SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

CROSS-SYSTEM CARE COORDINATION

I. Service Description

A. The provision of services is for youth and families with complex needs that are involved in multiple care systems and are involved with the Department of Child Services and/or Juvenile Probation.

B. Cross-system care coordination is designed to facilitate child and family teams comprised of youth, families, their natural support persons, local systems, agencies, and community members.

1. These teams design individualized service and resource plans based on the needs of the youth.

C. Services in this system of care should be:

1. Comprehensive
2. Incorporating a broad range of services and supports
3. Individualized
4. Provided in the least restrictive, appropriate setting
5. Coordinated at the system and service delivery levels
6. Involve youth and families as full partners
7. Emphasize early identification and intervention

D. Core values of a system of care are, that services are child centered and family driven, community based and culturally competent.

E. The services provided are comprehensive and will include:

1. Cross-system coordination
2. Case management
3. Safety and crisis planning
4. Comprehensive strength-based discovery and assessment
5. Activities of daily living training
6. Assistance to the FCM in the facilitation of child and family team process
7. Family and child centered care

F. The service is based on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, truly defined by what is in the best interest of the child.

G. It is meant to provide a single comprehensive system of care that allows children and families in the child welfare and/or juvenile probation system(s) with complex needs to receive culturally competent, coordinated, and uninterrupted care.

H. The services provided to the clients and covered in the per child allotment rate will include services necessary to meet the child's safety, permanency, and well-being needs and addresses criminogenic risk factors. They include but are not limited to:

1. Case Management Services
2. Behavioral Health Services
    1. Behavior Management Services
    2. Crisis Intervention
    3. Day Treatment
    4. Evaluation/Testing Services
    5. Family Assessment
    6. Family Therapy
    7. Group Therapy [referred youth and/or parent(s)]
    8. Individual Therapy [referred youth and/or parent(s)]
    9. Parenting/Family Skills Training Groups
    10. Special Therapy
    11. Substance Abuse Therapy- Group
    12. Substance Abuse Therapy- Individual
    13. Drug Screens [referred youth and/or parents(s)]
    14. Family Preservation- home based services
3. Mentor Services
    1. Clinical Mentor
    2. Educational Mentor
    3. Life Coach/Independent Living Skills Mentor
    4. Parent and Family Mentor
    5. Recreational/Social Mentor
    6. Supported Work Environment
    7. Tutor
4. Other Services
    1. Consultation with Other Professionals
    2. Team Meetings
    3. Transportation
    4. Supervised Visitation
    5. Diagnostic and Evaluation services for parents
5. Psychiatric Services
    1. Outpatient Assessments
    2. Medication Follow-Up/Psychiatric Review
6. Respite Services
    1. Crisis Respite

2. Planned Respite

7. Supervision Services
    1. Community Supervision
    2. Intensive Supervision
8. All Out of Home Placements
9. Services to meet the needs of children with complex medical needs or developmental delays
10. Goods and services related to increased child well-being

I. Family based services are included in the per diem if the referred child is participating in the service or if the service is to address the child's safety, permanency, or well-being needs.
    1. Outpatient Substance Use Disorder Services for parents are included in the rate.

J. Residential services for parents, individual services for siblings, and sex offender treatment for adults are not included.

K. Siblings who do not meet the target population will receive a Non-Eligible sibling referral.

L. All services provided under contracts for Cross System Care Coordination should be provided in accordance with any applicable service standard. For example, counseling services must be provided in accordance with the DCS Counseling Service Standard.

M. If mentoring services are being provided under this Service Standard, the Cross System Care Coordination provider must have a DCS approved Service Standard or policy related to the provision of the service.

II. Service Delivery

A. The Care Coordinator has the specific responsibilities for the following:
    1. Evaluates and interprets referral packet information and completes a strength based assessment with child and family and the Child and Adolescent Needs and Strengths Assessment (CANS).
    2. Collaborate with the Family Case Manager/Probation Officer in convening the family members, service providers, and other child and family team members to form a collaborative plan of care with clearly defined goals.
        a) Utilizes the CANS and IYAS (Indiana Youth Assessment System) as a basis for developing the plan for appropriate treatment.
    3. Addresses needs for and develops, revises, and monitors crisis plan with family and team members.

4. Ensures that parent and family involvement is maintained throughout the service period so that families have continual voice and choice in their care.
5. Maintains ongoing dialogue with the family and providers to assure that the philosophy of care is consistent and that there is progress towards service goals.
    a) Evaluates the progress and make adjustments as necessary.
6. Assures care is delivered in a manner consistent with:
    1. Strength based, family centered, culturally competent values
    2. Offers consultation and education to all providers regarding the values of the model
    3. Monitors progress towards treatment goals
    4. Assures that all necessary data for evaluation is gathered and recorded

B. Providing agency receives referrals 24 hours a day, 7 days a week.
1. There is a verbal determination between the referring worker and the agency that services are warranted, and there is agency availability for the service before the referral is sent.
2. The initial face-to-face contact with the family must occur no later than 48 hours following the receipt of the completed referral or as requested by the referring worker.
    1. Stabilization services must be provided as necessary to meet the safety needs of the family.

C. An abbreviated assessment to determine the needs of the youth and family is mutually established between the referral source and the care coordinator within 14 days of the completed referral.
    1. Goal setting and service planning are mutually established between the youth, caregiver, care coordinator, providers, and referral source based upon the comprehensive assessment within 21 days of the completed referral.
    2. The provider must contact any service providers already serving the family at the time of the CSCC referral and make arrangements to continue any needed services by transitioning responsibility of payment to the SCSS provider within 14 days of the referral.
    3. The provider should collaborate with the Family Case Manager to ensure any services being changed or canceled are transitioned as necessary to meet the needs of the family.

D. Each family receives access to services through a single care coordinator acting within a team, with supports available 24 hours a day, 7 days a week.

E. Regular assessment of needs and strengths of the youth and family will be completed and discussed within the Child and Family team to guide decision making on services and supports for the youth and family.
    1. System-related concerns and directives are included in these team discussions as well.

F. Safety is of paramount importance. If there are concerns about safety within the home there is an obligation for the care coordinator and the current worker to communicate to address all safety concerns, and document safety steps taken to resolve the issues.
    1. If any incidences occur, the care coordinator is to notify the current worker immediately of the situation.

G. Confidentiality must be maintained. Failure to maintain confidentiality may result in the termination of the service agreement.

H. After a 12 day period of no face-to-face contact with the child or youth, billing should be suspended until successful face-to-face contact is made.

III. Target Population

A. Services are restricted to cases where existence of complex needs has been documented within the following eligibility categories:
    1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with IA or CHINS status.
    2. Children and their families which have an Informal Adjustment (IA) or the children have the status of CHINS or JD/JS.
    3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.

B. Within the population listed above, Cross System Care Coordination will specifically target children who have a need for increased support, training or caregivers, and monitoring due to one or more of the following:
    1. Mental health issues and/or developmental delays/intellectual disabilities/autism and are in residential placements or at risk of residential placements (but do not qualify for the Medicaid funded services, Medicaid Rehabilitation Option and/or Children's Mental Health Wraparound Services).
    2. Significant substance abuse issues in conjunction with mental health issues.
    3. Sexually harmful/reactive behaviors
    4. Significant medical issues
    5. Legal issues within the delinquency system in addition to child welfare system involvement
    6. Significant criminogenic risk and needs

C. DCS may expand the target as necessary to ensure families and children receive the supports and services necessary to meet their needs.

IV. Goals and Outcomes

A. Goals and Outcomes will be established during the contract negotiation.

V. Minimum Qualifications

A. Clinical Consultant

1. Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related Human Services field; and,
2. Current license issued by the Indiana Social Worker, Marriage and Family Therapist, and Mental Health Counselor Board
3. The Clinical Consultant must staff each case a minimum of monthly with the Care Coordinator and the supervisor.

B. Supervisor

1. If the Clinical Consultant is not the supervisor of the Care Coordinator, the following are minimum requirements for the Direct Supervisor:
   a) Master's degree in social work, psychology, or directly related human services field from an accredited college and two (2) years of experience in delivering child welfare services or probation services, OR
   b) Bachelor's degree in social work, psychology, sociology, or a directly related human service field from an accredited college and five (5) years of experience delivering child welfare services or probation services. A minimum of one (1) year of the above experience must be in Cross System Care Coordination.

C. Care Coordinator

1. Bachelor's degree in social work, psychology, sociology, or a directly related human service field from an accredited college and three (3) years of experience in a human service field.
2. Other Bachelor's degrees will be accepted in combination with a minimum of five (5) years-experience working directly with families in the child welfare system.
3. Must possess a valid driver's license and the ability to use private car to transport self and others, and must comply with the state policy concerning minimum care insurance coverage.
4. In addition to above:
   a) Specialized training in care coordination
   b) Knowledge of child abuse and neglect
   c) Knowledge of child and adult development
   d) Knowledge of community resources

e) Ability to facilitate a team as well as work as a team member
f) Belief in helping clients change their circumstances, not just adapt to them
g) Belief in adoption as a viable means to build families
h) Understanding regarding issues that are specific and unique to adoption, such as:

(1) Mismatched expectations and flexibility
(2) Loss of familiar surroundings
(3) Customs and traditions of the child's culture
(4) Entitlement
(5) Gratification delaying
(6) Flexible parental roles
(7) Humor

VI. Billable Units

A. Billable units will be based on a per diem rate based on four levels of service:
1. Intensive- Youth in Residential Treatment, Day Treatment, intensive ABA, or Group Home Placements
2. Intervention- Youth at risk for Residential Treatment placements
3. Early Intervention- Youth with functional impairments across multiple life domains but who are currently functioning appropriately in the community
4. Non-Eligible Sibling- Siblings who will participate in family services but to not meet the target population for CSCC

B. The per diem will start the day of the first face-to face-contact after recommendation for acceptance into this program is approved by DCS.

C. Referrals will be made for 6 month time periods and the tier of service will remain unchanged for that time period.
1. In situations where an exception is necessary, the provider will work through the Regional Service Coordinator to request an adjustment.

D. After a twelve (12) day period of no face-to-face contact made by the care coordinator with the child or youth, billing should be suspended until successful face-to-face contact is made.

E. Interpretation, Translation, and Sign Language Services

1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
4. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
5. Certification of the Interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

VII. Case Record Documentation

A. Providers will be required to enter service logs into the KidTraks system. Entries should be made within 48 hours of service completion.

B. Case record documentation for service eligibility must include:

1. A completed, and dated DCS/Probation referral form authorizing services
2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source
3. Safety issues and Safety Plan Documetation
4. Documentation of Termination/Transition/Discharge Plans
5. Treatment/Service Plan
   a) Must incorporate DCS Case Plan goals and child safety goals
   b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
   a) Provider recommendations to modify the service/treatment plan
   b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
7. Progress/Case notes must document:
   a) Date
   b) Start time
   c) End time
   d) Participants
   e) Individual providing service
   f) Location

8. When applicable Progress/Case notes may also include
    a) Service/Treatment plan goals addressed (if applicable)
    b) Description of intervention/activity used towards treatment plan goal
    c) Progress related to treatment plan goal including demonstration of learned skills
    d) Barriers: lack of progress related to goals
    e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
    f) Collaboration with other professionals
    g) Consultations/Supervision staffing
    h) Crisis intervention/emergencies
    i) Attempts of contact with clients, FCMs, resource parents, other professionals, etc.
    j) Communication with client, significant others, other professionals, school, resource parents, etc.
    k) Summary of Child and Family Team Meetings, case conferences, staffing

9. Supervision notes must include:
    a) Date and time of supervision and individuals present
    b) Summary of supervision discussion including presenting issues and guidance given

VIII. Reporting

A. Providers will be required to prepare, maintain, and provide any statistical reports, program reports, other reports, or other information as requested by DCS relating to the services provided.

B. Reports are due by the 10th of the month following service.

C. DCS will require an electronic reporting system which will include documenting time and services provided to families.

D. DCS may also adopt a standardized tool for evaluating family functioning.

E. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

IX. Service Access

A. All services must be accessed and pre-approved through a referral form from the referring DCS/Probation staff.

B. In the event a service provider receives verbal or email authorization to provide service from DCS/Probation an approved referral will still be required.

C. Referrals are valid for a maximum of six (6) months unless otherwise specific by DCS/Probation.

D. DCS will have the option to put the referral on hold or terminate the family's referral at an earlier date due to changes in family status or loss of engagement.

E. The provider is to contact the Family Case Manager/Probation Officer after missed appointments.

1. After three (3) missed unsuccessful face-to-face contacts, the provider must notify the Family Case Manager/Probation Officer and billing must be suspended until successful face-to-face contact is made.

2. Family Case Manager/Probation Officer should be contacted to evaluate the need for early termination of the referral.

F. The referral must be accepted within the KidTraks vendor portal within 72 hours.

G. The provider has 24 hours to contact the referral source if unable to accept the referral based upon lack of capacity.

H. The provider will see the family within 48 hours of the referral.

X. Adherence to the DCS Practice Model

A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.

B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children

XI. Interpretation, Translation, and Sign Language Services

A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.

B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.

C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).

E. Sign Language should be done in the language familiar to the family.

F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.

H. No side comments or conversations between the Interpreters and the clients should occur.

XII. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (http://www.samhsa.gov/nctic/):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization

B. Trauma Specific Interventions: (modified from the SAMHSA definition)

1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIII. Training

A. Service provider employees are required to complete general training competencies at various levels.

B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.

C. Training requirements, documents, and resources are outlined at: http://www.in.gov/dcs/3493.htm

1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and agency responsibility.
2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIV. Cultural and Religious Competence

A. Provider must respect the culture of the children and families with which it provides services.

B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.

C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.

1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
3. The guidebook can be found at: http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf

D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.

E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XV. Child Safety

A. Services must be provided in accordance with the Principles of Child Welfare Services.

B. All services (even individual services) are provided through the lens of child safety.

1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.

2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statue, IC 31-33-5-1.

C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.