



INTENSIVE CARE COORDINATION (ICC)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Intensive Care Coordination (ICC) is a service that facilitates care planning and coordination 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.

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 Safety Plan and/or other Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families); 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 parents/caregivers to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parents/caregivers 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 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 ICP and a Safety Plan and/or other Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families). 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:

1. assisting the family to identify appropriate members of the CPT;
2. facilitating the CPT to identify strengths and needs of the youth and family in meeting their needs; and
3. 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.

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Development of an Individual Care Plan (ICP): Using the information collected through an assessment, the Care Coordinator convenes and facilitates the CPT meetings, and the CPT develops a child-centered and family-centered 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 health care 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:

1. convenes the CPT which develops the ICP;
2. works directly with the youth and family to implement elements of the ICP;
3. prepares, monitors, and modifies the ICP in concert with the CPT;
4. 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;
5. develops with the CPT a transition plan when the youth has achieved goals of the ICP; and
6. 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, performs such reviews and includes:

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

SERVICE COMPONENTS

1. ICC services are delivered by a service provider that is contracted as a Community Service Agency (CSA).
2. ICC services must be delivered by a provider with demonstrated infrastructure to support and ensure
 - a) Quality Management/Assurance,
 - b) Utilization Management,
 - c) Electronic Data Collection/IT,
 - d) Clinical and Psychiatric Expertise, and
 - e) Cultural and Linguistic Competence.
3. ICC services include, but are not limited to:
 - a) a comprehensive home-based assessment inclusive of the CANS and other tools as determined necessary, that occurs in the youth's home or another location of the family's choice;
 - b) family-driven identification of appropriate members of the CPT;
 - c) development and implementation of a youth-centered and family-centered ICP in collaboration with the family and collaterals;
 - d) development of one or more Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools) for families in collaboration with the family and collaterals;
 - e) regular contact by the Care Coordinator with the family, youth (where appropriate), and

- other relevant persons in the youth's life (collaterals);
 - f) facilitation of CPT meetings;
 - g) face-to-face contact with the youth and family, as determined by the youth and family and members of the CPT;
 - h) referrals and linkages to appropriate services along the continuum of care;
 - i) identification and development of natural supports;
 - j) assistance with system navigation;
 - k) family education, advocacy, and support;
 - l) monitoring, reviewing, and updating the ICP to reflect the changing needs of the youth and family; and
 - m) psychiatric consultation to the Care Coordinator regarding the youth's behavioral health treatment needs.
4. The ICC provider must be available by phone and staff must be equipped with on-call pagers to monitor the need for Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI) services and assist with access to those services for the youth and their families 24 hours a day, 365 days a year. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital Emergency Department (ED), is not acceptable.
 5. The ICC provider offers and delivers services in the youth's home or community and participates in CPT meetings and other activities in schools, day care, foster homes, and other community settings.
 6. Services shall be provided to the youth and family in the home/community. Providers may deliver services via a HIPAA-compliant telehealth platform at the family's request and if the service can be effectively delivered via telehealth. Services delivered through a telehealth platform must conform to all applicable standards of care. When providing services via telehealth, providers shall follow the current MassHealth and MCE guidelines regarding telehealth.
 7. With required consent, when the ICC provider is responsible for scheduling the meeting, CPT meetings are scheduled at a time and location when at least one family member can be available to attend in person. The ICC provider will not convene CPT meetings with collaterals without the youth, parent/guardian/caregiver unless the youth and/or parent/guardian/caregiver agree to the CPT meeting occurring. ICC providers will encourage other providers to arrange meetings in a similar manner.
 8. ICC is delivered in a manner that is consistent with Systems of Care philosophy and Wraparound planning principles and adheres to the four phases of Wraparound.
 9. The ICC provider addresses a variety of complex treatment and system issues. The Care Coordinator is skilled in providing education and planning regarding treatment access and service needs, parenting skills, conflict resolution, mediation, risk management/safety planning and intervention, and family advocacy and support.
 10. The ICC provider assists the youth to access medical, educational, social, therapeutic, and other services identified in his/her ICP, and is responsible for developing a plan to initiate and guide those service interventions.

STAFFING REQUIREMENTS

1. The ICC provider is staffed with Care Coordinators who have successfully completed skill- and competency-based training in the delivery of ICC consistent with Systems of Care philosophy and the Wraparound planning process and have experience working with youth with SED and their families.
2. The ICC provider employs both bachelor's level and master's level Care Coordinators who work with a range of youth and their families who present with varying degrees of complexity and needs.
3. The ICC provider ensures adequate staffing of Care Coordinators with master's degree in a mental health field (e.g., counseling, family therapy, social work, psychology, etc.) from an accredited college or university; and Care Coordinators with 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 Care Coordinators with an associate's degree or high school diploma and a minimum of five (5) years of experience working with the target population, experience in navigating any of the child/family-serving systems, and experience advocating for family members who are involved with behavioral health systems.
4. The ICC provider is responsible for ensuring that the number of youth assigned to each Care Coordinator (youth-to-Care Coordinator ratio) allows for the Care Coordinator to appropriately and effectively provide the ICC services each youth requires.
5. Care Coordinators must participate in weekly individual supervision with a behavioral health clinician licensed at the independent practice level. Additionally, Care Coordinators must participate in weekly individual, group, or dyad supervision (i.e., Dyad supervision is generally conducted in the same way as individual supervision, but the supervisor works with two supervisees at the same time) with the senior Care Coordinator. Each case will be reviewed, at a minimum, every 90 days by an independently licensed clinician.
6. The ICC provider ensures that a board-certified or board-eligible child psychiatrist or a child-trained psychiatric nurse mental health clinical specialist is available during normal business hours to provide consultation services to the Care Coordinator. The psychiatric clinician is available to provide phone or face-to-face consultation within one day of a request.
7. The ICC provider participates in, and successfully completes, all required training.
8. The ICC provider ensures that all Senior Care Coordinators complete the state-required training program for ICC and have successfully completed skill-based and competency-based training to supervise Care Coordinators.
9. The ICC provider ensures that all Care Coordinators complete the state-required training program for ICC and have successfully completed skill-based and competency-based training to provide ICC services.
10. The ICC provider's training program for all Care Coordinators, upon employment and annually thereafter, minimally includes the following:
 - a) systems of Care philosophy
 - b) family systems theory/family centered practice
 - c) peer support

- d) child and adolescent development including sexuality
- e) overview of the clinical and psychosocial needs of the target population, including LGBTQIA+
- f) community resources and services, for youth and families, including community mental health and the effects of substances on the developing brain
- g) the four phases of Wraparound and the 10 principles of Wraparound
- h) ethnic, cultural, and linguistic considerations of the community
- i) behavior management coaching
- j) mandated reporting
- k) social skills training
- l) psychotropic medications and possible side effects
- m) family driven crisis/safety planning and risk management
- n) introduction to child-serving systems and processes (e.g., DCF, DYS, DMH, DESE, etc.)
- o) basic IEP and special education information
- p) managed care entities' performance specifications and medical necessity criteria
- q) conflict resolution

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The ICC Care Coordinator facilitates the development of a CPT that is comprised of formal and natural supports of the youth and/or family's preference. The CPT includes, as appropriate, but is not limited to, the youth and family, the Care Coordinator, the Caregiver Peer-to-Peer Support staff, therapist, school personnel, relatives, primary care physician, prescribing clinician, clergy, other professionals providing services, state agency representatives, juvenile justice representatives, and others identified by the family. For youth enrolled in ICC who are in foster care or kinship care settings, the ICC provider works with DCF to determine the appropriateness of engaging the biological family in the ICC CPT based on the DCF permanency plan.
2. The youth is a core member and an integral part of the CPT. The youth is invited and supported to participate in every CPT in an age-appropriate manner. The ICC provider ensures the youth's participation to the greatest extent possible in developing and setting goals for ICC.
3. Using the information collected through the home-based assessment inclusive of the CANS, the Care Coordinator convenes and facilitates the CPT, which develops a youth-centered and family-centered ICP that specifies the goals and actions to address the medical, social, therapeutic, educational, and other needs of the youth. As part of the care planning process, the Care Coordinator works directly with the youth, the family, and others to identify the strengths, needs, and strategies of the youth and family in meeting their needs.
4. With consent, if required under applicable law, the Care Coordinator communicates and collaborates with other necessary individuals involved with the youth and his/her family, such as behavioral health providers including outpatient/in-home therapy services staff, DCF, DMH, DYS, and DDS workers, probation officers, guardian's ad litem, attorneys and advocates, teachers, special education administrators, primary care physicians and other physicians, and others. 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.

5. The Care Coordinator assists the family in identifying and including formal and natural supports and community-based agencies, services, and organizations, such as after-school programs, Big Brother/Sister, clergy, neighbors, and cultural organizations, in the care planning process. The Care Coordinator frequently contacts these key people by telephone and invites them to CPT meetings and with consent, provides them with copies of the completed ICP.
6. The ICC provider maintains linkages and a working relationship with local providers of all services in their service area to facilitate referrals from these providers and to ensure care is properly coordinated for youth and families served by both ICC and these providers.
7. The ICC provider maintains linkages and working relationships with the local ESP/MCI provider in their service area to facilitate referrals from the MCI provider and to ensure care is properly coordinated for youth and families served by ICC and ESP/MCI. With consent from the parent/guardian/caregiver, if required, when a youth and family involved in ICC is in need of intervention from ESP/MCI, as determined by the ICC provider, family and the ESP provider, the Care Coordinator is in contact with the ESP/MCI staff at the time of referral (or if not, the referral source immediately upon learning of referral to ESP/MCI) to provide relevant information, assistance, and recommendation for how ESP can best intervene to the ESP/MCI staff. If a youth is evaluated by a MCI team, and is awaiting placement for a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP):
 - a) ICC has daily contact with the caregiver to facilitate safety planning and stabilization in the home.
 - b) ICC has daily contact with the MCI provider for care coordination.
 - c) ICC convenes an emergency CPT to re-evaluate the youth's ICP and makes appropriate community-based referrals to stabilize youth in the community.
8. If the youth is determined to not meet level of care for a 24-hour behavioral health placement:
 - a) ICC has immediate contact with the youth and caregiver to update the safety plan and provide stabilization.
 - b) ICC convenes an emergency CPT to re-evaluate the youth's ICP and makes appropriate community-based referrals to stabilize youth in the community.
9. ICC needs to have a meeting with a family within 48 hours of MCI involvement.
10. The ICC provider maintains linkages and working relationships with the local Crisis Stabilization provider in their service area to facilitate referrals from the Crisis Stabilization provider and to ensure care is properly coordinated for youth and families served by both ICC and Crisis Stabilization.
11. With consent, if a youth is admitted to a 24-hour behavioral health level of care (e.g., Crisis Stabilization, inpatient hospital, CBAT, PHP), the Care Coordinator contacts the facility at the time of referral and provides preliminary treatment recommendations to initiate and guide treatment and schedules a CPT meeting at the facility within two days for care coordination and disposition planning. The CPT meeting includes the participation of the family and facility staff. The ICC provider and facility staff communicates and collaborate on a youth's treatment throughout his/her admission to develop, in concert with the family, a disposition plan that is consistent with his/her ICP. With consent, if required by applicable law, the Care Coordinator is required to participate in all meetings that occur during the youth's tenure in the facility as appropriate.

PROCESS SPECIFICATIONS

1. The ICC provider will adhere to a standard Operations Manual (and all subsequent revisions), that includes requirements related to successful completion of skill-based and competency-based training, care management provision and supervision requirements, care planning requirements, including a process for resolving disputes between team members, reporting of adverse incidents, and consent requirements. The Operations Manual will incorporate statewide interagency agreements concerning the role and responsibilities of representatives of each child-serving agency. The Operations Manual and other information related to ICC can be found at [Practice Guidelines | Mass.gov](#).
2. The ICC provider must comply with all requirements and standards in the ICC Operations Manual.
3. The ICC provider develops and maintains policies and procedures relating to all components of the ICC service that are consistent with the guidelines and standards in the ICC Operations Manual.
4. The ICC provider ensures all new and existing staff will be trained according to the guidelines and standards identified in the ICC Operations Manual.
5. The ICC provider ensures that all services are provided in a professional manner, ensuring privacy, safety and respecting the youth and family's dignity and right to choose.

Assessment, Treatment Planning and Documentation

1. Telephone the family within 24 hours of referral, including self-referral, to offer a face-to-face interview with the family, within three (3) calendar days for at least 50% of the clients, ten days for 75% of the clients, and no more than fourteen days for 100% of the clients to assess their interest in participation and gain consent for service.
2. Fourteen (14) days is the Medicaid standard for the timely provision of services established in accordance with 42 CFR 441.56(e),
3. The ICC provider will obtain voluntary consent required to participate in ICC.
4. Immediately upon gaining consent for participation, the ICC provider assesses the safety needs of the youth and family. The ICC provider, with the consent of and in collaboration with the youth and family, guides the family through the safety planning process that is in line with the family's present stage of readiness for change. This includes a review and use of the set of Crisis Planning Tools (e.g., Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) where appropriate and in accordance with the Companion Guide for Providers. As the family chooses, the ICC provider engages existing service providers and/or other natural supports, as identified by the youth and family, to share in the development of the Safety plan (e.g., Care Planning Team, Mobile Crisis Intervention, outpatient provider, etc.). The Safety Plan is reflective of action the family believes may be beneficial. This may include, but is not limited to, the following:
 - a) contacts and resources of individuals identified by the family who will be most helpful to them in a crisis,
 - b) goal(s) of the plan as identified by the family,

- c) action steps identified by the family,
 - d) an open format (the second side of the Safety Plan) that the family can choose to use as needed.
5. If a youth already has an existing Safety Plan or set of Crisis Planning Tools, the ICC provider will utilize the Safety Plan or set of Crisis Planning Tools as they apply to the current situation and/or reassess their effectiveness. Where necessary, the ICC provider collaborates with the youth's parents/guardians/caregivers and other providers, to build consensus for Safety Plan or Crisis Planning Tool revisions and to share them as directed by the family. The Safety Plan or set of Crisis Planning Tools will be confirmed and/or expanded as necessary at the first CPT meeting and subsequent meetings thereafter.
 6. The Care Coordinator reassesses the safety needs of youth and family as clinically indicated. The Care Coordinator for each youth reviews and updates the Safety Plan or set of Crisis Planning Tools. The youth and family's CPT will review the Safety Plan or set of Crisis Planning Tools periodically during CPT meetings. The Safety Plan or set of Crisis Planning Tools is reviewed and updated as needed but at a minimum after an encounter with the ESP/MCI team and at the time of discharge from a 24-hour facility. With signed consent, the ICC provider ensures that, for each youth, a written copy of the current Safety Plan or set of Crisis Planning Tools is sent to and maintained by the local ESP/MCI team.
 7. The Care Coordinator completes a comprehensive, strength-based assessment, consistent with Wraparound planning process and fidelity measures, in the home unless the youth and/or family choose another location. The comprehensive, home-based (whenever permitted) assessment includes interviews with the youth, parent/caregiver, family and other relevant persons, observations of the youth and the family, and use of the age-appropriate version of the Massachusetts CANS and the CRAFFT (youth 12 or older) within ten (10) calendar days of the date on which the family consented to ICC.
 8. If, upon referral to the CSA for the ICC service, a youth has already been assessed by a master's level behavioral health clinician who has determined a DSM-V diagnosis, the CSA may then have a non-master's level Care Coordinator complete the ICC comprehensive assessment, thus fulfilling the requirement for this youth. If, upon referral to the CSA for the ICC service, a youth has not already been assessed by a master's level behavioral health clinician who has determined a DSM-V diagnosis, the CSA must have a master's level behavioral health clinician (e.g., master's level Care Coordinator) complete the comprehensive assessment for this youth. It is not adequate for a bachelor's level staff to assess a youth with a DSM-V diagnosis for the purpose of evaluating SED criteria. Additionally, the CSA ensures that a behavioral health clinician, licensed at the independent practice level, reviews, and signs off on all comprehensive assessments completed by non-independently licensed staff.
 9. The Care Coordinator works with the family to determine the composition of their CPT.
 10. The CPT identifies strategies to meet the needs of the youth including the services the youth needs and coordinates with the service plans of child serving agencies. The CPT's determinations are incorporated into the ICP. The CPT is responsible for assisting the youth to access the needed medical, educational, social, and other services identified in the ICP.
 11. The first CPT meeting and the development of the ICP occur within 28 calendar days of consent to services. The Care Coordinator, together with the CPT, develops a youth-centered and family-centered ICP that specifies the goals and actions to address medical, social, educational, therapeutic, and other services that may be needed by the youth and

family. The ICP is subsequently revised at each CPT meeting to reflect changes or progress made since the last CPT meeting.

12. The second CPT meeting is convened within 30 calendar days of the first CPT meeting by the ICC Care Coordinator.
13. The CPT generally meets monthly, although 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. Each ICP must be reviewed at least quarterly.
14. ICC staff completes updates to the comprehensive clinical assessment, inclusive of the CANS and CRAFFT, every 90 days.
15. The ICP document is completed and distributed to CPT members within seven (7) calendar days of the CPT meeting.
16. The Care Coordinator, in consultation with the CPT, coordinates the implementation of the ICP, monitors the ICP, and modifies the ICP as needed. The Care Coordinator convenes the team as needed to reflect the changing needs of the youth and family. The Care Coordinator and the team perform such reviews and include whether services are being provided in accordance with the ICP, whether the services in the ICP are adequate, and whether there are changes in the youth's needs or status, and if so, adjust the ICP as necessary
17. Depending on the complexity and intensity of the youth and family's needs, the Care Coordinator, in collaboration with the family and CPT, determine the frequency of face-to-face contact with the youth and his/her family. Families presenting with higher intensity and/or more complex needs are anticipated to have more frequent meetings with their Care Coordinator than families presenting with lower intensity and/or less complex needs. The Care Coordinator documents the rationale for the frequency of visits for each family, including any missed visits and attempts to reschedule those visits in the youth's medical record. Visits/contacts are necessary to coordinate, communicate about, and monitor activities related to goals and services identified in the ICP and to assess and address changes in the child's needs.
18. The Care Coordinator will maintain at minimum weekly contact (telephonic or face-to-face) with the family of each enrolled youth they support.
19. When situations arise in which more than one MassHealth Standard-enrolled or CommonHealth-enrolled youth in a family requires ICC, the same Care Coordinator is assigned to all youth to ensure that services are coordinated and to minimize the number of individuals with whom the family/guardian/caregiver needs to communicate/work, unless the family/guardian/caregiver specifically requests a different Care Coordinator for the subsequently enrolled youth.
20. The ICC provider is available to provide support by phone or staff on-call pager to the youth and the family 24 hours a day, 365 days a year. During business hours (M-F, 8 a.m. - 8 p.m.), the ICC provider provides phone and face-to-face assessment of the need for ESP/MCI or emergency services and assistance with access to such services, including mobilizing to the home or community settings (e.g., school) to assess the youth's needs and coordinate responses to emergency situations. After hours (i.e., between 8 p.m. and 8 a.m. and on weekends), the ICC assesses the youth's need for crisis services and provides crisis support by phone. If, based upon the ICC'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. ICC

providers shall remain actively involved in monitoring and assessing the youth's need for services during MCI. An answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital ED, is not acceptable.

Discharge Planning and Documentation

1. The duration of ICC services is dependent on the youth continuing to meet medical necessity criteria for this service including an assessment by the CPT that ICC is continuing to support progress towards meeting the identified goals and the youth's age.
2. Prior to discharge from ICC, a CPT meeting is convened to develop an aftercare/transition plan for the family. The ICC conducts an assessment that utilizes the CANS to assist in identifying the youth's strengths and needs and making appropriate level of care recommendations. The aftercare/transition plan includes at a minimum:
 - a) documentation of ongoing strategies, supports, and resources to assist the child/adolescent and family in sustaining gains,
 - b) identification of the child/adolescent's needs according to life domains,
 - c) a list of services that are in place post-discharge and providers arranged to deliver each service,
 - d) a list of prescribed medications, dosages, and possible side effects, and
 - e) treatment/care recommendations consistent with the service plan of the relevant state agency for children/adolescents who are also DMH clients or children/adolescents in the care and/or custody of DCF, and for DDS, DYS, and uninsured DMH clients.
3. Prior to discharge, with consent, the Care Coordinator, in conjunction with the youth, family members, significant others, and all providers of care, develop an updated Safety Plan or set of Crisis Planning Tools. The purpose of the Safety Plan is to strengthen bridges within the family, the informal support network, and the formal treatment network as appropriate to each family. Its goal is to reduce or manage worsening symptoms, promote positive behaviors, prevent, or reduce the risk of harm or defuse dangerous situations.
4. The ICC provider ensures that the written Safety Plan or set of Crisis Planning Tools and aftercare/transition plan are both shared at the time of discharge from ICC services to the youth and parent/guardian/caregiver, and, with consent, to significant others, In-Home Therapy Services provider, outpatient or other community-based providers, ESP/MCI, the primary care physician/clinician, school, and other entities, and/or agencies engaged with, or significant to, the youth's aftercare.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.