COMMUNITY SERVICE AGENCY (CSA)
REQUEST FOR RESPONSE (RFR)

RFR Title: Community Service Agency (CSA) Procurement
See Appendix H for Glossary of terms referenced within this RFR.

I. PURPOSE OF PROCUREMENT AND SCOPE OF SERVICE DESCRIPTION

Significant changes are being made to behavioral health services for MassHealth-enrolled youth under the age of 21. These changes include improvements to behavioral health screening administered by primary care providers, improvements in behavioral health assessment practices and the development of new MassHealth behavioral health services.

The Children's Behavioral Health Initiative

The Secretary of the Executive Office of Health and Human Services (EOHHS), JudyAnn Bigby, M.D., developed the Children's Behavioral Health Initiative (CBHI) to coordinate EOHHS' activities with respect to Children's Behavioral Health. Below are EOHHS' Mission, Values, and Vision for the Children's Behavioral Health Initiative:

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

Values

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

Vision
The Children's Behavioral Health Initiative places the family and youth at the center of our service delivery system and will build an integrated system of behavioral health services that meets the unique needs of the youth and family. Policies, financing, management, and delivery of publicly-funded behavioral health services will be integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

Strategic Priorities

1. Increase Timely Access To Appropriate Services
2. Expand Array of Community-based Services
3. Support Clinical Best Practice and Innovation
4. Increase Integration and Collaboration Across State Agencies
5. Strengthen, Expand and Diversify Workforce
6. Ensure Mutual Accountability, Transparency and Continuous Quality Improvement

Community Service Agencies

In order to ensure that Massachusetts has the infrastructure to successfully support and implement the CBHI, the Massachusetts Behavioral Health Partnership (MBHP), in collaboration with the four MassHealth-contracted managed care organizations (MCOs) – Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Neighborhood Health Plan[1], and Network Health is procuring a network of Community Services Agencies (CSA). A CSA is a community-based organization whose function is to facilitate access to, and ensure coordination of, care for youth with serious emotional disturbance (SED) who require or are already utilizing multiple services or are involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health) and their families.

In total, 32 CSAs will be selected: 29 that are geographically consistent with the current 29 service areas for the Department of Children and Families (DCF) (previously known as Department of Social Services) and three culturally and linguistically specialized CSAs to address the needs of specific cultural or linguistic groups in Massachusetts. These culturally or linguistically specialized CSAs must have demonstrated expertise at providing behavioral health services to one or more cultural or linguistic populations. Specialized CSAs will be selected for their demonstrated ability to reach deeply into specific cultural or linguistic communities and tailor their services to engage and serve their specialized populations. Priority will be given to proposals that serve the most densely populated cities where service demand is expected to be highest. It is important to note that <u>all</u> CSAs are expected to be culturally competent and respond to the individualized needs of the youth and families they serve in accordance with *Wraparound* principles. Geographic CSAs and specialized CSAs working in overlapping areas will be expected to collaborate and partner in ways that strengthen services to families. See Appendix A for a list of the service areas for the 29 geographically defined CSAs.

The roles and responsibilities of the Community Service Agencies will initially focus on:

- Actively engaging youth and families seeking Intensive Care Coordination (ICC) services and Caregiver Peer to Peer Support Services[2] using the *Wraparound* care planning process[3]
- Providing infrastructure support for ICC and Caregiver Peer to Peer Support services

[1] Beacon Health Strategies (Beacon) is the behavioral health partner for Fallon and Neighborhood Health Plan.

[2] Caregiver Peer to Peer Support services delivered by a Family Partner may also be accessed for non-ICC enrolled MassHealth-eligible youth who meet medical necessity criteria for Caregiver Peer to Peer Support services. While all CSAs must provide, through direct hire or by subcontract, Caregiver Peer to Peer Support services, access to the service is not limited to the CSA only.

[3] ICC and Caregiver Peer to Peer Support Services are still pending approval from the Centers for Medicare and Medicaid Services.

- Actively participating in a quality improvement process to identify the "lessons learned" from youth, families, providers, and others. These "lessons learned" will continually shape the vision and functions of the CSA.
- Developing and supporting a local *Systems of Care Committee* that will be charged with supporting the service area's efforts to create and sustain collaborative partnerships among families, parent/family organizations, traditional and non-traditional service providers, community organizations, state agencies, faith-based groups, local schools, and other stakeholders

Each of these roles and responsibilities is presented in more detail in the following sections. It is expected that CSAs will begin enrolling youth in need of ICC services as of June 30, 2009.

Intensive Care Coordination and Caregiver Peer to Peer Support

ICC utilizes the four phases of the *Wraparound* care planning process to assist youth and families to identify needed services and supports; and to ensure that every youth served has a family-driven, youth-guided team, facilitated by a dedicated care coordinator, that plans and ensures access to needed services and supports[4]. ICC services include:

- A comprehensive home-based assessment of the youth's and family's strengths and needs inclusive of the Massachusetts Child and Adolescent Needs and Strengths (CANS) tool
- Development and facilitation of a care planning team including a Family Partner if desired by the family
- Creation of an individualized care plan
- Monitoring and follow-up activities to ensure successful implementation of the individualized care plan

In addition to the care coordinator, the CSA will offer those ICC-enrolled youth and families with a medical need for Caregiver Peer to Peer Support services, a Family Partner[5]. Family Partners are individuals who have had experience:

- as a caregiver of a youth with special needs, and preferably a youth with behavioral health needs;
- navigating child-serving systems; and
- who are trained to provide peer support, system navigation, and other types of assistance to families who have youth with SED.

Caregiver Peer to Peer Support is a service that provides a structured, one-to-one, strength-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment

[4] ICC care coordinators will be expected to coordinate a broad range of services and community resources, including natural supports that are identified through the care planning process. CSAs may deliver additional CBHI services and/or other MassHealth Behavioral Health services, depending on provider capacity, network capacity, and the procurement processes for these services.

[5] The CSA must provide either through direct hire or subcontract, Family Partners to deliver Caregiver Peer to Peer Support services to ICC-enrolled youth and their caregiver(s). It is expected that whether or not the Family Partners who are serving ICC-enrolled youth and their caregiver(s) are employed directly by the CSA or through a subcontract arrangement, that the ICC care coordinator and the Family Partner be co-located in order to facilitate well coordinated services to youth and families.

plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.

Appendices C and E, respectively, provide more detailed information on the service components, staffing requirements, and performance specifications for ICC and Caregiver Peer to Peer Support services.

As mentioned above, ICC services are delivered to the youth and family through the *Wraparound* planning process that adheres to the four phases and the "Ten Principles of *Wraparound*"[6], which are:

- **Family voice and choice.** Family and youth perspectives are intentionally elicited and prioritized during all phases of the *Wraparound* process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- **Team-based.** The care plan team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
- **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The care plan reflects activities and interventions that draw on sources of natural support.
- **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a care plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
- **Community-based.** The care plan team implements service and support strategies that take place in inclusive, responsive, accessible, and least restrictive settings available, and which safely promote youth and family integration into home and community life.
- **Culturally competent.** The *Wraparound* process demonstrates respect for, and builds on, the values, preferences, beliefs, culture, and identity of the youth and family, and their community.
- **Individualized.** To achieve the goals laid out in the care plan, the team develops and implements a customized set of strategies, supports, and services.
- **Strengths-based.** The *Wraparound* process and the care plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Persistence.** Despite challenges, the team persists in working toward the goals included in the care plan.
- **Outcome-based.** The team ties the goals and strategies of the care plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

[6] From: Eric J. Bruns, Janet S. Walker, Jane Adams, Pat Miles, Trina Osher, Jim Rast, and John VanDenBerg, (2004). The Ten Principles of Wraparound.

Additional information and resources on *Wraparound* are located in Appendix B.

For practitioners to adopt a new practice, training must be accompanied by ongoing coaching, opportunities for practitioners to practice the newly learned skill(s) and receive feedback on their performance, and occasions to obtain support during the implementation phase[7]. During the implementation phase, we anticipate that initial coaching and technical assistance will be offered to each CSA to assist them in developing the competencies and skills that are necessary to implementing a high fidelity model of *Wraparound* care planning such as:

1. Competence working in partnership with parents and other caregivers of youth with mental health needs, including engaging the family, identifying individual and family strengths, and facilitating the articulation of family vision and goals
2. Competence working in partnership with youth with behavioral health needs
3. Ability to integrate youth and family voice in governance of the organization
4. Ability to work with families in accordance with the principles of *Wraparound* planning process as articulated by the *National Wraparound Initiative*, http://www.rtc.pdx.edu/nwi/
5. Competence in organizing and facilitating community collaborations in youth and family services
6. Working relationships with community resources in the service area, including: emergency services and other behavioral health and social service providers, state agencies, law enforcement and courts, schools, recreational programs, family and youth organizations, primary care providers, adult behavioral health services providers; providers of substance use disorder services for youth and adults; and demonstrated ability to coordinate care and treatment across providers and service agencies
7. Governance and clinical and management infrastructure necessary to deliver quality care planning services based on *Wraparound* planning process and *Systems of Care* principles and philosophy
8. Ability to develop and ensure measurable, behaviorally-oriented care plan goals, and monitor and document progress in meeting those goals
9. Ability to recruit, hire, train, supervise, and retain competent staff to function within a model based on *Wraparound* planning process and *Systems of Care* principles and philosophy
10. Understanding of *Wraparound* planning process and *Systems of Care* principles and philosophy at all levels of the organization's management, as reflected in training and/or programming experience
11. Experience in providing evidence-based or best-practice services under a protocol of fidelity monitoring
12. Capacity to develop, implement, and update strengths-based, family-centered, youth-guided plans of care, ensure provision of services through engagement of formal and informal supports consistent with these plans, and implement sustainable discharge planning from ICC
13. Ability to provide services in a culturally competent manner, including access to informal and formal supports reflecting the family's cultural and linguistic preferences, including bilingual professionals and materials, interpreters, etc.
14. Ability to hire, develop, and retain culturally and linguistically competent staff

[7] Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). Implementation Research: A synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Providing Infrastructure Support for ICC and Caregiver Peer To Peer Support Services

Implementation of a project of this magnitude will require that the CSA have a robust infrastructure to ensure the efficient operations of the CSA including but not limited to:

- Established leadership infrastructure
- Information technology infrastructure
- Human resources infrastructure
- Financial viability
- Financial infrastructure
- Medical records infrastructure
- Appointment scheduling system
- Training and supervisory infrastructure
- A quality management program with capacity specifically to address quality issues involved in care planning consistent with *Wraparound* planning process and *Systems of Care* principles and philosophy, which includes relevant data collection, *Wraparound* fidelity measures (when appropriate), and outcome data monitoring and reporting
- Physical space ample enough to accommodate the needs of ICC meetings of various sizes on a regular basis including but not limited to: care plan team meetings, group activities, *Systems of Care* committee meetings, etc.
- Strong community relationships, partnerships with others as evidenced by advisory councils, affiliations with community organizations, etc.
- Information collected as part of a comprehensive assessment inclusive of the CANS

Quality Improvement Process

CSAs will also be required to actively participate in a data-driven continuous quality improvement process in order to analyze lessons learned from the implementation of the CSAs. Regular meetings will be convened by MassHealth in collaboration with the MCEs and other stakeholders to analyze data and to use this information to make both immediate and future changes to support the ongoing efforts of the Children's Behavioral Health Initiative (CBHI). At the onset, CSAs will be expected to collect and track quantitative and qualitative information that will assist MassHealth, the MCEs, state agencies, and other stakeholders with identifying and resolving barriers to implementation. Information of interest includes but is not limited to:

- The number of referrals of youth and families to CSAs
- Number of youth who receive ICC services
- Challenges with the referral process or with the numbers of youth being referred
- Successes and challenges to engaging and retaining youth and families who need ICC services and are served by the CSA
- Strengths and challenges in the authorization process for services in the care plans
- Fidelity to *Wraparound* principles and processes
- Identification of service and support gaps

- Successes and challenges in engaging providers, public child-serving systems, and natural helpers outside of CSA authority to participate in a high fidelity *Wraparound* approach
- Success in improving clinical and functional outcomes of youth served
- System-level measures, such as admissions and lengths of stay in residential treatment and inpatient care
- Family and youth satisfaction with services offered by the CSA
- Youth-level utilization of services as provided for under an individualized care plan, including the type, duration, frequency and intensity of home-based services

Systems of Care Committee

Each CSA will also be responsible for developing and supporting a local *Systems of Care* committee that will be charged with supporting the service area's efforts to create and sustain collaborative partnerships among families, parent/family organizations, traditional and non-traditional service providers, family and community organizations, state agencies, faith-based groups, local schools, and other stakeholders. The purpose of this committee is to support, at a local systemic level, access for ICC-involved youth and families to a broad array of community-based services and supports. EOHHS will support local committee activities through state agency directives, policies and procedures, and other activities designed to ensure consistent participation by child-serving agencies. The committee should meet monthly during the first year of CSA implementation.

II. ADDITIONAL REQUIREMENTS

A. Provider Qualifications

The organization contracted as a CSA must directly meet the following qualifications:

1. A currently contracted MassHealth Managed Care provider **or** a non-contracted MassHealth provider that can demonstrate meeting the following qualifications:
    a. Provides after-hours telephone service
    b. Employs an administrator responsible for overall operations, management of the organization and ensures compliance with all MCE requirements.
    c. Employs a Director of Clinical Services responsible for the direction and control of all professional staff members and services. The Director of Clinical Services must be licensed, certified, or registered as a psychiatrist, psychologist, social worker, LMHC, LMFT, or a Psychiatric Nurse Mental Health Clinical Specialist (formerly known as APRN).
    d. Employs a Medical Director that must be a psychiatrist (board-certified or board-eligible and in the process of applying). The Medical Director is responsible for establishing all medical policies and protocols and for supervising all medical services and works on site 4-8 hours a week.
    e. Employs a psychiatrist who may fill any of the roles above and in addition, is responsible for evaluating the physiological, neurological, and psychopharmacological status of the youth served by the organization.
2. An established physical location within the service area for a minimum of one year prior to the submission of an application for a CSA contract is preferred. Second priority consideration will be given to provider agencies with a physical location within the service area for less than one year. Third priority consideration will be given to provider agencies with a physical location in a contiguous service area for a minimum of one year.

3. Physical space ample enough to accommodate the needs of ICC meetings of various size on a regular basis including, but not limited to: Care Plan Team meetings, group activities, *Systems of Care* committee meetings, etc.

Additionally, it is preferred that CSA providers demonstrate the following characteristics and competencies. Bidders will be evaluated relative to these areas (see Narrative response section)

1. Demonstrated readiness to utilize the *Wraparound* planning process to develop and deliver ICC services within a *System of Care,* as evidenced by:
    a. A track record of consumer and/or parent and/or youth voice within the organization's governance structure, service delivery model, and/or evaluation mechanisms
    b. Current strength-based, family-driven practice and service models within the organization
    c. A track record of sustained, innovative partnerships with community organizations in the CSA's geographic area, such as schools, youth and family service providers, mutual aid societies, faith institutions, or other community programs

    The practices described above define a philosophical alignment with the *Wraparound/Systems of Care* approach that will be critical to successfully implementing ICC.

2. Demonstrated readiness to respond to the unique needs of the predominant racial, ethnic, cultural, and linguistic populations (population critical mass) in the CSA's geographic area, either directly or through subcontract, as evidenced by:
    a. Current racial, ethnic, cultural and linguistically tailored program models
    b. Collaboration with minority community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients
    c. Bilingual/bicultural staff for population
    d. Interpreter services for linguistic populations in the area for whom the organization does not currently have bilingual/bicultural staff
    e. Any cultural or linguistic competency plans and initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity

    While no organization is likely to have cultural and linguistic capacity to accommodate all segments of the community, the CSA must demonstrate a proactive commitment to working with culturally and linguistically diverse families, and an ability to subcontract with other organizations to address gaps in capacity.

3. A quality improvement program with capacity specifically to address quality issues involved in care planning consistent with *Wraparound* planning process and *Systems of Care* principles and philosophy, which includes relevant data collection, *Wraparound* fidelity measures (when appropriate), and outcome data monitoring
4. Experience delivering behavioral health services in community-based settings

B. Intensive Care Coordination Service Definition and Rate

The service definition for ICC is located in Appendix D. This document describes the service components that are included in the rate that will be paid for units of the ICC service.
The service definition, and therefore the rate, for ICC include ICC functions and operation of the *Systems of Care* committee. The rate does not include Family Partners, whose functions are separately billable as the Caregiver Peer to Peer Support service. The minimum unit rate established by MassHealth for ICC services performed by a master's level clinician is $15.97. The minimum unit rate established by MassHealth for ICC services performed by a non-master's level clinician is $13.14. One unit is equal to 15 minutes. Each CSA will be required to contract with every MassHealth MCE for this service. Each MassHealth MCE will have separate provider agreements with each CSA that details contractual requirements and the rate for services. We anticipate that MCEs will reimburse CSAs at a unit rate that is equal to or greater than the minimum established by MassHealth.

C. Intensive Care Coordination Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for ICC services. See Appendix D for a copy of the performance specifications.

D. Caregiver Peer to Peer Support Service Definition and Rate

The service definition for Caregiver Peer to Peer Support is located in Appendix I. This document describes the service components included in the rate that will be paid for units of the Caregiver Peer to Peer Support service. The minimum unit rate for Caregiver Peer to Peer Support Services established by MassHealth is $10.49. One unit is equal to 15 minutes. Each CSA will be required to contract with every MassHealth MCE for this service. Each MassHealth MCE will have separate provider agreements with each CSA that details contractual requirements and the rate for services. We anticipate that MCEs will reimburse CSAs at a unit rate that is equal to or greater than the minimum established by MassHealth.

E. Caregiver Peer to Peer Support Performance Specifications

All providers responding to this RFR agree to abide by the performance specifications for Caregiver Peer to Peer Support services. See Appendix E for a copy of the performance specifications.

F. Contracting with the Managed Care Entities

MBHP and those MassHealth-contracted MCOs that operate in a given service area will offer to contract with the provider selected as the CSA in that area.

G. Service Authorization

MCEs will establish utilization management processes for CBHI services. The utilization management processes will seek to address both over and under utilization of services. In developing the care plan for all needed services and supports for youth enrolled in ICC, the Care Planning Team will be responsible for identifying and recommending the frequency and intensity of behavioral health covered services. The provider of any recommended service in the youth's care plan will be responsible for following the authorization procedures established for that particular service.

III. ANTICIPATED DURATION OF THE CONTRACT

The CSAs, either all or specific areas, will be reprocured in three to five years at the discretion of the MCEs.

IV. PROCUREMENT PROCESS

A. Timeline

RFR Component	Date
RFR release	October 24th, 2008
Bidders' conference	November 5th 10 a.m. – Noon Worcester Crowne Plaza November 6th 10 a.m. – Noon Holiday Inn Woburn
Written question submission deadline	November 7th by 5 p.m.
Frequently Asked Questions (FAQ) release date	November 17th
Letter of Intent submission deadline	November 21st by 5 p.m.
RFR response submission deadline	January 6, 2009 by 5 p.m.
Awardees announcement	February 10th, 2009
Letters mailed to respondents	February 11, 2009

B. Bidders' Conferences

Two bidders' conferences will be conducted to allow potential bidders the opportunity to ask clarifying questions about the RFR.

Neither conference is mandatory; however, each bidder is encouraged to attend **one** of the conferences, limiting their representation to one or two people. We recommend bringing a copy of the RFR to the conference to reference during the discussion. The same information will be presented at both conferences.

Date: November 5th
Time: 10 a.m. – Noon
Location: Worcester Crowne Plaza
10 Lincoln Square
Worcester, MA 01608
(508) 791-1600
www.cpworcester.com

Date: November 6th
Time: 10 a.m. – Noon
Location: Holiday Inn Woburn
15 Middlesex Canal Park Road
Woburn, MA 01801
(877) 863-4780
www.holidayinn.com

C. Written Questions

Clarifying questions concerning this RFR will also be accepted in writing. They must be submitted by **November 7th, at 5 p.m.** Questions can be sent to CSARFR@valueoptions.com.

D. Frequently Asked Questions (FAQ)

Responses to both written questions and questions from the bidders' conferences will be posted by close of business on November 17th on the web sites for MBHP and the MassHealth-contracted MCOs (collectively, Managed Care Entities or MCEs)[8]:

www.masspartnership.com
www.bmchp.org
www.fchp.org
www.nhp.org
www.network-health.org
www.beaconhealthstrategies.com

It is the responsibility of the bidder to check the web sites for updates.

E. Letters of Intent

Any bidder planning to submit an RFR response for one or more CSA service areas or for a specialized CSA **must** submit a letter of intent via email attachment by 5:00 p.m. on November 21, 2008. The letter of intent must specify the name of the bidder and the geographic service area(s) or specialized population and area(s) in which the specialized CSA will cover. Letters of intent should be sent to:

Ms. Kerry Ayer, MSW
CSA Procurement Project Manager
c/o Massachusetts Behavioral Health Partnership
150 Federal St., Third Floor
Boston, MA 02110
CSARFR@valueoptions.com

Any letter of intent submitted after the deadline will not be accepted or considered. Additionally, any RFR response that was not preceded by a letter of intent will not be accepted or considered, even if it is received by the RFR response deadline. If no letters of intent are submitted for a given service area, the MCEs will post those service areas on their web sites and will invite letters of intent for those service areas only within a specified extended timeframe.

F. RFR Responses

In order for responses to be considered, each bidder must reply to this RFR by submitting a response that meets the response submission requirements specified in Section V by 5 p.m. on January 6th, 2009.

The response must be submitted by sending an electronic copy via e-mail **and** delivering one (1) bound original and five (5) unbound copies of the completed response and all required attachments to:

Ms. Kerry Ayer, MSW
CSA Procurement Project Manager
c/o Massachusetts Behavioral Health Partnership
150 Federal St., Third Floor

[8] Beacon Health Strategies (Beacon) is the behavioral health partner for Fallon Community Health Plan and Neighborhood Health Plan. Information regarding the procurement will also be posted on Beacon's web site.

Boston, MA 02110
CSARFR@valueoptions.com

Any response not meeting the response deadline will not be accepted or considered. Faxed transmissions are not acceptable. Submissions by postal mail must be received by the stated deadline as well.

G. Applications for More than One Service Area or Specialized CSA

For organizations interested in providing CSA services in more than one service area, a separate response is required for each proposed service area. For organizations interested in serving more than one specialized cultural or linguistic population, a separate response is required for each specialized population your organization intends to serve (e.g., if you intend to bid for more than one of the three specialized CSAs, your organization will need to submit a separate proposal for each specialized population you intend to serve.) An organization can bid to be a geographic CSA as well as a specialized CSA. This will require two separate responses.

H. Evaluation of Responses

A selection committee comprised of representatives from the five MCEs will review the responses received by the submission deadline and make the final selections for each of the 29 areas as well as for the three specialized CSAs. As part of the selection process, the MCEs are committed to ensuring input from families and reviewers with expertise in cultural and linguistic competent practice.

I. Announcement of Award

Selected providers will be announced on February 10, 2009, on the web sites of the five MCEs participating in this procurement process. Formal letters will be mailed on February 11, 2009.

J. Post-Award Debriefing Process

Organizations that are **not** selected to be a CSA, may request a debriefing meeting to ask questions regarding the evaluation of their response. Debriefings are designed to identify areas of a response needing improvements for future procurements. Requests for a debriefing should be made in writing within two weeks of the awardees announcement to CSARFR@valueoptions.com

V. RESPONSE SUBMISSION SPECIFICATIONS

A. Format of Response

All questions contained within this RFR must be answered. Submissions must be in 12-point font, with one-inch margins, and the total response is limited to **20 double-sided pages (40 total pages)**. Specialized CSA bidders can have an additional **3 double-sided pages** (6 pages total) in order to answer the additional questions asked of specialized CSA bidders in section 6 of the narrative response section of this RFR. Attachments are not included in the page limit. However, bidders should be judicious in their use of attachments and include only those that are required and those that will help reviewers evaluate their proposal. The response must include the elements below in the following order:

1. Attach the cover sheet located in Appendix I to the front of the proposal. The cover sheet includes the following information:
    a. Organization name

b. Proposed service area name or name of specialized population and the geographic area(s) covered for that specialized CSA

c. Mailing address for correspondence

d. Name of organization

e. Title or position of contact person

f. Telephone number, fax number, and e-mail address of contact person

g. Address of site or location at which CSA services will be delivered

h. Phone number of site referenced in g. above

i. Length of time in location referenced in g. above

2. Narrative response (see Section V.B below for details)

3. Appendices

   a. Letters of support from state or community agencies (optional)

      i. Letters of support from state or community agencies (e.g., YMCA, Boys and Girls Club) are welcome and can be added as appendices to the response. Letters should describe the specific nature of the bidder's affiliation with the community agency and the service, resource, or other way in which the affiliation will strengthen the bidder's ability to function as a CSA and benefit the youth and families served.

   b. Other attachments requested in the narrative response section

B. Narrative Response

Note: Please make clear throughout the response if you are describing current versus proposed practice at your organization.

1. *Wraparound* and Systems of Care Readiness *(50 points)*
Readiness to implement the Wraparound *care planning process for the delivery of ICC services and provide leadership within Systems of Care*

1.1 *Population served (10 points)*
The target group for the ICC service is individuals under age 21 that meet criteria for SED as defined by either the Individual with Disabilities Education Act (IDEA) OR the Substance Abuse and Mental Health Services Administration (SAMHSA) as follows:

a. IDEA definition: A condition exhibiting one or more of the following characteristics over a long period of time, and to a marked degree, that adversely affects educational performance:

   i. an inability to learn that cannot be explained by intellectual, sensory, or health factors;

   ii. an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

   iii. inappropriate types of behavior or feelings under normal circumstances;

   iv. a general pervasive mood of unhappiness or depression; or

v. a tendency to develop physical symptoms or fears associated with personal or school problems.

b. SAMHSA definition: Persons who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM), edition IV, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities

Using the above definitions for SED as a guide, describe your organization's experience in serving the eligible population. Your response should address, but not be limited to, the following:

i. Number of years of the provider organization's experience serving youth with SED and their families

ii. Number of youth and families served in the last fiscal year that meet the SED definition

iii. Description of any specialized expertise in treating subpopulations of youth with SED (e.g., youth with trauma histories, co-occurring disorders, transition age youth, refugee minors, youth involved with DCF, DYS, DMH, EEC, or special education)

iv. Even though all youth involved in ICC have SED and require care coordination, the needs of youth enrolled in ICC will vary in complexity, intensity, and acuity over time. Describe how your program will reliably respond to high levels of need in some youth while simultaneously reliably serving youth with less intense or acute needs.

1.2 *Systems of Care and care coordination experience (20 points)*

a. Why is your organization interested in becoming a CSA?

b. Describe any experience your organization has had in implementing the *Wraparound* care planning process, models of care planning teams, family group conferencing, or other systemic approaches to involving families and youth in care planning. Discuss any "lessons learned" from your experience in delivering care in this way. If your organization has not had any experience in implementing *Wraparound* values, approaches, and programs, describe your plan for how you would begin to change the culture of your organization so that families and youth are included in the areas listed above.

c. Part of the responsibility of a CSA is to convene a local *Systems of Care* committee in order to expand access to and coordinate integration of services across agencies and providers. Describe any experience your organization has had in convening a collaborative structure to integrate services across agencies.

1.3 *Family Driven, Youth-Guided Care (10 points)*

The Federation of Families for Children's Mental Health defines family-driven care as "… families having 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." The federal Substance Abuse and Mental Health Services Administration defines "youth-guided" care in these terms: "Young people have the right to be empowered and given a decision-making role in the care of their own lives as well as the policies and procedures governing the care of all youth in the community, state and nation."

a. Describe specific ways your organization promotes and infuses "family voice" and "youth voice" at both the family/youth-specific and agency-wide levels, while assuring that medically necessary MassHealth services as well as available social, education, and other services are identified. Your response should address, but not be limited to, the following:

   i. Setting goals for care

   ii. Designing, implementing, and evaluating programs

   iii. Agency management and governance

   iv. Obtaining or providing training for staff with a focus on "family voice" and "youth voice"

b. Describe the opportunities and challenges you foresee relative to promoting the family voice and the youth voice at both the family/youth-specific and agency-wide levels in your potential new role as a CSA provider.

If your organization does not currently include families or youth in having decision-making roles, describe your plan for how you would begin to change the culture of your organization so that families and youth are included in the areas listed above.

1.4 *Collaboration and coordination (10 points)*

The needs of youth with SED and their families are often complex, cutting across the various child-serving state agencies as well as many other systems and providers. Establishment of a collaborative working relationship among the youth, family, and all others involved is vital to the development of a successful care planning process.

a. Describe your organization's involvement, including any contracts, with the following agencies: Department of Children and Families (DCF), Department of Mental Health (DMH), Department of Youth Services (DYS), the Department of Mental Retardation (DMR), Department of Early Education and Care (DEEC), Department of Elementary and Secondary Education (DESE), courts, and schools in the service area of your proposed CSA.

b. Describe your organization's experience in working with "nontraditional" helpers and natural supports in the community, such as extended family members, neighbors, faith communities, cultural organizations, youth and family organizations, etc., to support the delivery of services to families. As a CSA, what additional strategies would you employ to engage these resources on behalf of youth with SED and their families?

c. Describe your organization's linkages with specific primary care clinicians in the service area, and give examples of how your staff coordinates care with them (e.g., pediatricians, family physicians, etc.).

d. Discuss your organization's working relationships with behavioral health services along the continuum of care including but not limited to: emergency service programs (ESP); adult behavioral health services; providers of substance use disorder services for youth and adults; inpatient; Community Based Acute Treatment (CBAT); and partial hospitalization providers.

2. Program Capacity *(70 points)*

Readiness to launch and rapidly grow a new program with fidelity to the Wraparound *care planning process*

2.1 *Structure and staffing capacity (20 points)*

a. Is your organization a currently contracted MassHealth provider[9]?

b. Is your organization licensed[10]? If yes, what licenses does your organization hold?

c. Is your organization accredited[11]? If yes, what accreditation(s) does your organization hold?

d. Please provide a current organizational chart indicating where ICC staff will sit within the organization. Additionally, detail your organization's current human resources, including a breakdown of the full-time equivalents (FTE) in the following categories:

   i. Executives (e.g., executive director, vice presidents, directors) specifically indicating who is responsible for overall operations and management of the organization and the person responsible for direction and control of all professional staff members and services (e.g., Director of Clinical Services)

   ii. Administrative support staff (e.g., administrative assistants, receptionists, etc.)

   iii. Medical director and other psychiatric clinicians (break down number of Doctors of Medicine (MDs) versus Psychiatric Nurse Mental Health Clinical Specialist (formerly known as Advanced Practice Registered Nurses). Please note if psychiatrists are board-certified in child and adolescent psychiatry.)

   iv. Doctor's level clinical staff (including number who are CANS-certified)

   v. Master's level clinical staff (licensed) (including number who are CANS-certified)

   vi. Master's level clinical staff (non-licensed) (including number who are CANS-certified)

   vii. Non-master's level staff who deliver direct services to agency clients (e.g., Community Support Program staff, Family Partners, etc.)

e. Please describe how your organization utilizes student interns if at all. What structures and support do you have in place currently as far as training support and supervision for interns?

f. It is expected that the demand for human service professionals at all levels may outpace supply. Please describe the different ways you will recruit staff –PhD/Masters, Bachelor's, and Family Partners. What steps will you take if a barrier around staffing resources exists? How has your organization dealt with staff shortages in the past?

g. While CSAs are likely to provide the bulk of ICC services directly (e.g., care coordination), and may directly provide services and supports needed in care plans, CSAs also are encouraged to develop subcontractual arrangements (subject to all applicable provisions of the CSAs requirements, if any) with other providers, family organizations, and natural helpers in their local communities to ensure access to a broad array of services and supports, including those that are culturally and linguistically diverse and customized for specialized populations. For instance, a CSA may choose to subcontract care coordination and planning functions to an agency that serves a linguistically or culturally diverse community or to specialized populations (e.g., youth who have hearing impairments or transition-age youth, or youth with co-occurring emotional disorders and developmental disabilities). In addition, CSAs may subcontract for other functions such as psychiatric consultation, billing, Caregiver Peer to Peer Support services[12], and/or

[9] It is not required to bid for a CSA contract to be a currently contracted MassHealth provider.

[10] It is not required for a CSA to be a licensed mental health clinic.

[11] It is not required for a CSA to be accredited by any organization.

[12] If your organization subcontracts for Caregiver Peer to Peer Support services and/or ICC, it is critical to the service delivery model that these staff persons be co-located.

information technology support. The CSA is legally responsible for all aspects of any subcontracted service or function. Please note that bidders who are awarded contracts must provide copies of all subcontract documents.

i. What if any functions will your organization subcontract for?

ii. Has your organization already identified a subcontractor? If so, please provide the name of the organization and what service(s) you are proposing to subcontract with them for.

iii. What are the key reasons for choosing to subcontract for the functions outlined above?

iv. How will you monitor and hold subcontracted providers accountable? If your organization intends to subcontract for ICC services or Caregiver Peer to Peer Support services, please describe how you would monitor the quality of services delivered by the subcontractor in terms of fidelity to the performance specifications of ICC and the *Wraparound* care planning process[13].

2.2 *Training support and supervision (10 points)*

Care delivery that is strength-based, culturally competent, family-driven, and youth-guided may require a major shift in how practitioners work with youth and families.

a. What is your organization's current training/professional development infrastructure?

b. It is expected that the CSAs will play a leading role in training care coordinators in the *Wraparound* planning process through a state supported train-the-trainer model. What challenges and opportunities do you anticipate in training new and existing staff persons in the *Wraparound* care planning process?

c. What is the current supervisory support for staff? Include supervision ratios, frequency of supervision, and types of supervision (e.g., group, individual, dyad, etc.).

d. How do supervisors monitor or assess staff performance? What specific approaches will be used for the different positions (e.g., supervising Family Partners or care coordinators)?

e. The CSA is required to employ Family Partners directly or by subcontract to deliver Caregiver Peer to Peer Support services. What is your organization's experience engaging non-master's level professionals for delivery of behavioral health services? How would you recruit such individuals? Family Partners will need to be supervised by a Senior Family Partner—do you currently have a senior staff person who can fulfill that role? If not, how will you go about including that person in your supervisory/leadership structure?

2.3 *Relevant program experience (15 points)*

a. *Community-Based Care*

ICC expects that the team will work in community settings, including the home, school, or other community environments. In addition, as part of the care planning process, the ICC care coordinator and Family Partner will draw on an array of home- and community-based services provided by the network for youth with SED. Please relate your responses to the following

[13] Note that it is required that ICC care coordinators and Family Partners be co-located even if the staff persons are part of a subcontract arrangement.

questions to your organization's experience in the specific service area for which you are applying for a CSA contract.

i. Describe your organization's experiences engaging families in home- and community-based settings. Describe the service type(s), location(s), population(s), volume, and number of years' experience.

ii. Describe your organization's philosophy, approach, policies, and procedures utilized in providing home- and community-based services.

iii. Provide a specific example of a recent barrier that your organization has encountered in delivering a current community service and the steps your organization took to overcome the issues. Were you successful in the end? Why or why not? Would you do anything differently, given lessons learned?

iv. What barriers do you anticipate in providing home-based and community-based services in your potential new role as a CSA provider, including any that are related specifically to the given service area? What strategies would you employ to mitigate these barriers?

b. *New Program Experience and Capacity to Grow New Programs*

i. In the past five years, has your organization implemented a new practice, program, or service delivery model? What was it? Report on any "lessons learned" and what, if anything, you would do differently if given the opportunity to become a CSA?

ii. By what percentage has your organization's revenue and staff FTEs grown in the past 1, 5, and 10 years. By how much do you expect it to grow within the next 1-3 years? What specific strategies and changes in your organization have you employed to adapt, accommodate, and manage growth? How have you been successful in managing growth? What have you learned? What additional measures will you take to manage growth your organization may undertake via CBHI?

2.4 Availability and responsiveness of services (15 points)

Ensuring availability of services that are responsive to the needs of youth and families' schedules, rather than the availability or convenience of the organization or their staff persons, is one marker of an organization that is committed to family-driven care.

a. What are your organization's current capacity, policies, and procedures for serving youth and families in the evening and on weekends? Include policies related to access to supervision or consultation, risk management, safety issues, etc. Specifically indicate how your organization currently ensures after-hours phone availability of clinical staff (e.g., pager system, answering service, etc.).

b. ICC services are required to be available 24/7. How would your organization ensure responsiveness to families' needs outside business hours?

2.5 Implementation plan (10 points)

a. Subject to all required federal approvals, the anticipated start date for the CSA service to be available to youth and families is June 30, 2009. This will follow a several month ramp-up phase that will begin after formal announcement of the RFR awardees by the MCEs. Provide a start-up plan and timeline for your CSA, describing the major tasks and benchmarks that would have to be met for this implementation deadline. Describe any anticipated challenges in accomplishing these tasks and how you plan to address them. Include in the plan areas such as

staffing, intake, and referral, based on volume, identifying and developing community resources, etc. Additionally, please provide an estimated start-up budget. Limited funds may be made available to assist CSAs with some start-up costs.

b. If your organization does not already have a physical location in the service area for which your organization is applying for a CSA contract, provide a detailed plan for how your organization will successfully establish a physical location in the service area by the expected start date and a strong rationale as to why you wish to operate in the service area.

3. Cultural and Linguistic Capacity and Responsiveness to Underserved Populations *(40 points)*

Readiness to respond to the unique needs of the underserved populations, including predominant racial, ethnic, and linguistic populations (population critical mass) in the CSA's geographic area. ***All*** *bidders must respond to question 3, both providers seeking geographic based CSAs and specialized CSAs as all CSAs are expected to be culturally and linguistically competent.*

3.1 Cultural and linguistic competency and capacity (25 points)

Address your organization's capacity to provide culturally and linguistically competent mental health services for youth and families. The Substance Abuse Mental Health Services Administration (SAMHSA) defines cultural competence as: "An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations."

a. Describe the racial, ethnic, cultural, and linguistic composition of MassHealth-enrolled youth in the service area for which your organization is applying for a CSA contract.

b. Describe any culturally and linguistically tailored program models that you currently operate. Describe the degree to which the staff and management of these programs reflect the cultural and linguistic populations served.

c. Describe any track record of funded partnerships with minority community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients.

d. Document the number of bilingual/bicultural staff employed by your organization for critical mass populations in your area. Document interpreter services for whom the organization does not currently have sufficient bilingual/bicultural staff.

e. Document any organizational initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity. Document any of the following that are currently in place within your organization with regard to delivering culturally and linguistically competent care: mission statements, definitions, policies, and procedures reflecting the organization's dedication to providing culturally competent care (please attach any relevant documents as appendices).

f. Document the extent to which the governance and senior management of your organization and relevant subcontractors reflect the significant cultural and linguistic populations within the CSA service area. Describe any of your organization's recent Board of Directors initiatives to strengthen cultural diversity of Board and/or senior management, and the results of those efforts.

g. Document the extent to which your direct care staff reflect the significant MassHealth-enrolled cultural and linguistic populations in your service area. Describe your organization's strategies

and outcomes relative to recruitment and retention of staff persons that reflect the population served by your organization to date. Include current linguistic capacity of staff persons.

h. List professional development activities and trainings that your organization has provided for staff at all levels of the organization relative to cultural competence within the two years prior to the due date for your RFR response. (Attach any relevant training curriculum.)

3.2 *Engagement and Retention Strategies for Underserved Populations (15 points)*

a. Describe your organization's efforts to engage or follow-up with families who your organization believes underutilize or prematurely drop out of services.

b. Describe how you will ensure access to care for families.

c. Describe your organization's efforts to increase awareness of the programs and services it offers to the community at large.

4. Infrastructure Capacity *(45 points)*
Administrative, financial, infrastructure, information technology capacity to support CSA role

4.1 *Information technology (IT) (10 points)*
It will be important that the CSA have a robust IT infrastructure to ensure the efficient operations of the various responsibilities and activities of the CSA, including: data management and reporting, service delivery, record keeping, billing, appointment scheduling, interface with the Virtual Gateway, and obtaining authorizations. Report on your organization's current IT infrastructure. Include in the description information regarding the following:

a. Staffing resources (number of IT staff, including titles, hours of availability of IT support)

b. Telephone (availability of conference phones)

c. Internet access (24/7 availability of broadband internet access, personal computers with a minimum of Internet Explorer 5.5, e-mail accounts)

d. Electronic medical record capacity

e. Other (such as laptops for staff in the field)

4.2 *Quality management (15 points)*
"There are many different aspects of systems of care that can be measured for quality. The most fundamental, however, is the quality of the interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided." (Pires, S. (2002). *Building Systems of Care: A Primer. Human Service Collaborative*: Washington, DC. p. 124)

a. Describe your organization's:

i. current quality improvement infrastructure (e.g., staffing and resources devoted) and the major activities of the department.

ii. Specifically describe quality improvement activities, within one year prior to the deadline for this RFR response, in the following areas:

- Family/client satisfaction
- Clinical/functional outcomes
- Program performance (e.g., cost, access, service utilization)

b. Describe how your organization uses the data it collects to inform treatment planning and to improve performance at the staff, program, and organizational levels.

c. Describe a recent successful measurable improvement (e.g., decreased no-show rates for an outpatient services program) for your organization, including the steps that were implemented to improve the issue.

d. Describe your organization's experience in having parents or consumers participate in quality monitoring.

e. Describe your organization's experience in monitoring disparities in access, utilization and outcomes data by race and ethnicity, and in using data to strengthen cultural and linguistic competence and capacity.

f. Measures to monitor *Wraparound* fidelity will be a required quality management component to ensure that ICC delivers high quality services consistent with the *Wraparound* care planning process (please see http://depts.washington.edu/wrapeval/WFI.html for more information). Fidelity to the four phases of *Wraparound* has been associated with improved outcomes for youth and families. What is your organization's experience with using fidelity instruments to improve program performance and treatment outcomes?

4.3 *Other infrastructure (10 points)*

a. Describe your organization's experience working with MassHealth MCEs. List current contracts with any MassHealth MCE and number of years your organization has held these contracts.

b. Describe your organization's physical plant in the proposed service area specifically detailing the availability of meeting space, accessibility to public transportation, and American's with Disabilities Act compliance (ADA).

4.4 *Program budget (10 points)*

Attach a proposed budget for your CSA using the following information below to assist you:

a. The floor rates established by MassHealth for ICC and Caregiver Peer to Peer support found on page 9 of this RFR

b. The volume projections in Appendix G

c. The estimated staffing for a fully staffed CSA located in Table 1

Note: Given the range of needs of youth with SED who will meet ICC medical necessity criteria, a CSA will be expected to provide care coordination services with a range of intensity and staffing. The CSA must assign, manage, supervise, and monitor care coordinators so that its staff provides the appropriate intensity of care coordination services to meet the needs of youth. In order to perform the required ICC activities, a CSA is likely to need 1 care coordinator for every 8-10 youth for those youth with the most intensive needs. In order to perform the required ICC activities, a CSA is likely to need 1 care coordinator for every 18 youth for those youth with the less intensive needs. It is suggested that ratios should not exceed an overall average of one care coordinator for every 14 youth across the population of youth that it serves.

The staffing outlined in Table 1 is for a CSA with an average monthly volume of 336 unique clients in a given month. Use Appendix G to size your CSA based on the number of estimated children in your service area[14].

TABLE 1

Position	FTE
ICC Program Director	1
Master's level care coordinator	12
Non-master's level care coordinator	12
Senior care coordinator	3
Caregiver Peer to Peer Support Services Program Director	1
Family Partner	24
Senior Family Partner	3
Psychiatrist	0.2
Administrative Assistant	1.5

5. Financial and Corrective Action

There are no points for the following questions, but the responses will be considered in the overall evaluation of the proposal. Information provided in this section could exclude your proposal from consideration.

5.1 Financial viability

The CSA will be a critical component of the behavioral health care delivery system for families in Massachusetts. It is, therefore, important to ensure that providers interested in becoming a CSA are financially stable so as to adequately support the operations of ICC services for the full duration of the contract. Please include, as attachments, independently audited financial statements for the two most recent fiscal years. If your organization does not have two years worth of audited financial statements, submit the most up to date financial statements with an explanation of why less than two years of statements are available.

5.2 Corrective actions or sanctions

If your organization has been placed on a corrective action plan or has had sanctions imposed by any state agency (DPH, DMH, etc.) or MCE in the past five years, please indicate the nature of the corrective action and what steps your organization took (or is taking) to ameliorate the situation.

6. Additional Narrative Responses for Specialized CSAs *(60 points)*

Specialized CSAs will be selected for their demonstrated ability to reach deeply in to specific cultural or linguistic communities and tailor their services to engage and serve their specialized populations. Priority will be given to proposals that serve the most densely populated cities where service demand is expected to be highest. *Response is required for Specialized CSA bidders only.*

[14] For specialized CSA bidders, provide an estimate of the size of the population you intend to serve and develop your budget for your CSA based on that estimate.

1. What is the special population that you are proposing to offer CSA services for? Estimate the size of the population you intend to serve and how you arrived at this estimate. *(10 points)*
2. Describe your experience and qualifications in serving the special population. *(10 points)*
3. Discuss why this population requires specialized CSA services. *(10 points)*
4. What about the *Wraparound* care planning process has to be uniquely tailored to this group? *(10 points)*
5. What is the geographic area you propose to cover, and why did you define the geographic area in that way? *(10 points)*
6. Like the geographic based CSAs, the specialized CSA is expected to serve all MassHealth eligible youth and families. How will you ensure the needs of any family seeking services are met either by our organization or by collaboration with the geographic CSA in your area? *(10 points)*

APPENDIX A: DCF SERVICE AREAS BY REGION[15]

Northeast Region						Boston Region
Lawrence Area Office	**Lowell Area Office**	**Lynn Area Office**	**Cape Ann Area Office**	**Haverhill Area Office**		**Area Offices (4)**
North Andover Andover Lawrence Methuen	Billerica Westford Tewksbury Chelmsford Dracut Lowell Dunstable Tyngsborough	Lynn Lynnfield Nahant Saugus Swampscott	Danvers Middleton Marblehead Hamilton Peabody Salem Beverly Essex Manchester Rockport Wenham Gloucester	West Newbury Boxford Topsfield Amesbury Groveland Georgetown	Haverhill Merrimac Ipswich Newbury Newburyport Salisbury Rowley	**Park Street Area Office**: Boston **Dimock Street Office**: Boston, Brookline **Hyde Park Office:** Boston **Harbor Area Office:** Winthrop, Chelsea, Revere, Boston

[15] There are 29 DCF Service Areas. The Boston Region consists of four separate service areas separated by zip code. Catchment areas for Springfield and Worcester are determined by street. For more specific information about the cities and towns covered in each area, please go to http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Social+Services&L4=Contact+Us&sid=Eeohhs2

Southeast Region							
Attleboro Area Office	**Brockton Area Office**	**Fall River Area Office**	**Plymouth Area Office**		**Cape and the Islands Area Office**		**New Bedford Area Office**
Mansfield Attleboro Berkley Dighton North Attleboro Norton Rehoboth Seekonk Taunton Raynham	Holbrook Avon Brockton Easton Stoughton W. Bridgewater E. Bridgewater Bridgewater	Fall River Somerset Swansea Westport Freetown	Rockland Whitman Abington Hanover Hanson Mattapoisett Halifax Lakeville Middleborough	Rochester Pembroke Duxbury Marshfield Plympton Marion Carver Kingston Plymouth Wareham	Bourne Edgartown Falmouth Hyannis Mashpee Oak Bluffs Sandwich Tisbury W. Tisbury Gosnold Aquinnah Chilmark Yarmouth	Barnstable Orleans Dennis Brewster Chatham Eastham Harwich Nantucket Provincetown Truro Wellfleet	Acushnet Fairhaven New Bedford Dartmouth

Central Region					
North Central Area Office	**South Central/Blackstone Valley Area Office**		**Worcester East Area Office**	**Worcester West Area Office**	
Templeton	Brimfield	Northbridge	Auburn	Warren	Spencer
Winchendon	Wales	Upton	Millbury	Barre	Holden
Ashby	Charlton	Milford	Boylston	Hardwick	Leicester
Ashburnham	Douglas	Bellingham	Shrewsbury	Oakham	Paxton
Fitchburg	Dudley	Blackstone	West Boylston	West Brookfield	Rutland
Gardner	Oxford	Franklin	Sterling	East Brookfield	Worcester
Leominster	Sutton	Hopedale	Berlin	Brookfield	Hubbardston
Lunenburg	Webster	Medway	Bolton	New Braintree	Princeton
Townsend	Southbridge	Mendon	Harvard	North Brookfield	
Westminster	Holland	Millville	Lancaster		
Pepperell	Sturbridge	Uxbridge	Grafton		
Ayer			Clinton		
Shirley			Worcester		
Groton					

Metro Region						
Coastal Area Office	**Framingham Area Office**		**Arlington Area Office**		**Malden Area Office**	**Cambridge Area Office**
Milton	Boxborough	Westborough	Lexington	Wellesley	North Reading	Winchester
Quincy	Hudson	Acton	Waltham	Weston	Reading	Wilmington
Hingham	Maynard	Carlisle	Foxboro	Westwood	Everett	Cambridge
Hull	Stow	Concord	Medfield	Sharon	Malden	Woburn
Weymouth	Southborough	Lincoln	Millis	Dedham	Medford	Somerville
Randolph	Holliston	Sudbury	Norfolk	Belmont	Wakefield	Burlington
Braintree	Ashland	Littleton	Norwood	Needham	Melrose	
Cohasset	Framingham	Bedford	Plainville	Newton	Stoneham	
Norwell	Hopkinton	Sherborn	Walpole	Arlington		
Scituate	Marlborough	Wayland	Wrentham	Canton		
	Northborough	Natick	Watertown			
		Dover				

Western Region						
Greenfield/Northampton Area Office			**Pittsfield Area Office**			**Holyoke Area Office**
Rowe Chesterfield Middlefield Worthington Heath Ashfield Buckland Charlemont Goshen Hawley Colrain Conway Deerfield	Greenfield Leyden Shelburne Whately Cummington Plainfield Easthampton Hadley Hatfield Northampton Pelham Westhampton Williamsburg	Shutesbury Erving Bernardston Gill Leverett Montague Northfield Sunderland Wendell Athol New Salem Orange	Williamstown West Stockbridge Alford Lee Lenox Richmond Stockbridge Tyringham Monterey Egremont Great Barrington	Mount Washington New Marlborough Sheffield Savoy Dalton Adams Cheshire Clarksburg Hancock Hinsdale Lanesborough	New Ashford North Adams Pittsfield Peru Washington Otis Sandisfield Becket Windsor Florida Monroe	Huntington Southwick West Springfield Westfield Tolland Blandford Granville Montgomery Russell Chester Southampton Agawam Holyoke
	Robert Van Wart Area Office		**Springfield Area Office**			
	Palmer South Hadley Ware Wilbraham Ludlow Hampden Monson Springfield Chicopee Granby Belchertown		East Longmeadow Longmeadow Springfield			

APPENDIX B: RESOURCES FOR WRAPAROUND CARE PLANNING

The word "wraparound" can have many meanings. For the purposes of this RFR, *Wraparound* Care Planning is described in the following materials, all of which are available online at the web site of the National Wraparound Initiative (www.rtc.pdx.edu/nwi).

Title	*Author*	*Date*	*URL*
Ten Principles of the Wraparound Process	Eric J. Bruns, Janet S. Walker, Jane Adams, Pat Miles, Trina Osher, Jim Rast, and John VanDenBerg, and the National Wraparound Initiative Advisory Group	2004	*www.rtc.pdx.edu/nwi/TenPrincWAProcess.pdf*
The Wraparound Process User's Guide: A Handbook for Families	Miles, P., Bruns, E.J., Osher, T.W., Walker, J.S., and the National Wraparound Initiative Advisory Group	*2006*	*www.rtc.pdx.edu/PDF/pbWraparound_Family_Guide.pdf*
Phases and Activities of the Wraparound Process	Janet S. Walker, Eric J. Bruns, John D. VanDenBerg, Jim Rast, Trina W. Osher, Nancy Koroloff, Pat Miles, Jane Adams, and the National Wraparound Initiative Advisory Group	*2004*	*www.rtc.pdx.edu/nwi/PhaseActivWAProcess.pdf*

Wraparound is now well enough defined to permit fidelity measurement. For information on *Wraparound* fidelity measurement and quality assessment tools, see the web site of the Wraparound Evaluation and Research Team (WERT) at Washington State University: http://depts.washington.edu/wrapeval/

Other useful materials on *Systems of Care* principles and *Wraparound* can be found at the following web sites:

1.	Research And Training Centers For Children's Mental Health, University Of South Florida, http://rtckids.fmhi.usf.edu/
2.	National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, http://gucchd.georgetown.edu/programs/ta_center
3.	Research and Training Center on Family Support and Children's Mental Health, Portland State University, http://www.rtc.pdx.edu (including the online bulletin, Focal Point, http://www.rtc.pdx.edu/pgFocalPoint.shtml, including the Fall 2003 Issue: "Quality and Fidelity in Wraparound")

APPENDIX C: PERFORMANCE SPECIFICATIONS FOR INTENSIVE CARE COORDINATION

Targeted Case Management Services: Intensive Care Coordination

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications.

Intensive Care Coordination (ICC) is a service that provides MassHealth youth, with serious emotional disturbance (SED), under the age of 21, and enrolled in MassHealth Standard or CommonHealth, services and supports are driven by the needs of the youth and developed through a *Wraparound* planning process consistent with *Systems of Care* philosophy.

ICC is defined as follows:

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

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

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

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

strengths and needs of the youth and family, and strategies for meeting their needs.

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

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

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

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

Components of Service

	1. ICC services are delivered by a service provider that is contracted as a 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 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- and family-centered ICP in collaboration with the family and collaterals d. Development of a risk management/safety plan 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 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 on-call pagers to monitor the need for ESP/Mobile Crisis Intervention 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. 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.

	7. 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.* 8. 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. 9. 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 master's level care coordinators and bachelor's level care coordinators or 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. The ICC provider ensures that a licensed, master's level senior care coordinator provides adequate supervision to

	each care coordinator on a weekly basis. 6. The ICC provider ensures that a board-certified or board-eligible child psychiatrist or a child-trained mental health APRN 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- 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- 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) Psychotropic medications and possible side effects c) Family systems d) Peer support e) Partnering with parents/guardians/caregivers f) Child and adolescent development g) Related core clinical issues/topics h) Overview of the clinical and psychosocial needs of the target population i) Available community mental health and substance-specific services within their natural service area, the levels of care, and relevant laws and regulations j) The four phases of *Wraparound* and the 10 principles of *Wraparound* k) Ethnic, cultural, and linguistic considerations of the community l) Community resources and services m) Family-centered practice n) Behavior management coaching o) Mandated Reporting p) Social skills training q) Psychotropic medications and possible side effects

	r) Risk management/safety plans s) Crisis Management t) First aid/CPR u) Introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.) v) Basic IEP and special education information w) Managed Care Entities' performance specifications and medical necessity criteria x) Child/adolescent development including sexuality y) Conflict resolution
Service, Community, and Collateral 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 or 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- 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, guardians 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 in order 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/Mobile Crisis Intervention provider in their service area in order to facilitate referrals from the Mobile Crisis Intervention provider and to ensure care is properly coordinated for youth and families served by ICC and ESP/ Mobile Crisis Intervention. With consent from the parent/guardian/caregiver, if required, when a youth and family involved in ICC is in need of intervention from ESP/Mobile Crisis Intervention, as determined by the ICC provider, family and the ESP provider, the care coordinator is in contact with the ESP/Mobile Crisis Intervention staff at the time of referral (or if not, the referral source immediately upon learning of referral to ESP/Mobile Crisis Intervention) to provide relevant information, assistance, and recommendation for how ESP can best intervene to the ESP/Mobile Crisis Intervention staff. 8. The ICC provider maintains linkages and working relationships with the local Crisis Stabilization provider in their service area in order 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. 9. 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 (2) 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.
Quality Management (QM)	
	1. The ICC provider participates in all network management, utilization management, and quality management initiatives and meetings. 2. The ICC provider participates in all fidelity-monitoring activities required by EOHHS and the payers.
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- 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. 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.
Treatment Planning and Documentation	1. Telephone contact is made with the family within 24 hours of referral, including self-referral, for ICC to offer a face-to-face interview with the family, which shall occur within three (3) calendar days to assess their interest in participation and gain consent for service. 2. The ICC provider will obtain voluntary consent required to participate in ICC. 3. Immediately upon gaining consent for participation, the ICC provider will complete, with the family, an initial risk management/safety plan that will be confirmed and/or expanded as necessary at the first CPT meeting. 4. The care coordinator for each youth reviews and updates the risk management/safety plan. The risk management/safety plan details a response plan for the family to provide stability in crisis situations and to prevent the need for out-of-home services, such as hospitalization, whenever possible. The youth and family's CPT will review this plan periodically during CPT meetings. The risk management/safety plan is reviewed and updated as needed but at a minimum after an encounter with the ESP/Mobile Crisis Intervention Team staff and at the time of discharge from a 24-hour facility. The ICC provider ensures that, for each youth, a written copy of the current risk management/safety plan is sent to and maintained by the local ESP/Mobile Crisis Intervention Team. 5. 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 within ten (10) calendar days of the date on which the family consented to ICC. 6. The care coordinator works with the family to determine the composition of their CPT. 7. 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. 8. 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. 9. The first CPT meeting and the development of the ICP occur within 28 calendar days of the family's consent to services. The care coordinator, together with the CPT, develops a youth- 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. 10. 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 11. Depending on the complexity and intensity of the youth and family's needs, the care coordinator, in collaboration with the family and CPT, make a determination regarding 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 in order to coordinate, communicate about, and monitor activities related to goals and services identified in the ICP and in order to assess and address changes in the youth's needs. 12. When situations arise in which more than one MassHealth Standard- or CommonHealth-enrolled youth in a family requires ICC, the same care coordinator is assigned to both/all youth in order 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. 13. 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/Mobile Crisis Intervention 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, Mobile Crisis Intervention is required, or in the event of an emergency, the ICC provider shall engage the ESP/Mobile Crisis Intervention. ICC providers shall remain actively involved in monitoring and assessing the youth's need for services during the course of Mobile Crisis Intervention. 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.
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 assess ment 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 youth and family in sustaining gains; b) identification of the youth'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 youth who are also DMH clients or youth in the care and/or custody of DCF, and for DDS, DYS, and uninsured DMH clients. 3. Prior to discharge, the care coordinator, in conjunction with the youth, family members, significant others, and all providers of care, develop an updated risk management/safety plan. The purpose of this plan is to communicate and expedite a youth-focused disposition to other levels of care when clinically indicated and to ensure ongoing supports within the community. 4. The ICC provider ensures that the written risk management/safety plan and aftercare/transition plan are both provided 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/Mobile Crisis Intervention, the primary care physician/clinician, school, and other entities, and/or agencies engaged with, or significant to, the youth's aftercare.

APPENDIX D: SERVICE DEFINTION FOR INTENSIVE CARE COORDINATION

The service definition for ICC includes the following components billed in 15-minute increments. Please refer to the performance specifications for this service in Appendix C for more detailed information about the service components and related provider responsibilities. (1 unit = 15 minutes)

- Comprehensive home-based assessment inclusive of the Massachusetts Child and Adolescent Needs and Strengths (CANS)
- Care Planning Team (CPT) meetings
- Individual Care Plans (ICP)
- Risk management/safety plan(s)
- Care coordination, including:
  - Links and referrals for supports and services
  - Assistance with systems navigation
  - Collateral contacts (phone and face-to-face)
  - Direct time with providers (e.g., attendance at IEP, hospital discharge, and other meetings)
  - Aftercare planning
- Individualized and family-driven interventions and/or supports for the youth and parent/caregiver
- Regular contact with youth and parent/caregiver
- Telephone support for youth and parent/caregiver
- 24/7 crisis response
- Psychiatric consultation to the team
- Member transportation provided by staff
- No-shows (up to 30 minutes)
- Supervision (received by supervisee)
- Documentation

The following activities are included in the rate and are not billable as separate units:

- Supervision (provided by supervisor)
- Utilization review with payer
- Administrative paperwork as required by host agency
- Translation services
- Training activities
- Attendance at *System of Care* Committee meetings
- Staff travel time

APPENDIX E: PERFORMANCE SPECIFICATION FOR CAREGIVER PEER TO PEER SUPPORT

CAREGIVER PEER TO PEER SUPPORT

Providers contracted for this level of care or service will be expected to comply with all requirements of these service-specific performance specifications.

Caregiver Peer to Peer Support is a service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings. Caregiver Peer to Peer Support is a service that provides a structured, one-to-one, strength-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (DCF, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.

Caregiver Peer to Peer Support is delivered by strength-based, culturally and linguistically appropriate qualified paraprofessionals under the supervision of a licensed clinician.

Caregiver Peer to Peer Support services must achieve a goal(s) established in an existing behavioral health treatment plan/care plan for outpatient or In-Home Therapy, or an Individual Care Plan, for youth enrolled in ICC. Services are designed to improve the parent/caregiver's capacity to ameliorate or resolve the youth's emotional or behavioral needs and strengthen their capacity to parent.

Components of Service

	1. Providers Caregiver Peer-to-Peer Support services are outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. Providers of Caregiver Peer-to-Peer Support services utilize Family Partners to provide these

	services. 2. The Caregiver Peer to Peer Support service must be operated 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 e. Cultural and Linguistic Competence 3. The Caregiver Peer-to-Peer Support provider engages the parent /caregiver in activities in the home and community. These activities a. are designed to address one or more goals on the youth's treatment plan for outpatient or In-Home Therapy, or ICP, for youth enrolled in ICC . b. are designed to assist him/her with meeting the needs of the youth and meet one or more of the following purposes: i. educating ii. supporting iii. coaching iv. modeling v. guiding c. and may include: o education o teaching the parent/caregiver how to navigate the child-serving systems and processes o fostering empowerment, including linkages to peer/parent support and self-help groups o teaching the parent/caregiver how to identify formal and community-based resources (e.g., after-school programs, food assistance, housing resources, etc.). 4. The Caregiver Peer to Peer Support provider develops and maintains policies and procedures relating to all components of consumer peer support services. The provider will ensure that all new and existing staff will be trained on these policies and procedures. 5. The Caregiver Peer to Peer Support provider delivers services in the parent /caregiver's home and community. 6. The Family Partner delivers services in accordance with an existing outpatient, or In-Home Therapy treatment plan that

	is jointly developed by the outpatient, or In-Home Therapy provider with the parent/caregiver, and the youth whenever possible, and may also include other involved parties such as school personnel, other treatment providers, and significant people in the youth and parent/ caregiver's life. For youth in ICC, Caregiver Peer to Peer services are delivered in accordance with the ICP.
Staffing Requirements	
	1. Minimum staff qualifications for a Family Partner includes: • experience as a caregiver of a youth with special needs, and preferably a youth with mental health needs; • bachelor's degree in a human services field from an accredited university and one (1) year of experience working with the target population; or • associate's degree in a human service field from an accredited school and one (1) year of experience working with children/adolescents/transition age youth; or High school diploma or GED and a minimum of two (2) years of experience working with children/adolescents/transition age youth; and • experience in navigating any of the child and family-serving systems and teaching family members who are involved with the child and family serving systems. 2. Family Partners possesses a current/valid driver's license and an automobile with proof of auto insurance. 3. The Caregiver Peer to Peer Support provider ensures that all staff, upon employment and annually thereafter, before assuming their duties, complete a 20-hour training course that minimally includes the following: • Overview of the clinical and psychosocial needs of the target population • *Systems of Care* principles and philosophy • The four phases of *Wraparound* and the 10 principles of *Wraparound* • Role within a CPT • Ethnic, cultural, and linguistic considerations of the community • Community resources and services • Family-centered practice • Behavior management coaching

	• Social skills training • Psychotropic medications and possible side effects • Risk management/safety planning • Crisis Management • First aid/CPR • Introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.) • Basic IEP and special education information • CHINS/juvenile court issues • Managed Care Entities' performance specifications and medical necessity criteria • Child/adolescent development including sexuality • Conflict resolution Documentation of the provider's training curriculum is made available upon request. 4. The provider ensures that Family Partners receive supervision on a weekly basis from a Senior Family Partner and a licensed clinician who has specialized training in parent support, behavioral health needs of youth, family-centered treatment, and strengths-based interventions, and who is culturally and linguistically competent in working with youth and families with behavioral health needs. 5. The provider ensures that a senior licensed clinician is available during normal business hours for consultation, as well as during all hours in which any Family Partners provide services to parent/ caregiver(s), including evenings and weekends.
Service, Community, and Collateral Linkages	
	1. The provider offering Caregiver Peer to Peer Support services will assist the parent /caregiver(s) with learning how to network and link to community resources and services that will support them in caring for the youth. Family Partners teach the parent/caregiver how to promote linkages with other treatment providers, and the ICC care coordinator for youth in ICC, and assist the parent/ caregiver in advocating for and accessing resources and services to meet the youth's and parent/caregivers' needs. This may include, but is not limited to, access to support groups, faith groups, and community supports that will assist the parent to address the youth's emotional and behavioral needs. 2. For youth in ICC, the Family Partner participates as a member of the CPT and clearly outlines the goals of

	Caregiver Peer to Peer services in the ICP. 3. For youth who are not engaged in ICC, the Caregiver Peer to Peer Support provider works closely with the family and any existing/referring behavioral health provider(s), to implement the objectives and goals identified in the referring provider's treatment plan. 4. The Family Partner will participate in all care planning meetings and processes for the youth. When state agencies (DMH, DCF, DYS, DPH, DESE/LEA, DMR, MRC, ORI, probation office, the courts, etc.) are involved and consent is given by the parent/guardian/caregiver, the Family Partner participates and interacts, as appropriate, with these agencies to support service/care planning and coordination, on behalf of, and with, the youth and parent/caregiver(s).
Quality Management (QM)	
	The identified Caregiver Peer to Peer Support provider participates in quality management activities as required.
Process Specifications	
Treatment Planning and Documentation	1. When Caregiver Peer to Peer Support is identified as a need in the treatment plan for outpatient or In-Home Therapy, or an ICP, for those enrolled in ICC, the referring provider is responsible for communicating the reasons for referral and the initial goals to the Caregiver Peer to Peer Support provider. 2. For youth engaged in ICC, the Family Partner must coordinate with and attend all CPT meetings that occur while they are providing Caregiver Peer to Peer Support. At these meetings, the Family Partner gives input to the CPT in order to clearly outline the goals of service in the ICP and provide updates on the youth's progress. The Family Partner develops and identifies to the CPT an anticipated schedule for meeting with the parent/caregiver and a timeline for goal completion. The Family Partner determines the appropriate number of hours per week/month for Caregiver Peer to Peer Support services based on the needs of the youth and the parent/caregiver as identified in the ICP. 3. For youth who are not engaged in ICC, the Family Partner must coordinate with the referring provider and attend all treatment team meetings in order to clearly outline the objectives and goals of the service as identified in the

	referring provider's treatment plan and to provide updates on the youth's progress. The Family Partner develops and identifies to the referring/existing behavioral health provider an anticipated schedule for meeting with the parent/caregiver and a timeline for goal completion. The Family Partner determines the appropriate number of hours per week/month for Caregiver Peer to Peer Support services based on the needs of the youth and the parent/caregiver as identified in the treatment plan. 4. The Caregiver Peer to Peer Support provider contacts the parent/caregiver to initiate services within three (3) business days of receipt of the referral. 5. The Caregiver Peer to Peer Support provider matches the parent /caregiver's ethnicity, culture, language, needs, and strengths as closely as possible with available Family Partners. 6. The Family Partner has at least one contact per week, and more if needed, with the youth's ICC, In-Home Therapy Services, or outpatient provider to provide updates on progress toward goals identified in the treatment plan or ICP. 7. The Caregiver Peer to Peer Support provider ensures that all services are provided in a professional manner, ensuring privacy, safety, and respect for the parent/ caregiver's dignity and right to choice. 8. Family Partners document each contact in a progress report in the Caregiver Peer to Peer Support provider's record for the youth. 9. Family Partners follows the crisis management protocols of the provider agency during and after business hours.
Discharge Planning and Documentation	1. When the parent/ caregiver decides that he/she no longer wants or requires services, or the referring/current treater(s) along with the parent/guardian/caregiver determine that there is no longer a need for Caregiver Peer to Peer Support, or the goals of the treatment plan/ ICP are met, a discharge-planning meeting is initiated to plan the discharge from the Caregiver Peer to Peer Support service. 2. The discharge plan is agreed upon and signed by the parent/guardian/caregiver, and is shared, with consent, with current treater(s), or with the CPT for youth in ICC. 3. The reasons for discharge and all follow-up plans are clearly

	documented in the staff's record for the youth. 4. If the parent/ caregiver terminates without notice, the provider makes every effort to contact him/her to obtain their participation in the services and to provide assistance for appropriate follow-up plans (i.e., schedule another appointment, facilitate an appropriate service termination, or provide appropriate referrals). Such activity is documented in the provider's record for the youth. 5. The Family Partner writes a discharge plan that includes documentation of ongoing strategies, supports, and services in place for the youth and parent/caregiver(s), and resources to assist the youth and parent/caregiver(s) in sustaining gains. The plan is given to the parent/guardian/caregiver and the current/referring provider(s) within five (5) business days of the last date of service.

APPENDIX F: SERVICE DEFINTION FOR CAREGIVER PEER TO PEER SUPPORT

The service definition for Caregiver Peer to Peer Support includes the following components billed in 15-minute increments. Please refer to the performance specifications for this service in Appendix E for more detailed information about the service components and related provider responsibilities. (1 unit = 15 minutes)

- Family Partner coaching, training, and supporting parent/caregiver
- Assistance with learning to how to network/link to community resources and treatment providers
- Assistance with parent/caregiver in assessing youth's needs with regards to education, support, coaching, modeling, and guidance
- Assist parent/caregiver in understanding how to advocate for services and resources to meet the youth's needs
- Support parent/caregiver in reaching out for support in the form of individual, peer/parent support and self-help groups
- Collateral contacts (phone and face-to-face)
- Direct time with providers (e.g., attendance at IEP, hospital discharge, treatment team, and other meetings)
- Discharge planning
- Participation in Care Planning Team (CPT)
- Engaging the parent/caregiver in activities in the home and community that are designed to address one or more goals on the youth's treatment plan or ICP
- Telephone support for parent/caregiver
- Member transportation provided by Family Partner
- No-shows (up to 30 minutes)
- Supervision (received by supervisee)
- Documentation

The following activities are included in the rate and are not billable as separate units:

- Supervision (provided by supervisor)
- Utilization review with payer
- Administrative paperwork as required by host agency
- Translation services
- Participation in *System of Care* committee meetings
- Staff travel time
- Training

APPENDIX G: VOLUME PROJECTIONS

DCF Area Office	Estimated # of SED Children
Arlington Area Office	353
Attleboro Area Office	532
Brockton Area Office	386
Cambridge/Somerville Area Office	260
Cape & Islands Area Office	423
Cape Ann Area Office	338
Coastal Area Office	297
Dimock Street Area Office	425
Fall River Area Office	494
Framingham Area Office	565
Greenfield/Northampton Area Office	429
Harbor Area Office	304
Haverhill Area Office	341
Holyoke Area Office	417
Hyde Park Area Office	559
Lawrence Area Office	440
Lowell Area Office	981
Lynn Area Office	316
Malden Area Office	236
New Bedford Area Office	449
North Central Area Office	394
Park Street Area Office	956
Pittsfield Area Office	348
Plymouth Area Office	431
South Central/Blackstone Valley Area Office	292
Springfield Area Office	355
Van Wart Area Office	805
Worcester East Area Office	981
Worcester West Area Office	372

APPENDIX H: GLOSSARY

APRN – Advanced Practice Registered Nurse

CANS – Child and Adolescent Needs and Strengths

CBAT – Community-Based Acute Treatment

CBHI – Children's Behavioral Health Initiative

CHINS – Children In Need of Services

CPT – Care Planning Team

CSA – Community Service Agency

DCF – Department of Children and Families

DMR – Department of Mental Retardation

DMH – Department of Mental Health

DPH – Department of Public Health

DSM-IV – Diagnostic and Statistical Manual of Mental Disorders

DYS – Department of Youth Services

EBP – Evidence-Based Practice

ED – Emergency Department

EOHHS – Executive Office of Health and Human Services

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

ESP – Emergency Services Program

FFS – Fee-For-Service

ICC – Intensive Care Coordination

ICP – Individual Care Plan

IDEA – Individual with Disabilities Education Act

IEP – Individualized Educational Program

IT – Information Technology

MCE – Managed Care Entity

MBHP – Massachusetts Behavioral Health Partnership

MD – Doctor of Medicine

PAL – Parent Professional Advocacy League

PHP – Partial Hospitalization Program

RFR – Request for Response

SAMHSA – Substance Abuse and Mental Health Services Administration

SED – Severe Emotional Disturbance

SOC – Systems of Care

APPENDIX I: COVER SHEET

CSA RFR Cover Sheet

Organization name: _____

Is this an area-based CSA proposal? (circle one): YES NO

Proposed service area name: _____

Is this a specialty CSA proposal? (circle one): YES NO

Proposed special population: _____

Proposed service area(s): _____

Mailing address for correspondence:

_____

_____

_____

Contact person for correspondence (name and title):

(Name) _____

(Title) _____

Telephone number, fax number, and e-mail address of contact person:

(Telephone Number) _____

(Fax Number) _____

(Email Address) _____

Address of site or location at which CSA services will be delivered:

_____

_____

_____

Phone number of site referenced above: _____

Length of time in location referenced above: _____