CAPE ATLANTIC I.N.K.
Integrated Network for Kids
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Care Management Program Description

Cape Atlantic Integrated Network for Kids (I.N.K.) is a private, nonprofit care management organization (CMO) that provides face to face and telehealth care management services to youth/young adults ages 5 to 21 with moderate to high behavioral health needs, intellectual and developmental needs and substance use needs in Cape May and Atlantic Counties. Care management services are provided by bachelor's and master's degree professionals in the Human Service field who are trained and certified as Care Managers by the New Jersey Children's System of Care. Care management services are delivered in the youth/young adult's home, community or a location preferred by the family. Office hours are Monday through Friday 8:00AM to 5:00PM however Care Managers have the ability to meet with families seven days a week at the time that is preferred by the family.

After hours support is available seven days a week to assist with any immediate needs. Each youth/young adult receiving care management services is assigned a Care Manager who assists them in meeting their family vision by using the research based Wraparound Model of care management. In the Wraparound Model, the Care Manager works with each youth/young adult and their guardian to build a Child Family Team (CFT) made up of informal and formal support people that assist the youth/young adult and guardian to develop and implement an Individual Service Plan (ISP) to meet their needs.

The Care Manager conducts monthly face-to-face or telehealth meetings with the youth/young adult, maintains weekly contact with all CFT members and meets at a minimum quarterly with the CFT to oversee that the Individual Service Plan is effectively meeting the youth/young adults and family's needs. The Individual Service Plan is modified as many times as needed to meet the needs of the youth/young adult.

The goal of Cape Atlantic I.N.K. Wraparound care management services is to keep youth successfully in their home, in school and successful in their communities. Treatment is always be delivered in the least restrictive setting.

Cape Atlantic I.N.K.'s care management services are funded through state and federal Medicaid funds as well as state funds administered through the New Jersey Children's System of Care (CSOC). Youth/Young Adults and their families do not pay any fees for care management or behavioral health home services.

Referrals to Cape Atlantic I.N.K. are made through the Contracted Systems Administrator (CSA), Perform Care, after a Needs Assessment, Clinical Summary or Mobile Response referral is clinically reviewed and determined appropriate for care management intensity of service. Any guardian or young adult can call Perform Care at 1 877-652-7624 for services.

Cape Atlantic I.N.K. works in partnership with youth/young adults and their families to improve and expand the services and supports available in their local community. The organization partners with formal and informal child serving systems including but not limited to Child Protective Services, Juvenile

Justice, Special Education, Medicaid, Clinical and Behavioral providers, Medical providers, Churches and Grass Roots Organizations to meet the complex needs of the youth/young adult served. Service needs and gaps identified by Child Family Teams are address at an organizational level to assist both the youth/young adult and family as well as the entire community. This parallel process is a part of the Wraparound Model.

The values of Wraparound care management services include:

Family-Centered: The family is an essential part of the care management process. We are here to listen and advocate for family voice and choice in planning for youth/young adults.

Strengths-Based: We believe that all youth/young adults and their families have strengths. We build upon these strengths and those of the community to help meet youth/young adult and family needs.

Culturally Diverse: Our staff is diverse and reflects the community we serve. Each of our staff is skilled in learning and implementing family's culture, values, preferences, and interests into the planning process.

Individualized: Services will be tailored to suit youth/young adult and family's needs.

Community-Based: We strive to keep youth/young adults within the home/community.
We help build a network of care that offers easily accessible, long-term, community-based sources of support for youth/young adult and families.

Easily- Accessible: Cape Atlantic I.N.K. office hours are Monday through Friday 8:00AM to 5:00PM however Care Managers meet with families seven days a week at the time that is preferred by the family. Care Managers work flexible schedules to meet youth/young adults and families at the time, day and location preferred by families. Cape Atlantic I.N.K. also offers 24-hour on-call coverage to assist youth/young adult and families in time of crisis.

Enrollment Criteria:

The following criteria must be met in order to be eligible for enrollment into Cape Atlantic I.N.K:

- **A.** The youth is between the ages of 5 and 21. Special consideration will be given to youth under age 5 or over 21.
- **B.** The legal guardian resides in Cape May or Atlantic Counties in New Jersey
- **C.** Youth demonstrates moderate to severe emotional or mental health challenges consistent with a DSM 5/ICD 10 diagnosis, which adversely affects his or her capacity to function adequately in significant life domains such as family, school, community, social, or recreational/vocational. When the etiology of the symptoms is unclear (behavioral health vs. developmental/intellectual disability), an assessment describing the youth's functional capacity within school, home, and the community, as well as his/her ability to think or perceive surroundings accurately and interact appropriately with others demonstrates that the youth's functioning can be improved with the provision of services.
- **D.** The Children's System of Care (CSOC) Assessment and other relevant information indicate that the youth need care management provided by a CMO and requires service coordination and linkages such as with specialized behavioral health services or medication management services, and coordination with Child Study Teams, other school personnel, DCP&P, adult services, Juvenile Detention/Justice, and/or medical health services. The CSOC assessment and other relevant information indicates a decline in the youth's baseline functioning or demonstrates that the youth's functioning can be improved with the provision of CMO services.
- **E.** The youth and his/her family require face to face assistance in obtaining or coordinating treatment, rehabilitation, medical, financial, and/or social services, without which the youth could

reasonably be expected to require more intensive service to improve or maintain functioning in the community.

F. The persons with authority to consent to treatment for the youth voluntarily agree to participate. The consent of a youth who is not authorized under applicable law to consent to treatment is desirable, but not required.

G. The youth must also either: demonstrate at risk behaviors or other psychosocial factors which place him/her at increased likelihood for Out of Home (OOH) treatment or psychiatric hospitalization; be awaiting OOH treatment; have recently been transitioned from a CCIS, other inpatient psychiatric hospitalization, or other institutional or residential community based treatment program, and is returning to a community setting; have multiple episodes of inpatient psychiatric hospitalization or other institutional or residential community based treatment program within the past 12 months;

H. Youth with an intellectual or developmental disability in the absence of a co-occurring mental health challenge, may be exempted from b) above, but must additionally meet the following criteria:

- Youth has been determined DD eligible by CSOC (or previously determined eligible by DDD)
- Youth manifests moderate to severe behavioral challenges and skill building needs resulting in a high to moderate level of functional impairment which adversely affects his or her capacity to adequately function in significant life domains, such as family, school, community, social, or recreations/vocational activities.

Continued stay criteria:

The Child Family Team meets at a minimum every 90 days to review planning, progress and service delivery. At each CFT meeting a Strengths and Needs Assessment is completed with the youth/young adult and family to ensure the youth/young adult continues to meet eligibility requirements as listed above. Continued stay with care management services is dependent on meeting all the above criteria. On an annual basis, each youth/young adult has an annual review meeting which allows the Child Family Team (CFT) to highlight any recommended changes in services and to reassess whether requested services continue to be appropriate to address needs.

Transition Criteria:

Transition planning for youth/young adults receiving CMO services is intentionally considered within the context of the ongoing ISP process and guides the team process from the time of the family's referral. The goal of the CFT process is to empower the family to manage their own plan within the community. It is understandable that families may have needs in the future, but the goal is for them to develop skills and resources to negotiate them independent of Children's System of Care (CSOC) by accessing the necessary formal supports on their own. It is essential that the Care Manager introduce this goal at the beginning of the process and ensure that the family understands that the team will continually work with them to assess their readiness so that transition does not happen until both the family and the team feel that enough progress has been made for them to be successful with the supports they have developed. Peer support through the Family Support Organization, Youth Partnerships, Mom to Mom and other support groups may continue after CMO involvement.

Transition planning requires the CM to balance the family's current need for support with preparing them to transition out of CSOC by teaching the family the process of the CFT. From the initial meeting forward, the CM will encourage the family to drive the CFT process by reinforcing their strengths, highlighting their successes, and empowering them to apply the skills learned to problem solve on their own.

A transition plan is formally developed if one or more of the following criteria are met:

- The goals of the ISP have been substantially achieved
- The CFT determines that the youth no longer require the intensive level of care management provided by the CMO
- The CFT determines that the youth is ready to be transitioned to adult services
- The family requests transition, or is unreachable for sixty days despite documented best efforts to contact family
- The family or youth moves out of New Jersey
- The youth is sentenced to a term of incarceration

If the youth/young adult at any time is no longer eligible for CMO services due to not meeting the eligibility criteria, the Child Family Team completes a Transitional Child Family Team meeting to discuss community-based alternatives that do not require CMO involvement. A Care Manager may also contact the referral source to inform of the youth/young adult or family's transition plan.