Intensive Care Coordination

Program Requirements

Definitions:

- Care Planning Team (CPT): Facilitated by the care coordinator, the Care Planning Team (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.

- Care Planning Team Meeting (CPTM) Comprised of the Care Planning Team (as noted in CPT definition), the CPTM is a team gathering, held minimally every 30 days, where all decisions regarding the Individual Care Plan are made.

- Certified Family Support Specialist (CFSS): An integral member of the ICC Team, and assigned for every child/family, this individual self-identifies as having lived experience as a parent or caregiver of a youth with behavioral health needs.

- Intensive Care Coordination (ICC)Assessment: Comprehensive youth-guided and family-directed assessment and periodic reassessment of the individual to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, developmental or other services and include activities such as: taking individual history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual.

- Individualized Care Plan (ICP): A wrap-around team-developed plan, based on the assessment, which specifies the goals of providing care coordination and the actions to address the medical, social, educational, developmental, and other services needed by the individual, including activities that ensure active participation by the individual and others.

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Service Definition

Intensive Care Coordination (ICC) is a service that facilitates care planning and coordination of services for TennCare youth, with serious emotional disturbance (SED), under the age of 21. Care planning is driven by the needs of the youth and developed through a *Wraparound-inspired* planning process based upon the *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 an ICC team 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.

Intensive Care Coordination is differentiated from traditional care coordination, Continuous Treatment Team (CTT), and Comprehensive Child and Family Treatment (CCFT) Services by:

- Coaching and skill building of the individual and parent/caregiver to empower their self-activation and self-management of their personal resiliency, recovery and wellness towards stability and independence.
- The intensity of the coordination: an average of three hours of coordination weekly.
- The frequency of the coordination: an average of one face-to-face meeting weekly.
- The caseload: an average of twelve children/youth per care coordinator.
- Development of a Care Planning Team, minimally comprised of the individual, parent/caregiver, and ICC Team (CC, CFSS, and one natural support).
- A Care Planning Team Meeting (CPTM) held minimally every 30 days, where all decisions regarding the Individual Care Plan are made.

Intensive Care Coordination includes the following components as frequently as necessary:

- Comprehensive youth-guided and family-directed assessment and periodic reassessment of the individual to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, developmental or other services and include activities such as: taking individual history; identifying the needs, strengths, preferences and physical and social environment of the individual, and

completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual.

- Development and periodic revision of an individualized care plan (ICP), based on the assessment, which specifies the goals of providing care coordination and the actions to address the medical, social, educational, developmental, and other services needed by the individual, including activities that ensure active participation by the individual and others. The ICP will include transition goals and plans. If an individual declines services identified in the ICP, it must be documented.
- Referral and related activities to help the individual obtain needed services/supports, including activities that help link the eligible individual with medical, social, educational, developmental providers, and other programs or services that are capable of providing services to address identified needs and achieve goals in the ICP.
- Monitoring and follow-up activities that are necessary to ensure that the ICP is effectively implemented and adequately addresses the needs of the individual. Monitoring includes direct observation and follow-up to ensure that ICPs have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of individuals and their families/caregivers/legal guardians with the ICP. These activities may be with the individual, family members, providers, or other entities, and may be conducted as frequently as necessary to help determine: whether services/supports are being furnished in accordance with the individual's ICP; whether the services in the ICP are adequate to meet the needs of the individual; whether there are changes in the needs or status of the individual. If changes have occurred, the individual's ICP and service arrangements with providers will be updated to reflect changes.
- Intensive Care Coordination may include contacts and coordination with individuals that are directly related to the identification of the individual's needs and care, for the purposes of assisting individuals' access to services, identifying needs and supports to assist the individual in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the individual's needs. Examples of these individuals include, but are not limited to, school personnel, child welfare representatives, juvenile justice staff, and primary care physicians.
- Intensive Care Coordination also assists individuals and their families or representatives in making informed decisions about services, supports and providers.
- Partnering with and facilitating involvement of the required CFSS.

Required Components

- Access to parent peer support shall be offered. This access is a required complement to this service.
- The family must be contacted within 48 hours of the initial referral.

- The family must be met face-to-face by care coordinator and/or family peer support staff within 7 business days of the initial referral to begin the engagement and assessment processes.
- An initial CPTM must be held within 30 days from the initial enrollment for all individuals.
- CPTMs must be held at a minimum of every 30 days to minimally include the parent or legal guardian (or their representative), individual, one natural support and ICC Team to accommodate full participation, parent, or legal guardian (or their representative), individual and natural support may participate telephonically or through other electronic means). Service providers (behavioral health and medical), child-serving agency personnel (child welfare, juvenile justice, education) and other natural and informal supports should also be a part of the Care Planning Team.
- The CPTM process should be family-driven and youth-guided.
- An CPTM must be held within 72 hours of a crisis.
- Direct supervision by the supervisor must occur at least monthly Group/team case consultation by the supervisor must occur at least twice monthly.
- Provision of direct observation of staff in the field by the supervisor at least monthly.
- All staff must be trained in High Fidelity Wraparound before providing this service.
- Ensure that families are utilizing natural supports and low-cost, no-cost options that are sustainable.
- Provision of crisis response, 24/7/365 to the individual they serve, to include face-to-face response when clinically indicated.
- The Care Coordinator will average 3 hours of care coordination per week per individual served.
- The Certified Family Support Specialist will meet with families 2 times weekly; 1 weekly contact must be face-to-face.
- The Care Coordinator will average 1 contact weekly and 2 face-to-face visits monthly, of which one is the Care Planning Team Meeting.
- To promote team cohesion, Care Coordinators must have weekly contact with the CFSS on the ICC team in support of the individual/family.

Phases of ICC

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. The phases of ICC are as follows:

Assessment:

The care coordinator facilitates the development of the Care Planning Team (CPT), who utilize multiple tools, including a strength-based assessment (e.g., DLA-20), 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
- 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 clinically appropriate.

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
- collaborates with the other service providers and state agencies (if involved) on 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

• whether these are changes in the needs or status of the youth and if so, adjusting the plan of care as necessary

Staffing Requirements

Intensive Care Coordination providers will minimally have:

1. Care Coordinators who can serve at a 12 individual to 1 care coordinator ratio:
   - Care Coordinators must possess a minimum of B.A or B.S. degree in social work, psychology, or related field with a minimum of two (2) years clinical intervention experience in serving youth with SED or emerging adults with mental health conditions. All Bachelor level and unlicensed care coordinators must be supervised at minimum by a licensed mental health professional (e.g., LCSW, LPC, LMFT). Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
   - Effective verbal and written communication skills.
   - Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
   - Ability to develop and deliver case presentations.
   - Ability to analyze complex information, and to define and solve problems.
   - Ability to work effectively in a team environment.
   - Ability to work in partnership with family support specialists with lived experience."

2. Intensive Care Coordination Supervisor:
   - The ICC Supervisor must possess a minimum of M.A. or M.S. degree in social work, psychology, or related field with a minimum of two (2) years clinical intervention experience in serving youth with SED or emerging adults with mental health conditions. All unlicensed ICC Supervisors must be supervised at minimum by an independently licensed mental health practitioner (e.g., LCSW, LPC, LMFT). Education can be substituted for experience.
   - Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
   - Effective verbal and written communication skills.
   - Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
   - Ability to develop and deliver case presentations.
   - Ability to analyze complex information, and to define and solve problems.
   - Ability to work effectively in a team environment.

3. A Program Director who is responsible for the overall management of this service. The Director oversees the implementation of numerous activities that are critical to ICC administration and management including but not limited to supervision of team personnel; model adherence, principles, values, and fidelity; participation and monitoring of continuous quality improvement.
4. A CFSS assigned for every child/family team:
    - Be certified as a Family Support Specialist or be eligible to become certified within one year of employment;
    - Self-identify as being or having been the biological parent, adoptive parent, foster parent, or relative caregiver with legal custody of a child or youth with a mental, emotional, behavioral, or co-occurring disorder (TDMHSAS reserves the right to request supporting documentation of diagnosis and/or guardianship);
    - Meet specific competency and ethical conduct requirements;
    - Possess minimum work, and/or volunteer experience requirements;
    - Possess minimum education and training requirements;
    - Pass the written competency course exam; and
    - Complete minimum continuing education credits annually.

Service Accessibility

1. Providers will be available for meetings at times and days conducive to the families, to include weekends and evenings for Care Team Meetings.
2. To promote access, providers may use telemedicine as a tool to provide direct interventions to individuals enrolled in this service and their families/caregivers, as a last resort.

Clinical Operations

1. Providers must adhere to the MCO Provider Manual and their MCO Contractual Agreement. Provider must accept all coordination responsibility for the individual and family.
2. Provider must ensure care coordination and tracking of services.
3. Provider must ensure that prior authorization is obtained before initiating services. Provider must have an organizational plan that addresses how the provider will ensure the following:
    a. Documented direct supervision by the supervisor must occur at least monthly.
    b. Group/team case consultation by the supervisor must occur at least twice monthly.
    c. Provision of oversight and guidance around the quality and fidelity of Wrap Process by the supervisor.
    d. Provision of oversight and guidance around the quality and fidelity to family-driven and youth-guided care by the supervisor.
    e. Supervisors complete a document review with Care Coordinators monthly for each child and family team.
    f. Provision of crisis response, 24/7/365 to the youth they serve, to include face-to-face response when clinically indicated.

Documentation Requirements

The following must be documented:

1. Child/Youth/Young Adult and family orientation to the program, to include family and individual expectations.
2. Team progress notes are documented for all individual and family interventions and coordination interventions.
3. Evidence that the child/youth/young adult's needs have been assessed, eligibility established and needs prioritized.
4. Evidence of child/youth/young adult participation, consent and response to support are present.
5. Evidence that methods used to deliver services and supports to meet the basic needs of individual are in a manner consistent with normal daily living as much as possible.
6. Evidence of minimal participation in each CPTM as described in *Required Components*.
7. Evidence of CPTMs occurring as described in *Required Components*.
8. Documentation of active CFSS participation in the team process.

Service Exclusions

Intensive Care Coordination providers cannot bill the following services while providing Intensive Care Coordination to an individual:

- Tennessee Health Link (THL)
- Comprehensive Child and Family Treatment Services (CCFT)
- Continuous Treatment Team (CTT/SCTT)
- Family Intensive Treatment Team (FITT/CAST)
- Systems of Support (SOS)
- Children & youth in DCS custody
- Infant and Early Childhood Mental Health (IECMH)

While "care coordination" is often considered a managed care product, this service does not function in that manner. This is a direct service benefit to individuals and families, provided side-by-side with them in their own homes/communities. The service includes (among other elements) provision of direct coaching, support, and training specific to developing the individual/family skills to self-manage services coordination.

Clinical Exclusions

1. The following diagnoses are not considered to be a sole diagnosis for this service:
   - Rule-Out (R/O) diagnoses
   - Personality Disorders

- Severe and Profound Intellectual/Developmental Disabilities

2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that an additional psychiatric diagnosis is the foremost consideration for psychiatric intervention:
   - Conduct Disorder
   - Traumatic Brain Injury
   - Mild Intellectual/Developmental Disabilities
   - Moderate Intellectual/Developmental Disabilities
   - Autism Spectrum Disorder