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**Rosie D. Feature Article July 2014**

**The Role and Importance of Care Coordination**

In his 2006 liability decision, Judge Ponsor described effective care coordination as a “critical service,” the importance of which was “impossible to overstate.” Ensuring youth with SED have access to both appropriate care coordination and the benefits of a wrap-around, team-based treatment planning process are central goals of the Judgment in Rosie D. v. Patrick, and have remained an area of focus in ongoing implementation efforts.

Intensive care coordination is the hallmark of successful wraparound programs, and is widely recognized as a critical service with a unique role in the children’s mental health system of care. In wraparound, child and family-driven teams have a central function in the development of individualized treatment plans. These plans are designed around the youth’s and family’s vision of wellness and their goals for home-based services.

Wraparound care coordination models like ICC work with youth and families to comprehensively assess their needs and strengths, develop a single, integrated treatment plan, and facilitate a team process designed to implement that plan’s goals and objectives. Care coordinators work with families to ensure the effective delivery of formal services while cultivating the involvement of other natural supports. They ensure appropriate communication and collaboration with educational providers and state agencies which are involved with the youth, and monitor the ongoing delivery of those home-based services in a way no other clinical service can.

Appropriate care coordination is critical to the delivery of effective, collaborative treatment interventions. It is necessary to ensure providers communicate regularly regarding youth and family progress, adjust to their changing needs, and work together towards to achieve improved and durable treatment outcomes. Plaintiffs have long been concerned that utilization of ICC, the Commonwealth’s Intensive Care Coordination service, is far lower than many other wraparound systems of care. Since September 2010, ICC monthly enrollment has remained relatively flat, sometimes varying by as little as five to ten youth per month. Over the last three years of implementation, these enrollment numbers have ranged from 3,500 to 3,800 youth per month, reaching a high of 3,868 youth in May of 2013. This represents less than 9% of Medicaid-eligible youth with SED and less than 20% of youth with severe SED. At the same time, ongoing disengagement activities and data collection have shown that youth with complex mental health needs, who need or receive services from multiple providers or state agencies are still relying on outpatient or In-Home therapy for access to, and coordination of, their home-based services, often without even knowing they may be eligible for ICC.

Recent SOCPR reports raise serious concerns about the quality of assessments for youth in IHT, as evidenced by findings that a significant percentage of these youth need and are eligible for more intensive team-based care coordination.1As a result, the vast majority of these youth are receiving neither information on, nor referrals to, ICC.2The SOCPR reports also confirm persistent doubts with regard to the sufficiency of treatment planning and care coordination for many youth with In-Home Therapy as the primary provider of treatment planning and service coordination.3In the most recent Central Massachusetts report, only 25% of reviewers agreed moderately or very much that the level of care coordination provided to youth receiving only IHT was appropriate. Taken together, these findings reaffirm that IHT cannot serve as a substitute for the rigors of the wraparound care planning process, and that disparate utilization of IHT for service planning and coordination is leaving a significant number of youth without the level of treatment planning and care coordination they require.4

1In the Central Massachusetts sample, 66% of youth with IHT were found to be in need of a care planning team, and in only 33% of cases did reviewers agree moderately or very much that a thorough assessment was conducted.

2In the Central region, three quarters of reviewers indicated that the IHT sampled youth had not been enrolled in ICC previously and 83% found that the option of ICC had never been discussed with the youth/family.

3The Central Massachusetts SOCPR report mirrors concerns found in the other regional reviews, while documenting the complexity of needs found among youth with IHT hubs.  In this sample, 66% of youth needed or were receiving multiple services and needed a care planning team to help coordinate those services.  In addition, 33%of youth needed or were receiving services from state agencies or special education and needed a care planning team to help coordinate those services. Three quarters of the sample  needed assistance  in coordinating and collaborating with school personnel.  However, only 33% of reviewers agreed moderately orvery much that these service systems were involved in planning for the youth, and only 42% felt IHT was connecting with these service systems.

4Utilization data for the period July-December 213 indicates a total of 6,254 youth were enrolled in ICC as compared to 13,268 youth in IHT.  Given that a third of these ICC teams included IHT providers, at least 7,000 and possibly as many as 11,000 youth  were depending on IHT as their clinical hub during this period.

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