# Targeted Case Management Services: Intensive Care Coordination

Intensive Care Coordination (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. Care planning is driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

Intensive Care Coordination (ICC) provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the youth, are developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy that results in an individualized and flexible plan of care for the youth and family. ICC is designed to facilitate a collaborative relationship among a youth with SED, his/her family and involved child-serving systems to support the parent/caregiver in meeting their youth's needs. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to enable the youth to be served in their home community.

The care coordinator facilitates the development of a Care Planning Team (CPT) comprised of both formal and natural support persons who assist the family in identifying goals and developing an Individual Care Plan (ICP) and risk management/safety plan; convenes CPT meetings; coordinates and communicates with the members of the CPT to ensure the 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. The provision of ICC services reflects the individualized needs of youth and their families. Changes in the intensity of a youth's needs over time should not result in a change in care coordinator.

Delivery of ICC may require care coordinators to team with family partners. In ICC, the care coordinator and family partner work together with youth with SED and their families 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 caregiver's access to these resources.

ICC is defined as follows:

**Assessment**: The care coordinator facilitates the development of the Care Planning Team

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

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

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

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

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

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

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

and include

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

## Criteria

**Admission Criteria**

***All*** *of the following are necessary for admission to this level of care*:

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

<u>Part I:</u>

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

<u>Part II</u>:

The youth exhibits one or more of the following characteristics

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| | 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<br><br>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.<br><br>2. The youth:<br><br>a. needs or receives multiple services other than ICC from the same or multiple provider(s)<br>OR<br>b. needs or receives services from, state agencies, special education, or a combination thereof;<br>AND<br>c. needs a care planning team to coordinate services the youth needs from multiple providers or state agencies, special education, or a combination thereof<br><br>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.<br><br>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 |
| **Psychosocial, Occupational, Cultural, and Linguistic Factors** | ***These factors may change the risk assessment and should be considered when making level-of-care decisions.*** |

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| **Exclusion Criteria** | ***Any*** *of the following criteria is sufficient for exclusion from this level of care*:<br>1. The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in ICC.<br>2. The youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports. |
| **Continued Stay Criteria** | ***All*** *of the following criteria must be met for continued treatment at this level of care*:<br>1. The youth's clinical condition(s) continues to warrant ICC services in order to coordinate the youth's involvement with state agencies and special education or multiple service providers.<br>2. Progress toward Individualized Care Plan (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<br>3. Progress has not been made, and the Care Plan Team (CPT) has identified and implemented changes and revisions to the ICP to support the goals of the youth and family. |
| **Discharge Criteria** | ***Any*** *of the following criteria is sufficient for discharge from this level of care*:<br>1. The youth no longer meets the criteria for SED.<br>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.<br>3. Consent for treatment is withdrawn.<br>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.<br>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 |

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| | supports or ICC.<br>6. The youth turns 21. |