



Children's Targeted Case Management

PRACTICE GUIDELINES

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Produced in collaboration with the University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Public Sector Innovation, Center for Learning.

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MISSION STATEMENT & PHILOSOPHY

Children's Targeted Case Management Services are grounded in the Wrap-around Process, and embrace the concept of child & family-centered planning. Case managers assist families to enhance their independence and self-determination in meeting the therapeutic needs of their child.

Some of the values of the Wraparound Process include the following:

- Treat children and families with fairness, respect, politeness, and compassion
- Learn about the family's history and strengths
- Gain an understanding of the family's culture
- Input from child/family is a central part of the process in planning services
- Collaboration is key; communicate with and develop ongoing relationships with other providers who the family agrees to have as partners
- Build and foster natural and community based supports

(Grealish, 2000.)

INTRODUCTION

These *Targeted Case Management Practice Guidelines* have been developed through a collaborative effort with the Department of Health & Human Services (DHHS) Children's Behavioral Health Services (CBHS), the Targeted Case Management (TCM) contracted agencies, and parents. The intent is to provide guidance to case managers and supervisors, and parents/guardians/ caregivers of children receiving services. The first edition of the *Case Management Practice Guidelines* (formerly *Case Management Standards*) was established on April 1, 2000. These *Guidelines* are effective July 1, 2005, and represent the second edition. They supplement and augment information provided in the DHHS-CBHS Children's TCM contract.

The *Children's Targeted Case Management Practice Guidelines* will serve as the programmatic foundation for Children's Behavioral Health Services contracted targeted case management services and are consistent with the following:

- Title 34B M.R.S.A. *5001 (DHHS-CBHS Statute)
- MaineCare Section 13.12
- DHHS-CBHS -Mental Health Licensing Standards-Community Standards
- DHHS-CBHS Rider A Contract Language
- Risinger Timeliness Standards (14 472 CMR Ch. XX CBHS Rule)
- DHHS-CBHS Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment

In the spring of 2003, the 121st Maine Legislature enacted PL 2003, Chapter 20, Part K, directing that the Department of Human Services and the Department of Behavioral and Developmental Services merge into a single department named the Department of Health and Human Services. The merger of the two Departments was accomplished by the passage of PL 689 by the Maine Legislature in May 2004.

DEFINITIONS

Agency	A firm, partnership, association, corporation, organization, or trust providing services to children as described in this manual.
Assessment	The process of identifying a child's strengths, problems and service needs for the purpose of developing the child's plan.
Case Record	A unified, comprehensive collection of documentation concerning services provided to a child. It includes all intake, evaluation, assessment, level of care determination, individual support planning documents as it relates to the child; any and all written notes regarding the child, the family or the care provided; any and all collateral information regarding the child or the family, including third party payer information; and information about crisis interventions. This is a confidential collection of documents, and shall not be removed in whole or in part from the agency premises.
Central Enrollment	<p>A unified process of determining baseline eligibility for services in accordance with Title 34B and Chapter 790 legislation, which governs the scope of the DHHS-CBHS.</p> <p>Goals of the Central Enrollment Process:</p> <ul style="list-style-type: none">• To ensure that every child requesting services from DHHS-CBHS has an intake assessment to determine baseline eligibility for CBHS services.• To facilitate referrals to appropriate service providers.• To expedite delivery of services to children in need of service(s).• To reliably track the service status of children enrolled in the system.• To gather data that will inform the Department of resource development needs.
Children's Enrollment Form (CEF)	The record of basic information needed by DHHS-CBHS to establish a child's enrollment into the system of care.
Child/Youth	Any person birth through their 20th year.

Child and Family Team	Individuals identified by the child and/or parent or legal guardian to help shape the direction of a plan for a child. The group should include the child, when appropriate, immediate and extended family members, guardians, relevant professionals, and any other community members significant to the child and/or family's life. Each family team is unique to the person(s) it supports.
Client	A child/youth who uses the services described in these guidelines.
Community Inclusion	Includes the participation of a child in typical community activities that are both age and developmentally appropriate and identified in the Individual Support Plan (ISP).
Community Support	Services and resources provided to a child that promote his or her inclusion in the community. Community Supports must be identified in the Individual Support Plan (ISP).
Confidentiality	A protection of private information (DHHS-CBHS Confidentiality Draft 6-25-01 and HIPAA regulations).
Crisis	A situation, condition or major event with a high probability of leading to the need for emergency intervention.
Critical Incidents	The reporting, evaluation, and analysis of critical incidents is a DHHS-CBHS Quality Improvement activity, as required by statute (Title 34B MSRA Section 1207). Informing children of this activity is the responsibility of the licensed contracting provider. See Appendix B for reporting procedures.
Cultural Competence	The ability to understand, respect and effectively work with children, families and groups of various cultural backgrounds, including age and gender.
Department	Department of Health and Human Services-Children's Behavioral Health Services, also referred to as DHHS-CBHS.
Eligibility	The process of meeting known requirements for a given service, before the service can be delivered.
Enterprise Information	The DHHS-CBHS integrated information system to support MaineCare/health planning, management, and quality

System (EIS) Evaluation	improvement for its service populations. A systematic process of data gathering and analysis for the purpose of determining a diagnosis(es).
Family	The people who are involved with the child—both formally and informally, including relatives, non-blood kin, friends, colleagues, neighbors, service providers, foster parents, spiritual leaders, volunteers, teachers, social workers, probation officers, counselors, sponsors and others who care about the child.
Family-Driven Care	Families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation (Federation of Families for Children’s Mental Health, http://www.ffcmh.org).
Family Involvement	Participation of the family members listed above in all aspects of their child’s services and treatment, and at all levels of care.
Flexible Funding	Flexible funds provide time limited funding to fill identified gaps in services that cannot be addressed through any other funding source. Services are designed to meet the specific, individualized treatment needs of the child and family that are identified on the child's individual support plan.
Grievance Procedure	Process by which a child and/or guardian enrolled in the DHHS-CBHS system of care may submit a formal complaint alleging any violation of basic human rights or a complaint related to the denial, decrease, or termination of MaineCare Services.
Guardian	Person(s) or agency with ongoing legal responsibility for ensuring the care of the individual. In the case of minor children (under 18), this may include biological or adoptive parents, or an agency appointed by the court.
HIPAA	The acronym for the Health Insurance Portability and Accountability Act of 1996 that requires the federal Department of Health and Human Services to establish national standards for addressing efficiency, effectiveness, security and privacy of health data.

Homeless Youth	A person under 21 years of age who lacks having a fixed, regular, and adequate nighttime residence or having a primary residence.
Individual Support Plan (ISP)	A comprehensive plan of care for the child that is based on results from a comprehensive strengths and needs assessment across the life domain areas in which specific goals and measurable objectives are developed. It should also be in compliance with DHHS-CBHS licensing requirements and MaineCare rules.
Individual Treatment Plan (ITP)	The plan of care developed by the treatment team in consultation with the family. The ITP uses a strengths-based approach to assess the treatment needs of a child and, when appropriate, his/her family circumstances. The ITP must consider and be appropriate to the developmental level of the child and shall address all the domains of a child's life. The ITP must specify the following: the service components to be provided; the names and titles of those who will be accountable for provision of the service; the frequency and duration of each service component; the expected duration of treatment; and the expected short and long-range treatment and/or rehabilitative goals or outcomes of the services. When there is an ITP for identified services, it should be referenced in the ISP.
Informed Consent	Consent obtained in writing from a child's legal representative, for a specific procedure or service. Elements of a valid informed consent include the following: the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided.
Intake	The collection of data and completion of initial paperwork by a provider agency.
Kinship Care	Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or clans,

godparents, stepparents, or any adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment. Kinship care is typically categorized in two ways - informal and formal:

- **Informal kinship care** is when the family decides that the child will live with relatives or other kin. In this informal kinship care arrangement, a social worker may be involved in helping family members plan for the child, but a child welfare agency does not assume legal custody of or responsibility for the child. The parents still have custody of the child. Relatives need not be approved, licensed, or supervised by the state.
- **Formal kinship care** involves the parenting of children by kin as a result of a determination by the court and the child protective service agency. The courts rule that the child must be separated from his or her parents because of abuse, neglect, dependency, abandonment or special medical circumstances. The child is placed in the legal custody of the child welfare agency, and the kin provide the full-time care, protection and nurturing that the child needs. Formal kinship care is linked to state and federal child welfare laws.
(from Child Welfare League of America)

Least restrictive alternative

The least intrusive service or treatment that can effectively and safely address the child's needs and stated preferences including, but not necessarily limited to, location.

Least restrictive treatment environment

"To a maximum extent appropriate, children with emotional, psychological, and cognitive disabilities will be treated in their families, schools, and communities, along with their typically developing peers. Removal of children with these disabilities from the families, schools, and communities will only occur when the nature or severity of the disability is such that the treatment cannot proceed safely or satisfactorily in their home, school or community. There is a broad range of restrictive environments from the most restrictive (locked inpatient psychiatric unit) to the least restrictive (at home, in the community). Least restrictive

environments vary with the child’s and family’s capacity and the child’s impairment at any given point in time” (Individuals with Disabilities Act Amendments of 1997, Sect 1412(a)(5)(A) and Section 300.550(b)(1)(2) of Title 34 of the Code of Federal Regulations).

Legal Representative

For a child under 18, the legal representative refers to those able to make decisions on behalf of the child and include the child’s biological or adoptive parents, legal guardian, or guardian *ad litem*.

Legally Emancipated Minor

A child over 16 who has a district court order of emancipation conferring power to make decisions about his/her care.

Level of Care

Type, frequency, and intensity of services.

Level of Care Assessment Tools

DHHS-CBHS approved Level of Care Assessment Tools are:

- Child and Adolescent Level of Care Utilization System (CALOCUS);
- Child and Adolescent Functional Assessment Scale (CAFAS); Family Empowerment Scale (FES);
- Ages & Stages Questionnaires (ASQ);
- ASQ Social-Emotional Questionnaires (ASQ: SE);
- Children’s Habilitation Services Assessment Tool (CHAT).

The purposes of the Level of Care Assessment Tools are to:

- Guide and inform decision making on the appropriate level and intensity of services and supports a child and family may need;
- Guide service and support planning for children and families;
- Measure and document child and family progress in identified functional and strength areas;
- Guide and inform caseload and resource planning activities;
- Evaluate the effectiveness of services and supports provided to children and families; and
- Guide statewide program and service system planning and development.

MaineCare Benefits for Members

Federal regulation requiring state Medicaid plans (MaineCare) to offer early, and periodic screening, diagnostic and treatment services to eligible children under

under 21 Medically Necessary Services	<p>the age of 21 (formerly called “<i>Early & Periodic Screening, Diagnostic, and Treatment</i>”).</p> <p>Services provided for the purpose of preventing, diagnosing or treating an illness, injury, condition or disease in a manner that is:</p> <ul style="list-style-type: none"> • Consistent with generally accepted standards of medical practice; • Clinically appropriate in terms of type, frequency, extent, site, and duration; • Demonstrated through scientific evidence to be effective in improving health outcomes or is generally accepted as representative of “best practices” in the medical profession; • Not primarily for the convenience of the child, their family, physician, or other health care practitioner.
Monthly Status Update Form	Information submitted by contracted agencies to DHHS-CBHS monthly capturing referrals for services, and the status of each referral.
Natural Supports	The relatives, friends, neighbors, faith-based organizations, and other community resources that a family goes to for support.
Open Status	The first face-to-face meeting with the child and/or family after service eligibility has been determined and informed consent has been obtained.
Outcomes	Measurable benchmarks in the child’s plan that indicate progress.
Outreach	A service that systematically reaches into the community for identifying children in need of services, alerting children and their families to the availability and location of services, and enabling people to enter and accept the service delivery system.
Parent	A person who provides a home for and lives with the child who is treated under this service. The parent may be the biological, adoptive, or foster parent; the legal guardian or designee, or a person who provides kinship care.
Performance Indicators	Measurable statements of outcomes, outputs, or inputs needed to achieve in order to accomplish a performance

	goal.
Permanency	A child lives or will live with a parent or caregiver; or will return to the parents/caregiver from a hospital admission, a residential treatment facility, or a youth correctional facility such as Long Creek and Mountain View Youth Development Centers; or lives in another planned living arrangement such as long-term foster care.
Policy	A statement of the principles that guide and govern the activities, procedures, and operations of a program or the provision of services.
Prior Authorization	A review of the child’s proposed treatment plan before the child enters treatment. The purpose of the review is to determine the clinically appropriate level of care. Prior authorization assesses whether the proposed treatment best meets the needs of the child, is within the standards of practice, and that discharge criteria and planning are initiated at time of admission. The Regional Offices of DHHS-CBHS or its designated contracted agency conducts prior authorization.
Prioritization	The assignment of a child to a position on the wait list based on the child’s level of need, when compared to others on the same list and/or number of days wait for services.
Procedure	A series of activities designed to implement the goals or policies of a program.
Program	An organized system of services with a mission, philosophy and model of service delivery designed to address the needs of children.
Progress Note	An objectively written note used to document ongoing information about the child and family, changes in their status, and progress made toward goals/objectives in the ISP.
Quality Management	Processes designed to assure and/or improve the quality and delivery of services within an organization.
Referral	Presentation of an identified child to an agency for a specific service.

Release of Information	Authorization from a legally responsible parent/guardian to obtain or disclose information.
Sliding fee	<p>The legislative directive (PL 2003, c.673) requiring families who receive certain state grant-funded services through DHHS-CBHS to pay fees according to a sliding fee scale. The fee requirement is imposed on all service providers under contract with DHHS-CBHS that receive grant funds for the following services:</p> <ul style="list-style-type: none"> • targeted case management • outpatient • home-based mental health services • respite care <p>The sliding fee scale is based on the federal, non-farm income, official poverty line data and is re-determined annually. These fees do not apply to children eligible to receive these services under the MaineCare Program. The rule was effective September 1, 2004.</p>
System of Care	A comprehensive array of services and supports for children, birth through 20, with behavioral and/or developmental health needs.
Targeted Case Management Services	Children’s targeted case managers utilize the Wraparound Process to develop and coordinate individual support plans and monitor services to be provided to a child and his/her family or guardian in consultation with the family, a multidisciplinary team of professionals from schools, child, welfare, mental health, and other agencies, and other support people chosen by the parents. Children’s targeted case managers conduct intake; coordinate comprehensive assessments of the child’s strengths and needs; produce an individualized support plan (ISP) to address those needs; coordinate, advocate for and develop services identified in the plan; monitor the child’s progress, and evaluate the appropriateness and effectiveness of services.
Transition Planning	Assessment, planning, referral, and interagency collaboration in the process of coordination of services for an adolescent beginning at 16 years of age in preparation for accessing services through the adult service system to help prepare for adult life. Education, employment, housing,

health and other significant areas identified by the young person and his/her family are all part of the planning process.

Trauma Informed System of Care

A system of care involving a basic understanding of trauma dynamics, including those caused by childhood sexual and/or physical abuse. This awareness is used to accommodate and address the vulnerabilities of trauma survivors. All components of the system of care, from policy to treatment, are considered and evaluated while understanding the challenges that trauma presents for those seeking mental health services.

Treatment

The broad range of planned and continuing services (including, but not limited to counseling, medical, psychiatric, psychological, and social service care) that may be extended to children of a program to influence their behavior toward identified goals and objectives.

Utilization Review (UR)

The process of ensuring that the clinical care provided to a child is consistent with best practice standards and is medically necessary, as defined in 24-A MRSA §4301-A, sub-§6, and is cost-effective. Utilization review is an ongoing process in order to ensure the child's treatment meets his or her changing developmental needs. Utilization Review as described in MBM, Chapter I also governs this Section.

V-9 Extended Care or Status

A written agreement for continued care that allows a child who is 18 through 20 years of age to continue to be under the care and custody of the Department of Health and Human Services. Normally, a child who reaches the age of 18 is automatically dismissed from custody and achieves full adult rights and responsibilities. The child may negotiate a written agreement with DHHS, Child Welfare Services for the following reasons:

- To obtain a high school diploma or general equivalency diploma, or obtain post-secondary educational or specialized post-secondary education certification;
- To participate in an employment skills support service;
- To access mental health or other counseling support;
- To meet specialized placement needs;
- Is pregnant and needs parenting support; or
- Has medical and special health conditions or needs.

No child in care may be accepted for continuing services after his or her 18th birthday unless an "Application and Agreement of Responsibility for Continued Care" (V-9) has been signed by both the child and the child's caseworker prior to the child's 18th birthday. Most children having this status must participate in full-time secondary or post-secondary education approved by the DHHS caseworker and that caseworker's supervisor.

Wait List

An unduplicated collection of names of children who have requested a service and for whom the service is not currently being provided.

Wraparound Process

A family and community centered, strengths-based, highly individualized planning process aimed at helping children meet their needs both within and outside of the formal human services systems, while they remain in their homes and communities, whenever possible.

INTAKE POLICIES & PROCEDURES

INTAKE POLICIES & PROCEDURES

The values of the Wraparound Process should be conveyed from the very beginning of the intake process when the relationship with the family is first formed (Grealish, 2000).

The agency must have a written protocol for providing a standard intake evaluation for all children and families served. The written protocol will delineate agency policies and procedures regarding the following:

- a) responding to the initial phone call or initial referral;
- b) referral information to be gathered and the method (oral, written, face to face) in which it may be gathered;
- c) incorporation of the Children's Enrollment Form (CEF) into the referral and intake process;
- d) criteria and procedures for transferring families from the wait list to active case management; and
- e) consistency of intake process with the Risinger Timeliness Standards set forth in 14 472 CMR Ch XX. (See *Service Time Frame* on Page 17 for specifics.)

ACCESS

The agency must have written policies and procedures describing how targeted case management services may be accessed by families, health care providers, schools, state agencies or others making a referral on behalf of a family. These policies will describe access for both a) non-emergency needs and b) crisis or emergency services.

DHHS-CBHS system of care clearly asserts the family/legally responsible person as having primary responsibility for fulfilling the needs of the child which includes participating in their child's treatment. Referrals/requests for targeted case management that are not directly initiated by the family must include the family as active, informed, and consenting participants. (See "Youth Accessing Services" in *Rights of Recipients of Mental Health Services Who are Children in Need of Treatment*, Part C, Section III-C.)

The agency must have a written policy regarding how they will inform each child and family of their rights as recipients of services in accordance with DHHS-CBHS

Rights of Recipients of Mental Health/Mental Retardation Services Who are Children in Need of Treatment.

The Children's Enrollment Form (CEF) will be used to gather basic demographic information for all children and families from all departmental populations (mental health, mental retardation/developmental disabilities, autism, and substance abuse) and sent to DHHS-CBHS within five (5) days. The CEF will be used at the first point of contact with the agency, wherever that occurs.

TIME FRAMES

Providers of Children's Targeted Case Management Services must deliver services within specified time frames as delineated in DHHS Mental Health Licensing Standards, where applicable, and Risinger Timeliness Standards.

The service time frame guidelines below identify targeted case management activities completed within specific time frames.

Service Time Frame

WITHIN 5 DAYS:

- A referral/request for service is made.
- The parent(s) have been contacted and want services.
- A Children's Enrollment Form has been completed and sent to DHHS-Children's Behavioral Health Services.
- Timeline standards for Risinger start with either a request for service OR the date of MaineCare eligibility—whichever is later.

WITHIN 30 DAYS:

- Secure releases.
- Collect treatment information/confirm service eligibility (a letter from an MD or arrange for a timely clinical assessment to be provided).
- Evaluations can be conducted by a psychiatrist, physician, licensed clinical psychologist, advanced practice psychiatric nurse, licensed clinical social worker, licensed master of social work/conditional, licensed clinical professional counselor, or a licensed clinical professional counselor/conditional, which includes primary and secondary diagnoses in accordance with the *Diagnostic and Statistical Manual of Mental Disorders IV* or the *Diagnostic Classification: 0-3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Diagnoses of mental retardation and autism will be accepted from a physician or a licensed clinical psychologist.
- Determine MaineCare eligibility. If not currently receiving MaineCare services, assist family in applying for benefits.

- Determine initial level of care.
- A case manager is assigned and will contact child & family within 5 business days.
- The child is in active service once first face-to-face contact has occurred and informed consent has been established.
- Explain the rights of recipients of mental health services and establish informed consent.
- A comprehensive assessment consistent with the Wraparound Process, which identifies the strengths and needs of the child and family across the life domains, is completed.
- DHHS-CBHS approved assessment tools are completed, consistent with the *Child/Adolescent Assessment Program Manual*, September 2003.
- ISP is completed within 30 days of child being in active service.

Within 180 days of request of services or date of MaineCare eligibility (whichever is later), all the above items must be completed in accordance with Risinger Timeliness Standards (14 472 CMR CH. XX CBHS Rule).

CENTRAL ENROLLMENT

Enrollment is a unified process of determining baseline eligibility for services in accordance with Title 34B and Chapter 790, which governs the scope of DHHS-Children's Behavioral Health Services, (formerly BDS, Services For Children with Special Needs).

When a referral for MaineCare Section 13.12 Targeted Case Management Services, Section 65 H Behavioral Health Services, or Section 24 Day Habilitation Services is submitted on a Children's Enrollment Form to the Department, a child is enrolled into the Department's system of care and the referral for service is entered into the Enterprise Information System.

WAIT LIST

All agencies providing Section 13.12 Targeted Case Management Services shall maintain a wait list. Separate, unduplicated wait lists shall be kept for the referrals to targeted case management services, using the child's full name. Siblings who have been determined to need the same services shall be maintained on the wait list as individuals, not as family groups.

Agencies shall have documented contact with the child's guardians, reevaluating the continuation of referral for service at least every 30 days. Copies of the wait lists themselves shall be provided to the Department by the 10th day of each month.

A child name is added to a wait list when:

- Parent/Guardian requests or confirms desire for service.
- MaineCare eligibility is confirmed/in place for the child.
- Diagnosis of eligibility is available and documented.

While a child is on a wait list, the following happens:

- The child has been offered or provided information and referral regarding other support and treatment services.
- The child is referred to other appropriate services including other TCM providers.
- The agency has contact with parent/guardian every thirty (30) days.

Removing a child from the wait list will occur when:

- The child's case is open for targeted case management services.
- The family declines service.
- Eligibility cannot be determined.
- The child is assigned to another TCM agency.
- The child is assigned to other appropriate services and no longer needs TCM services.
- The child moved out of the catchment area.
- The child is not eligible for services at this time.

SAFETY OF STAFF

The agency will have written policies and procedures to maintain staff safety when faced with issues of potential violence, public health issues, or other situations potentially dangerous to staff in the office or community. Every effort should be made to ensure the health and safety of staff while still meeting the needs of families. This may involve agreements to meet outside of the home to avoid significant health issues or potentially violent family members while assisting the family in addressing these issues. It is reasonable to share expectations of behavior and environmental health and safety with families, preferably as part of the informed consent sign-on process (intake). Termination or denial of services for these reasons is seen as a last resort, only if all other potential accommodations are exhausted.

TARGETED CASE MANAGEMENT LEVELS AND SERVICES

TARGETED CASE MANAGEMENT LEVELS AND SERVICES

Case managers understand that:

- families want to be able to manage their own services;
- families are capable of acquiring these skills or using existing skills;
- building in natural supports in the system of care increases independence for families; and
- families want to be able to re-access the system if needed in the future, once services have been terminated.

Families should have a level of targeted case management that best suits their needs. In addition to direct family input, the determination of the appropriate level of care should also include feedback from additional members of the child and family team and outcomes from the Level of Care Assessment tools.

Transition between levels of case management is to be expected and family desires and choices should be taken into consideration as much as possible.

Children and their families will receive services at the following levels of intensity:

- Level I addresses minimal to moderate needs and is specifically for those families needing information or help accessing resources or guidance in doing their own case management and advocacy. Children assigned this level are eligible to receive the least intensive level of care. Such services will focus on, but not be limited to: information, referral, support, advocacy, development of an individualized service plan, and the coordination of services. All children receiving Level I targeted case management services must have an individualized support plan (ISP).
- Level II addresses moderate to extensive needs and is for children with more complicated resource needs and/or family circumstances which require a higher level of intensity, frequency and duration of services than Level I case management. All children receiving Level II targeted case management services must have an individualized support plan (ISP) developed by a Child and Family Team.

CASELOAD SIZE

Unless otherwise mutually agreed upon between the Provider and the Department, the average minimum caseload ratio for targeted case management shall be:

1:25 for Level I

1:15 for Level II

It is expected that caseload sizes are consistent with quality services. Factors that should be considered in determining caseload sizes and assignments include geographic issues, financial resources available, intensity of caseloads, and diversity of service needs of a given caseload (serving only children from one of the levels or having a mixed caseload). The provider shall cooperate with the Department in monitoring caseload sizes.

COMPREHENSIVE ASSESSMENT AND LEVEL OF CARE DETERMINATION

COMPREHENSIVE ASSESSMENT

A comprehensive assessment must be administered to all children receiving targeted case management services. This assessment must:

- be completed within 30 days of opening of targeted case management services and must be obtained through direct face-to-face encounter(s) with the child and at least one parent or guardian.
- be updated annually, at a minimum (required by licensing standards).

The assessment process involves the ongoing collection of information from individuals who are familiar with the child and family, in order to increase the team's awareness of the child's and family's needs, strengths, and resources. In addition, the use of natural and formal supports should be thoroughly explored and documented throughout the assessment process.

The assessment process should:

- Occur on a continuous, evolving basis;
- Prioritize the child's and family's strengths, needs and interests;
- Allow the family to choose how they would like to be involved in the assessment process;
- Inform the family of the assessment process and timelines;
- Inform the family of legally mandated reporting requirements;
- Provide the family with copies of any information that is received or developed with or about them; and
- Provide information in a format that is understandable to the family and allows opportunities for the family to clarify or add information prior to any decision-making.

(Some of the above information was referenced and quoted from *Family-Centered Services for Children and Families Best Practice Standards and Essential Elements*, 1996.)

The assessment must, minimally, include the following:

- The child's strengths, needs, and interests;
- The family's strengths, needs, and interests;
- The child's perception of his/her strengths and needs;
- The family's perception of the child's strengths and needs;

- The child's and family's unique culture;
- Diagnosis with source and date;
- A personal, family, and social history, including a developmental history of the child;
- The child's physical health status and history, including use of prescribed and over-the-counter medication and level of access to medical care providers;
- The identified need for further cognitive function assessment, neurological assessment, and nutritional assessment;
- Reasons and lengths of stay for any admissions to a hospital or a residential treatment facility;
- Past and current drug and/or alcohol use;
- Physical and environmental barriers that may impede the child's and family's ability to obtain services;
- History of education and special education, successes, and needs;
- History of any traumatic experiences including: physical, emotional and/or sexual abuse or maltreatment, or other trauma;
- Past and current involvement with the juvenile justice system or the child welfare service system;
- The vocational, educational, social, living, leisure/recreational, and medical domains;
- The potential need for crisis intervention services;
- Possible sources of assistance and support in meeting the needs expressed by the child and family, including state and federal programs;
- Housing and financial needs; and
- The identified need for other evaluations and assessments.

Documentation of the results of all evaluations and assessments should appear in the child's record. The record should clearly delineate the source of all information, how it was obtained, and the date it was obtained.

LEVEL OF CARE DETERMINATION/ DESIGNATED SCREENING AND ASSESSMENT TOOLS

Upon completion or receipt of the comprehensive evaluation, the agency must further assess the child/family using the DHHS-CBHS designated screening and assessment tools. These tools include: the level of care determination, functional assessments, and evaluation of child, family and/or guardian strengths and resources. Only persons trained by DHHS-CBHS to administer the tools should perform these assessments. For further information, please use the *DHHS-Child/Adolescent Assessment Program Manual*, revised 10/16/03

and/or access the DHHS-CBHS website. The DHHS-CBHS website can be accessed through the following link:

http://www.maine.gov/dhhs/bds/children/Child_index.htm

Please use the visual tool below to identify the DHHS-CBHS approve level of care assessment tools:

PROGRAM SERVICE AREA	ASQ	ASQ:SE	CAFAS	CALOCUS	CHAT	FES
Case Management - Early Intervention	X	X				X
Case Management - Mental Health			X	X		X
Case Management - Mental Retardation/Autism				X	X	X
Children's Habilitation Services - Section 24				X	X*	X
Children's Behavioral Health Services - Section 65-H			X*	X		X
Children's Crisis Services				X		

*NOTE: Instrument includes the use of an intensity of services guide when being used for Section 24 or Section 65 H Services

DHHS-CBHS Level of Care Assessment Instruments:

- ASQ** Ages & Stages Questionnaires
- ASQ:SE** ASQ Social-Emotional Questionnaires
- CAFAS** Child and Adolescent Functional Assessment Scale
- CALOCUS** Child and Adolescent Level of Care Utilization System
- CHAT** Children's Habilitation Services Assessment Tool
- FES** Family Empowerment Scale

INDIVIDUAL SUPPORT PLAN (ISP)

OVERVIEW OF ISP PROCESS

The agency must have documented policies and procedures regarding the development of an Individual Support Plan for each child/family/guardian. The case manager will coordinate a Child and Family Team meeting for the development of an ISP for all children.

The Child and Family Team shall consist of the following individuals, at a minimum:

- the eligible child unless contraindicated; and/or
- the child's parent(s) or other legal or designated representative, such as legal guardian or advocate;
- other key persons identified and approved by the family, such as extended family members, friends, neighbors, and others who provide informal and natural support to the child and family and may assist in meeting their needs; and
- the case manager.

The following individuals may be included on the team as appropriate:

- a special education or other educational professional;
- a health/mental health professional (physician, psychiatrist; psychologist, social worker, nurse, crisis intervention worker, according to the needs of the child); and
- other key providers deemed appropriate by the Child and Family Team to identify and address the specific strengths and needs of the child.

A Child and Family Team will be created for all children and adolescents receiving Level II targeted case management services and, when appropriate, for children receiving Level I targeted case management services.

The Individual Support Plan or ISP is grounded in the principles and values of the Wraparound Process and embraces the concept of child and family planning.

The ISP is the comprehensive plan of care for the child based on results from both a comprehensive strengths and needs assessment. The comprehensive assessment of the child and family identifies their strengths and needs across

the life domains in which specific goals and measurable objectives are developed. Family teams may prioritize the life domain areas and decide which areas should be focused upon in the ISP. Safety for the child/family/community is of paramount importance in the ISP. Life domains may include (but are not limited to) the following:

- Safety
- Culture
- Health
- Legal
- Family
- Place to live
- Emotional/Psychological
- Social
- Permanent Relationships
- Spirituality
- Education
- Work
- Behavior
- Accountability
- Public safety
- Competency Development
- Restitution
- Finances
- Immigration/Citizenship Status
- Language/Communication
- Transportation

The ISP should be strengths-based, needs driven, and focused on outcomes. Need statements are specific, positive, and reflect a practical understanding of what it takes to get the child from point A to point B, and are written in the child's and family's words. Outcome statements are clear, optimistic, realistic, and measurable. The unmet needs, when met, become the bridges between the desired outcomes and the current reality. (Grealish, 2000.)

The ISP also includes strategies that will be used to approach identified needs. The child's and family's strengths and preferences are a central aspect of developing strategies. In addition, the ISP will have goals and strategies that empower parents to be their child's own case manager.

ISPs will include:

- Goal and Outcome Statements
- Needs

- Strengths
- Strength-Based Strategies
- Actions (services, supports, and specific tasks identified)
- Responsible person to complete identified tasks
- Crisis, Transition, and Discharge Plans
- Identification of clear measures when targeted case management services will no longer be needed

ISPs must be developed within 30 days from open service and must be monitored monthly. The ISP must be evaluated for effectiveness every 90 days (or more frequently as the needs of the child or family dictate).

The ISP review document must be included in the child's record.

Planning For Transitions As Part Of The ISP Process

Planning for transitions reflects a down to earth understanding of how difficult change is for all human beings. Children and their families have an active role throughout all phases of the planning process. Transitions throughout the normal course of life will be anticipated and planned for by the child and family team and documented in the child's ISP. This process will incorporate the formal transition plans (for example, education, employment, and adult services) (Grealish, M. 2000).

Whenever possible, agencies should follow these principles when assisting children and families with transition planning:

- To whatever extent possible, establish children and their families as their own "life managers."
- Assist families to arrange for continuity of support during residential, educational, employment, community, and other relevant life transitions.
- Enhance family's self-advocacy skills so that they can manage transitions as independently as possible.
- Consider the child's and family's skills, strengths, preferences, cultural values, challenges, interests, and personal goals.
- Assist families in identifying and accessing natural support systems.
- Incorporate the changing needs of children and their families, and provide support services that are individualized and flexible.
- Ensure effective collaboration among relevant support resources and services.
- Track outcomes and evaluate the effectiveness of transition plans.

(Deschenes, N. and Clark, H.B.,1999)

As part of the overall ISP process, the child/family must be provided with a full explanation of the risks and benefits of the recommended services and include the signature of both the child (as appropriate) and the parent/legal guardian. The child and family shall be provided with a copy of the ISP.

CRISIS/SAFETY

The agency must have documented policies and procedures regarding the development of crisis stabilization plans for each child. Case Managers are responsible for coordinating development of Individual Support Plans which "shall detail . . . a written crisis plan that identifies early warning signs of a possible crisis situation, behavioral indicators which necessitate crisis intervention, an indication of what actions have been helpful and/or hurtful in past crisis situations, and who to involve as well as who not to involve in resolving the crisis" (MaineCare Benefits Manual 13.12-3B(4)).

A crisis plan is a detailed, practical response that prevents or minimizes potential crises and safety issues.

- The plan must realistically and thoroughly assess whether or not the individual or family faces uncomfortable or difficult transitions and it plans how to help them manage change.
- Crisis planning should recognize the cyclical nature of crisis from equilibrium to escalation triggered by an event, a peak, then recoil and eventually a return to equilibrium.
- At a minimum, a plan must address potential safety issues that can help to keep children, families, and team members safe.
- Plans must be realistic, capturing the feelings, values and actual responses of individuals in crisis.
- Plans include as many informal supports as possible, capitalizing on positive relationships or helping to build them.
- A proactive crisis plan should be developed to prevent crises and identify known and potential "triggers" that could result in a crisis situation.
- The plan builds on individual, family and team strengths to achieve enduring change.
- There is a focus on positive actions rather than exclusive reference to what to avoid.
- The plan reflects a practical attitude about situations in which ongoing crises are likely to continue, despite intervention.

Transitional crisis plans should be developed when significant changes are expected in children's lives in order to reduce or eliminate the amount of time children spend in formal therapeutic environments. These plans should

acknowledge the universal difficulty of change, and account for differences in companionship, support, external motivation and structure.

(For further reading on how crisis/safety plans can be effective, please find more specifics in: Grealish, M. (2000). *The Wraparound Process Curriculum*, Orientation Part 2: How it Works, pages 38-39, Community Partners Inc.)

DISCHARGE FROM TARGETED CASE MANAGEMENT SERVICES

Discharge is the process of ending or terminating services with children and families. Discharge from targeted case management services should result from child and/or family functional improvement and/or family choice. The discharge planning process should be discussed regularly from the very inception of service delivery. The agency must have documented policies and procedures regarding the discharge planning process.

CBHS reason codes for closing/discharge in targeted case management are as follows:

1. Family has not responded to contacts (phone calls, letters or visits);
2. Family no longer wants services;
3. Child is currently receiving services through another agency;
4. Family has moved to a different area;
5. Child's goals have been met;
6. Child is currently in a long-term out of home placement (includes removal by DHHS or DOC);
7. Child was found to be ineligible for services; or
8. Other (any other reason given by the agency which does not meet one of the above categories).

It is also important to note the following procedures for discharge:

- A discharge summary must be entered into the child/family record within 15 days of discharge or on the 90th day of inactive status.
- The discharge summary must include documentation of the child's course of treatment as well as any ongoing needs at discharge.
- A letter must be sent to the family notifying them of the closure.

Each discharge summary must also minimally address, but need not be limited to, the following (Licensing regulations, CS 15. A. 1. - CS. 15. A. 4.):

- The reasons for termination of service;
- The final assessment, including the general observations and significant findings of the child's condition initially, while services are being provided and at the time of discharge; (To ensure that required assessments are completed at the time of discharge, please see CBHS' Children's

Assessment Instruments, revised 10/16/03, on page 26 of these *Practice Guidelines*.)

- The course and progress of the child with regard to each identified problem; and
- The recommendations and arrangements for further continued services if needed.

Some principles that define best practices for discharge planning as well as incorporate the Wraparound Process are as follows:

- Assist children and their families in not only accomplishing goals that were established in the ISP, but also help them develop plans to pursue and maintain gains they can achieve after discharge.
- Help children and their families anticipate stressors and negative forces that may lead to a crisis, as well as identify interventions.
- Help children and their families plan for potential crisis that may occur immediately after discharge. Assist children and their families to safely manage the crisis, as well as to be closely connected with both formal and informal supports so that they are not navigating the system alone.
- Provide opportunities for a family member to facilitate team meetings so that eventually the case manager plays less of a role on teams and over time, no longer needs to attend team meetings.
- Recognize that in order for services to end, families don't need to be free of all problems. Be realistic about what can be accomplished in this process.
- Be sensitive to the loss, sadness, joy, and sense of accomplishment that families may be experiencing at the time that services are terminated.

(Some of the above language that defines best practice is referenced from Lee LeGrice, n.d. *Begin with the End in Mind: Strategies for Successful Graduations*.)

TRANSITION

Agencies should have written policies and procedures for children and their families transitioning to adult services. They should also have written policies and procedures for children and their families who may be experiencing transitions to/from the following settings:

- Schools
- Hospitals
- Foster Care
- CDS (Child Development Services)
- Juvenile Justice/Corrections Facilities
- Group Homes
- Homeless Shelters
- Residential Care/Treatment Facilities

Case managers should be provided with ongoing professional development training opportunities as needed. Training curricula should include how to support children and their families throughout the transition, including an awareness of the impact and dynamics of trauma during transition, as well as responsive interventions.

Some best practices related to the overall process of transition are:

- Revising/monitoring the child's transition plan, ensuring that it is consistent with Wraparound Process principles and pertinent to the unique circumstance that the child and family are experiencing;
- Identifying risks, strengths-based interventions, and resources that may help to meet the child's needs;
- Establishing protocols to determine the need for further assessments and follow up;
- Assisting the family to identify and explore natural and formal supports, and to whatever extent possible, supporting them to access these supports as soon as they are available;
- Assisting families to be fully involved and empowered as partners in the child's transition; and
- Working toward full engagement and active involvement of the child throughout the transition process.

Memoranda of Understanding exist between DHHS-CBHS and other child serving state departments outlining resources and protocols that are in place for children and families experiencing transition. These include:

- The Protocol for the Coordination of Transition of Children Under BCFS Care to the Adult Service programs Under BDS or BEAS – October 2002;
- BDS Case Management Transition Guidelines for Children Needing Adult Mental Retardation Services – October 2003; and
- The “at risk” protocol/agreement with DHHS/BCFS for children receiving Intensive Temporary Out-of-Home Treatment Services (ITOOHTS).

The following site can be accessed for more information:

http://www.maine.gov/dhhs/bds/children/Child_index.htm

QUALIFICATIONS OF CASE MANAGERS

(from Section 13.12-4, MaineCare Benefits Manual)

Targeted case management services may be provided by the following qualified staff:

Level I Case Manager

Level I case managers may be either professional positions as defined for Level II case managers, or may be performed by agency staff who have parented a child or adolescent with special needs. For staff who perform Level I services, the designated provider shall specify staff qualifications, training, and ongoing supervision, which must be approved by DHHS-CBHS.

Level II Case Manager

Level II case managers are professional positions. Staff must have a minimum of:

- a Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, child development, special education, counseling, rehabilitation, sociology, nursing or closely related field; or
- be a graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, or closely related field; or
- be a Registered Nurse with at least two years of full-time equivalent psychiatric experience with children or adolescents; or
- have a Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one year of full-time equivalent relevant human services experience.

QUALIFICATIONS OF CASE MANAGER SUPERVISORS

Supervision of case managers providing targeted case management services to children or adolescents with emotional disturbance, behavioral disorder, or mental illness must be provided by a:

- licensed psychiatrist,
- licensed psychologist,
- licensed clinical social worker,
- licensed clinical professional counselor,
- advanced practice psychiatric nurse, or a
- psychiatric nurse or a licensed social worker as defined in Professional Staff in MaineCare Benefits Manual.

All professional staff must be conditionally, temporarily, or fully licensed and approved to practice (advanced practice registered nurses) as documented by written evidence from the governing body. All professional staff must provide services only to the extent permitted by Qualified Professional Staff licensure and approval to practice (advanced practice registered nurses).

- A **Social Worker** must: a) hold a Master's degree from a school of social work accredited by the Council of Social Work Education, and b) be either licensed or certified in accordance with 32 M.R.S.A., Chapter 83 & 7001 or be eligible for examination by the Maine Board of Social Worker Registration, which eligibility is documented by written evidence from such Board.
- A **Licensed Clinical Professional Counselor**, a **Psychiatrist**, and a **Psychologist** must be licensed in the state or province in which services are provided.
- A **Psychiatric Nurse** must be licensed as a registered professional nurse and certified by the American Nursing Credentialing Center or other acceptable national certifying body for this specialty.
- An **Advanced Practice Psychiatric Nurse** must be licensed as a registered professional nurse, certified as a psychiatric nurse practitioner or psychiatric and mental health clinical nurse specialist by the American Nurses Credentialing Center, and approved to practice as an advanced practice registered nurse by the Maine State Board of Nursing, or other acceptable national certifying body for this specialty, within the specialty of psychiatric nursing.
- **Supervisors of Case Managers** providing targeted case management services to children and adolescents with mental retardation or pervasive developmental disorder must have:
 - a Bachelor's Degree, plus a minimum of four years experience in the field;
 - experience supervising staff providing these services;
 - knowledge of the public education system in Maine; and
 - training in flexible funding and family focused service provision.

Supervision

The agency providing targeted case management must have written policies and procedures regarding the provision of supervision of case managers. The policies and procedures must delineate the provision of: a) clinical/program supervision and b) administrative supervision, and shall further define the interrelationship between administrative managers and clinical/program supervisors. Clinical supervision will be provided as appropriate to the clinical specialty of the case manager, and as mandated by applicable government entities, professional associations, or similar bodies.

ROLE & SKILLS OF SUPERVISORS

Role of Supervisor

The role of the targeted case management supervisor is to teach & guide the case manager in areas of:

- Wraparound Process
- Professional Ethics
- Best Practices
- Family Systems
- Family Engagement
- Assessment
- Diagnosis & Treatment needs
- Safety of Child, Family, and Staff
- Transition & Discharge Planning
- Licensing & Compliance Requirements
- Time Management
- Development of formal & informal resources
- Advocacy
- Identification of trauma history

The supervisor should meet regularly with the case manager to monitor and evaluate the performance of the case manager in the coordination and delivery of services.

Targeted Case Management Supervisory Skills

Targeted case management agency staff must have an understanding of and adherence to policies, procedures, and guidelines identified in the DHHS-CBHS contract specifications for Targeted Case Management Services and MaineCare Benefits Manual, Section 13.12. These include but are not limited to the following:

- Intake & Assessments

- Eligibility Determination
- Enrollment & Reporting requirements
- Discharge Planning
- Crisis/Safety planning
- Development of Individualized Support Plans

Research/Evaluation Skills

Outcome Evaluation Systems & Data Collection Skills: Supervisors should have the knowledge and skills to effectively develop and implement a tracking system that evaluates how outcomes for children and their families have been determined and achieved.

Optimizing the reliability and accuracy of data collected: Supervisors should have skills in identifying areas for data collection, analysis of data collected, and how data will be utilized.

(For more information: Grealish, M. (2000). *The Wraparound Process Curriculum*; Competency Development for Supervisors and Managers, Community Partners Inc.)

Recognition of Skills & Talents in Current and Prospective Staff

Supervisors must have the ability to recognize the skills, talents, and attributes that make staff efficient at implementing the Wraparound Process, as well as have the ability to recruit and hire potential staff with these attributes. They must also have the ability to recognize how case managers apply their skills, talents, and attributes to practice. (For example, supervisors should support case managers toward implementing their knowledge of a strengths-based approach into their daily practice as facilitator and coordinator of services for children and their families.)

Use of Supervision

Supervision of full-time case managers must, minimally, meet the following licensing standards: 4 hours per month for case managers not licensed to practice independently or the amount of supervision required by their professional licensing authority (whichever is greater).

Time spent in supervision should be structured in ways that are aligned with best practices and professional standards. Actual time in supervision should include discussions and guidance of the implementation of Wraparound Process values and principles related to everyday practice.

TRAINING & COMPETENCIES OF STAFF

Role of the Case Manager

The role of targeted case management is to consistently work with the family to assist in:

- Understanding the treatment needs of the child;
- Identifying the child's and family's strengths;
- Increasing knowledge and development of natural supports and community resources;
- Developing self-advocacy skills;
- Utilizing a proactive and collaborative planning process; and
- Enhancing service coordination skills.

Core Competencies

The Children's Services Case Management core competencies listed below were developed in 2002-2003 by a workgroup charged with identifying consistent expectations relating to knowledge, skills and attitudes of case managers. The workgroup consisted of representatives of the Department, the Muskie School's Center for Learning, and agencies that provide children's targeted case management services. The following core competencies reflect best practice and may involve a combination of training, background, education, experience, and supervision. These core competencies are not mandated training requirements but are meant to guide agencies in the development of their internal training curriculum.

Children's Services Case Management Competencies:

1.00 Legal and Statutory Bases

- 1.01 **Rights of Recipients:** Has an understanding and knowledge of the rights of recipients for DHHS-CBHS children's services within state and federal laws.
- 1.02 **Legal Supports:** Understands and has a working knowledge of the Risinger Settlement Agreement and other relevant legal supports.
- 1.03 **Guardianship:** Understands guardianship laws and issues as they pertain to DHHS-CBHS and Corrections.
- 1.04 **Behavior Management:** Knowledge of regulations surrounding emergency and behavior management interventions.
- 1.05 **Mandatory Reporting:** Understands responsibility, laws, policies and procedures of reporting suspected child abuse. Understands incident report procedures.

2.00 Definitions

- 2.01 **Definition of Population:** Has a basic understanding of the mental illness disorders and developmental disabilities as listed within the Diagnostic and Statistical Manual.
- 2.02 **Major Mental Health Disorders:** Understands "major mental health disorders", including "severe and profound mental illness" as categorized in the Diagnostic and Statistical Manual and prioritized within the medical and mental health systems.
- 2.03 **Signs and Symptoms:** Understands and recognizes the many signs, symptoms and indicators associated with behavioral and developmental diagnoses.
- 2.04 **Behavioral Health:** Understands the definition of behavioral health, within a continuum of behavioral health and health issues.
- 2.05 **Severe and Prolonged Mental Illness:** Knowledge of the category "severe and prolonged mental illness" as identifying special needs and a criterion for services.
- 2.06 **Trauma Disorders:** Understands trauma-based disorders and symptoms, and recognizes the signs, symptoms and indicators associated with severe abuse and neglect trauma.
- 2.07 **Co-occurring Disorders:** Understands the occurrence of multiple disabilities/disorders, including those of addiction, medical conditions, PTSD and other trauma related conditions, developmental disabilities, and mental retardation; understands the importance of collaborative efforts among multiple providers.

3.00 Assessments

- 3.01 **Initial Screening:** Understands and uses appropriate screening techniques for children's case management services.
- 3.02 **History and Background:** Understands and utilizes appropriate techniques to develop an accurate historical picture of the child and family, including traumatic experiences of individual child and family system.
- 3.03 **Assessment Tools:** Is able to utilize a wide range of strengths-based, family-centered, level-of-care, assessment tools to determine the child's level of need. Is able to assess for existence and impacts of abuse to determine most appropriate interventions and/or referrals.

- 3.04 **Information and Referral:** Is able to provide appropriate information, support and assistance based on the child's and family's strengths and needs.
- 3.05 **Confidentiality:** Understands, explains and follows procedures regarding confidentiality, informed consent and rights of recipients.
- 3.06 **Safety Check:** Is able to assess safety of child and of family, provide assistance as needed and/or provide referral to safety services.
- 3.07 **Connection to Planning Process:** Able to use assessment information for planning process.

4.00 Approaches to Children's Services

- 4.01 **Bio-psychosocial Practice:** Understands holistic practice that includes an understanding of the physical, social, emotional, and spiritual aspects of each person served.
- 4.02 **Psychosocial Rehabilitation Techniques:** Has knowledge of client centered psychosocial rehabilitation techniques.
- 4.03 **Medical Model:** Understands the theoretical framework and dynamics of the medical model's approach to mental health.
- 4.04 **Trauma Model:** Understands impacts and sequel of psychological trauma (e.g. physical, sexual abuse, severe neglect, witnessing of violence). Understands the theoretical framework and dynamics of the trauma model's approach to behavioral health, how it differs from the medical model, and ways in which both models may integrate for the benefit of the child. Knows the connection of the trauma model to diagnoses of mental and addictive disorders.
- 4.05 **Recovery-based:** Understands that recovery is possible, individually defined and developed on the basis of hope, self-determination, empowerment, and the skills and resources to support wellness.
- 4.06 **Family Systems Model:** Understands the theoretical framework and dynamics of the family systems approach to behavioral health issues.
- 4.07 **Cognitive and Behavioral Model:** Has a working knowledge and understanding of the cognitive and behavioral model approach to mental illness.
- 4.08 **Complementary Practices:** Has an understanding of new and promising approaches to mental illness and/or trauma disorders, for example the narrative model or body therapies.

- 4.09 **Spirituality:** Understands the dynamics of spirituality as it relates to the support of behavioral health issues.
- 4.10 **Role-Modeling:** Actively incorporates and demonstrates personal and professional empowerment principles such as conflict management, assertive communication, respect and acknowledgment of biases.
- 4.11 **Basic Pharmacology:** Has knowledge of basic pharmacology including therapeutic effects and side effects in conjunction with the service recipient's viewpoint on both.

5.00 Child And Adolescent Development (Cognitive, Psychosocial, Physical)

- 5.01 **Developmental Stages:** Has a basic understanding of stages, process and milestones of normal physical, cognitive, social, and emotional development for infants, children and adolescents through post adolescence (21 years).
- 5.02 **Social Development:** Understands the importance of recreation and leisure, developing friends and becoming part of a peer group.
- 5.03 **Developmental Disabilities:** Has a basic understanding of the variety of developmental disabilities including mental retardation, cerebral palsy, epilepsy, autism, spinal bifida, Down's syndrome, attention deficit disorder, fetal alcohol syndrome, pervasive developmental disabilities and other conditions that delay or impair development.
- 5.04 **Developmental Challenges:** Understands how mental illness or emotional problems, and mental retardation or learning disabilities, and adverse childhood experiences such as physical and sexual abuse, neglect, and witnessing of violence can affect children's rate and retention of learning and contribute to variations in performance.
- 5.05 **Bonding and Attachment:** Understands importance of bonding and attachment with primary caregivers and the results of disruptions in this process, and feelings and behaviors associated with this disruption.
- 5.06 **Adolescent Mental Health:** Knows the primary symptoms of serious emotional disturbances, early and/or ongoing history of abuse, and mental illness of adolescents, and how these can impact learning and development.
- 5.07 **Physical Development:** Understands the physical changes experienced in childhood and adolescence and the effect on sense of self and identity.

- 5.08 **Identity Formation:** Understands that during adolescence children are developing their sense of personal identity and that they may need access to resources to help them deal with the complexities of formulating their answer to the question - "Who am I?".
- 5.09 **Emotional and Psychological Independence:** Understands that children and youth may vacillate between their desire for independence and need to be dependent as they assert their independence and individuality, and as a result may exhibit mood and behavioral swings.
- 5.10 **Sexuality:** Understands that children and youth's personal identity includes their own attitude about what it means to be male or female, which influences values about sexual behavior and their sense of masculinity and femininity.
- 5.11 **Developing Value System:** Understands that children and adolescents develop their own value system and will join with, as well as have conflict with, family, friends, and others at this time as they define their own ideology.
- 5.12 **Spirituality:** Knows of and respects spiritual beliefs and festivals and is able to guide youth as they discover and grow within their religion and learn about others.
- 5.13 **Abuse and Neglect:** Understands the impact on children's physical, cognitive, social and emotional development as manifested during different ages and stages of development.

6.00 Working with Children and Youth

- 6.01 **Developing Competencies:** Creates opportunities for families to connect positively and for children and youth to build on strengths and to encourage practicing skills, learning about relationships, and connecting with their community.
- 6.02 **Cultural Awareness:** Understands the need for children and youth to explore their culture.
- 6.03 **Enhancing Self-Esteem:** Has a willingness to work with children and youth to identify activities that challenge them to gain confidence in their skills, to demonstrate knowledge and to develop their capabilities.
- 6.04 **Self as Resource:** Provides youth and families with opportunity to recognize self as a resource for others because of life experience (e.g., legislation, training professionals).

7.00 Education

- 7.01 **Educational Resources:** Knows the services and resources that contribute to children and youth's positive educational outcomes and helps the family access them (e.g., knowledge of Special Ed 504 accommodations and partnering with continuum of care through Child Development Services).
- 7.02 **Post-Secondary Preparation and Options:** Works collaboratively with school officials and guidance counselors to identify appropriate plans for supports and services to assist youth in preparing for post-secondary education. Knows programs and services for youth who choose to continue their education (e.g., Job Corps, vocational and higher education, etc.).
- 7.03 **Educational Goals:** Works with children and youth to develop educational goals and a plan for attaining these goals.

8.00 Substance Abuse

- 8.01 **Dynamics and Indicators:** Understands substance use as a continuum and recognizes the dynamics and indicators of substance use/abuse problems that occur throughout the continuum.
- 8.02 **Use:** Understands reasons why youth may choose to use alcohol and other substances, and recognizes when substances are used as a way of coping with trauma.
- 8.03 **Resources:** Works with youth to identify treatment and prevention services and to understand referral procedures so that youth are able to address substance abuse issues.
- 8.04 **Addiction:** Understands dynamics of, and various philosophical approaches to addiction, such as disease, trauma, self-medication, bio-psychosocial perspectives.
- 8.05 **Dual Diagnosis:** Understands and is able to identify symptoms and dynamics of dual diagnoses and the need for collaborative efforts for better therapeutic outcomes for this population.
- 8.06 **Recovery:** Understands and is able to identify stages of recovery from addiction and the effects of the recovery process on family members and care providers.

9.00 Teen Parenting

- 9.01 **Resources:** Knows resources that are available to youth who become parents (e.g., prenatal care, hospital services, parenting programs, delivery education, well-child care, immunization schedules, support groups, adult education and financial entitlements).
- 9.02 **Pregnancy:** Works with youth to assess options, identify services, and secure support as needed during pregnancy.
- 9.03 **Parenting Skills:** Works with youth to identify classes and other programs to develop skills needed to successfully parent.

10.00 Health – Maintenance Services

- 10.01 **Managing Medical, Dental, and Mental Health Needs:** Works with families and children to help them manage their own medical, dental, and mental health needs by helping them gain an understanding of their health care needs and the importance of keeping appointments, maintaining records and complying with insurance/MaineCare requirements.
- 10.02 **Identifying Health Resources:** Works with families and children to identify and connect with appropriate health resources in their own communities.

11.00 Life Skills for Youth

- 11.01 **Continuum:** Understands the four-stage continuum (informal learning, formal learning, supervised practice and self-sufficiency) that enables youth in independent living programs to move through a series of phases to acquire tangible and intangible skills.
- 11.02 **Needs and Goals:** Understands that youth's acquisition of life skills is dependent on their own developmental needs and their independent living goals.
- 11.03 **Core Skills:** Knows and understands core set of life skills and approaches for youth to learn/practice the skills.
- 11.04 **Joint Planning and Consistency:** Knows the importance of joint planning and of consistency in approach and expectation by all adults teaching independent living and self-management skills to youth.

- 11.05 **Practices:** Consistently works with youth to create opportunities to practice daily living skills in a real world environment to promote confidence.
- 11.06 **Trauma Symptom Management Skills:** Understands dynamics and symptoms of trauma and knows core set of symptom management skills that empower youth to gain understanding and mastery over impacts of trauma.

12.00 Community Services

- 12.01 **Community Based Supports and Services:** Has a working knowledge of the community based service agencies and supports available to assist children with behavioral health issues, and their families.
- 12.02 **Residential - Out of Home Services:** Has a working knowledge and understanding of the residential and hospital based services available to assist the children and their families.
- 12.03 **Residential In-Home Supports:** Is knowledgeable about resources available to provide in-home supports to families.

CONFIDENTIALITY & RECORD-KEEPING

CONFIDENTIALITY

Agencies must have a written policy and procedure regarding confidentiality and protocols for record-keeping for children and families. These policies should describe how and when providers are able to share information. In addition, they must ensure that confidential information about the child and family is protected. Minimally, agency policies and procedures will meet the following standards:

- Make every effort to restrict information from being shared for inappropriate purposes and inappropriate situations;
- Notify families of any potential circumstance in which information may be disclosed without consent; and
- Whenever possible, make every effort to seek consent from families before disclosing information.

Suggestions for Best Practices:

- Engage in conversations about the child and family with professionalism and only in appropriate, relevant settings.
- Provide the child & family with as much control over their privacy as possible at all times.
- Before disclosing any private information about a child and family to any external source, be clear about the purpose and goal of that disclosure and ensure that it is in compliance with the HIPAA Privacy Rule. (See reference below.)
- Within the office, make reasonable efforts to limit access only to employees who need it as part of their work responsibilities.
- Provide training to new employees regarding confidentiality and HIPAA compliance.
- Provide ongoing training regarding confidentiality and HIPAA compliance for all employees as needed.
- Provide training relating to confidentiality and circumstances with sensitive status, such as HIV and substance abuse.

(Some of the above information was taken from Gudeman, R., July-September 2003, *Journal of the National Center for Youth Law*.)

RELEASE OF INFORMATION

A release form signed by the parent/guardian, and child when appropriate, is required for all requests for information, whether this release is for information **FROM** another party or is for information in the child's file that is to be released **TO** another party.

- Information released will be only what has been designated by the child/parent /guardian and is limited to the specific purpose noted on the release form.
- Children/Parents/Guardians have the right to review the information being released prior to its release, unless waived.
- A release of information should be time-limited and specific to its purpose. Under no circumstance will a release of information be valid for longer than one year.
- The description of the information and the purpose for which it is being obtained or released must be written clearly on the release form.

The recipient and the recipient's legally responsible parents, guardians or custodians have the right to review the recipient's record at any reasonable time upon request, including prior to its authorized release. Rights of Recipients can be accessed at the following website:

http://www.maine.gov/dhhs/bds/children/Child_index.htm

Court and legal mandates may require information to be given without consent of the child/parent/guardian. The child/parent/guardian will be informed in writing as soon as possible, except when safety issues or emergency situations exist.

Agencies must have written procedures delineating compliance with DHHS-CBHS contract stipulations pertaining to the confidentiality of all records and information for children regarding the following:

- a child of divorced parents
- HIV status and test results
- treatment and diagnosis of drug or alcohol abuse
- confidentiality as it relates to child abuse and mandated reporting laws
- use of cellular phones
- use of fax machines
- use of electronic mail (email)

Agencies must have written policies and procedures regarding the protection of confidentiality of each member of a family when the agency is actively involved in case management and/or with other service providers for 1 or more members of the family. Policies and procedures should be consistent with the HIPAA privacy rule.

(For more information see: Summary of the HIPAA privacy rule, HIPAA Compliance Assistance. United States Health & Human Services. OCR Privacy Brief. Website address: <http://www.calhipaa.com>.)

RECORD-KEEPING

Agencies must have written policies and procedures regarding the maintenance, upkeep, and confidential security of the case records. Case records must be kept in a locked file, withdrawn only by those staff privileged to the information therein, and returned to the locked file at the end of each working day.

A **case record** is a unified, comprehensive collection of documentation concerning all services provided to a child. It includes:

- all intake information
- evaluation(s)
- assessment(s)
- level of care determination
- Individual Support Planning documents
- any and all written notes regarding the child, the family, or the care provided
- any and all collateral information regarding the child or the family, including third party payer information; and information about crisis interventions.

This is a **confidential** collection of documents. Only the case manager, his or her supervisor, and other agency staff such as clinical professionals involved in the child's care, or quality assurance staff, shall obtain information from a case record without the child's (or guardian's) prior written consent.

Any and all information regarding the child is to be kept confidential and secure at all times.

QUALITY MANAGEMENT – OUTCOMES

POLICIES AND PROCEDURES

Each agency must have written policies and procedures in place, which ensure that each child/family is provided with quality services. The policies will clearly delineate how the Individual Support Plan outcomes will be measured, documented, and utilized. Support outcomes must be:

- Targeted
- Objective
- Observable
- Measurable

The agency must have written policies and procedures which govern when and how the Individual Support Plan will be evaluated. Best practice guidelines for targeted case management recommend ongoing evaluation of the ISP; however, compliance with contractual agreement, mental health licensing, and MaineCare rule requires evaluation of the ISP minimally every 90 days.

The evaluation must include:

- Review of a child's status or progress in the support plan or service interventions;
- Documentation of changes or modifications in the ISP if there is little or no change or progress in the above;
- Level of Care status;
- Changes in child/family strengths/needs; and
- Documentation of the evaluation of the ISP.

Agencies are required to submit data to the Department which measure, record, and reflect their overall process of case management delivery. These may include but are not limited to:

- Utilization of crisis services
- Discharge criteria of ISP goals or objectives

- Implementation of Wraparound values, principles
- Number of children moved from the wait list to active case management
- Number of children moved from more restrictive environments to less restrictive environments

An agency's reporting requirements are stipulated in their contractual agreement with DHHS-CBHS and include the following forms:

- Children's Enrollment Form (CEF)
- Children's Change of Status Form
- Quality Improvement Plan
- Monthly Status Report for Case Management Services

In addition, each agency must have policies and specific procedures used for measuring and evaluating child and family satisfaction with services provided to them.

RESEARCH & EVALUATION (Outcome Evaluation Systems)

For suggestions of best practices regarding Outcome Evaluation Systems, the following source is referenced: Grealish, M. (2000). *The Wraparound Process Curriculum*, Competency Development for Supervisors and Managers: Community Partners, Inc.

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- Risinger Timeliness Standards* (14 472 CMR CH. XX CBHS Rule).
- Summary of the HIPAA Privacy Rule*, HIPAA Compliance Assistance. United States Health & Human Services. OCR Privacy Brief. Website address: <http://www.calhipaa.com>

INTERNET RESOURCES

The websites listed below will provide you with more information about targeted case management and the Wraparound Process:

http://www.maine.gov/dhhs/bds/children/Child_index.htm

<http://www.maine.gov/dhhs/bms/general.htm>

www.WraparoundSolutions.com

For additional information, please contact your regional office. Contact information can be found on the DHHS-CBHS website.

CRITICAL INCIDENTS REPORTING PROCEDURES

<p>The following types of incidents must be reported by phone to the DHHS Regional Director or Facilities Operations Director immediately (within 4 hours) after incident becomes known to staff and followed by a faxed incident report:</p> <p><u>Level I Incidents</u></p> <ul style="list-style-type: none"> A. Suicides B. Homicides/Other Unexplained Deaths C. Major physical plant disasters D. Other events that significantly jeopardize child and/or public safety (e.g., Serious crimes (assault or hostage taking), serious injury to consumer or staff requiring emergency medical intervention, arson, lost or missing child with adverse results, etc., or with children events which present extreme risk of harm) D1. Serious suicide attempt 	<p>The following incidents must be reported by phone to the DHHS Regional Director or Facilities Operations Director within 24 hours after an incident becomes known to staff and followed by a faxed incident report:</p> <p><u>Level II Incidents</u></p> <ul style="list-style-type: none"> A. Major medication errors or other adverse clinical events resulting in the need for immediate/emergency medical attention B. Alleged physical and/or sexual abuse of a child by a staff member or by another child, or with children a report of physical or sexual abuse filed with DHHS.
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Note: Reporting critical incidents should include proactive efforts to prevent the incident from continuing to occur in the future.

Note: Case managers should use the most current form when reporting critical incidents.