Connect Nevada: Strengthening Youth, Empowering Families

Child, Youth, Young Adult, and Family Handbook

MagellanofNevada.com
February 1, 2024

Magellan HEALTHCARE®

CONNECT NEVADA: STRENGTHENING YOUTH, EMPOWERING FAMILIES

Child, Youth, Young Adult, and Family Handbook

www.MagellanofNevada.com
February 1, 2024

Magellan Healthcare, Inc. (Magellan of Nevada), program administrator on behalf of the Nevada Department of Health and Human Services, Division of Child and Family Services

Table of Contents

Acknowledgement and Receipt Form

Please fill out this form and give it to your care coordinator.

My Magellan care coordinator gave me a copy of this Connect Nevada: Strengthening Youth, Empowering Families Program Handbook. The handbook includes important information such as:

- How to contact Magellan
- How to get help in an emergency or mental health crisis
- Anti-discrimination
- Language interpretation and translation services
- My rights and responsibilities
- Connect Nevada services
- How to get services
- How to file a Complaint/Grievance and Appeal

I acknowledge I have received this Handbook and will read it as soon as I can. If I have any questions, I will ask my Magellan care coordinator.

_____ _____

Signature of young adult or child's parent/guardian Date

_____

Printed name of child

_____

Printed name of young adult or parent/guardian

_____

If guardian, relationship to child

Language Interpretation and Translation Services

If you have English as a second language or are hearing impaired, you can get free oral interpretation, TTY, or American Sign Language services when you talk to Magellan or providers in any setting. To get these services, please call Magellan at 1-833-396-4310 (TTY 711).

Magellan can translate important written materials to prevalent non-English languages in Nevada. For members with vision impairment, we can provide important written materials in other formats such as audio, large print or Braille. For help with written materials, please call Magellan at 1-833-396-4310 (TTY 711).

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-396-4310 (TTY 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-396-4310 (TTY 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-396-4310 (TTY 711)。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-396-4310 (TTY 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-396-4310 (TTY 711)
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-396-4310 (TTY 711) 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-833-396-4310 (հեռատիպ՝ 711)
Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-833-396-4310 (TTY 711) تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-396-4310 (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-833-396-4310 (TTY 711) まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-833-396-4310 (رقم هاتف الصم والبكم: 711).
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-833-396-4310 (TTY 711)'ਤੇ ਕਾਲ ਕਰੋ।
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-833-396-4310 (TTY 711)។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-833-396-4310 (TTY 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-833-396-4310 (TTY 711) पर कॉल करें।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-833-396-4310 (TTY 711).

Chapter 1: Welcome to Connect Nevada: Strengthening Youth, Empowering Families

Welcome to the **Connect Nevada: Strengthening Youth, Empowering Families** program (Connect Nevada). The goal of this program is to help children and young adults stay safely at home/in the community with their friends and families instead of in hospitals, residential treatment centers, or other settings outside of the home. Magellan of Nevada (Magellan) manages this program for the Nevada Department of Health and Human Services, Division of Child and Family Services (DCFS).

About Connect Nevada

Connect Nevada is a child/young adult-guided, family-driven, strengths-based approach to mental health services and supports, coordinated across state agencies and providers. Connect Nevada offers:

- Care Coordination: High-Fidelity Wraparound, intensive care coordination, and targeted case management
- Intensive home-based treatment
- Emergency and planned respite
- Family peer support (through Nevada PEP)
- Youth peer support

See Chapter 4, Connect Nevada Services, for more information about these services.

About Magellan Healthcare

Magellan is a behavioral healthcare services organization with over 50 years of experience. We have expertise in child, youth, and adult state programs that help people live good lives. We have run programs like Connect Nevada in other states for many years. We are excited to bring our experience to help Nevadans.

Who is Eligible

To be eligible for Connect Nevada services, children and young adults must be ages 3 through 20, have complex mental health needs, and are either:

- At risk of out-of-home placement
- Placed in a residential treatment facility or other inpatient setting
- Involved in multiple child-serving systems
- At risk of custody relinquishment to a state or county agency due to behavioral health needs

Services are available to eligible children/young adults and their families. It does not matter if you have health insurance or what kind of health insurance you have.

How to sign up

Parents and caregivers can refer a child/young adult to be screened for eligibility. Young adults may submit a referral for themselves as well. Others who can refer a child/young adult for screening include mental health professionals, teachers, and counselors. A referral can be made by contacting Magellan in one of these ways:

- Visit MagellanofNevada.com/refer and complete the referral form
- Call us at 1-833-396-4310 (TTY 711).

Magellan will screen the child/young adult to see if they are eligible for Connect Nevada.

Connect Nevada Services are not Required

You do not have to use Connect Nevada services. You have the right under state law to accept or refuse services offered.

If you choose to accept Connect Nevada program services, you or your parent/guardian will need to sign a consent form. This is called a "Freedom of Choice & Consent Form." A Magellan care coordinator will give you/your parent/guardian the form, help you complete it, and tell you how to send it back to Magellan. This form must be completed to get Connect Nevada services. It also gives Magellan and DCFS permission to see your records.

About this Handbook

This Connect Nevada Handbook explains services available to eligible children/young adults and their families. It also includes:

- Contact information
- Emergency and mental health crisis information
- Details on how to get help and information in other languages and formats
- Rights and responsibilities
- Descriptions of and instructions on how to get services
- Complaint/Grievance and Appeal processes

A Care Coordinator will give you/your parent/guardian a printed copy of this handbook in person once you are enrolled in Connect Nevada. You or your parent/guardian will be asked to sign the Acknowledgement and Receipt Form on page 5 saying you received this handbook. You and your parent/guardian should read the handbook all the way through. Keep it in a place where you can easily come back to it. If something in this handbook changes, Magellan will send you a letter. Please keep all change letters with this handbook.

Chapter 2: Important Information

Magellan Healthcare Contact Information

Website:	www.MagellanofNevada.com
Email:	ConnectNV@MagellanHealth.com
Phone:	1-833-396-4310 (TTY 711) 24 hours a day, 7 days a week
Physical Address:	6671 Las Vegas Blvd South, Building D, Suite 210 Las Vegas, NV 89119 Monday-Friday, 8:00 a.m.-5:00 p.m. local time
Mailing Address:	P.O. Box 95994 Las Vegas, NV 89193-5994

Emergency help

An emergency is when a person thinks they must act fast to prevent or get help for serious health problems. If you don't know if you need emergency help, call Magellan at 1-833-396-4310 (TTY 711), 24 hours a day, 7 days a week.

How to get help in an emergency

- Call 911 for medical emergencies
- Call 988 for mental health crises
- Go immediately to the nearest emergency room

You can use any hospital for emergency care even if you are in another city or state. You do not need approval from Magellan to get medical emergency or mental health crisis care.

If you have a Medical Emergency

Emergency services are inpatient and outpatient services that are needed to evaluate and stabilize a person. An emergency medical condition is a physical problem so bad that a person with no medical training would say someone's life or long-term health is at risk. You do not have to get approval from Magellan to get emergency care. You can go to any emergency room you choose.

If you have a medical emergency:

- Call 911, or
- Go to the nearest emergency room.

If you have a Mental Health Crisis

A mental health crisis is when a person does something unexpected or suddenly acts in a way that:

- Puts them at risk of hurting themselves or others, and/or
- Prevents them from functioning or being able to care for themselves

If you or someone you know is in immediate danger of harm to self or others, call 911 or 988, or go to the nearest emergency room.

If you need mental health crisis help:

- Go to the nearest emergency room
- Call, text, or chat 988 for Crisis Support Services of Nevada, 24 hours a day, 7 days a week
- Call the Children's Mobile Crisis Response Team:
    - Southern & Rural Nevada: (702) 486-7865 (TTY 711)
    - Northern Nevada: (775) 688-1670 (TTY 711)

You do not have to get approval from Magellan to get mental health crisis services. You can go to any emergency room you choose.

How to get Mental Health Crisis help when you are out of town

If you need mental health crisis help when you are out of town, call 911 or 988, or go to the closest emergency room or crisis center. You can use any hospital for emergency care even if you are in another city or state.

What to do After the Mental Health Crisis is over

Before you go home, the hospital will help you get an appointment for follow-up care. Magellan and your Child and Family Team can also help you get an appointment if you contact us for assistance. Some services may need to be approved first.

Nevada Department of Health and Human Services (DHHS)

Nevada 211

Nevada 211 is an information and referral line to help you find resources for everyday needs and in times of crisis.

Through Nevada 211, you can find assistance for a variety of services, such as:

- Addiction counseling
- Affordable housing
- Alzheimer's assistance
- Child care
- Counseling
- Education
- Emergency Food
- Dental & Medical Healthcare
- Drug Abuse Treatment
- Homeless services
- Senior services
- Suicide prevention
- Volunteer opportunities

For more information, visit Nevada211.org or dial 211 on your phone, 24 hours a day, 7 days a week.

Division of Child and Family Services (DCFS)

Adult Protective Services (APS)

Report vulnerable adult abuse, neglect, exploitation, isolation, or abandonment.

- Submit a report 24 hours a day, seven days a week at https://www.nevada211.org/aps/.
- Talk to an APS representative by phone, Monday through Friday 8:00 a.m. – 5:00 p.m. at:
    - (702) 486-6930 (TTY 711) in Las Vegas/Clark County
    - 1-888-729-0571 (TTY 711) in all other areas

Victims of Crime

The Victims of Crime Program provides assistance to qualified victims of violent crimes that occur in Nevada. Business Hours: 8:00 a.m. to 4:00 p.m.

- Visit: voc.nv.gov/
- Email: VOCP@dcfs.nv.gov
- Call:
    - (702) 486-2740 (TTY 711) Southern Nevada
    - (775) 688-2410 (TTY 711) Northern Nevada
- Fax: (702) 486-2825

Mobile Crisis

The Mobile Crisis Response Team (MCRT) provides crisis intervention and short-term support to children under the age of 18 dealing with a behavioral or mental health crisis.

- Visit: knowcrisis.com/
- Call:
    - (702) 486-7865 (TTY 711) Southern and Rural Nevada
    - (775) 688-1670 (TTY 711) Northern Nevada

Child Protective Services (CPS)

CPS looks into reports of child abuse and neglect. They provide helpful services to children and families.

- Visit: dcfs.nv.gov/Programs/CWS/CPS/CPS
- Call:
    - 1-833-900-7233 (TTY 711) in Washoe County (Reno/Sparks)
    - (702) 399-0081 (TTY 711) in Clark County (Las Vegas/Henderson)
    - 1-833-571-1041 (TTY 711) in all other counties
    - After hours and weekends, please call local law enforcement

Division of Public and Behavioral Health (DPBH)

DPBH protects, promotes and improves the physical and behavioral health of the people of Nevada.
Business Hours: 8:00 a.m. to 5:00 p.m.

- Visit: https://dpbh.nv.gov/
- Email: dpbh@health.nv.gov
- Call: (775) 684-4200 (TTY 711)
- Fax: (775) 687-7570

Division of Welfare and Supportive Services (DWSS)

DWSS provides public assistance benefits to all who qualify and reasonable support for children with absentee parents to help Nevadans achieve safe, stable, and healthy lives. DWSS oversees many programs for child support and care, energy assistance, food, healthcare, welfare and financial assistance.

- Visit: https://dwss.nv.gov/
- Apply: accessnevada.dwss.nv.gov/public/landing-page

Discrimination is against the law

Magellan complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex. Magellan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Magellan:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Important written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Important information translated to other languages

If you need these services, call Magellan at 1-833-396-4310 (TTY 711).

If you believe that Magellan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with Magellan at:

Civil Rights Coordinator, Corporate Compliance Department
8621 Robert Fulton Drive
Columbia MD 21046
Phone: 800-424-7721 (TTY 711)
compliance@magellanhealth.com

You can file a complaint by mail or email. If you need help writing your complaint, call Magellan at 1-833-396-4310 (TTY 711).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

Child, Youth, Young Adult, and Family Rights and Responsibilities

As a Connect Nevada participant, you have certain rights and responsibilities. Your rights are important. Your care coordinator will explain your rights and responsibilities before you accept Connect Nevada Services.

As a program participant, you have the right to:

- Exercise your rights without regard to race, color, religion, sex, sexual orientation, or national origin; cultural or educational background; or the source of payment for your care.
- Have all paperwork and procedures explained to your child and you, as their legal guardian, in a language that is easy to understand.
- Be treated with respect and recognition of your dignity and right to privacy.
- Receive culturally competent medical, psychosocial, and rehabilitative care; treatment and training, including prompt and appropriate medical treatment and care for physical and mental ailments and for the prevention of any illness or disability. All care must be consistent with standards of practice of the respective professions within the community.
- Receive written information about Magellan Healthcare, Inc., its staff, providers in Nevada, programs and services, role in the treatment process, and your rights and responsibilities.
- Request the name of the provider who has primary responsibility for your treatment planning and treatment, and the names and professional relationships of others who may provide your care.
- Choose your qualified provider and ask for their work history and training.
- Easily access care in a timely fashion.
- Extend rights to any person who may have a legal responsibility to make decisions regarding your care on your behalf.
- Receive treatment only if you, or your legal guardian, give informed consent in writing.
- Receive as much information about any proposed treatment options as you may need to give informed consent or to refuse a course of treatment.
- Receive information about clinical guidelines used in providing and managing your care.
- Full consideration of privacy concerning your treatment, with confidential and discreet case discussion, consultation, and treatment. You have the right to be advised why any individual is present during your treatment or treatment planning.
- The prompt development of a Plan of Care, with thorough reviews of treatment occurring at least every three months, and to inspect the records.
- Participate actively in the development of your Plan of Care. The Plan of Care must provide for the least restrictive treatment procedures that may reasonably be expected to help you and allow you to refuse treatment as permitted by law.

- Receive information about your diagnosis, proposed treatment, alternative treatment, risks and benefits, including no treatment, in language and terms you can understand. If you have a hearing impairment or do not speak English, you may request access to an interpreter.
- Prompt and periodic discussion of your rights and treatment progress and reasonable requests for service.
- Keep confidential all communications and records pertaining to your treatment. Written permission from you or your authorized representative shall be obtained before the records of your treatment can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.
- Be advised if any research or human experimentation is a part of treatment. You have the right to refuse to participate in such research projects.
- Be informed of continuing treatment recommendations and referral and assistance in planning for post-discharge needs and services.
- Freely file a Complaint/Grievance or Appeal and have Magellan help you do it.
- Have the Complaint/Grievance procedure explained to you and your legal guardian in commonly used child- and family-friendly language.
- Receive information about Magellan staff's qualifications.

Chapter 4: Connect Nevada Services

The Connect Nevada program includes:

- Care Coordination: High-Fidelity Wraparound, Intensive Care coordination, Targeted Case Management
- Intensive home-based treatment
- Emergency and planned respite
- Family peer support (through Nevada PEP)
- Youth peer support

Care Coordination: High-Fidelity Wraparound, Intensive Care Coordination, Targeted Case Management[1]

High-Fidelity Wraparound (HFW) is a strengths-based approach that helps children and young adults grow up in their homes and communities. It is a planning process that involves a Care Coordinator, the child/young adult, and their family and providers. It can also include friends, teachers, and others who are close and supportive. This group is called a Child and Family Team (CFT). The CFT works together to create a comprehensive Plan of Care. The CFT and Plan of Care help the child/young adult and their family succeed at home and in the community.

HFW has certain principles, phases, and activities. The "High-Fidelity" part of the name means that all of the principles, phases and activities are faithfully followed. You should expect to be respected, listened to, and a part of all decisions. You should also expect to get copies of all plans and reports. You can find details about all of this in Appendix A, Learn About Wraparound. Each phase has a checklist so you can make sure all steps are being followed.

Intensive Care Coordination (ICC) is a model similar to High-Fidelity Wraparound but is offered to youth who may not have a caregiver, or to youth and families who would prefer a less intensive level of engagement.

Targeted Case Management (TCM) is the lowest intensity service that allows youth and their families/caregivers to have a periodic check-in with a care manager while they receive other services under the Connect Nevada program.

[1] Source: Miles, P., Bruns, E.J., Osher, T.W., Walker, J.S., & National Wraparound Initiative Advisory Group (2006/2019). *The Wraparound Process User's Guide: A Handbook for Families*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University. Accessed November 26, 2023 at https://nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf.

How HFW, ICC, and TCM Work

Once you are enrolled in Connect Nevada, you are assigned a care coordinator (CC). They will get to know you and your family so that they can give you the best help possible. The steps in the process are:

- Your CC will talk to you and your family and do some assessments. The assessments will help identify your strengths and needs. Your CC will review the assessment results with you and your family. The results will be used in the next steps of building your Child and Family Team (CFT) and Plan of Care.
- Your CC will help you and your family build your CFT. Your CFT will include you, your CC, your family, your providers, and people you trust like:
    - Friends
    - Neighbors
    - Teachers
    - Counselors
    - Other community members

  Your CC may ask you to sign papers so that they can talk to these people to prepare for your first CFT meeting.
- Your first CFT meeting will take place within 30 days after you meet your CC. You will have regular meetings with your CFT.
- You and your CFT will come up with a Plan of Care to meet your needs. You and your family will make decisions with your CFT's help.
- Your Plan of Care will include a Crisis Plan. The Crisis Plan can help you know and remember who you can call for help.
- Your CC will connect you to providers and others in the community for services.
- Your Plan of Care will change as you and your family change.
- You have the right to speak up if your Plan of Care is not getting the results you want.

How to Prepare for HFW/ICC/TCM

You do not have to do anything before your care coordinator contacts you, but before your call you may want to:

- Make a list of strengths for yourself and each of your family members. Think about what you/they do well, what you/they like and what is best about you/them.
- Make a list of people who have helped you and your family and who care about what happens to you all.
- Make a list of people outside of your family who you trust and would like to help you and your family succeed.
- Make a list of your goals and what you would like your family life to be like in the future.

These lists will help the CC with their assessments and building your CFT and Plan of Care so you can get the best support possible.

Intensive Home-Based Treatment

Intensive Home-Based Treatment (IHBT) is for children/young adults who are at risk of out-of-home (OOH) treatment or returning from OOH treatment. These services are provided at home, at school, and in the community. One goal of IHBT is to help the youth manage mental and behavioral health needs that put them at risk. Another goal is for youth to stay safe in the most familiar environment they can.

IHBT services respect and build on the family's strengths. They honor the family's language, race, culture, and ethnicity. Services promote positive development and healthy family functioning.

IHBT Services

IHBT Services may help with one or more of the following, depending upon the needs of the youth and family:

- Behavioral health assessment and care planning
- Crisis response, stabilization, and safety planning
- Psychiatric referral/treatment, if necessary
- Behavioral health counseling and therapy: individual and family, as necessary
- Cognitive and emotional coping skill development, with a focus on trauma-informed care
- Family psychoeducation/skill building (parenting and behavior management)
- Resilience- and support-building interventions

IHBT Services are offered through community-based agencies that contract with Magellan to provide these services.

Emergency and Planned Respite

Respite gives temporary relief for parents/guardians caring for a child/young adult with mental health needs. It can also help parents/guardians in a situation that can put a child/young adult at risk of out of home treatment or child welfare involvement. Respite can be planned or given during a crisis (emergency).

Parents/guardians can use community-based or self-directed respite services:

- **Community-based** respite care is given near the child's or young adult's home. It can be at places like:
  - Community centers
  - Parks and recreation locations

    - Boys and Girls Clubs
    - Art or music classes
    - Other location with activities that give the child/young adult a positive experience
- **Self-directed** respite is given by a provider the parent/guardian chooses when they are unable to find a community-based provider who can meet their needs. They can choose a trusted friend, neighbor or relative who can care for the child/young adult. Magellan will work with the parent/guardian to train the person to care for the child/young adult.

Planned Respite

Planned respite is given to parents/guardians on a scheduled basis. Parents/guardians get support services and time to recharge.

Emergency Respite

Emergency respite is immediate temporary or short-term care for children/young adults. It is for families who are facing a crisis and no other safe childcare options are available. Emergency respite gives parents/guardians immediate stress relief. It can keep a crisis from getting worse. It can also prevent physical or emotional injury to the child/young adult and their family members.

Your care coordinator will discuss respite services with you to help determine the amount and type of respite that will meet your family's needs. The respite plan will be in your Plan of Care.

Emergency respite may take place in the home or out of the home. Emergency respite services include linking families to long-term community-based services and supports.

To learn more and get help, email Magellan at ConnectNV@MagellanHealth.com or call 1-833-396-4310 (TTY 711) 24 hours a day, 7 days a week.

Family and Youth Peer Support

Peer support is when a person helps another person like them. Connect Nevada partners with community-based agencies who provide peer-to-peer support. Peer Support Partners have lived experience with challenges the child, young adult, or family experience. The goal of peer support is to inspire hope, reduce isolation, and provide education, information, referrals, and resources.

Peer Support Partners work in person, by phone, or by telehealth. They can give services to individuals or groups. Support includes:

- Emotional support
- Information and education
- Strategies on navigating the system of care
- Serving as models of success

All Connect Nevada participants can get family and/or youth peer support but do not have to use it.

Family Peer Support

Family Peer Support Partners are people who have lived experience with:

- Taking care of a child/young adult with mental health needs
- Navigating child-serving systems

Family Peer Support Specialists are trained to help families with children or young adults who have serious or complex mental health needs. They can help find information, support and resources, and provide compassion and understanding of the unique needs of the family. They are also available to help parents or caregivers advocate and get support and services to help at home, in the community, and at school.

Family Peer Support is a service provided by Nevada PEP, a non-profit organization that is contracted with the Division of Child and Family Services. Magellan will refer families to Nevada PEP for support if needed. For more information about Nevada PEP, visit nvpep.org.

Youth Peer Support

Youth Peer Support Partners are young people ages 18 to 26 who have lived experience with their own mental health needs. They may have experience with child-serving systems. They are trained to give children/young adults encouragement and support through their recovery process. They can help them find information, support, and resources. Youth Peer Support Partners can help others feel less alone by sharing their own lived experience.

Youth Peer Support is provided in the Connect Nevada program and must be included in the Plan of Care.

Chapter 5: Mental Healthcare Services

Your Plan of Care may include mental healthcare services that are part of Connect Nevada. If you need these services, your care coordinator will help you get them. They will work with your providers to get referrals. They will help you find the right provider for your needs.

When Magellan works with providers, we make sure they meet our standards. Here is what we require mental healthcare providers to do:

- Make sure that you know how to get care 24 hours a day, 7 days a week.
- Tell you what to do if you need care when they are closed.
- Make sure someone can give you care when they are not available. They must have an answering service with emergency contact information.
- Respond to your calls and messages in a timely manner.
- Get you immediate care during an emergency or potentially life-threatening situation.
- Get you an appointment within one hour of referral in an emergency situation. An emergency situation is when there is an immediate concern that a mental health or substance use crisis could result in serious harm to your health or wellbeing.
- Get you an appointment within 7 days of when you leave a hospital or residential stay.
- Contact you if you do not follow up with recommended services.

If your provider is unable to see you, please email Magellan at ConnectNV@MagellanHealth.com or call us at 1-833-396-4310 (TTY 711).

Chapter 6: How to get Services

Magellan will help you get the right kind of care based on your needs. We work with people and groups who may care for you in an office, your home, or your community. The people who care for you are called providers. Providers are organizations or individuals who have licenses or other permissions to offer healthcare services and supports.

Pre-Authorization

You will need a pre-authorization to get care. A pre-authorization is an approval to get a service. If your care coordinator (CC) thinks you need a service, they will help you get a pre-authorization.

What does "Medically Necessary" mean?

We use Medical Necessity Guidelines to see if a service is right for you. "Medically necessary" means that a service or medicine does one of the following:

- Prevents an illness, condition or disability
- Reduces or improves the physical, mental or developmental effects of an illness, condition, injury or disability
- Helps you get or keep the ability to perform daily tasks expected of people like you

If you would like a copy of these Guidelines, please do one of these things:

- Ask your CC
- Visit MagellanofNevada.com
- Email us at ConnectNV@MagellanHealth.com
- Call 1-833-396-4310 (TTY 711)

Scheduling, Changing and Cancelling Appointments

Scheduling an Appointment

After your Plan of Care has been developed, when you need to make an appointment with a provider, call them to schedule it. Your CC can help schedule your appointment if you are having a hard time doing so.

If you need to make an appointment with your CC, call the number they gave you or email them at the email address they gave you.

Changing or Cancelling an Appointment

As soon as you know you need to change or cancel an appointment with a provider, your CC or another person at Magellan, please call the provider or Magellan as soon as you can and tell them. Your CC can help you change or cancel appointments with providers.

Changing Providers

How to Change a Provider

If you want to change your provider, talk to your care coordinator (CC) to talk about what to do. If you change providers, be sure to call your old provider to cancel any appointments.

If you give a written OK, your old provider may call your new provider. You can give your written OK by signing a form called the Authorization of Use and Disclosure of Protected Health Information (AUD) form. By signing this form, it gives your old provider permission to talk to your new provider about your care. You can find the AUD form online at MagellanofNevada.com. Your CC, someone else at Magellan, or a provider can help you fill out this form.

If you move

If you move too far away to easily access services, you might need to change providers. We want you to keep getting the services you need, so as soon as you know you are moving, please tell your care coordinator and your providers. We will work together to help you.

When you find your new providers, please sign the AUD form so that your old providers can send your records to the new providers. You can find the AUD form online at MagellanofNevada.com. Your CC, someone else at Magellan, or a provider can help you fill out this form.

If you are not Happy with the way a Provider Treats you

If you are not happy with the way a provider treats you, or if you think they violated your rights, you can file a Complaint/Grievance. See Chapter 7: Complaints/Grievances and Appeals, for information on how to do this. You can also change providers.

Chapter 7: Complaints/Grievances and Appeals

Complaints/Grievances

A Complaint/Grievance is when you tell Magellan about something you are unhappy about. It could be about Magellan or a provider. You can file a Complaint/Grievance when you are unhappy about things like:

- Access to care
- Quality of services
- How Magellan staff treat you
- How a provider treats you
- Not having your rights respected
- Not being treated with dignity

You can file a Complaint/Grievance yourself. You can also ask someone you trust to file one for you. If you want someone to file a Complaint/Grievance for you, please fill out and sign a form called the Authorization of Use and Disclosure of Protected Health Information (AUD) form. You can find the AUD form and instructions on how to fill it out online at MagellanofNevada.com in the "For Youth and Families" section under "Handbook and Forms." Your provider or someone at Magellan can help you fill out the form so that someone you trust can file a grievance and complaint for you.

Once you are ready to file your Complaint/Grievance, you can do it in one of these ways:

Online: Visit MagellanofNevada.com and click on "For Youth and Families." Then click on "Complaints/Grievances and Appeals" and follow the instructions. You can fill out an online form or download and print a form to fill out and send to Magellan.

Email: Email a completed form or a description of your Complaint/Grievance to NevadaAppealsGrievances@magellanhealth.com.

Fax: Fax a completed form or a letter describing your Complaint/Grievance to 1-888-656-5426.

Mail: Complete a form and mail it to:
Magellan of Nevada
Appeals & Grievance Department
P.O. Box 2188
Maryland Heights, MO 63043

Call: 1-833-396-4310 (TTY 711) between 8:00 a.m. - 5:00 p.m. local time. Tell the person who answers the phone that you want to file a grievance and complaint.

Magellan will try to resolve your Complaint/Grievance as soon as possible. If you file your Complaint/Grievance in writing, we will mail you a letter. The letter will explain that Magellan received your Complaint/Grievance. We may contact you to make sure you are OK and talk about

your Complaint/Grievance. We may need to report your Complaint/Grievance to the State of Nevada or child protective services if a provider hurt you or treated you poorly.

After we resolve your Complaint/Grievance, we will send you a letter within 30 calendar days of when we received your Complaint/Grievance. The letter will explain what we did to solve your problem.

Some issues require you to file an Appeal instead of a Complaint/Grievance. This process is described in the next section.

Appeals

An Appeal is a request for Magellan to review a decision we made about your care or something we did not do. You can file an Appeal if Magellan:

- Does not approve a service or only approves part of a service your provider asked for
- Reduces, holds up or cancels a service that we pre-authorized
- Will not pay for a service or part of a service
- Does not provide services in a timely manner
- Fails to process appeals within the required timeframes

If one of these things happens, Magellan will tell you and your provider in a letter. The letter is called a Notice of Denial. The Notice of Denial will explain why we made our decision and tell you how to file an Appeal.

You can ask for a free copy of all of the information we used to make our decision by calling Magellan at 1-833-396-4310 (TTY 711). If you think we made a mistake, you can file an Appeal. You have 60 calendar days from the date on the Notice of Denial letter to file an Appeal.

You can file an Appeal yourself. You can also ask someone you trust to file one for you. If you want someone to file an Appeal for you, please fill out and sign a form called the Authorization of Use and Disclosure of Protected Health Information (AUD) form. You can find the AUD form and instructions on how to fill it out online at MagellanofNevada.com in the “For Youth and Families” section under “Handbook and Forms.” Your provider or someone at Magellan can help you fill out the form so that someone you trust can file an Appeal for you.

When you file an Appeal, be sure to tell us why you think our decision was wrong. Please give us as much proof or information that supports why you think our decision was wrong.

Once you are ready to file your Appeal, you can do it in one of these ways:

Online: Visit MagellanofNevada.com and click on "For Youth and Families." Then click on "Complaints/Grievances and Appeals" and follow the instructions. You can fill out an online form or download and print a form to fill out and send to Magellan.

Email: Email a completed form or a description of your Appeal to NevadaAppealsGrievances@magellanhealth.com.

Fax: Fax a completed form or a letter describing your Appeal to 1-888-656-5426.

Mail: Complete a form and mail it to:
Magellan of Nevada
Appeals & Grievance Department
P.O. Box 2188
Maryland Heights, MO 63043

Call: 1-833-396-4310 (TTY 711) between 8:00 a.m. - 5:00 p.m. local time. Tell the person who answers the phone that you want to file an Appeal.

We will make a decision within 30 calendar days of getting your Appeal.

Appendix A: Learn About Wraparound

Taken from The National Wraparound Initiative (NWI) website at nwi.pdx.edu and *The National Wraparound Initiative (NWI) Handbook for Families* at nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf.

What is Wraparound?

According to the National Wraparound Initiative, "Wraparound is a planning process that follows a series of steps to help children and their families realize their hopes and dreams. The wraparound process also helps make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from different parts of the whole family's life." High-Fidelity Wraparound includes trainers, coaches and mentors to ensure best practices and conformity to the model.

Wraparound Principles

1. **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.
2. **Team-based**: The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, community support and service relationships.
3. **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 wraparound plan reflects activities and interventions that draw on sources of natural support.
4. **Collaboration**: Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives and resources. The plan guides and coordinates each team member's work toward meeting the goals.
5. **Community-based**: The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible, and that safely promote youth and family integration into home and community life.
6. **Cultural humility**: The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, identity of the youth and family and their community.
7. **Individualized**: To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports and services.
8. **Strengths-based**: The wraparound process and the wraparound plan identify and build on the capabilities, knowledge, skills and assets of the youth and family, their community and other team members.

9. **Unconditional**: Despite challenges, the team persists in working toward the goals until the team reaches agreement that a formal wraparound process is no longer required.
10. **Outcome-based**: The team ties the strategies of the wraparound plan to clear goals for success, monitors progress and revises the plan accordingly.

When these ten principles and the steps outline below are followed, the Wraparound program is considered a High-Fidelity Wraparound program. Staying faithful to the principles and steps has proven to improve outcomes for children/young adults and their families.

Wraparound Phases

Phase One: Engagement and Team Preparation

You and your family will meet your Wraparound care coordinator. This initial meeting will be held at a location that you find most comfortable. It should seem more like a conversation than a formal meeting or intake appointment.

The Wraparound care coordinator will give you an opportunity to describe, from your perspective, what things have worked in the past to help your family and what you would like to see happen in the Wraparound process. You will talk about people who care about your child/youth and family as well as who has been helpful for each family member.

The care coordinator will listen closely as you describe your child and family. You will describe your family's beliefs and traditions as well as family members' strengths – things that they are good at and that help them to succeed. The care coordinator will then develop a family narrative to ensure that everyone on the team understands your family and has empathy for what your family has been experiencing.

This initial meeting should last from one to two hours and will occur with you and your care coordinator. Depending on your preference, the care coordinator can meet first with you and then your child or youth, or you can all meet with the care coordinator at the same time.

After this initial meeting, the care coordinator will talk with other people in your life to get their commitment to participate on your Wraparound team.

You will then work with your care coordinator to contact team members to invite them to your first Wraparound child and family team meeting.

This phase takes several meetings over about one month.

Phase One Checklist

- ☐ Met with care coordinator and explained our story
- ☐ Addressed immediate needs and crises and put together an initial crisis plan
- ☐ Generated a strengths list
- ☐ Generated a team member list

- ☐ Generated a family vision
- ☐ Agreed on first meeting
- ☐ Agreed on who will contact potential team members
- ☐ Got more information about this process

A Note about Crisis Planning: Throughout the Wraparound process, crisis response will occur. In the first phase of the Wraparound process, before the team even meets, immediate crises must be addressed, and an initial crisis plan should be developed. During later phases, you and your team will work together to develop an effective crisis plan. Good plans identify what could go wrong and how people should respond if they do. Good crisis planning ensures the family and team have an opportunity to practice the crisis response in much the same way that schools practice fire drills or law enforcement does disaster drills. Good crisis plans should also include who will notify who and when. Finally, good crisis plans should be portable – all team members should have a copy they can easily carry and refer to when they're needed.

Phase Two: Initial Plan Development

The Wraparound plan of care (or "Wraparound plan") is like a continually updated agenda for your family as it goes through the process.

During the first planning meeting, your child and family team members will introduce themselves and then will review the strengths list that was developed from talking with you and other team members. All team members will get a chance to add to that strengths list.

The care coordinator will lead the team in collaboratively developing a team mission statement. To do this, the entire team will discuss the purpose of working together and create a statement that gives a sense of direction for each team member and a shared goal.

Eventually, those statements will be boiled down to one simple mission statement that you can all agree to and remember. This statement will serve to guide the team's work.

Next, needs statements for individual family members will be identified and recorded. Then you and your team will select 2–3 needs that will get you closer to realizing your team's mission and/or your family's vision. It is important to note that the need statements will be about the underlying reasons behind behaviors. The Wraparound process helps team members learn about the thoughts and feelings that are driving behavior, rather than just focusing on the behavior itself.

The care coordinator will lead the team in brainstorming strategies to meet each chosen need. These strategies should be creative and individualized to your family's needs. When several strategies have been listed for each need, strategies that best match your strengths list and that you and your family think will be most effective will be chosen.

Action steps to implement these strategies will then be brainstormed. Volunteers will be selected from all team members to follow through on the action steps for the chosen strategies.

For each strategy, you and your child will also work with the team to identify outcomes that will let you know when the strategy has succeeded. Outcomes will be connected back to the concerns that brought you and your family to Wraparound.

Results of this plan development phase should include the mission, strengths list, needs statements, strategies, outcomes, and action steps. These will be summarized in a plan of care or Wraparound plan and distributed to team members.

This phase takes 90 minutes. If more time is needed, another meeting is held within 1-2 weeks of the first.

Phase Two Checklist

- ☐ Participated in one or two youth/family team meetings
- ☐ Listed and reviewed our strengths, as well as those of the team members
- ☐ Developed a team mission statement that reflects what we and other team members hope to get out of this
- ☐ Reviewed needs that reflect our concerns and worries
- ☐ Picked a few needs to keep us and the team from becoming overwhelmed
- ☐ Brainstormed a variety of strategies to meet those needs
- ☐ Chose strategies to meet those needs which matched to our strengths
- ☐ Assigned all team members to activities in the plan
- ☐ Distributed plan to all team members

Phase Three: Plan Implementation

Now that the initial plan of care has been developed, you and your team members are responsible for actually implementing it. The Implementation Phase is characterized by regular team meetings that occur formally and regularly over many months. It is also the phase during which people follow through outside of team meetings to do what they committed to do.

Ongoing Team Meetings

Ongoing team meetings follow a regular agenda that starts with **Accomplishments**. The care coordinator asks team members to share accomplishments since the last meeting as well as summarize progress made during the last thirty days. This keeps the team focused in a positive way.

Second, you and your team members will **Assess whether the plan is working**. This involves looking at whether people did what they said they were going to do. This is a first check for follow through. It also involves identifying whether the action step actually helped to get the strategy accomplished. In addition, the team will review outcomes the family and team identified. As a family member, your input will be actively sought to check whether outcomes were accomplished, and whether your family's needs are being met.

When reviewing is done, the care coordinator will lead the team in identifying any changes to the plan. **Adjustments** will happen by changing some action steps, stopping some actions, or adding some new

ones. During this part of the team meeting, the group will do new brainstorming to come up with new strategies to meet old needs that have not been successfully met, or to address newly identified needs.

Finally, when the team has selected the next set of actions designed to meet needs, the team members will **Assign** and take responsibility for specific actions. After each meeting, the care coordinator should update the plan of care to reflect the adjustments and assignments made by your team.

Between Team Meetings

Formal team meetings aren't the only way that work gets done in Wraparound. Between Wraparound team meetings, you and your team members communicate as needed to complete the tasks listed in the plan. Team members have developed your plan together and everyone should have the same document describing the plan. In addition, the care coordinator should be actively following up with team members about the success of action steps in between meetings. This should reduce the possibility of misunderstandings and result in a better situation for your family.

Team meetings are held every 30 days. Team members complete assigned action steps. Phase continues as needed.

Phase Three Checklist

- ☐ Activities promised are being provided
- ☐ Accomplishments are reviewed and recorded
- ☐ Assessment of the plan is occurring
  - ☐ Team is meeting often enough to check on follow-through
  - ☐ We're being asked if actions are meeting our needs
- ☐ Adjustment of the plan is occurring based on our feedback
- ☐ Assignments are being made and recorded at each team meeting
- ☐ Copies of the minutes and updated plan of care are sent to all team members
- ☐ Regular progress reports are written and sent out
- ☐ We practice what to do if a crisis occurs with our family and the team

Phase Four: Transition

Sooner or later, you and your Wraparound team will come up with the right mix of strategies and interventions, delivered in the right way at the right time. Your team will find that outcomes are being accomplished, and the team's mission has been met or is close to being met. Things will be going well for you and your family. At this point, transition is discussed among all team members.

The care coordinator should have conversations with you and your child and family members to discuss transition regularly. Eventually, you and your care coordinator will raise the issue and begin to have team members voice any ideas they may have. Formal transition planning should begin at least 90 days in advance of Wraparound ending.

The team then brainstorms follow-up options that will help and support your family to succeed outside of the formal Wraparound structure. Team members also identify what type of follow-up support they can personally provide to the family. The care coordinator and the team should also determine how to regularly check in with you and your youth/child and family.

The care coordinator typically takes this information and puts it into a transition plan and returns it to the next team meeting for review. Once the team has reworked the transition plan the entire team negotiates a schedule for transition.

Finally, if its agreeable to you and your child or youth, the team figures out some sort of final celebration of the team's accomplishments and work well done.

Once this celebration or ritual is completed, the care coordinator completes a formal transition letter (which should be no more than 2–3 pages) identifying the family strengths as well as accomplishments of the team and interventions that were helpful.

All team members including the family get a copy of this final transition summary in electronic or paper version so they can use it if they need to reenter a formal system for help in the future.

As the team negotiates and agrees on an ending, plans for follow-up care and response should be developed. The care coordinator will lead the team in identifying who will introduce your family and the team's accomplishments to follow-up providers. This might include drafting a letter of introduction you can keep in their records or meeting with other service providers to describe what is going to be helpful or not. Sometimes this is most efficiently done in team meetings and other times it occurs outside of a team setting.

Transitions happen throughout the process. Completion may be done in one meeting or take several weeks.

Phase Four Checklist

- ☐ We have held practice crisis drills and are confident we know what to do if things go wrong
- ☐ We have a way to access services in the future
- ☐ We have a way to connect with other families who have been through the process
- ☐ Our concerns have been considered
- ☐ We have a list of team member phone numbers we can contact if needed
- ☐ Leaving Wraparound has been discussed with the whole team
- ☐ We have written documents that describe our strengths and accomplishments

Wraparound Terms

Action Steps: Statements in a Wraparound plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

Care Coordinator: A person who is trained to coordinate the Wraparound process for an individual family. This person may also be called facilitator, navigator, Wraparound specialist, resource care coordinator or some other term.

Formal Supports: Services and supports provided by professionals (or other individuals who are "paid to care") under a structure of requirements for which there is oversight by state or federal agencies, national professional associations, or the general public arena.

Life Domains: Areas of daily activity critical to healthy growth and development of a child or successful functioning of a family. Life domains include such areas as safety, school/work, health, social/fun, a place to live, legal issues, culture, behaviors, emotions, transportation, and finances.

Mission Statement: A statement crafted by the Wraparound team that provides a one- to two-sentence summary of what the team is working toward accomplishing together. This includes the youth and family.

Natural Supports: Individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors, and so forth.

Outcomes: Child, family, or team goals stated in a way that can be observed and measured.

Plan of Care or Wraparound Plan: A dynamic document that describes the family, the team, and the work to be undertaken to meet the family's needs and achieve the family's long-term vision.

Strengths: Strengths are the assets, skills, capacities, actions, talents, potential and gifts in each family member, each team member, the family as a whole, and the community. In Wraparound, strengths help family members and others to successfully navigate life situations; thus, a goal for the Wraparound process is to promote these strengths and to use them to accomplish the goals in the team's plan of care.

Vision: A statement constructed by the youth and family (with help from their care coordinator) that describes how they wish things to be in the future, individually and as a family.

Wraparound Principles: A set of 10 statements that defines the Wraparound philosophy and guides the activities of the Wraparound process.

Child and Family Team: A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's plan, address unmet needs, and work toward the family's vision.

Wraparound Troubleshooting

Things may not always feel like they are going OK during the Wraparound process. See pages 14-19 of The Wraparound Process User's Guide: A Handbook for Families for FAQs that will help you. And remember, you can always talk to your Care Coordinator.

Magellan Healthcare, Inc. (Magellan of Nevada), program administrator on behalf of the Nevada Department of Health and Human Services, Division of Child and Family Services

Magellan HEALTHCARE®