachusetts General Law Ch. 112 s. 12F states in part: *"Any minor may give consent to his medical or dental care at the time such care is sought if (i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care of the child; or (iii) he is a member of any of the armed forces; or (iv) she is pregnant or believes herself to be pregnant; or (v) he is living separate and apart from his parent or legal guardian, and is managing his own financial affairs."*

  In this instance, the eligible young person may consent to Intensive Care Coordination services, and ICC Care Coordinator will work directly with the youth to develop the Care Planning Team. As part of the referral process, DYS will provide assistance in documenting that such a youth is eligible to give consent to behavioral health care under the conditions of MGL Ch 112.

Note: Youth residing in hardware-secure DYS facilities are not eligible for MassHealth services until they leave the facility.

For Referrals to Mobile Crisis Intervention Service

For MassHealth enrolled Youth Living in the Community

- Prior to discharge, the DYS Caseworker and DYS clinician will provide the family with the written contact information for Mobile Crisis Intervention service and inform the family that Mobile Crisis Intervention Service will come to locations in the community where the youth is located, including home, school or other community setting. The family will be urged to call the Mobile Crisis Intervention Service in their area if the youth is in a crisis.
- The DYS Case worker can support the family in making this call if he/she is contacted by the family. DYS case workers will have the number of their local Mobile Crisis readily available.

For MassHealth enrolled Youth in Staff Secure Treatment Facilities:

- As the children-serving arm of the Emergency Services Program to be used for MassHealth eligible youth under 21, Mobile Crisis will be called by DYS staff in the event of a behavioral health crisis.
- The phone number of the Mobile Crisis in the area will be posted in appropriate locations in the facility.
- DYS clinicians are responsible for delivering behavioral health intervention services in DYS staff secure facilities. The Mobile Crisis Intervention provider will be accessed when additional intervention including level of care assessment is required.

Referrals to MassHealth Behavioral Health Services for MassHealth-enrolled DYS Youth Residing in the Community

- The DYS case worker is responsible for identifying and addressing the evolving needs of a youth living in the community under a grant of conditional liberty. These needs and related services are added to the DYS Service Plan as the needs emerge, and are reviewed and revised every 6 months. For DYS youth in community placement, the DYS

Caseworker will identify, address and document each youth's behavioral health needs in the youth's Individual Service Plan (ISP) and Relapse Prevention Plan (RPP). The caseworker will then facilitate access to those ISP services.

- If the behavioral health needs of a youth change while the youth is living in the community, the DYS case worker will:
  - Consult with the DYS Community Clinical Coordinator and with any behavioral health provider(s) treating the youth, and devise an appropriate intervention plan. This may include a review meeting to review and revise the youth's ISP and RPP and referrals to additional behavioral health services and supports, as needed.
  - If the youth is not currently receiving behavioral health services, refer the youth to a MassHealth behavioral health provider for a behavioral health assessment and appropriate services intervention.
  - Document changes in the youth's behavioral health needs and related services in the youth's ISP and RPP.

Expected MassHealth Provider Response to Referrals of DYS Clients

- **For Referrals to Intensive Care Coordination**
  - Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the youth, parent or guardian to offer a face-to-face interview.
  - A face-to-face interview with the youth and/or family will be offered within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
  - The comprehensive home-based assessment inclusive of the CANS must be completed within 10 calendar days of the date on which consent for ICC was obtained.
  - The ICC care coordinator and DYS referral source will be expected to confer to discuss the reason for referral (with proper consent as required by law) as part of of the comprehensive home-based assessment process. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure youth, parent or guardian authorization and to convey it by fax, mail or hand delivery to DYS and the providers with whom they want to speak.
  - The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the youth, parent or guardian's consent to treatment.
- **For Referrals to In-Home Therapy**
  - The In-Home Therapy provider responds telephonically to all referrals within one business day.
  - During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.
- **General**
  - If the child or youth does not meet the medical necessity criteria for the service, or if the youth and family do not wish to participate, the behavioral health provider is expected to

discuss this with the DYS Caseworker and provide a referral to other services, if appropriate.

Ensuring Continuity of Care

- For youth in DYS staff-secure facilities who are eligible for Intensive Care Coordination or In-Home Therapy, enrollment in ICC may occur no more than 180 days prior to discharge from the residential/secure setting.
- Once the family and provider agree on a specific community-based behavioral health service, the provider will be named in the DYS Individual Service Plan.
- During the pre-release process, if the family decides that ICC is an appropriate service, and the ICC service is medically necessary, the DYS clinician and the DYS case worker will meet with the Care Coordinator and family to document a planned transition to ICC. Where possible, DYS will allow ICC care coordinators and family partners to hold care planning meetings on site at DYS staff-secure facilities during this transition.
- With the permission of the parent/guardian, the DYS clinician will provide a printed copy of the CANS to the ICC provider as part of the referral process.
- The Caseworker and DYS clinician will participate in one or more transition meetings to ensure continuity of care and a smooth transition planning into community-based behavioral health services.
- The DYS Caseworker responsible for working with the youth when s/he returns to the community will participate in the transition planning process with the DYS clinician, the family and potential community-based behavioral health providers to support a smooth transition to the community. For youth enrolled in ICC, the DYS Caseworker will represent DYS on the youth's care planning team, from commitment to discharge from the Department.

Note: Youth residing in hardware-secure DYS facilities are not eligible for MassHealth services until they leave the facility.

DYS Participation In ICC Care Planning Team

- **DYS's Goal for ICC:** DYS's goal is to work collaboratively as part of the Care Planning Team with the shared mission of keeping the youth safely in the community.
- **DYS Representation on Care Planning Teams:** The DYS case worker will serve on the Care Planning Team for the youth in their case load and regularly attend Care Planning Team meetings.
- **DYS Caseworker Role:** The DYS case worker is expected to play an active role in the ICC Care Planning Team with the goal of keeping the family engaged and the youth safely in the community. The DYS case worker is responsible for bringing the concerns of DYS to the ICC Care Planning Team so that a collaborative effort can be made by the Team to adequately address all DYS concerns and to try to come to a shared plan of action. All ICC team members are expected to comply with all laws and regulations governing confidentiality of all information regarding its clients whether protected health information, CORI, or other confidential data.

- **DYS Case Worker Service Plan:** The DYS case worker will regularly update the youth DYS Individual Service Plan within the rules and regulations of DYS regarding such plans to reflect the agreements and plans defined in the ICC Care Planning Team, in an effort to ensure that the two plans, the youth DYS Individual Service Plan from DYS and the ICC Individual Care Plan are consistent and integrated to the greatest extent possible.
- **ICC Risk Management/Safety Plan:** The Care Planning Team, including the DYS case worker, will develop an integrated plan for dealing with potential risk, including contingencies related to revocation of the youth under the youth's DYS Individual Service Plan. The ICC Risk Management/Safety Plan will be referenced in the DYS Individual Service Plan. However, nothing in the ICC Risk Management/Safety Plan limits DYS' statutory authority to determine and establish the conditions under which a youth is released to the community, to enforce compliance with those conditions and to revoke the grant of liberty afforded the youth based on non compliance with those conditions of release.

DYS Revocation of a Grant of Conditional Liberty for a youth in ICC

- **DYS Legal responsibility:** The legal mandates and mission of DYS are unchanged by the ICC process.
- **Decision to revoke grant of conditional liberty:** DYS is solely responsible for granting and revoking a grant of conditional liberty of youth committed to DYS, however, the DYS caseworker will explore the options with the Care Planning Team prior to revocation whenever possible. To the extent possible, plans and contingencies should be reflected in the ICC Risk Management/Safety plan, developed in advance of a crisis.
- **Communication about revocation with ICC Care Coordinator and Care Planning Team:** In the event that DYS revokes a youth's grant of conditional liberty for either a short or long term period, the ICC care coordinator will be notified by the DYS Case Worker within 1 day of any revocation which results in the youth's removal by DYS from the community, unless such communication cannot be made due to safety concerns for the youth. The ICC care coordinator is responsible for communicating the notification of the revocation to the rest of the team and immediately convening the Team, including its DYS representative, to discuss the implications of this decision on ongoing care and treatment.
- **Care Planning Team Role After Revocation:** For short-term revocation, the ICC team will continue to meet and to plan the youth's transition back into the community. In the event of a long-term revocation lasting more than 6 months, the ICC team will convene for a final meeting as soon after revocation as possible for transition planning as well as discussing anticipated issues for the pre-release process. If a youth wishes to receive ICC upon discharge, a new request for ICC services must be made as part of the pre-release process. If the youth or parent/guardian requests to work with the same Care Coordinator or Family Partner, the Community Service Agency will make reasonable efforts to assign the requested staff. Readmission to ICC may occur no more than 180 days prior to discharge from the staff-secure facility.
- **DYS youth who are hospitalized or placed in a psychiatric residential treatment facility while in ICC:** In the event an ICC-enrolled youth requires inpatient

hospitalization or placement in a residential treatment facility, the CPT may continue to meet monthly or as needed in order to plan for return to the community. For youth whose hospitalization or placement exceeds 6 months, ICC will need to convene a final meeting to transition from ICC services. Re: enrollment to ICC may occur no more than 180 days prior to discharge from the hospital or psychiatric residential treatment facility.

What Happens When A Youth Enrolled in ICC Is Newly Committed to DYS?

Background

- When ICC enrolled youth are newly committed to DYS, the ICC Care Coordinator will convene the youth's Care Planning Team, including appropriate DYS staff. The purpose of the meeting is to provide DYS with recent assessment information, including the youth's progress toward meeting Individual Care Plan goals, to inform DYS' comprehensive behavioral health assessment of the youth.
- As part of the pre-release process, the DYS clinician will make a new referral to ICC as described above. If ICC is medically necessary, the family may request the same care coordinator or family partner as they had previously, and the CSA will make its best effort to accommodate that request, but is not under obligation to do so.

Trainings To Ensure Coordination Between DYS and Intensive Care Coordination

- **DYS Staff Training:** All DYS District Managers, Case Worker Supervisors, Case workers, clinicians and Court Liaisons and other designated DYS Community provider staff will receive training in the Wraparound care planning process and in these protocols. This training will also be offered on an ongoing basis for new DYS staff members. The purpose of the Wraparound training is to understand the process of collaborative care planning, and Systems of Care values and principles and the various roles of DYS caseworkers, supervisors and area directors in the process.
- **CSA Training:** Care coordinators and family partners will receive training on the DYS system and how it works, collaborative approaches to working with DYS, including the needs of transition-aged youth, the care coordination needs of court-involved youth, and how DYS's mandate may impact the care planning process. DYS staff will help deliver this aspect of CSA training.

DYS Participation in Local System of Care Committees

- The DYS Regional Director or their designee will represent the Department at each of 29 Local System of Care committees.
- When issues arise within the Local System of Care committee meetings of concern to the DYS representative, these issues will be referred to the DYS Regional Director and, as appropriate, to the DYS representative on the CBHI Interagency Team at the State level.

Youth in Detention/Pre-trial

Youth in DYS detention are not eligible for MassHealth.

Department of Mental Health

Guide to New and Current MassHealth Behavioral Health Services

Table of Contents

Section 1
MassHealth: New and Current Services

I. The Children's Behavioral Health Initiative (CBHI)

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

The Children's Behavioral Health Initiative is defined by a shared commitment to providing services to families that reflect the following values:

- **Family Driven, Child-Centered and Youth Guided**

  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

- **Culturally Responsive**

  Services are responsive to the family's values, beliefs, norms, and to the socio-economic and cultural context.

- **Collaborative and Integrated**

  Services are integrated across child-serving agencies and programs.

- **Continuously Improving**

  Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence and best practice.

The Initiative places the family and child at the center of our service delivery system, and will build an integrated system of behavioral health services that meets the individual needs of the child and family. The goal is to make it easier for families to find and access appropriate services and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

For more information visit: www.mass.gov/masshealth/childbehavioralhealth

II. MassHealth: New and Current Services

MassHealth pays for many important health care services for a wide range of people who meet the eligibility rules. During 2009, MassHealth will significantly expand behavioral health services available to its MassHealth Standard and CommonHealth members under the age of 21 by paying for six new home and community-based services. The goal of these services is to help children and youth with significant behavioral, emotional and mental health needs achieve success in home, school and community.

These services have been designed, and are being implemented according to Children's Behavioral Health Initiative Values:

- **Family Driven, Child-Centered and Youth Guided**
- **Strengths-based**
- **Culturally Responsive**
- **Collaborative and Integrated**
- **Continuously Improving**

These new services *complement* the behavioral health services currently available to MassHealth Standard and CommonHealth members under the age of 21. Below, you will find brief descriptions of the *new* services, and of the *current community-based* MassHealth Behavioral Health Services.

NOTE: These new services are NOT for the treatment of the behavioral health needs of a youth's parents or caregivers. Behavioral Health services for parents or caregivers should be sought through their health care insurer, or MassHealth, if they are eligible.

New MassHealth Community-Based Behavioral Health Services[2]

What follows are brief descriptions of the new services, with some suggestions of who might benefit from each of the new services.

This information is intended to provide staff with guidance on how to help families and youth to access appropriate MassHealth behavioral health services. It is important to note that MassHealth members may also self-refer to any behavioral health service they think might be helpful. Families and youth are always welcome to inquire with a provider about a particular service.

This guidance is intended to be informative and to illustrate the potential usefulness of each service. It does NOT replace the Medical Necessity Criteria, attached in Appendix B. Providers of each of the services will use the Medical Necessity Criteria (MNC) to evaluate whether the child or youth has a medical need for the service. Medical Necessity decisions made by providers may be reviewed by the child's or youth's MassHealth Managed Care Plan.

A. Standardized Behavioral Health *Screening* in Primary Care

As part of well-child visits, the primary care doctor or nurse checks the child's or youth's health, development, need for immunizations, dental health and behavioral health. MassHealth now requires primary care doctors or nurses to offer to use a behavioral health screening tool to check the child's or youth's behavioral health. There are eight approved screening tools. They typically consist of a short list of questions, or a checklist, that the parent, caregiver or youth fills out and then talks about with the primary care doctor or nurse. The screening tool helps to spot concerns early so problems can be found and helped

earlier. If there are concerns about a child's or youth's behavioral health, the primary care doctor or nurse will work with the parent/caregiver or youth to decide if a referral to a behavioral health provider for further assessment and treatment is needed, and can help the parent/caregiver/youth get needed services.

B. Standardized Behavioral Health *Assessment,* using the Child Adolescent Needs and Strengths tool (CANS)

Beginning November 30, 2008, MassHealth began requiring a uniform behavioral health assessment process for MassHealth members under the age of 21 receiving behavioral health services. The uniform behavioral health assessment process includes a comprehensive needs assessment using the Child and Adolescent Needs and Strengths (CANS) tool.

The CANS is a tool that organizes clinical information collected during a behavioral health assessment in a consistent manner, to improve communication among those involved in planning care for a child or youth. The CANS is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. The CANS is used in child and youth serving systems in more than 30 states. There are two forms of the Massachusetts CANS: CANS Birth through Four and CANS Five through Twenty. Both versions include questions that enable the assessor to determine whether a child meets the criteria for Serious Emotional Disturbance (SED), in addition to the CANS assessment questions. (Meeting the definition of SED is a component of the Medical Necessity Criteria for the new service Intensive Care Coordination.)

C. Intensive Care Coordination (starting June 30, 2009)

ICC is a care coordination service for children and youth with serious emotional disturbance (For definitions of Serious Emotional Disturbance, see ICC Medical Necessity Criteria, Appendix B). ICC will use a model called *Wraparound Care Planning.* In Wraparound Care Planning, families and youth work together with professionals, talk about their strengths and needs, and actively guide their own care. In ICC, a team leader, called a Care Coordinator, helps families bring together a team of people to create a child's treatment 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 part of the team. Together, the team comes up with ways to support the family's goals for the child (or youth's goals, in the case of an older child), creating an Individual Care Plan. This plan, which also focuses on the family's strengths and respects their cultural preferences, lists all the 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 all providers and state agencies to integrate services.

The Care Planning Team will usually meet monthly and sometimes more often for children and youth with more complex needs. At these meetings the family, youth and other team members can talk about progress, work to solve problems, and make any needed changes to the Individual Care Plan.

Additionally the ICC care planning team seeks to:

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

Who is likely to need ICC?

Children and families who need or receive services from multiple providers or who need or receive services from multiple state agencies, including special education. ICC can help prioritize goals and monitor progress, ensuring that interventions being used are effective and coordinated. ICC can also address needs other than behavioral health needs, such as connecting families with a variety of sustainable supports. Examples of sustainable supports include recreational activities for the child or youth, connection to mentors and opportunities for mutual support and social interaction with other families.

Who may benefit from referral to a different service?

- *A child or youth in acute emotional, behavioral or mental health crisis. Consider referring instead to Mobile Crisis Intervention* for immediate stabilization and support.
- *Family of a child or youth with a single service need who does not need a Care Planning Team to coordinate services:* Consider referring instead to the service(s) that may be needed.
- *A family in too much immediate distress to participate in the team-based sequence of steps of the Wraparound process.* Consider referring first to another behavioral health service such as Family Stabilization Teams (until November 1, 2009) or In-home Therapy (available November 1 2009, during which the need for other services including ICC will be assessed).

How do I make a referral?

See the list of Community Service Agencies in Appendix A.

Geographically-Based CSAs: MassHealth's Managed Care Contractors have selected 29 Community Service Agencies (CSAs), one for each of 29 service areas. The service areas correspond to the Areas of the Department of Children and Families.

Culturally and Linguistically Specialized CSAs: MassHealth's Managed Care Contractors have also selected 3 culturally and linguistically specialized CSAs. These CSAs were chosen for their demonstrated ability to reach deeply in to specific cultural or linguistic communities and tailor their services to engage and serve their specified populations. Like all CSAs, Specialized CSAs are expected to serve any family seeking appropriate service without regard to race, ethnicity or language.

- Children's Services of Roxbury specializes in serving the African-American population in Greater Boston.
- The Gandara Center specializes in serving the Latino population in the Springfield/Holyoke area.
- The Learning Center for the Deaf, Walden School specializes in serving the Deaf and Hard of Hearing population, particularly in the eastern/central part of the state.

Families with children or youth enrolled in MassHealth are not required to choose a CSA in their area or a culturally or linguistically specialized CSA, but may choose to work with any CSA.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

D. In-Home Therapy (starting November 1, 2009)

In-Home Therapy Services provides intensive family therapy for a child and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. In-Home Therapy Services

are provided in the home or other location which is appropriate and convenient to the family. It is provided by a skilled behavioral health provider who may work in a team with a paraprofessional. In-Home Therapy providers work to understand how the family functions together and how these relationships can be strengthened to benefit the child. Together with the child and family, they create and implement a treatment plan. Goals in a treatment plan might include helping the family identify and use community resources, learn to more effectively set limits and establish helpful routines for their child, problem-solve difficult situations or change family behavior patterns that get in the way of their child's success. Note: Parents may also have individual behavioral health needs that may require separate behavioral health treatment.

Who is likely to need In-Home Therapy?

- ***Families in need of more urgent or intensive help with a youth's emotional and behavioral challenges than could be addressed through outpatient therapy.***
- ***Families that have identified their primary need as learning new ways to relate to one another, or new ways to set limits or regulate child behavior, or who have tried outpatient therapy but not found it effective.*** **IHT offers more flexibility than outpatient therapy, not only in intensity but in treatment setting. Therapeutic intervention in a natural environment can offer opportunities for understanding behavior and for rehearsing new strategies which are not available in a clinic environment.**

Who may benefit from referral to a different behavioral health service?

- ***A child or youth in acute crisis*****. Consider referral to Mobile Crisis intervention.**
- ***Children and families with needs involving multiple providers or state agencies.*** **Consider referral to ICC.**
- ***A child with a disorder that can benefit from outpatient individual or family treatment.***

How do I make a referral?

Referrals can be made directly to the In-Home provider or the child may access In-Home therapy through ICC or outpatient therapy.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

For a list of the common network of In-Home providers selected by all MassHealth's Managed Care entities, see Appendix A. For additional providers selected for MBHP's "extended network", also see Appendix A. The most up-to-date information on the In-Home Therapy provider network can also be found on the website of the appropriate MassHealth Managed Care entity or by calling the Managed Care entity.

E. Mobile Crisis Intervention (starting June 30, 2009)

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 72 hours of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as

needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Who is likely to benefit?

A child with MassHealth who is in a behavioral health crisis and who is likely, without intervention, to escalate in a way that would pose a risk of harm to themselves or others. If in doubt, call the Mobile Crisis Intervention team and consult with the team on whether they should intervene.

Who may benefit from a different service?

If a child is in treatment he or she may have a Risk Management/Safety Plan which may identify other steps prior to calling Mobile Crisis.

Note that Mobile Crisis Intervention is only for a child/youth on MassHealth. A person who does not have MassHealth should be triaged through the 800 number on the back of the health insurance card or sent to the local emergency services program or hospital emergency room.

If the child/youth is an acute safety risk to self or others and the risk cannot be safely managed in the current setting, call 911.

How do I make a referral?

Mobile Crisis Intervention is provided by the Emergency Service Provider (ESP) in the region. See the list of ESPs in Appendix A.

F. Additional new MassHealth-covered services can be accessed through outpatient therapy, In-Home therapy or Intensive Care Coordination, as part of the youth's Individual Care Plan (ICP) or treatment plan (for Outpatient or In-Home Therapy).

- **Family Support and Training** *(Starting June 30, 2009)*

Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community.

Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.
In ICC, the care coordinator and Family Support and Training Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Support and Training Partner works one-on-one and maintains regular frequent contact the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/ caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator

and CPT. The Family Support and Training Partner educates parents/ caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the parent's/caregiver's access to these resources.

Family Partners are offered to families as part of Intensive Care Coordination.

- ***In-Home Behavioral Health Services –*** Starting October 1, 2009

In-Home Behavioral Health Services offers valuable support to children and youth with challenging behaviors that get in the way of everyday life. Services are provided by a behavioral health provider, such as a therapist, who is skilled in understanding and treating difficult behaviors in children and youth. The provider works closely with the child and family to create a specific behavior plan to improve the child's functioning. The provider may also work as a team with a skilled paraprofessional called a behavioral management monitor. The monitor works with the child and family to implement the child's behavior plan. In-Home Behavioral Health Services can be provided in places where the child is located, including home, school, childcare centers and other community settings.

- ***Therapeutic Mentoring Services –*** Starting October 1, 2009

A therapeutic mentor works one-on-one with a child or youth who, because of their behavioral health needs, require support and coaching to learn social skills that will allow them to do well in typical, normative environments. These skills may include better ways of communicating with other children and adults, dealing with different opinions and getting along with others. The therapeutic mentor works with the child to achieve goals in a treatment plan written by an outpatient therapist, In-Home Therapy Services provider or Intensive Care Coordination (ICC) team. The mentor is supervised by a behavioral health clinician and can work with a child in his or her home, school, or other social and recreational setting.

For families and youth who may need or benefit from these services, social workers should consider facilitating a referral process with the out-patient provider, in-home therapist, or ICC team.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

G. Current MassHealth Community-Based Services (in addition to the New Services)

The following are other community-based (e.g. non-24 hour) behavioral health services that are available to youth enrolled in MassHealth. This is not meant to be an exhaustive list of available benefits but an overview of behavioral health services that are available in addition to the new MassHealth services described earlier in this document.

- **Outpatient Behavioral Health Services:** Outpatient services include individual, family, and group therapies, as well as medication evaluation and monitoring. Outpatient services can be provided in an office, clinic environment, a home, school, or other location. Outpatient services can be used to treat a variety of behavioral health and/or substance abuse issues that significantly interfere with functioning in at least one area of the youth's life (e.g., familial, social, occupational, educational). Outpatient is the least intensive level of care available to youth.
- **Family Stabilization Team (FST) Program:** Provides intensive, therapeutic services in the home setting to assist the family in stabilizing youth during a period of emotional, behavioral, and/or psychiatric disturbance, and secondarily, after out-of-home treatment such as inpatient hospitalization or community-based acute treatment. Services may include counseling, crisis intervention, case management, skill building, mentoring, and other non-traditional services. *(NOTE: As of November 1, 2009, FST will be replaced by In-Home Therapy, which will provide the*

stabilization services described here as well as ongoing treatment as described earlier in this document under In-Home Therapy.)

- **Community Support Programs (CSPs):** Provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals. CSP services are appropriate for youth who have behavioral health issues challenging their optimal level of functioning in the home/community setting. These services are designed to be maximally flexible in supporting youth who are unable to independently access and sustain involvement with needed services. Services may include: assisting youth in enhancing their daily living skills; case management, skill building, developing a crisis plan; providing prevention and intervention; and fostering empowerment and recovery, including linkages to peer support and self-help groups. *NOTE: As of October 1, 2009, CSP for youth under 18 will be replaced by the new community based behavioral health services, described earlier in this document. Youth 18 through 20 will have access to both CSP services as well as the new community based behavioral health services.*
- **Structured Outpatient Addiction Program (SOAP):** SOAP is a short-term, clinically intensive, structured day and/or evening substance abuse service. SOAP can be used by youth, including pregnant youth, who need outpatient services, but who also need more structured treatment for substance abuse. SOAPs provide multidisciplinary treatment to address the sub-acute needs of youth with addiction and/or co-occurring disorders, while allowing them to maintain participation in the community, continue to work or attend school, and be part of family life.
- **Partial Hospitalization Program** is a nonresidential treatment program that may or may not 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.

How Do I Make a Referral?

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly.

To locate a provider for youth **NOT** enrolled in a MassHealth Managed Care Plan, please call: MassHealth Customer Service 1-800-841-2900: TTY: 1-800-497-4648.

For youth who **ARE** enrolled in a MassHealth Managed Care Plan, please call:

- **Boston Medical Center (BMC) HealthNet Plan** 1-888-566-0010 (English and other languages) 1-888-566-0012 (Spanish) TTY: 1-800-421-1220
- **Fallon Community Health Plan** 1-800-868-5200 TTY: 1-877-608-7677
- **Neighborhood Health Plan** 1-800-462-5449 TTY: 1-800-655-1761
- **Network Health** 1-888-257-1985 TTY: 617-888-391-5535
- **Primary Care Clinician (PCC) Plan** 1-800-841-2900 TTY: 1-800-497-4648
- **Massachusetts Behavioral Health Partnership** 1-800-495-0086 TTY: 617-790-4130

Section 2
Department of Mental Health Protocols

DRAFT

STRATEGIC OVERVIEW
And
DMH PROTOCOLS

June 18, 2009

Strategic Opportunities for the Department of Mental Health

The Children's Behavioral Health Initiative (CBHI) is a collaborative of EOHHS child-serving agencies chaired by the Commissioner of the Department of Mental Health to create an integrated system of care for children's behavioral health in Massachusetts.

The Department of Mental Health (DMH) views the CBHI as a unique opportunity to 1) expand and integrate the array of services for youth with mental health needs and their families in the Commonwealth; 2) develop new approaches to serving these youth and their families; and 3) lay the groundwork for a future seamless delivery system across public and private payers. The protocols described below identify how DMH will interact with the new MassHealth behavioral health services.

CBHI affords DMH the opportunity to expand its role in serving children, youth and families and to build the capacity of the overall system. As the lead voice in policy design, planning and standard setting for serious mental health issues for children, youth, young adults and families, the Department of Mental Health will focus in the coming years on the following strategic priorities:

- **Ensure continuity of care for children, adolescents and young adults with serious mental health needs**

  1. Promote community tenure for youth with serious mental health problems by providing ongoing services and supports for:

     - Youth with long-term mental health needs who no longer qualify for Intensive Care Coordination or other MassHealth services, but who need one or more services to sustain their tenure in the community, such as case management or flexible community supports.
     - Youth with long-term, significant mental health needs and their families for whom Intensive Care Coordination or other MassHealth services are not a good match but whose needs may be met through a different array of services and supports.
     - Youth and families who are not eligible for MassHealth services and whose needs cannot be met through insurance or other public services.

  2. Provide services and supports to parents and caregivers with serious mental health problems and their children, so that the family unit can remain intact and children can remain in their homes and community
  3. Maintain and expand an infrastructure which provides support to all families and caregivers of children with serious mental health needs, regardless of insurance or DMH status, so that they can more easily manage the strenuous demands of keeping the child at home and in the community.
  4. Continue to provide an array of community services including after school, respite and flexible supports which are not reimbursable by Medicaid or private insurance.
  5. Expand community-based partnerships which model best practice for supporting transition-aged youth and young adults with serious mental health issues.
  6. Provide state-of-the-art residential and continuing care inpatient services which link with a community care plan to minimize the duration of out-of-home placement.

7. Provide leadership in partnering with private health plans in Massachusetts to expand the array of services covered by health insurance

- **Serve as a hub for cutting edge research in the field of community-based practice, along with high quality training and peer-learning.**

1. Develop and implement a Children's Behavioral Health Research and Training Center which guides the direction and practice of behavioral health intervention and treatment with children and families served by the public and private sectors.
2. Support the implementation of evidence-based and promising practices in a range of treatment settings.
3. Utilizing best practices, support interventions across HHS agencies which reduce health care disparities in access and engagement.
4. Identify workforce needs across disciplines and establish linkages with professional schools and associations re: curriculum development and recruitment strategies.
5. Measure outcomes of the public children's behavioral health system and assure the design and development of quality management and improvement approaches.
6. Develop standards for children's behavioral health services across the continuum of care and across state agencies and monitor their implementation.
7. Implement child and family behavioral health training for EOHHS agencies and Department of Early Education and Care (DEEC).

- **Community and Systems Consultation, Education and Health Promotion**

1. Provide clinical and programmatic consultation to state child serving agencies to improve the identification and treatment of youth with serious mental health issues.
2. Implement Early Identification initiatives which can impact the trajectory of a youth's mental illness.
3. Secure federal and private funding to implement state of the art strategies for prevention and treatment, including public education and awareness campaigns.
4. Partner with Department of Early Education and Care (DEEC) to expand pilots linking preschools with mental health consultation.

DMH Protocols for Accessing and Coordinating with MassHealth Behavioral Health Services

Helping MassHealth-Eligible Youth Access Community-Based Behavioral Health Services

DMH staff will support youth and families access MassHealth behavioral health services in different ways, depending upon their current relationship with DMH:

1. Callers previously unknown to DMH seeking services
2. Applicants submitting written applications for DMH services
3. MassHealth-enrolled youth currently receiving DMH services

1. **For Callers previously unknown to DMH seeking services** (including those contacting DMH for services for themselves or individuals calling on their behalf). The DMH staff first determine what information or services the caller is seeking, including whether there is an individual in psychiatric crisis. DMH staff will direct the caller to appropriate resources available through MassHealth, commercial insurance, DMH, and/or community agencies and organizations, including emergency services if necessary.

   For MassHealth-enrolled youth:

   - **If the caller indicates that the youth is experiencing a psychiatric crisis**, the caller will be directed to the Emergency Services Program for Mobile Crisis Intervention services, with DMH providing assistance as needed.
   - **If the youth already has an outpatient clinician or psychiatrist,** the DMH staff will share information about the array of MassHealth services as well as DMH services and encourage the caller to have the consenting youth or Legally Authorized Representative (LAR) confer with the youth's outpatient clinician or psychiatrist.
   - **If the youth does not have a history of receiving behavioral health services,** the DMH staff will typically begin by suggesting that the youth or family set up an appointment with an outpatient clinician for a diagnostic behavioral health assessment and a discussion of service options. The DMH staff may also suggest that the youth and family consult with the youth's Primary Care Clinician to ascertain if there are medical conditions causing or contributing to the youth's problem.
   - **If the youth has a history of significant behavioral health needs or significant trauma, but does not currently have an outpatient clinician or psychiatrist,** the DMH staff will share information with the caller about MassHealth behavioral health services that might meet the youth's need for assessment and services. The DMH staff will provide the individual with contact information for the core services, outpatient, In-Home Therapy and Intensive Care Coordination. These services will conduct an assessment and make appropriate referrals. For guidance to DMH staff, Medical Necessity Criteria, including service descriptions for all new services can be found in Appendix C. Lists of providers for each service by region are included in Appendix A.

- **If a youth or LAR knows that s/he is are interested in receiving Intensive Care Coordination or In-Home Therapy services**, the consenting youth or family may go directly to a local Community Service Agency for ICC or In-Home Therapy provider to receive a behavioral health assessment and determination of medical need for the service. The DMH staff will assist the youth or LAR in identifying the service providers in their area. (See Appendix A for provider lists.)

For youth with no insurance, or without coverage for the mental health services sought:

- If the youth may be eligible for MassHealth, the caller will be directed to the local MassHealth Customer Service Center at 1-800-841-2900.
- If the caller believes the youth may be disabled and eligible for SSI, the caller will be informed about simultaneously filing an application for SSI. An application for SSI can be initiated through the Social Security Administration's Field offices, or by calling the SSA National Teleservice Line at 1-800-772-1213.

2. For DMH Applicants (individuals submitting written applications for DMH services)

As part of the DMH application process, the DMH Eligibility Determination Specialist contacts the consenting youth or LAR to assess whether current medical entitlements and or insurance are available and sufficient to provide for the needs of the youth for whom services are being sought.

If the youth is enrolled in MassHealth:

- DMH Eligibility Determination Specialist will provide the DMH Applicant with information about those MassHealth services that might meet the youth's need for assessment and or services. Medical Necessity Criteria, including service descriptions for all new services can be found in Appendix C.
- The DMH Eligibility Determination Specialist will provide the applicant with contact information for each of the potentially relevant providers serving the youth's community. A list of providers for each service by region are identified in Appendix A.
- If the youth or LAR intends to seek Intensive Care Coordination services, the Eligibility Determination Specialist will inform the individual that if an ICC Care Planning Team recommends a Child-Adolescent DMH service as an option to meet a goal on the Individual Care Plan, the recommended service may be applied for directly through the DMH liaison assigned to the CSA. Access to such services, either directly through DMH or through the CSA, is subject to DMH's determination that the youth meets DMH's clinical criteria, the clinical appropriateness of the service, priority and availability, in accordance with DMH service application regulations.
- If the youth or LAR is not interested in participating in MassHealth Intensive Care Coordination, but is interested in receiving DMH services in conjunction with MassHealth behavioral health services, s/he must complete the DMH application process.
- Access to all DMH adult community based services (available at age 18) will require the DMH application.

- All MassHealth enrolled youth and families will be informed about Mobile Crisis services during the application process.

If the youth has MassHealth in addition to private insurance:

- As of July 1, 2009, MassHealth-covered behavioral health services that are medically necessary but that are not covered by the youth's primary health insurer will be provided through MassHealth Behavioral Health Partnership (MBHP). Other MassHealth benefits will continue on a fee-for-service basis. Members affected by this change will receive a letter from MassHealth telling them that they have been enrolled in MBHP, as well as a booklet explaining their behavioral health benefits.
- The process for accessing MassHealth and DMH services for such youth will be the same as above.

If the youth is not insured or has no coverage for mental health services, and if the youth may be eligible for MassHealth:

- DMH will continue the DMH application process, and simultaneously refer the youth or LAR to the local MassHealth Enrollment Center at 1-800-841-2900.
- If the youth might be considered disabled as a result of his/her physical or behavioral health problems, the DMH Eligibility Determination Specialist will advise that the Disability section of the MassHealth application be completed.
- The applicant will also be advised about simultaneously filing an application for SSI. An application for SSI can be initiated through the Social Security Administration's Field offices, or by calling the SSA National Teleservice Line at 1-800-772-1213.

3. MassHealth-Enrolled DMH Clients

- **For any DMH-enrolled youth being referred to any MassHealth services,** DMH and its providers will seek written authorization to discuss the youth's situation with relevant MassHealth providers and to provide records and participate in joint planning activities as necessary to assist in the transition to MassHealth services.
- **If the youth has a DMH Crisis Plan**, such plan will include information about what should trigger a call to Mobile Crisis Intervention. If a youth or family calls DMH first, DMH staff can support the youth family in making this call.
- **If DMH is contacted concerning a MassHealth-enrolled youth having a behavioral health crisis**, the youth, LAR or family will be urged to call the ESP/ Mobile Crisis Intervention service in their area. The DMH staff will have the number of the local ESP/Mobile Crisis Intervention provider available, and will assist in making this call if s/he is requested to do so.
    - If the youth is in a community residential treatment program, the program staff will be directed to contact the ESP/Mobile Crisis Intervention Service directly.
    - If the youth is receiving DMH case management, the DMH case manager will continue to be involved with any youth referred to mobile crisis services, will participate in all crisis planning meetings, may convene an ISP meeting to review

the youth's ISP, and will follow up if additional or different support services are needed.

- **If the youth is currently receiving DMH case management,** the DMH case manager will inform the youth or LAR about Intensive Care Coordination and offer the option to transfer to that service or remain with DMH case management. For such youth who receive MassHealth services other than ICC, the DMH case manager will coordinate these services consistent with the youth's DMH Individual Service Plan (ISP)

- **If the youth is living in the community and receives DMH services other than case management,** and DMH or program staff responsible for reviewing client progress identify a MassHealth service(s) that can assist the youth to meet his/her goals and objectives, they will inform the youth or LAR about those services

- **If the youth is being discharged from DMH residential out-of-home placement, IRTP, or continuing care inpatient services to a community setting:**
    - As part of the discharge planning process, DMH staff will seek to ascertain what the youth's MassHealth enrollment status will be subsequent to discharge, and will support the youth or LAR in securing MassHealth coverage for community-based services, such as applying for MassHealth.
    - If the youth will not have coverage in the community, and might be considered disabled as a result of his/her physical or behavioral health problems, the DMH staff will advise that the Disability section of the MassHealth application be completed.
    - The core element of discharge planning from DMH residential or inpatient services involves discussion of the youth's ongoing needs and the options available to meet those needs. As part of the discussion, the DMH case manager assigned to the youth or to the program will share with the youth or LAR the options for care coordination and other MassHealth behavioral health services in the community. With authorization, the DMH case manager will refer to the behavioral health service selected, and the program will forward requested clinical information and treatment summaries.
    - In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC may be made up to 180 days, but in any case 90 days, prior to a planned discharge. For youth enrolled in ICC, post-discharge care planning will begin no later than 60 days prior to discharge.
    - The DMH-funded inpatient or residential provider is responsible for inviting the ICC to program discharge planning meetings. In addition, they will assist the ICC care coordinator in arranging meetings with the youth, family and/or Care Planning Team at the residential program site. At the time of discharge, the youth and families will be informed about the availability of Mobile Crisis Intervention in the community. DMH will amend its contracts with DMH-funded providers (including continuing care inpatient, IRTP and DMH residential) to clarify expectations regarding this responsibility.
    - Mobile Crisis Intervention is not used by CIRT, IRTP or continuing care inpatient programs as they have access to their own clinical staff at all times.

Expected MassHealth Provider Response to Referrals of DMH Clients

For Referrals to Intensive Care Coordination

- Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the youth or LAR to offer a face-to-face interview.
- The ICC provider must offer a face-to-face interview with the youth and/or family within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
- The comprehensive home-based assessment inclusive of the CANS must be completed within 10 calendar days of the date on which consent for ICC was obtained.
- The ICC care coordinator and DMH referral source will be expected to confer to discuss the reason for referral (with proper consent as required by law) as part of the comprehensive home-based assessment process. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure youth or LAR authorization and to convey it by fax, mail or hand delivery to DMH and the providers with whom they want to speak.
- The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the youth or LAR's consent to participate in ICC.

For Referrals to In-Home Therapy

- The In-Home Therapy provider responds telephonically to all referrals within one business day.
- During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.

General

- If the child or youth does not meet the requirements of the service, or if the youth and family do not wish to participate, the behavioral health provider is expected to provide a referral to other services, as appropriate.

Ensuring Continuity of Care

For youth leaving a DMH out-of-home residential or inpatient program when the youth or LAR has authorized a referral to ICC or In-Home Therapy:

- DMH staff responsible for monitoring utilization of community residential, IRTP, or inpatient programs will ensure that the DMH-contracted provider invites the designated ICC or In-Home Therapy provider to discharge planning meetings and that a minimum of one transition-planning meeting takes place prior to discharge.
- For youth in IRTP or DMH Inpatient programs, the updated CANS completed by the Child/Adolescent residential program clinician will inform the transition to non-residential services. The clinician will provide a printed copy of the CANS to the ICC, In-Home Therapy staff or other MassHealth provider as appropriate. The CANS should be reviewed as part of the discharge planning process.

- DMH-funded residential or inpatient staff responsible for discharge planning will participate in any onsite Care Planning Team meeting (ICC) or treatment planning meeting (for In-Home Therapy) for the purpose of transition to a community setting.
- For youth receiving DMH case management (and not ICC), the DMH case manager will be responsible for coordinating all services, including MassHealth services, identified in the youth's DMH ISP.

For Youth Leaving ICC with a referral to DMH services.

- If ICC and MassHealth community-based services cannot adequately address the youth's needs, (either because the youth has completed ICC service and needs long-term maintenance case management support, or because the youth or LAR determine that ICC is not an appropriate match), the CSA may make a referral to DMH for child adolescent case management or other services. The DMH liaison will provide the CSA program director with information on the type of documentation needed by DMH to complete the DMH service application process. The DMH liaison will initiate the service authorization process within DMH, and inform the CSA of the outcome of the DMH service application. If the youth is accepted, the liaison will facilitate the transition from ICC to DMH services.
- If the referral is for a youth age 18 or older (MassHealth-enrolled youth may remain enrolled in ICC, or other behavioral health services, until their 21st birthday) the DMH liaison will be contacted by CSA program director who will provide information on the youth's needs. The DMH liaison will brief the DMH adult services staff and assure telephone contact between the youth's care coordinator and the adult specialist within 2 days, to discuss the appropriateness of the referral and needed documentation. If the youth meets the criteria for DMH services, the Liaison will participate in discussion with DMH adult staff and the CSA representative about the most effective way to structure services for the particular youth including assessing the potential roles for the ICC, DMH staff, and the DMH provider.

For a youth in ICC who is admitted to a DMH-funded out-of-home residential or inpatient program.

- If a youth is accepted into DMH-funded residential or inpatient stay is expected to last less than 180 days, the ICC Care Planning Team may continue to meet to plan the youth's transition back to the community. DMH Area staff responsible for residential and inpatient utilization management will invite the ICC care coordinator to participate in pre-admission, service planning, progress review, and discharge planning meetings to facilitate the youth's transition back into the community.
- If a residential or inpatient stay is expected to last more than 180 days, involvement in ICC will end upon the youth's admission. However, prior to admission there will be at least one meeting between appropriate DMH Area and program staff and the ICC Care Planning Team which will include transition and other preadmission planning as well as anticipated issues for discharge planning. If the youth or LAR wishes to receive ICC upon discharge, a new request for ICC services must be made as part of the discharge planning process. If the youth or LAR requests to work with the same Care Coordinator or Family Partner, the Community Service Agency will make reasonable efforts to assign the requested staff. In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC may be made up to 180 days, but in any case 90 days, prior to a planned

discharge. For youth enrolled in ICC, post-discharge care planning will begin no later than 60 days prior to discharge.

For MassHealth Youth Transitioning from DMH Case Management To ICC:

- DMH case managers will be available to participate in transition activities with proper authorization from the youth or LAR. Activities include but are not limited to: record sharing; provision of telephone consultation; and attending care planning meetings during the transition period as necessary.

Partnering With Community Service Agencies (CSAs) Providing Intensive Care Coordination (ICC)

Establishing a DMH/CSA Collaborative Relationship:

The Area Directors or designee will establish a working relationship with the director of the Community Service Agency (CSA) in their areas to facilitate collaboration for families served by both agencies. If a Specialized CSA also serves their area, the Area Director or designee will also establish a working relationship with the Specialized CSA. Area Directors or designee are encouraged to meet quarterly with CSA directors.

DMH Liaisons to Each CSA

DMH has designated a DMH liaison to each of the CSAs. This DMH CSA liaison will have several roles including but not limited to:

- Link inquiring families and inquiring providers to the CSA
- Distribute information to pediatric practices, schools and pre-school programs in their designated geographic area about the CSA and other services as requested.
- Educate CSA staff about DMH services, including clinical criteria for different age groups and service specific authorization criteria.
- Authorize access to DMH community resources as available for youth in ICC who meet the DMH service criteria.
- Provide individuals with information about appeals processes for DMH service denials.
- Facilitate the DMH service application process, if appropriate, for youth whose needs cannot be adequately addressed through ICC and MassHealth community-based services and who are seeking either DMH case management or residential services.
- Consult to Care Planning Teams about planning and strategies for assisting families where there is a caretaker with mental illness.
- Provide information to adult caretakers with mental illness about the DMH adult service system and assist in service applications
- Communicate regularly with the DMH appointed designee to the local System of Care Committee.

- Provide assistance to youth and families whose MassHealth entitlement is ending in accessing DMH or other community services

DMH's Role In Individual ICC Care Planning Teams

Because youth are not expected to simultaneously receive DMH case management and Intensive Care Coordination except during the transition from out-of-home placement, DMH staff will not ordinarily serve as ongoing members of individual ICC care planning teams. Rather, working through the CSA program director, the DMH staff liaison will serve as a resource to all Care Planning Teams within the CSA, providing resource linkages and access to DMH services as available and necessary. DMH staff may attend care planning teams during transition to CC or otherwise, upon request and as their time permits. DMH contracted providers delivering services to ICC youth shall participate in the youth's care planning team, with consent of the youth or LAR.

Trainings to Promote Collaboration

- **Training of DMH staff:** All DMH Site and Area managers and relevant staff will receive training in Wraparound and the details of these protocols. The purpose of the Wraparound training is to provide an understanding of the process of collaborative care planning and the various roles of DMH staff with respect to this process.
- **CSA Training:** CSA Directors, Care Coordinators and Family Partners will receive training in the following: DMH clinical criteria for children/adolescent and for adults; the service authorization process including criteria for enrollment in specific services; the array of DMH funded services for children, adolescents, transition age youth and adults; and the roles that DMH and its providers are expected to play for youth and families served through ICC.

DMH Participation In The Local System of Care Committee

The DMH Area Director will designate staff to represent DMH at each of the local System of Care Committees.

When issues arise within a local System of Care Committee of concern to the DMH representative, the representative will bring it back to the DMH Director of Child/Adolescent Services and, as appropriate, to the DMH Site Director, DMH Area Director and/or the DMH representative on the CBHI interagency team at the State level.

Section 3
Appendices

Appendix A:

Provider Lists

These up-to-date lists can be accessed in the following location:

www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers

Appendix B:

Medical Necessity Criteria

Intensive Care Coordination
In Home Therapy Services
Mobile Crisis Intervention
Family Support and Training
In Home Behavioral Services
Therapeutic Mentoring Services

These can be accessed in the following location:

www.masspartnership.com < CBHI Information < Medical Necessity Criteria for CBHI Services

Appendix C:

Description of DMH Community Liaison and System Specialist

DMH Community Liaison and Systems Specialist

Each DMH Area will assign a Case Management Supervisor or an Eligibility Determination Specialist to serve as a liaison to each of the 32 Community Service Agencies (CSA) within the Area. CSAs are private agencies contracted by the Medicaid managed care entities to provide Intensive Care Coordination as part of the Rosie D remedy. The key functions assumed by the DMH staff liaison are to serve as a source of information about DMH services and child/adolescent mental health, and to provide interface between the CSA and DMH.

The following are expectations of the Liaison in regard to the CSAs:

1. Introduce him/herself in person to each of the CSA directors and the supervisors of the Intensive Care Coordinators (ICC); explain the role of the DMH Liaison and the structure of DMH services for children/adolescents (C/A), transition age youth (TAY) and adults.
2. Provide or arrange for the CSA and Care Planning Teams(CPT) to receive training and materials on the following
    - DMH clinical criteria for children/adolescents and adults
    - Service array and service authorization criteria for services available to children, adolescents, transition age youth (TAY) , adults and families
    - DMH requirements related to confidentiality and release of information
3. Facilitate access to DMH child/adolescent and adult services as needed
    - The Liaison will be the main point of contact between the CSA and DMH. The CSA director or ICC supervisor (s) will contact the Liaison about any youth or family who the CSA believes to need DMH child/adolescent or adult services.
    - Consultation.
        1. DMH Liaison may consult to the ICC supervisor, and, when necessary and as time permits, to the ICCs and Care Planning Teams about other ways of meeting the youth and family's needs without a referral to DMH.
        2. The Liaison will arrange for consultation from other DMH staff, e.g. adult case manager supervisors, regarding particular issues, such as service planning for families where the caretaker has a mental illness
        3. The Liaison will provide information/consultation about community resource options for youth with SED, how to access such services; and how to work with service providers to mainstream youth with SED.
    - Linkage to DMH services

      The CSA director will initiate contact with the Liaison regarding potential referrals to DMH of CSA-involved youth or their family members.

        1. If non- residential Child/Adolescent (C/A) services are being sought to supplement ICC and the MassHealth services, the Liaison will ascertain the availability of the requested service, authorize enrollment if there are vacancies in child/adolescent non-residential programs, or inform CSA when an opening is expected to be available.
        2. If referral to DMH Child/Adolescent services is being sought because the CSA thinks that ICC and the MassHealth community based services cannot adequately address the youth's needs, the Liaison will inform the CSA of the type of documentation needed by DMH, initiate the service authorization process within

DMH, and inform the CSA of the outcome of the DMH service application. If the youth is accepted for DMH service, the liaison will facilitate the transition from ICC to DMH services.

3. If the referral is for a youth age 18 or older, the Liaison will review options available within the DMH Community Based Flexible Support Services contracts, help clarify what is being sought, brief the DMH Area Adult Application Specialist and assure telephone contact between the CSA and the Adult Specialist within 2 days, to discuss the appropriateness of the referral and needed documentation. If the youth meets the criteria for DMH services, the Liaison will participate in discussion with DMH adult staff and the CSA representative about the most effective way to structure services for the particular youth, including assessing the potential roles for the ICC, the DMH provider, and/or DMH case management.
4. If the referral is for an adult caretaker willing to apply for DMH services, the Liaison will assure telephone contact between the CSA and the Adult Specialist within 2 days. If the caretaker is DCF involved, DMH will offer services for up to 60 days pending a decision about service authorization.
5. If a youth is losing MassHealth entitlement for any reason, the CSA will discuss the youth and family's ongoing service needs with the Liaison. The Liaison will assist in identifying appropriate resources that can provide care continuity in the community for the youth and family

4. Provide feedback to the CSA regarding the treatment and progress of individuals receiving both ICC and DMH services
    - Given appropriate authorization, the Liaison and the CSA will use a standardized protocol to update each other, on a regular basis, regarding individual progress and salient issues.
5. Provide information to the public about CSA's
    - The Liaison with distribute materials describing the CSA and MassHealth Services in the course of providing information to the public and to professionals about the range of local mental health services.
    - DMH will provide information about the CSA's to callers and applicants requesting information and will provide them with contact information for the CSA.

Appendix D:

Community Liaison Directory

Department of Mental Health Community Liaison Directory

Organization Name	Service Area	Liaison	Contact Number
The Home for Little Wanderers	Park Street	Mel Stoler	617-626-8975
MSPCC	Dimock Street	Chris Donovan	617-626-8749
The Home for Little Wanderers	Hyde Park	Mel Stoler	617-626-8975
North Suffolk Mental Health Association	Harbor Area	Karen Vaters	617-626-8966
Children's Friend & Family Services	Lawrence	Marianne Vesey	978-738-4539
MSPCC	Lowell	Jim Farren	978-322-5017
Children's Friend & Family Services	Lynn	Sue Kingston	781-477-8212
Health & Education Services	Salem/Cape Ann	Sandy Cormier	978-232-7307
Health & Education Services	Haverhill	Fred Knowles	978-738-4517
Community Counseling of Bristol County, Inc.	Attleboro	Holly Calamese-Grazette	508-897-2056
BAMSI	Brockton	Laura Krim	508-897-2197
Family Services of Greater Fall River	Fall River	Lorna Ketin	508-235-7297
Bay State Community Services	Plymouth	Paul D'Espinosa	508-732-3006
Justice Resource Institute	Cape and Islands	Kristine Monteiro	508-957-0906
Child and Family Services, Inc.	New Bedford	Dawn Nickerson	508-996-7921
Community Healthlink	North Central	Patricia Surette	508-368-3616
Y.O.U. Inc	South Central/Blackstone Valley	Patricia Surette	508-368-3616
Community Healthlink	Worcester East	Rasa Chiras	508-368-3386
Community Healthlink	Worcester West	Rasa Chiras	508-368-3386
Wayside Youth & Family Support Network	Framingham	Meagan Belton	508-616-2197
Bay State Community Services	Coastal	Linda Stanton	617-626-9035
Riverside Community Care	Arlington	Allen Bachrach	781-641-8116
Guidance Center Inc.	Cambridge	Bill Foreman	617-626-8971
Eliot Community Human Services	Malden	Linda Richards	781-224-7915
Clinical & Support Options	Greenfield/Northampton	Julianne Cole	413-587-6485
Brien Center for Mental Health and Substance Abuse Services	Pittsfield	Kathy Casella	413-395-2007
Carson Center for Human Services Inc.	Holyoke	Denise Hurst	413-493-8009
Behavioral Health Network	Robert Van Wart	Denise Hurst	413-493-8009
Behavioral Health Network	Springfield	Denise Hurst	413-493-8009
Gandara Center - Hispanic	Springfield/Holyoke	Denise Hurst	413-493-8009
Children's Services of Roxbury-African American	Boston	Karen Vaters	617-626-8966
The Learning Center for the Deaf, Walden School- Deaf and Hard of Hearing	Statewide with focus on Metropolitan Boston	TBD- in process	

Email addresses are: First-name.Last-name@Massmail.state.ma.us

Appendix E:

Notice to Parents/Caregivers on New MassHealth Services

This can be accessed in the following location:

www.masspartnership.com < CBHI Information < CBHI Member Notice

Appendix F:

Intensive Care Coordination (ICC) and Family Support and Training Briefing Guide

This is the ICC Operations Manual, which can be accessed in the secure CSA Working Documents section of www.masspartnership.com

Department of Public Health

Guide to New and Current MassHealth Behavioral Health Services & Bureau of Substance Abuse Services Protocols

Table of Contents

Section 1
MassHealth: New and Current Services

I. The Children's Behavioral Health Initiative (CBHI)

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

The Children's Behavioral Health Initiative is defined by a shared commitment to providing services to families that reflect the following values:

- **Family Driven, Child-Centered and Youth Guided**
  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
- **Culturally Responsive**
  Services are responsive to the family's values, beliefs, norms, and to the socio-economic and cultural context.
- **Collaborative and Integrated**
  Services are integrated across child-serving agencies and programs.
- **Continuously Improving**
  Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence and best practice.

The Initiative places the family and child at the center of our service delivery system, and will build an integrated system of behavioral health services that meets the individual needs of the child and family. The goal is to make it easier for families to find and access appropriate services and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

For more information visit: www.mass.gov/masshealth/childbehavioralhealth

II. MassHealth: New and Current Services

MassHealth pays for many important health care services for a wide range of people who meet the eligibility rules. During 2009, MassHealth will significantly expand behavioral health services available to its MassHealth Standard and CommonHealth members under the age of 21 by paying for six new home and community-based services. The goal of these services is to help children and youth with significant behavioral, emotional and mental health needs achieve success in home, school and community.

These services have been designed, and are being implemented according to Children's Behavioral Health Initiative Values:

- **Family Driven, Child-Centered and Youth Guided**
- **Strengths-based**
- **Culturally Responsive**
- **Collaborative and Integrated**
- **Continuously Improving**

These new services *complement* the behavioral health services currently available to MassHealth Standard and CommonHealth members under the age of 21. Below, you will find brief descriptions of the *new* services, and of the *current community-based* MassHealth Behavioral Health Services.

NOTE: These new services are NOT for the treatment of the behavioral health needs of a youth's parents or caregivers. Behavioral Health services for parents or caregivers should be sought through their health care insurer, or MassHealth, if they are eligible.

New MassHealth Community-Based Behavioral Health Services

What follows are brief descriptions of the new services, with some suggestions of who might benefit from each of the new services.

This information is intended to provide staff with guidance on how to help families and youth to access appropriate MassHealth behavioral health services. It is important to note that MassHealth members may also self-refer to any behavioral health service they think might be helpful. Families and youth are always welcome to inquire with a provider about a particular service.

This guidance is intended to be informative and to illustrate the potential usefulness of each service. It does NOT replace the Medical Necessity Criteria, attached in Appendix B. Providers of each of the services will use the Medical Necessity Criteria (MNC) to evaluate whether the child or youth has a medical need for the service. Medical Necessity decisions made by providers may be reviewed by the child's or youth's MassHealth Managed Care Plan.

A. Standardized Behavioral Health *Screening* in Primary Care

As part of well-child visits, the primary care doctor or nurse checks the child's or youth's health, development, need for immunizations, dental health and behavioral health. MassHealth now

requires primary care doctors or nurses to offer to use a behavioral health screening tool to check the child's or youth's behavioral health. There are eight approved screening tools. They typically consist of a short list of questions, or a checklist, that the parent, caregiver or youth fills out and then talks about with the primary care doctor or nurse. The screening tool helps to spot concerns early so problems can be found and helped earlier. If there are concerns about a child's or youth's behavioral health, the primary care doctor or nurse will work with the parent/caregiver or youth to decide if a referral to a behavioral health provider for further assessment and treatment is needed, and can help the parent/caregiver/youth get needed services.

B. Standardized Behavioral Health *Assessment*, using the Child Adolescent Needs and Strengths tool (CANS)

Beginning November 30, 2008, MassHealth began requiring a uniform behavioral health assessment process for MassHealth members under the age of 21 receiving behavioral health services. The uniform behavioral health assessment process includes a comprehensive needs assessment using the Child and Adolescent Needs and Strengths (CANS) tool.

The CANS is a tool that organizes clinical information collected during a behavioral health assessment in a consistent manner, to improve communication among those involved in planning care for a child or youth. The CANS is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. The CANS is used in child and youth serving systems in more than 30 states. There are two forms of the Massachusetts CANS: CANS Birth through Four and CANS Five through Twenty. Both versions include questions that enable the assessor to determine whether a child meets the criteria for Serious Emotional Disturbance (SED), in addition to the CANS assessment questions. (Meeting the definition of SED is a component of the Medical Necessity Criteria for the new service Intensive Care Coordination.)

C. Intensive Care Coordination (starting June 30, 2009)

ICC is a care coordination service for children and youth with serious emotional disturbance (For definitions of Serious Emotional Disturbance, see ICC Medical Necessity Criteria, Appendix B). ICC will use a model called *Wraparound Care Planning*. In Wraparound Care Planning, families and youth work together with professionals, talk about their strengths and needs, and actively guide their own care. In ICC, a team leader, called a Care Coordinator, helps families bring together a team of people to create a child's treatment 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 part of the team. Together, the team comes up with ways to support the family's goals for the child (or youth's goals, in the case of an older child), creating an Individual Care Plan. This plan, which also focuses on the family's strengths and respects their cultural preferences, lists all the 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 all providers and state agencies to integrate services.

The Care Planning Team will usually meet monthly and sometimes more often for children and youth with more complex needs. At these meetings the family, youth and other team members

can talk about progress, work to solve problems, and make any needed changes to the Individual Care Plan.

Additionally the ICC care planning team seeks to:

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

Who is likely to need ICC?

Children and families who need or receive services from multiple providers or who need or receive services from multiple state agencies, including special education. ICC can help prioritize goals and monitor progress, ensuring that interventions being used are effective and coordinated. ICC can also address needs other than behavioral health needs, such as connecting families with a variety of sustainable supports. Examples of sustainable supports include recreational activities for the child or youth, connection to mentors and opportunities for mutual support and social interaction with other families.

Who may benefit from referral to a different service?

- *A child or youth in acute emotional, behavioral or mental health crisis. Consider referring instead to Mobile Crisis Intervention* for immediate stabilization and support.
- *Family of a child or youth with a single service need who does not need a Care Planning Team to coordinate services:* Consider referring instead to the service(s) that may be needed.
- *A family in too much immediate distress to participate in the team-based sequence of steps of the Wraparound process.* Consider referring first to another behavioral health service such as Family Stabilization Teams (until November 1, 2009) or In-home Therapy (available November 1 2009, during which the need for other services including ICC will be assessed).

How do I make a referral?

See the list of Community Service Agencies in Appendix A.

Geographically-Based CSAs: MassHealth's Managed Care Contractors have selected 29 Community Service Agencies (CSAs), one for each of 29 service areas. The service areas correspond to the Areas of the Department of Children and Families.

Culturally and Linguistically Specialized CSAs: MassHealth's Managed Care Contractors have also selected 3 culturally and linguistically specialized CSAs. These CSAs were chosen for their demonstrated ability to reach deeply in to specific cultural or linguistic communities and tailor their services to engage and serve their specified populations. Like all CSAs, Specialized

CSAs are expected to serve any family seeking appropriate service without regard to race, ethnicity or language.

- Children's Services of Roxbury specializes in serving the African-American population in Greater Boston.
- The Gandara Center specializes in serving the Latino population in the Springfield/Holyoke area.
- The Learning Center for the Deaf, Walden School specializes in serving the Deaf and Hard of Hearing population, particularly in the eastern/central part of the state.

Families with children or youth enrolled in MassHealth are not required to choose a CSA in their area or a culturally or linguistically specialized CSA, but may choose to work with any CSA.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

D. In-Home Therapy (starting November 1, 2009)

In-Home Therapy Services provides intensive family therapy for a child and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. In-Home Therapy Services are provided in the home or other location which is appropriate and convenient to the family. It is provided by a skilled behavioral health provider who may work in a team with a paraprofessional. In-Home Therapy providers work to understand how the family functions together and how these relationships can be strengthened to benefit the child. Together with the child and family, they create and implement a treatment plan. Goals in a treatment plan might include helping the family identify and use community resources, learn to more effectively set limits and establish helpful routines for their child, problem-solve difficult situations or change family behavior patterns that get in the way of their child's success. Note: Parents may also have individual behavioral health needs that may require separate behavioral health treatment.

Who is likely to need In-Home Therapy?

- ***Families in need of more urgent or intensive help with a youth's emotional and behavioral challenges than could be addressed through outpatient therapy.***
- ***Families that have identified their primary need as learning new ways to relate to one another, or new ways to set limits or regulate child behavior, or who have tried outpatient therapy but not found it effective.*** **IHT offers more flexibility than outpatient therapy, not only in intensity but in treatment setting. Therapeutic intervention in a natural environment can offer opportunities for understanding behavior and for rehearsing new strategies which are not available in a clinic environment.**

Who may benefit from referral to a different behavioral health service?

- ***A child or youth in acute crisis.*** **Consider referral to Mobile Crisis intervention.**

- ***Children and families with needs involving multiple providers or state agencies.*** **Consider referral to ICC.**
- ***A child with a disorder that can benefit from outpatient individual or family treatment.***

How do I make a referral?

Referrals can be made directly to the In-Home provider or the child may access In-Home therapy through ICC or outpatient therapy.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

For a list of the common network of In-Home providers selected by all MassHealth's Managed Care entities, see Appendix A. For additional providers selected for MBHP's "extended network", also see Appendix A. The most up-to-date information on the In-Home Therapy provider network can also be found on the website of the appropriate MassHealth Managed Care entity or by calling the Managed Care entity.

E. Mobile Crisis Intervention (starting June 30, 2009)

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 72 hours of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Who is likely to benefit?

A child with MassHealth who is in a behavioral health crisis and who is likely, without intervention, to escalate in a way that would pose a risk of harm to themselves or others. If in doubt, call the Mobile Crisis Intervention team and consult with the team on whether they should intervene.

Who may benefit from a different service?

If a child is in treatment he or she may have a Risk Management/Safety Plan which may identify other steps prior to calling Mobile Crisis.

Note that Mobile Crisis Intervention is only for a child/youth on MassHealth. A person who does not have MassHealth should be triaged through the 800 number on the back of the health insurance card or sent to the local emergency services program or hospital emergency room.

If the child/youth is an acute safety risk to self or others and the risk cannot be safely managed in the current setting, call 911.

How do I make a referral?

Mobile Crisis Intervention is provided by the Emergency Service Provider (ESP) in the region. See the list of ESPs in Appendix A.

F. Additional new MassHealth-covered services can be accessed through outpatient therapy, In-Home therapy or Intensive Care Coordination, as part of the youth's Individual Care Plan (ICP) or treatment plan (for Outpatient or In-Home Therapy).

- **Family Support and Training** *(Starting June 30, 2009)*

Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community.

Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.

In ICC, the care coordinator and Family Support and Training Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Support and Training Partner works one-on-one and maintains regular frequent contact the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/ caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Support and Training Partner educates parents/ caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the parent's/caregiver's access to these resources. Family Partners are offered to families as part of Intensive Care Coordination.

- ***In-Home Behavioral Health Services –*** Starting October 1, 2009

In-Home Behavioral Health Services offers valuable support to children and youth with challenging behaviors that get in the way of everyday life. Services are provided by a behavioral health provider, such as a therapist, who is skilled in understanding and treating difficult behaviors in children and youth. The provider works closely with the child and family to create a specific behavior plan to improve the child's functioning. The provider may also work as a team with a skilled paraprofessional called a behavioral management monitor. The monitor works with the child and family to implement the child's behavior plan. In-Home Behavioral Health Services can be provided in places where the child is located, including home, school, childcare centers and other community settings.

- ***Therapeutic Mentoring Services –*** Starting October 1, 2009

A therapeutic mentor works one-on-one with a child or youth who, because of their behavioral health needs, require support and coaching to learn social skills that will allow them to do well in typical, normative environments. These skills may include better ways of communicating with other children and adults, dealing with different opinions and getting along with others. The therapeutic mentor works with the child to achieve goals in a treatment plan written by an outpatient therapist, In-Home Therapy Services provider or Intensive Care Coordination (ICC) team. The mentor is supervised by a behavioral health clinician and can work with a child in his or her home, school, or other social and recreational setting.

For families and youth who may need or benefit from these services, social workers should consider facilitating a referral process with the out-patient provider, in-home therapist, or ICC team.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

G. Current MassHealth Community-Based Services (in addition to the New Services)

The following are other community-based (e.g. non-24 hour) behavioral health services that are available to youth enrolled in MassHealth. This is not meant to be an exhaustive list of available benefits but an overview of behavioral health services that are available in addition to the new MassHealth services described earlier in this document.

- **Outpatient Behavioral Health Services:** Outpatient services include individual, family, and group therapies, as well as medication evaluation and monitoring. Outpatient services can be provided in an office, clinic environment, a home, school, or other location. Outpatient services can be used to treat a variety of behavioral health and/or substance abuse issues that significantly interfere with functioning in at least one area of the youth's life (e.g., familial, social, occupational, educational). Outpatient is the least intensive level of care available to youth.
- **Community Support Programs (CSPs):** Provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals. CSP services are

appropriate for youth who have behavioral health issues challenging their optimal level of functioning in the home/community setting. These services are designed to be maximally flexible in supporting youth who are unable to independently access and sustain involvement with needed services. Services may include: assisting youth in enhancing their daily living skills; case management, skill building, developing a crisis plan; providing prevention and intervention; and fostering empowerment and recovery, including linkages to peer support and self-help groups. *NOTE: As of October 1, 2009, CSP for youth under 18 will be replaced by the new community based behavioral health services, described earlier in this document. Youth 18 through 20 will have access to both CSP services as well as the new community based behavioral health services.*

- **Structured Outpatient Addiction Program (SOAP):** SOAP is a short-term, clinically intensive, structured day and/or evening substance abuse service. SOAP can be used by youth, including pregnant youth, who need outpatient services, but who also need more structured treatment for substance abuse. SOAPs provide multidisciplinary treatment to address the sub-acute needs of youth with addiction and/or co-occurring disorders, while allowing them to maintain participation in the community, continue to work or attend school, and be part of family life.

- **Partial Hospitalization Program** is a nonresidential treatment program that may or may not 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.

How Do I Make a Referral?

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly.

To locate a provider for youth **NOT** enrolled in a MassHealth Managed Care Plan, please call: MassHealth Customer Service 1-800-841-2900: TTY: 1-800-497-4648.

For youth who **ARE** enrolled in a MassHealth Managed Care Plan, please call:

- **Boston Medical Center (BMC) HealthNet Plan** 1-888-566-0010 (English and other languages) 1-888-566-0012 (Spanish) TTY: 1-800-421-1220
- **Fallon Community Health Plan** 1-800-868-5200 TTY: 1-877-608-7677
- **Neighborhood Health Plan** 1-800-462-5449 TTY: 1-800-655-1761
- **Network Health** 1-888-257-1985 TTY: 617-888-391-5535
- **Primary Care Clinician (PCC) Plan** 1-800-841-2900 TTY: 1-800-497-4648
- **Massachusetts Behavioral Health Partnership** 1-800-495-0086 TTY: 617-790-4130

Section 2

DPH Bureau of Substance Abuse Services Protocols

Strategic Opportunities for the Department of Public Health and the Children's Behavioral Health Initiative

The Massachusetts Department of Public Health (DPH) has a strong focus on child wellbeing which requires incorporating a consideration of behavioral health into all of our child and youth serving programs. We recognize that effective coordination between DPH and other behavioral health programs and related agencies is a critical component to optimally serving children and their families.

To that end, DPH seeks to be an active partner with other state agencies in the effort to successfully implement the Children's Behavioral Health Initiative (CHBI). DPH endorses the following core principles as informing this partnership:

1. In its child and family serving programs, especially substance abuse services, school based health centers and Early Intervention (EI) programs, DPH will work for a robust collaboration with CHBI supported programs through:
   - Seamless referrals to mental health providers.
   - Integrated care planning, including discharge and transition planning, by substance abuse, school-based health centers, EI programs and mental health providers. Any care plan developed by one of these programs for a multiply involved child should be informed by the participation of and/or consultation with the other involved services.
   - Participation in the local systems of care committees.
2. DPH will promote collaborations between local community service agencies (CSA), substance abuse service and EI providers, as well as school based health centers.
3. DPH is committed to training our staff and that of our sponsored programs on the newly available behavioral health resources available through the Children's Behavioral Health Initiative to ensure optimal coordination. This training will include:
   - Introduction to the goals of the integrated, wraparound model;
   - Education about the protocols described in this document;
   - Information on screening, assessment and referral resources available;
   - A focus on collaborative care planning to ensure that roles, processes and expectations are clear.
4. DPH shares the goal of minimizing disruptive transitions for families experiencing behavioral health issues by having DPH sponsored programs provide information on the most appropriate services available to a family based on their specific situation.

DPH is committed to supporting the successful implementation of the Children's Behavioral Health Initiative and will work to ensure that these protocols are integrated into the work of our department and our supported agencies and programs.

DPH Protocols for the Children's Behavioral Health Initiative

Bureau of Substance Abuse Services (BSAS) *Adolescent, Young Adult and Family Programs*

Overview

DPH Bureau of Substance Abuse Services sponsors an array of substance abuse programs serving adolescents and young adults, as well as programs that serve families with children.

BSAS Office of Youth and Young Adult Services currently offers the following programs:

1. **Adolescent Outpatient Substance Abuse Providers:** Approximately 60 community based outpatient providers are approved to provide adolescent services (list in Appendix D). Providers bill to insurance, including MassHealth.
2. **Adolescent Detox./Stabilization Service**: This service provides youth in crisis with medical monitoring necessary to facilitate stabilization of their physical and emotional states. Once stabilized, the adolescent receives a comprehensive biopsychosocial assessment of substance use, social, emotional, behavioral and mental health status and needs; treatment planning; referral to appropriate treatment and support services. These services are for males and females between the ages of 13 and 17. There are currently two 24 bed units open. This service bills to insurance, including MassHealth. DPH is the "payer" of last resort.
3. **Adolescent Residential Treatment:** There are currently five gender-specific residential programs (three male and two female). These are short-term substance abuse treatment services for medically stable youth between the ages of 13 and 17. Length of stay in the programs varies based on the youth's treatment needs.

   Programs are located in:

   - Danvers (boys)
   - Quincy (boys)
   - Springfield (boys)
   - Lawrence (girls)
   - Worcester (girls)
4. **Adolescent/Young Adult Recovery Home**: Two gender specific recovery home model residential programs for substance abusing youth between the ages of 16 and 19. The residential component consists of three phases and may be up to a 6 month program**.**
5. **School based programs**

- **Recovery Schools**. Recovery High School is designed to meet the needs of high school students who have had a history of substance abuse but who have made a firm commitment to recovery. There are three recovery high schools in Massachusetts located in Beverly, Boston, and Springfield, with the capacity to serve approximately 30-50 students.
- **CasaSTART: CA**SASTART is a community-based, school-centered Intervention program for high risk youth. CASASTART serves youth 8-13 years old who are at high risk for or involved in delinquency, substance abuse, school failure, family violence, and social and behavioral problems. CASASTART is currently in 5 middle and elementary schools in Boston with 2-5 more communities coming on line in FY10

6. **DYS CasaSTART**

   BSAS has partnered with the MA Department of Youth Services (DYS) to adapt and implement the CasaSTART program for DYS community based District Offices across the Commonwealth. There are currently five sites across the state: Holyoke, Springfield, Lawrence, Dorchester, and Roxbury.

BSAS also offers several Family Services that serve parents and their children:

Family Services

1. **Family Residential Treatment** Services provide a safe and supportive treatment environment for families when the caretaking parent(s) has a chronic substance abuse problem. Programs provide housing, individual and family treatment and case management of substance abuse treatment and other services for families in order to support and sustain sobriety. A portion of the family slots are designated for homeless families referred from the Department of Transitional Assistance.
2. **Supportive Housing for Homeless Families** are called Community Housing programs. The target population for these programs is homeless families and individuals affected by substance abuse. Community Housing participants must meet the HUD McKinney Program definition of homelessness (see Homeless Services section for definition).
3. **The Family Recovery Project** (FRP) provides individuals and families with intensive home-based substance abuse engagement and treatment. The FRP serves families who are impacted by parental substance use and are not actively engaged in treatment AND who have children at imminent risk of placement, or children who are in out of home placement with the goal of reunification.

I. Screening

BSAS actively promotes awareness of the CRAAFT, one of MassHealth's Approved Standardized Behavioral Health Screening Tools for children under the age of 21. The CRAFFT Screening Toolkit has been distributed by DPH to pediatric health care providers across the state and training has been provided to all School based Health Center Nurses and as well as staff of other state agencies.

II. Eligibility for MassHealth Behavioral Health Services

- **If a youth (under age 21) is enrolled in MassHealth Standard or Commonhealth,** covered services include the **new** MassHealth behavioral health services, if the service is medically necessary, as well as all other MassHealth-covered behavioral health services. (Generally, about 85% of all youth enrolled in MassHealth have Standard or CommonHealth, although enrollment statistics vary over time.)

- **If a youth has MassHealth Family Assistance, Basic or Essential coverage types,** the youth is eligible for Mobile Crisis intervention and In-Home Therapy, as well as many other MassHealth Behavioral Health services. The other **new** MassHealth behavioral health services, such as Intensive Care Coordination, are not covered services.

- **If a youth not enrolled in MassHealth Standard or CommonHealth has serious emotional disturbance (SED)** (as determined by through a CANS or other clinical assessment) he or she may be eligible for CommonHealth, a MassHealth program for people with disabilities. There is no income limit for CommonHealth. If the youth's family's income is more than 100% of the federal poverty level, the family may have to pay a premium or pay a one-time deductible. To apply for CommonHealth, parent/guardian should contact MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648), to request both a new "Medical Benefits Request (MBR)" form, and a "Disability Supplement" form.

- **If the youth or family/guardian does not know which type of MassHealth insurance the youth has,** staff can check the Eligibility Verification System (EVS) or help the family check with their MassHealth Plan:

  - **Boston Medical Center (BMC) HealthNet Plan** 1-888-566-0010 (English and other languages) 1-888-566-0012 (Spanish) TTY: 1-800-421-1220
  - **Fallon Community Health Plan** 1-800-868-5200 TTY: 1-877-608-7677
  - **Neighborhood Health Plan** 1-800-462-5449 TTY: 1-800-655-1761
  - **Network Health** 1-888-257-1985 TTY: 617-888-391-5535
  - **Primary Care Clinician (PCC) Plan** 1-800-841-2900 TTY: 1-800-497-4648
  - **Mass. Behavioral Health Partnership** 1-800-495-0086 TTY: 617-790-4130

- **If a family does not know which Health Plan their child is on,** they can look at the Health Plan card they give their doctor or nurse during an office visit. If they do not have a card, they can call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648). If

they are enrolled in MassHealth, but not yet enrolled in a Health Plan, they can call MassHealth customer service and be helped to enroll in a Health Plan.

- **If the youth is not insured or has no coverage for mental health services, but may be eligible for MassHealth,** staff can help the youth/ parent/guardian contact the appropriate regional MassHealth Enrollment Center, or call the MassHealth Customer Service number. Again, if the child has serious emotional disturbance, the family should request a disability supplement form, in addition to a Medical Benefits Form. (See above)

MassHealth Customer Service: 1-800-841-2900 (TTY: 1-800-497-4648)	
MassHealth Regional Enrollment Centers	
Revere	781-485-2500
Taunton	508-828-4600
Tewksbury	978-863-9200
Springfield	413-785-4100

- **If the youth has private insurance,** staff can help the youth/parent/guardian contact their insurance company to access services covered by the insurer.

III. Assessment of Youth with Co-Occurring Substance Abuse and Mental Health Needs

All BSAS youth and family providers will identify youth and young adults on MassHealth who may have co-occurring substance abuse and mental health needs in order to refer to appropriate MassHealth Behavioral Health services.

- **Outpatient substance abuse programs** complete an assessment during the admission phase of outpatient that includes the client's psychological, social, health, co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling. When a youth is identified who may have co-occurring mental health needs, an internal or external referral is made to a mental health provider for a comprehensive mental health assessment. For youth on MassHealth, this comprehensive mental health assessment includes a CANS.
- **CasaSTART and for Recovery Schools** who identify a youth who may have co-occurring mental health needs will make a referral to a mental health provider for a comprehensive mental health assessment including CANS. While these school based programs provide a fairly intensive level of case manaqement, if the youth has significant mental health needs that exceed the capacity of the CasaSTARt or Recovery high school case management program, a referral to Intensive Care Coordination may be appropriate
- **Youth Residential Treatment programs** require a comprehensive mental health assessment from an approved substance abuse or mental health provider as a standard part of their enrollment process. For youth on MassHealth, outpatient providers conduct an assessment that includes a CANS.

- **Family Residential Programs** conduct an assessment of parent and child(ren's) needs. For children who may have a behavioral health need, a referral is made to a mental health provider for an assessment, including CANS, followed by treatment or referral to an appropriate service.

IV. Referring to A MassHealth Provider for a Mental Health assessment and Services

- When the provider identifies a young person with mental health needs, the provider will share information with the youth and their parent/guardian about potentially appropriate mental health services.
- Referrals may be made to an outpatient provider, an In-Home Therapy provider or to a Community Service Agency (CSA) delivering Intensive Care Coordination.
- The substance abuse provider can help minimize the number of clinical transitions for the youth and family by providing information about the most potentially appropriate service. Providers can learn more about the different services in the MassHealth Services section at the beginning of this manual, along with more detailed Medical Necessity Criteria included in Appendix B.
- The youth, custodial parent or legal guardian has the right to seek behavioral health treatment, including a pre-treatment assessment, from any provider of any service in the youth's managed care network.

Referral Guidelines

- **If the child already has an outpatient clinician or psychiatrist**, the substance abuse treatment provider should confer with the child's clinician before making a referral for an assessment.
- **If a child has a history of significant behavioral health needs or significant trauma, but is not currently seeing an outpatient clinician or psychiatrist,** the provider should share information with the youth and family about the array of MassHealth behavioral health services to help the youth and family determine the most appropriate service and will provide the youth and family with assistance in accessing that service.
- **If a family knows that they are interested in receiving Intensive Care Coordination or In-home Therapy services**, the family may go directly to a local Community Service Agency for ICC or an In-home Therapy provider to receive a behavioral health assessment and determination of medical need for the service. The substance abuse provider should assist the family in identifying the service provider in their area. (See Appendix A for provider lists.)
- **If a child is in a psychiatric crisis,** the parent/guardian or caregiver will be directed to call for Mobile Crisis Intervention through their local Emergency Services Provider (ESP).

Mobile Crisis Intervention (MCI) will come to any location in the community where the child or youth is located, including home, school or other community setting. MCI is a short-term service that provides child-trained clinicians to respond to a youth experiencing a behavioral health crisis. Teams assess, treat and stabilize the crisis situation, remaining involved for up to 72 hours, including supporting the family by phone. MCI can also help families access additional MassHealth behavioral health services for their child. (For more information, see detailed service descriptions above and in Appendix B. See Appendix A for provider contact information in your area.)

V. Expected Response from Behavioral Health Providers to Referrals

For Referrals to Intensive Care Coordination

- Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the parent or guardian to offer a face-to-face interview.
- A face-to-face interview with the youth and/or family will be offered within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
- The comprehensive home-based assessment must be completed within 10 calendar days of the date on which consent for ICC was obtained. Eligibility for ICC services is determined as part of the comprehensive home-based assessment.
- The ICC care coordinator is expected to contact the referring substance abuse provider (with proper consent as required by law) to discuss the referral before scheduling the comprehensive home-based assessment. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure parent or guardian authorization and to convey it by fax, mail or hand delivery to the referring substance abuse provider and other providers with whom they want to speak.
- The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the parent/guardians consent to treatment.

For Referrals to In-Home Therapy

- The In-Home Therapy provider responds telephonically to all referrals within one business day.
- During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.

For Referrals to Mobile Crisis Intervention

- Mobile Crisis Intervention arrives within 1 hour of receiving a telephone request.

- For remote geographical areas, Mobile Crisis Intervention arrives within the usual transport time to reach the destination.

VI. Referrals To Substance Abuse Services from Behavioral Health Providers:

- When a Community Service Agency, In-Home Therapy provider and outpatient provider identifies a need for substance abuse services, the provider may make a referral to one of the services sponsored by the Bureau of Substance Abuse Services.
- Service descriptions, provider lists by geographic area, and the referral process are included in Appendix D.
- The Massachusetts Substance Abuse Information and Education Helpline (800-327-5050) can provide information on BSAS programs including adolescent and family services and answer questions about the referral process.
- Central Intake & Care Coordination staff will facilitate referrals to both Family treatment programs and youth residential. Central Intake staff is located at the Institute for Health and Recovery 617-661-3991, toll free number 866-705-2807.

VII. Continuity of Care

- **Establishing a Collaborative Relationship With Your Local Community Service Agency (CSA):** The director of each adolescent and/or family substance abuse program is encouraged to establish a working relationship with the director of the Community Service Agency (CSA) in their area to facilitate collaboration for youth with co-occurring substance abuse and mental health needs. If a Specialized CSA serving a specific target population is also in the area, the provider should also establish a working relationship with the Specialized CSA. For about geographic and specialized CSAs, see Appendix A.
- **Participation on ICC Care Planning Team by Community-based Substance Abuse Providers:** If a youth is simultaneously receiving a community-based substance abuse service AND Intensive Care Coordination service through a Community Service Agency, the substance abuse provider will, with the consent of the family, be asked to serve as a member of the youth's Care Planning Team. The team will work with the youth and family to develop an integrated care plan across providers that addresses the needs of the youth and family.
- **Transition Care Planning by adolescent and family providers**
    - As part of the treatment planning process, BSAS youth and family residential staff will seek to ascertain what the youth's MassHealth enrollment status will be subsequent to

discharge, and will support the youth or family in securing MassHealth coverage for community-based services, such as applying for MassHealth.

- If the youth might be considered disabled as a result of his/her physical or behavioral health problems, the provider will advise that the Disability section of the MassHealth application be completed.
- Since all residential substance abuse treatment is short-term, all residential treatment programs are short-term, and discharge planning begins on the day the youth arrives at the facility. (Detox/Stabilization is generally 2 weeks; residential treatment is generally 3 months, or residential recovery home and family treatment programs up to 180 days). Planning for mental health service needs of the youth will be a standard part of the discharge planning process.
- The core element of discharge planning from residential services involves discussion of the youth's ongoing needs and the options available to meet those needs. As part of the discussion, the case manager will share with the youth or family the options for care coordination and other MassHealth behavioral health services in the community.
- In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC should be made as soon as the need for service is identified but will be made no more than 180 days prior to planned discharge. For youth enrolled in ICC, post-discharge care planning will begin during this transition period.
- The residential provider is responsible for inviting the ICC to program discharge planning meetings. In addition, they will assist the ICC care coordinator in arranging meetings with the youth, family and/or Care Planning Team at the residential program site. At the time of discharge, the youth and families will be informed about the availability of Mobile Crisis Intervention in the community. DPH BSAS Youth and Family services will amend its contracts with providers to clarify expectations regarding this responsibility.

- **Participation in Local System of Care Committees**: Each Community Service Agency will convene a Local System of Care Committee focused on strengthening integration and communication among providers, families and other stakeholders serving youth with significant behavioral health needs. The director of each BSAS Youth and Family services community-based and residential program (or designee) will participate on the Local System of Care Committee.

VIII. Training To Ensure Coordination

- **Training for DPH Youth Substance Abuse Providers:** Program Directors will receive training in the new MassHealth services and in these protocols, including an introduction to the Wraparound process, with the goal of increasing collaboration and integration between substance abuse and mental health services in the community.

- **CSA Training:** Care coordinators and family partners will receive training in the array of youth and young adult services available through DPH BSAS/OAAYS, and how to collaborate effectively with providers of these services.

Section 3
Appendices

Appendix A:

Provider Lists

These up-to-date lists can be accessed in the following location:
www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers

Appendix B:

Medical Necessity Criteria

Intensive Care Coordination
In Home Therapy Services
Mobile Crisis Intervention
Family Support and Training
In Home Behavioral Services
Therapeutic Mentoring Services

These can be accessed in the following location:

www.masspartnership.com < CBHI Information < Medical Necessity Criteria for CBHI Services

Appendix C:

Notice to Parents/Caregivers on New MassHealth Services

This can be accessed in the following location:

www.masspartnership.com < CBHI Information < CBHI Member Notice

Appendix D:

BSAS Services: Provider Lists

Massachusetts Youth Substance Abuse Services

Detoxification/Stabilization Units

Motivating Youth Recovery (MYR)
Community Health Link
12 Queen Street, Worcester, MA 01610
508-860-1244 Fax: 508-860-1245 Homepage only:
http://communityhealthlink.org/index.html

The CASTLE (Clean and Sober Teens Living Empowered)
(High Point Treatment Center)
10 Meadowbrook Road, Brockton, MA 02301
508-638-6000 Fax: 508-638-6099
http://www.hptc.org/thecastle.html

Residential Referrals:

Central Intake & Care Coordination for Residential Referrals
The Institute for Health and Recovery
(617) 661-3991 or (866) 705-2807
http://www.healthrecovery.org/projects/adolescent_services/youth_centralintake_and_care_coordination.asp

Residential Programs

CAB The Adolescent Residential Program
111 Middleton Road
Danvers, MA 01923
978-739-7601 or
800-323-2224
http://www.cabhrs.org/adolescent_residential_program.shtml

Highland Grace House
280 Highland Street,
Worcester, MA 01602
(508) 860-1172
http://www.communityhealthlink.org/htlmpages/yfs-GH.html

Pegasus House
482 Lowell Street Lawrence MA, 01841
(978) 687-4257
Homepage only:
http://www.tpc1.org/index.php

Phoenix Academy at Springfield
15 Mulberry Street
Springfield, MA 01105
(413) 739-2440
http://www.phoenixhouse.org/locations/new-england/new-england-drug-help/massachusetts/adolescent-programs-ma/

Project Rebound
Rebound Adolescent and Family Treatment Center
Boston Harbor Long Island P.O. Box 220648
Boston, MA 02122
Phone: 617-773-0722 Fax: 617-773-6457
http://www.voamass.org/Services/AtRiskYouth/Rebound/tabid/1472/Default.aspx

Cushing House Girls
Cushing House Boys
54-58 Old Colony Avenue
South Boston, MA 02127
617-269-2933
http://www.gavinfoundation.org/Cushing_House.html

Recovery High Schools

William J. Ostiguy High School
19 Temple Place, Boston, MA 02111
617-348-6070 x 7530 Fax: 617-956-0902
http://www.bostonabcd.org/programs/youth-development/wjo-hs/

North Shore Recovery High School
502 Cabot Street, Beverly, MA 01915
978-922-3305
www.nsedu.org

Springfield Academy for Excellence (SAFE)
334 Franklin St.
Springfield, MA 01104
413-787-6998
www.sps.springfield.ma.us

DYS CASASTART Programs

Department of Youth Services
27 Wormwood Street, Suite 400
Boston, MA 02210
Peter Kosciusko (617) 727-7575
(Springfield, Holyoke, Lawrence, Lynn, Roxbury, Dorchester)

School Based CASASTART Programs

North Suffolk Mental Health Association
Serving Winthrop
Rebecca Allen
rallen@northsuffolk.org

Wideko Children Services
Serving South Boston
Diana Parad
dparad@rcn.com

Massachusetts Outpatient Providers Serving Adolescents

Boston Region

Bay Cove Human Services, Inc./Chelsea ASAP 100 Everett Avenue, Unit 4 Chelsea, MA 02150 617-884-6829 Amy Harris	Bridge Over Troubled Waters 47 West Street Boston, MA 02111 617-423-9575 Tracey Barton	Children's Hospital Boston 300 Longwood Avenue Boston, MA 617-355-2727	Children's Hospital Martha Elliot Health Center 75 Bickford Street, Jamaica Plain 02130 617-971-2100
Dimock Community Services Corporation 56 Dimock Street Roxbury, MA 02119 617-442-8800 x1608 Laurie Kaslow, Child Behavioral Health Manager	JRI Health Sidney Borum Jr. Health Center 130 Boylston Street Boston, MA 02116 617-457-8140 Liz Geisel, Assessments	Massachusetts General Hospital Addiction Recovery Management Services 151 Merrimac Street Boston, MA 02114 617-643-4699	North Suffolk Mental Health Agency Noddle's Island Multi Service Agency, Inc. 14 Porter Street East Boston, MA 02128 617-912-7500 (main line) 1-888-294-7802 (intake line)
North Suffolk Mental Health Agency Noddle's Island Multi-Service Agency, Inc. 37 Hawthorne Street Chelsea, MA 02150 617-912-7500 (main line) 1-888-294-7802 (intake line)	South Boston Community Health Center South Boston Collaborative Center 8 Burke Street South Boston, MA 02127 617-269-7500 Assessments: Andrew Ward 617-469-5875		

Central Region

Community Health Link 71 Jacques Street Worcester, MA 01604 508-860-1000 Penny Lionne 508-791-3261	Henry Lee Willis Community Center, Inc. 44 Front Street Suite 380/490 Worcester, MA 01609 508-755-9471	L.U.K. Crisis Center, Inc. 545 Westminster Street Fitchburg, MA 01420 978-345-0685 Terry Manning, clinician Sandra Donahue, clinician Dave Hamalsky, Director	L.U.K. Crisis Center, Inc. 1280 Main Street Worcester, MA 01603 508-438-1490

Spectrum Outpatient Services 76 Summer Street Fitchburg, MA 01420 978-343-2433 (main)	Spectrum Outpatient Services 585 Lincoln Street Worcester, MA 01605 508-854-3320 x1161 Erika Roseborough	Wayside Youth and Family Support Network 10 Asylum Street Milford, MA 01757 (508) 478-6888 Amy Leone	Youth Opportunities Upheld, Inc. (Y.O.U., Inc.) 81 Plantation Street Worcester, MA 01604 508-849-5600

Metro-West Region

Advocates, Inc. 340 Maple Street Marlborough, MA 01752 (508) 485-9300	Bay State Community Services 549 Columbian Street Weymouth, MA 02190 781-331-1906 Pam Miller, Director	Bay State Community Services Center for Community Counseling and Education 32 Common Street Walpole, MA 02081 508-668-3223 x26 Elizabeth Doupé	Bay State Community Services 13 Temple Street Quincy, MA 02169 Marcia Murray, Referrals
CASPAR, Inc. 162 Highland Avenue Somerville, MA 02143 617-623-2080	Genesis Counseling Services 24 Union Avenue, Suite 11 Framingham, MA 01701 508-620-2992	Mount Auburn Hospital 330 Mount Auburn St Cambridge, MA 02138 617-499-5052	Somerville Mental Health Association 5 Hall Avenue Somerville, MA 02144 617-623-3278 Tom Farina, Dir SA Prog
Wayside Metro-West Counseling Center Wayside Youth and Family Support Network 88 Lincoln Street Framingham, MA 01702 508-620-0010 Anne Priestly, Program Director	Wayside Youth and Family Support Network 118 Central Street Waltham, MA 02453 781-891-0555 Carol Flynn-Roberts		

Northeast Region

Amesbury Psychological Center 24 Morrill Place Amesbury, MA 01913 978-388-5700	Cab Health and Recovery Services, Inc. 27 Congress Street, Ste, 105 Salem, MA 01970 978-740-1580 Lisa Innis, Intake Coordinator	Lowell House 555 Merrimack Street Lowell, MA 01854 978-459-8656 Nancy McManus	Team Coordinating Agency, Inc. 76 Winter Street Haverhill, MA 01830 978-373-1181 x42 Peggy, Intake Coordinator
The Psychological Center, Inc. 11 Union Street Lawrence, MA 01843 978-685-1337 Myrna Burgos, Intake Coor.			

Southeast Region

Community Care Services 140 Park Street Attleboro, MA 02703 508-222-7525 Simone, x262	Community Care Services 70 Main Street Taunton, MA 02780 508-821-7777 Angela, Intake Coodinator, x297	Gosnold, Inc. 111 Torrey Street Brockton, MA 02301 Central Intake: 508-540-6550	Gosnold, Inc. 1185 Falmouth Road Centerville, MA 02632 Central Intake: 508-540-6550
Gosnold, Inc. 196 Ter Heun Drive Falmouth, MA 02541	Gosnold, Inc. 681 Falmouth Road Mashpee, MA 02649 Central Intake: 508-540-6550	Gosnold, Inc. 870 Country Road Pocasset, MA 02559 Central Intake: 508-540-6550	Gosnold, Inc. 30 Conwell Street Provincetown, MA 02657 Central Intake: 508-540-6550

Central Intake: 508-540-6550			

High Point Treatment Center 1800 North Front Street, 3rd Floor New Bedford, MA 02740 508-994-0885 x3150	High Point Treatment Center 842 Purchase Street New Bedford, MA 02740 508-992-1500	High Point Treatment Center 2 School Street Plymouth, MA 02360 508-830-1234 Marion Oxenhorn, Director	High Point Treatment Center 4 Post Office Square Taunton, MA 02780 508-823-5291
Seven Hills Behavioral Health Melville Plaza 850 Pleasant Street, Suite 2 New Bedford, MA 02723 508-996-8501 Marie Johnson	South Bay Mental Health 37 Belmont Street Brockton, MA 02301 508-580-4691 Ask for Sharolta Sebe, Dual Diagnosis Team Director, x307	Stanley Street Treatment and Resources, Inc 386 Stanley Street Fall River, MA 02720 508-679-5222	

Western Region

Baystate Health System Sloan Clinic 140 High Street Springfield, MA 01199 413-794-5555 Phil Day, Director	The Brien Center for Mental Health and Substance Abuse Services, Inc. 60 Cottage Street Great Barrington, MA 01230 413-528-9156	The Brien Center for Mental Health and Substance Abuse Services, Inc. 25 Marshall Street North Adams, MA 01247 413-664-4541	The Brien Center for Mental Health and Substance Abuse Services, Inc. 251 Fenn Street Pittsfield, MA 01201 413-496-9671 Jim Mucia , Director
The Carson Center for Human Services, Inc. 20 Broad Street Westfield, MA 01085 413-568-1421 Lindsey, Intake Coordinator	Cooley Dickinson Hospital Outpatient Behavioral Health 10 Main Street Florence, MA 01062 413-586-8550 Chris Rose, Director	Gandara Center, Inc. 2155 Main Street Springfield, MA 01104 413-736-0395 Maria Santana, SA supervisor, x56 or Emily Lopez, Intake Coordinator, x13	Phoenix Outpatient Program 15 Mulberry Street Springfield, MA 01105 413-739-2440 (main line, choose #1 for Adolescent Admissions)
Providence Behavioral Health Hospital 1233 Main Street Holyoke, MA 01040 413-539-2973 or 1-800-274-7724 Lisa Golembiewski, Clinical Manager	Wing Memorial Hospital Griswald Center 40 Wright Street Palmer, MA 01069 413-283-7651 Maria McCarthy, Clinician		

Bureau of Substance Abuse Services
Residential Substance Abuse Services for Pregnant & Post-Partum Women

Serenity House
P.O. Box 344
Hopkinton, MA 01748
508-435-9040
508-435-2008

Women's View
584 Haverhill Street
Lawrence, MA 01841
978-687-1658
978-681-6075

Cope Women's Residential Program
117 Common Street
Lynn, MA 01902
781-581-9273
781-581-2177

New Day
242 Highland Avenue
Somerville, MA 02143
617-628-8188
617-628-8460

Faith House
Worcester, MA 01606
508-438-5625
508-438-5627

Steppingstone Women's House
522 North Main Street
Fall River, MA 02720
508-674-2788
508-674-2780

Steppingstone Women's Program
979 Pleasant Street
New Bedford, MA 02740
508-984-1880
508-984-1892

Gandara Residential Services for Women
507 Appleton Street
Holyoke, MA 01040
413-540-9881
413-540-9884

Spectrum Women & Children's Program
154 Oak Street
Westborough, MA
508-870-5555
508-898-1578

Latinas Y Ninos for Families
263 Eustis Street
Roxbury, MA 02119
617-445-1104
617-541-1882

Emerson House
200 Ter Huen Drive
Falmouth, MA 02540
800-444-1554

Edwina Martin House
678 North Main Street
Brockton, MA 02301
508-583-0493

My Sister's House
89 Belmont Avenue
Springfield, MA 01108
413-733-7891

Bureau of Substance Abuse Services
Family Residential Programs

All Referrals for Family Residential Programs must go through Central Intake (Institute for Health & Recovery) 617-661-3991

Family Residential Programs

Grace House
143 West Street
Northampton, MA 01060
866-705-2807

Angel House
309 South Street
Hyannis, MA 02601
866-705-2807

Genesis II Family Center
295 Adams Street (rear)
Newton, MA 02458
866-705-2807

Sage House (Male parents and M/F couples)
61 Clinton Street
Framingham, MA 01701
866-705-2807

H.A.R.T. House
365 East Street - Bldg. IV
P.O. Box 477
Tewksbury, MA 01876-0477
866-705-2807

Entre Familia Program
249 River Street, 1 West
Mattapan, MA 02126
866-705-2807

Orchard Street
17 Orchard Street
Leominster, MA 02139
978-537-3109

Appendix E:

Intensive Care Coordination (ICC) and Family Support and Training Briefing Guide

This is the ICC Operations Manual, which can be accessed in the secure CSA Working Documents section of www.masspartnership.com

DPH State Agency Protocol
Web Locations of Supporting Documents

DPH Training Booklet [www.masspartnership.com < CSA Working Documents < DPH State Agency Protocols < DPH]

Intensive Care Coordination (ICC) Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

Family Support and Training (FS&T) Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

In-Home Therapy (IHT) Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

In-Home Behavioral Services Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

Mobile Crisis Intervention (MCI) Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

Therapeutic Mentoring (TM) Medical Necessity Criteria [www.masspartnership.com < CSA Working Documents < Medical Necessity Criteria]

Intensive Care Coordination (ICC) & Family Support and Training (FS&T) contacts [www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers]

In-Home Therapy (IHT) contacts [www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers]

In-Home Behavioral Services contacts [www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers]

Therapeutic Mentoring (TM) contacts [www.masspartnership.com < CBHI Information < CBHI Services and Referral Contact Numbers]

ESP/MCI Directory [www.masspartnership.com < ESP < ESP Directory]

Appendix N

CSA Monthly Reporting Definitions and Instructions

CSA Monthly Reporting Definitions and Instructions

Please note that MBHP is collecting this data on behalf of all the MCEs and MassHealth. Therefore, numbers submitted should reflect all activity regardless of insurer.

Definitions

Referrals:	Referrals are defined as calls to the CSA requesting ICC services on behalf of a member, where the referral source (if not the family themselves) has spoken with the family and believes the member is appropriate for and interested in the ICC service. Referrals exclude calls regarding people who are out of the age range for the service, or who do not have MassHealth Standard or CommonHealth.
Youth #	This is a system generated number that is not changeable.
Youth Name	Youth name as known to CSA. Please note, if referral does not become a request for Intensive Care Coordination, and the member is referred to outside service, or the family declines the service, the name may be left blank. However record the referral and member status for reporting purposes. Column with names will be automatically removed when the data is submitted to MBHP.
MH #	Youth's MassHealth identification number. Please note, if referral does not become a request for Intensive Care Coordination, and the member is referred to outside service, or family declines the service, the MassHealth number may be left blank. This column will be automatically removed when the data is submitted to MBHP.
Referral Date	Date referral made, even if just a message. All dates may be entered either m/d/yy or m/d/yyyy.
Referral Source	Use drop down menu to choose one of following sources for referral: 1) Family/youth; 2) DCF personnel; 3) DMH personnel; 4) DYS personnel; 5) DDS personnel; 6) School personnel; 7) Mobile Crisis Intervention personnel; 8) In-home therapy provider; 9) Outpatient provider; 10) PCP; 11) Psychiatric Hospital; 12) CBAT/TCU; 13) Probation; or 14) Other
Date Family or Youth Requests ICC	This is the date that the family or youth directly talks to the CSA and says they are interested in ICC. If it is a case that is self-referred, this will be the same as a referral date. In reporting wait times, this is the date from which a wait for a service begins.
Date Initial Appointment Offered	This is the date of the first available appointment offered to the family, whether or not family accepts appointment or the appointment actually occurred on this date.

Date Service Started	This is the date when family has provided written consent to participate and has met with a care coordinator, not a family partner. This date is used in calculating the number of new members receiving the service in the month.
Referral/Member Status	This field provides the information as of 7 days after the end of the month on the status of the members' referral, intake process, or service start. Use the drop down menu to pick one of the following categories: 1) "Service Started" defined as above. 2) "Family Not Yet Reached" defined as youth for which a referral has been made but CSA staff are still attempting to reach the family. 3) "Initial Appointment Scheduled", defined as youth for whom an appointment has been scheduled but the care coordinator or family partner has not yet met face to face with the family. 4) "Waiting to Schedule 1st Appointment" defined as youth/family is waiting for future appointment that is not yet scheduled, due to CSA capacity. 5)"Waiting for Preferred Staff" defined as youth/family who choose to wait to schedule a first appointment in order to work with a particular family partner or care coordinator, or person with particular characteristic (e.g. gender, etc.). 6) "Family Declines Service" defined as when family indicates that they are not interested in ICC services at this time either verbally or in writing to the CSA OR by not responding to outreach attempts.
	7) "Referred Outside" defined as youth/family who are referred to more clinically appropriate service, such as MCI, IHT, or outpatient, and who are not interested in ICC at this provider at this time. This would include youth who choose to go to another ICC provider, or another service and who are not added to the wait list for ICC. 8) "Not MassHealth Eligible" Defined as youth/family who are no longer eligible for MassHealth Standard or CommonHealth.
ICC Staff Number	The number from the staff listing in this workbook used to identify the care coordinator assigned to the youth/family. Used for Caseload Reporting.
FP Staff Number	The number from the staff listing in this workbook used to identify the family partner assigned to the youth/family if one is assigned. Cell may be left blank. Used to identify the percent of youth/ families with a family partner assigned.
Discharge Date	Date member is discharged from ICC. Used for report on discharges.
Discharge Reason	Use the drop down menu to pick one of the following reasons for discharge:

	1) "Goals Met" defined as youth who no longer meets medical necessity criteria because goals met and continued services not required to prevent worsening of behavioral health condition. 2) "Not SED" defined as youth who no longer meets medical necessity criteria due to SED criteria no longer being met. 3) "Youth 21" defined as youth who has aged out because he/she is now 21. 4) "Consent withdrawn" defined as youth/family who indicate they who no longer want services, either by formally withdrawing consent, or by no longer engaging in or participating in services. 5) "Out of home" includes youth who are placed out of home and unable to return to community even with ICC supports. 6) "Disenrolled MH" includes youth disenrolled from MassHealth and youth still enrolled in MassHealth but disenrolled from an ICC eligible benefit category. Does not include youth changing to a different MCE. 7) "Family Moved" includes youth/family who move too far away for the current CSA or move out of the CSA area because of a change in caretaker. 8) Other.
Active Status	System calculated field allowing referrals to be filtered into groups depending on whether referral is: 1) YES (Active); 2) D/C (Discharged); 3) New (Referral in Process), OLD (Completed Referral without ICC), or Blank (Referral for Next Month).
LOS	System calculated field showing length of time in months for active or discharged youth and in days for referrals in process.
Staff Number	This is a system generated number that is not changeable.
Staff Name	Enter the staff name, last name first. If a staff member leaves employment and then returns, start a new line with the same name. This column will be automatically removed when the data is submitted to MBHP.
FTE	Put the current FTE amount for this staff member up to 1. This number should be current for all active staff as of the end of the reporting month.
Position	Use the drop down menu to pick the appropriate staff category. Use "ICC-Other" for program director or other administrative staff who may have a caseload.
Start Date	Date staff member eligible to begin accepting referrals. All dates may be entered either m/d/yy or m/d/yyyy.
End Date	Last date staff member available to see youth. Leave cell blank for all active staff. All dates may be entered either m/d/yy or m/d/yyyy.
Active	System generated field with "YES" for active and "NO" for inactive during reporting month.
Staff Type	System generated field with value of either "ICC" or "FP" for type of staff.

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

Instructions

For questions, e-mail: MBHP-CSA@valueoptions.com or call your MBHP TA manager.

Macro Instructions

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

General Instructions

2	If you want to past information into the "Member List" or "Staff" tables, please use "Paste Special", click on "Values" so that formatting is not disturbed.
3	When saving this file, you may change the name but remove any "COPY OF" wordage that Word sometimes adds.
4	On SetMonth sheet enter, month, year, and CSA number. Month and year should always be month and year corresponding to reporting month and year. Initially be sure that the month is "7" and year is "2010".
5	Enter all currently active staff.
6	Enter members on member list sheet with all appropriate fields completed. Enter only ongoing youth and referrals that are active as of July 1, 2010. For ongoing youth enrolled before 7/1, referral information (columns "D" through "G") does not need to be completed.
7	On member list sheet, cells will become colored if not all data is entered.
8	After initial 25 members, click on "insert of new row" button to add a row for a new member. You may click on this button multiple times so you can enter several youth at the same time.
9	When ready to send data for month to MBHP, click on "Send file without PHI to MHBP" button on SetMonth sheet. Please send file by 13th of following month. Make sure that you have saved you current file before hitting the send button. You will automatically get a copy of the file that you send in the same folder as the data entry workbook.
10	Before sending data, use filters to check that all data is completed. For example, click on filter for "Active Status' column to check if all cells are completed for "NEW" referrals.
11	Use filters to create a printout of various categories of youth. For example, filtering on "YES" in "Active Status" column will allow you to printout all active cases.
12	To print out staff, filter so that you will not get to long a printout. Suggest filtering on "YES" in "Active Status" column.

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

Pivot Table Worksheets

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

CSA Specific Worksheets

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

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

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

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

Appendix O

Letter to CSAs
Regarding
Fidelity Monitoring Plan
For FY11

Dear providers: June 14, 2010

I am writing to inform you of the Fidelity monitoring plan for FY11.

For FY11 we will continue to use the Team Observation Measure (TOM) and the *Wraparound* Fidelity Index (WFI) as the data gathering instruments to measure fidelity to the *Wraparound* model within each of your CSAs. The specifics for gathering this data are outlined below:

TOM

Existing ICC staff

- Each ICC staff member that convenes CPTs must have two TOMs completed per year of employment.

New staff

- New staff must have two TOMs completed within months four and six from the date of hire. This allows adequate training of staff before utilizing the TOMs.

The data from the TOM will continue to need to be entered in the *Wraparound* Online Data Entry and Reporting System (WONDERS).

WFI

- Each CSA will continue to have a target of 20 completed interviews which will be conducted by Consumer Quality Initiatives (CQI). CSAs will need to fax consents to CQI beginning October 1st, 2010 for those youth enrolled in ICC for at least a three-month period of time. Please fax consents to the attention of **Melissa Goodman at (617) 445-5846.** CQI will conduct interviews between January and June of 2011.

The MCEs will continue to monitor the number of TOMs entered into the WONDERS system by each of your organizations and will update CSAs accordingly.

If you have any questions, please feel free to contact me at (617) 350-1919.

Andrea Gewirtz on behalf of the MCEs

Appendix P

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

An Evaluation of Services and Supports for Children and their Families

Evaluation Summary and Acknowledgement of Consent for Caregivers

_____ (name of CSA) is committed to providing high-quality care. We want to know what families in our CSA think about the services.

As a result, _____ (name of CSA) is asking families enrolled in ICC to help us learn more about how well the process is working. To do this, we ask you to participate in a brief phone interview. These interviews, using the Wraparound Fidelity Index, will last about 30 minutes.

An outside vendor, Consumer Quality Initiatives (CQI), has been hired to conduct these phone interviews. CQI is a consumer and family member run mental health research and evaluation organization.

The information collected will be used to help improve the quality of services you and other families receive.

All data will be anonymous.

You do not have to participate in these interviews in order to receive services. If you choose to participate you will receive a **$15 incentive** for your participation in this process.

If you have any questions about this program evaluation, you can call _____ (program contact) at: _____ or contact Melissa Goodman at CQI: (617)427-0505 ext 304 or mgoodman@cqi-mass.org

****

I understand that the findings from this evaluation may eventually be published, and that anything I say will remain confidential to the maximum extent allowable by law. All identifying information will be removed, and only group results will be reported.

I have read this information and/or it has been read to me and I have had a chance to ask questions about it, and these have been answered to my satisfaction.

I agree to participate in this evaluation, and I have received a copy of this form:

_____ _____

Caregiver Signature Date

CALL INFORMATION SHEET

Caregiver name (please print): _____

CSA Monthly Statistics Member #:_____

Full name of youth(s) receiving services: _____

Age of youth(s) receiving services: _____

Date of enrollment with ICC: (MUST be included) _____

Phone # ( ) _____ Alt #:_____

Languages in which interview can be conducted: _____

Best days to call to schedule and/or conduct interview: (Please circle all that apply)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Best time(s) of day to call: (Please circle all that apply)

8 am – 11 am 11 am – 2 pm 2 pm – 5 pm 5 pm – 9 pm

Specific instructions about the best day/time to call to schedule/conduct interview:

_____
_____
_____

Address: _____
_____
_____

CSA: Please fax this form when completed to Melissa Goodman
Fax #: (617) 445-5846

Una Evaluación de Servicios y Apoyo para Niños y su Familiares

Evaluación Detallada, Consentimiento de Reconocimiento para los Cuidadores

_____ (nombre de CSA) se compromete a brindar atención de alta calidad. Queremos saber qué familias en nuestro CSA piensan sobre los servicios que están recibiendo.

Consecuentemente, el _____ (nombre de CSA) está preguntando a familias en ICC para ayudarnos a aprender más sobre como el proceso de CSA está trabajando. Para hacer esto, pedimos que usted participe en una entrevista breve por teléfono. Estas entrevistas, usando el índice de fidelidad de Wraparound, estas entrevistas, durarán cerca de 30 minutos.

Han contratado a un vendedor exterior, Iniciativas de Calidad del Consumidor (CQI), para conducir éstas entrevistas por teléfono. CQI es una organización de investigación y de evaluación que es corrido por consumidores y familiares.

La información recogida será utilizada para ayudar a mejorar la calidad de servicio usted y otras familias reciben. Repuestas serán anónimos. Usted no tiene que participar en esta entrevista para recibir servicios. Si usted elige participar usted recibirá un estipendio de $15 para su participación en este proceso.

Si usted tiene cualquier clase de pregunta sobre esta evaluación, usted puede llamar _____ (contacto del programa) o pueden llamar Melissa Goodman en CQI: (617) 427-0505 extensión 304 o por correo electronico, mgoodman@cqi-mass.org.

****

Entiendo que los resultados de esta evaluación pueden ser publicados eventual, y que cualquier cosa que digo permanecerá al máximo permisible confidencial por ley. Toda la información de identificación será quitada, y solamente los resultados del grupo serán divulgados. He leído esta información y/o se ha leído a mí y he tenido una ocasión de hacer preguntas y mis preguntas se han contestado a mi satisfacción. Me gustaria participar en esta evaluación, y he recibido una copia de esta forma:

_____

Firma del Cuidador y Fecha

HOJA DE INFORMACIÓN DE LLAMADA

Nombre del cuidador (imprima por favor):_____

Estadística mensual del miembro en CSA #: _____

Nombre completo de niños que reciben servicios: _____

Edad de juventudes que reciben servicios: _____

Fecha de inscripción con ICC: (DEBE ser incluido) _____

Teléfono # (___) _____ Alt #: _____

Idiomas preferidas para entrevista: _____

Los mejores días a llamar para programar y/o para conducir entrevista: (Marque por favor todos que se apliquen)

Lunes Martes Miércoles Jueves Viernes Sábado Domingo

El mejor tiempo del día para llamar: (Marque por favor todos que apliquen)
8 a.m.–11 a.m. 11 a.m.– 2 p.m. 2 p.m.-5 p.m. 5 p.m. - 9 p.m.

Instrucciones específicas sobre el mejores día/tiempo de llamar para programar/entrevista:
_____
_____
_____

Dirección: _____
_____
_____

CSA: Envíe por favor esta forma por fax cuando está terminado a Melissa Goodman Fax #: (617) 445-5846

Appendix Q

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

Mission

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

Values

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

Appendix R

MCE Web Sites

Beacon Health Strategies: www.beaconhealthstrategies.com

BMC HealthNet Plan: www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: www.nhp.org

Network Health: www.network-health.org

Massachusetts Behavioral Health Partnership: www.masspartnership.com

Health New England: www.healthnewengland.com/