## TARGETED CASE MANAGEMENT

TRAINING FOR CASE MANAGERS

Presented by: Leila Norden

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## Our Mission

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

## TRAINING OVERVIEW

- 1. Review of regulations
- 2. Location of regulations
- 3. Breakdown of individual components
- 4. Documentation process
- 5. Exclusions

10 CCR 2505-10 8.760 10 CCR 2505-10 8.761 10 CCR 2505-10 8.607.3 10 CCR 2505-10 8.607.6

## TARGETED CASE MANAGEMENT ELIGIBILITY

- Eligible for Medicaid
- Developmental disability or developmental delay
- Enrolled in:
  - HCBS-DD Home and Community Based Services-Persons with Developmental Disabilities or
  - HCBS-SLS Home and Community Based Services-Supported Living Services or
  - HCBS-CES Home and Community Based Services-Children's Extensive Support

10 CCR 2505-10 8.761.2.21

## **DEFINITION**

Targeted Case Management services for persons with developmental disabilities consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources.

10 CCR 2505-10 8.761.14

## COMPONENTS OF TARGETED CASE MANAGEMENT

There are four different components that make up Targeted Case Management

10 CCR 2505-10 8.761.14

## FIRST COMPONENT

Comprehensive assessment and periodic reassessment of individual needs

Assessment activities include:

- Gathering an individual's history
- Identifying the individual's needs, completing related documentation, and gathering information to form a complete assessment

10 CCR 2505-10 8.761.14(a)

## SECOND COMPONENT

Development and periodic revision of a specific care plan

### Service Plan or Revision requires:

- Active participation by the individual
- Based on assessment information
- Specifies goals
- Identifies actions to address needs

10 CCR 2505-10 8.761.14(b)

## THIRD COMPONENT

Referral and related activities to help an individual obtain needed services

## Case Manager:

- Sends referrals to providers
- Assists with scheduling

#### Referrals include those to:

- Medical, Social, or Educational providers
- Other programs and services

10 CCR 2505-10 8.761.14(c)

## FOURTH COMPONENT

## Monitoring and follow-up activities

## Monitoring:

Addresses individual's health, safety, and services

#### Ensures services are:

- Provided as specified in Service Plan
- Adequate for individual's needs
- Person-centered
- Adjusted if needs change

10 CCR 2505-10 8.761.14(d)

## FOURTH COMPONENT (cont'd)

Monitoring and follow-up activities (cont'd)

Required for HCBS-DD, HCBS-SLS, and HCBS-CES:

- At location of service delivery for the individual
- At least once per quarter
- Face-to-face with the individual

10 CCR 2505-10 8.761.14(d)

## REVIEW OF COMPONENTS

- 1. Comprehensive assessment and reassessment
- 2. Development and revision of Service Plans
- 3. Referrals for needed services
- 4. Monitoring of the Service Plan and services

Note: Only designated Community Centered Boards may be reimbursed for Targeted Case Management services for persons with developmental disabilities.

## SERVICE AND SUPPORT COORDINATION

## Responsibility of CCBs

### Partnership with:

- Individual receiving services and/or
- Parents of a minor
- Legal guardian
- Others, at request of individuals receiving services

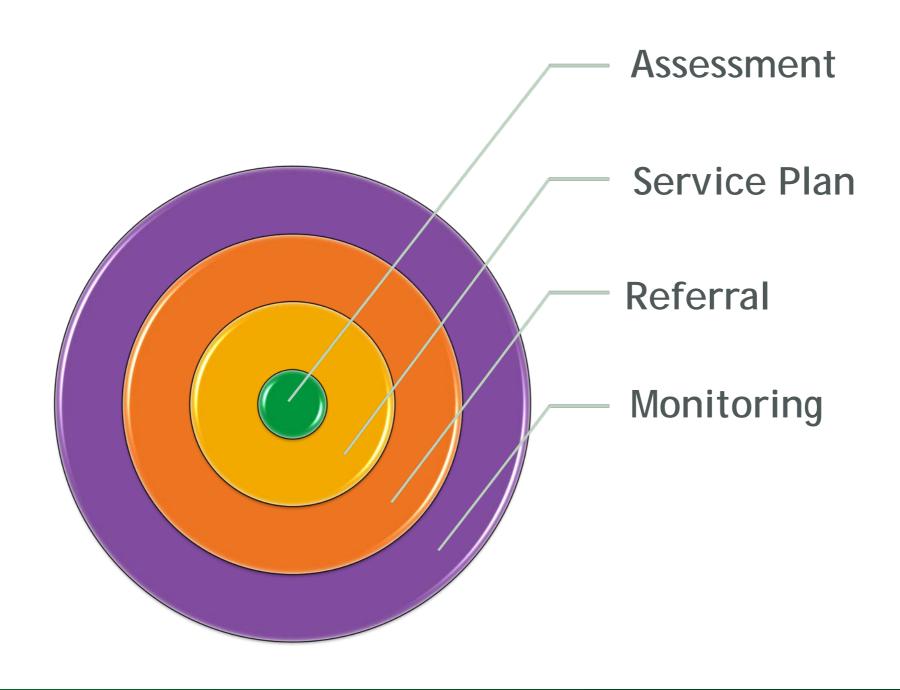
10 CCR 2505-10, 8.607.3

# SERVICE AND SUPPORT COORDINATION

- Individualized Plan developed
   Development and revision of Service Plans
- Access to and provision of services and supports
  - Referrals for needed services
- Coordination of services and supports
  - Monitoring of the Service Plan and services
- Periodic review of Individualized Plan
  - Comprehensive assessment and reassessment

10 CCR 2505-10, 8.607.3

## WHAT DOES THIS LOOK LIKE?



# COMPREHENSIVE ASSESSMENT AND PERIODIC REASSESSMENT OF INDIVIDUAL NEEDS

Assessment of individual needs may include review of:

- Review of Supports Intensity Scale (SIS) assessment or ULTC 100.2
- Diagnoses / Professional Medical Information Page (PMIP)
- Assessments (e.g. Psychological, SOMB Risk Assessments)
- Review of services / progress documentation
- Review of Incident Reports and/or Critical Incident Reports
- Regular contact with the individual

# COMPREHENSIVE ASSESSMENT AND PERIODIC REASSESSMENT OF INDIVIDUAL NEEDS (cont'd)

- Completed at least annually
- When change is desired or warranted
- Determines necessary/desired services and supports
- Assessment activities include:
  - Reviewing client history and information
  - Reviewing information provided by
    - Individual receiving services
    - Natural and professional supports

### Information utilized to assess individual needs

- 1. Sex Offense Management Board (SOMB) Risk Assessment
  - Recommendations:
    - Line of Sight Supervision
    - Male Providers for services
- 2. Conversation with individual
  - Agrees to Line of Sight Supervision
  - Prefers to live in North side of town, close to grandfather

## Case Manager next steps

- 1. Review by Human Rights Committee (HRC):
  - Line of Sight supervision requires Suspension of Rights process
- 2. Referral documentation:
  - Indicate need for Suspension of Rights / Line of Sight supervision
  - Indicate preference of housing location
  - Indicate recommendation for gender of providers

# DEVELOPMENT AND PERIODIC REVISION OF A SPECIFIC CARE PLAN

#### This includes:

- Completion of the initial and annual Service Plan
- Completion of any Revisions to the Service Plan

## DEVELOPMENT AND PERIODIC REVISION OF A SPECIFIC CARE PLAN (cont'd)

- Utilizes information collected through assessment
- Specifies goals and actions to address services needed
- Ensures active participation by the individual (or individual's representative) to develop goals
- Identifies a course of action

## Completion of annual Service Plan

Through Assessment, Case Manager identified:

- Individual wants a job
- Has not attended day program on Mondays
- PMIP reports new diagnosis and new prescription

## Completion of annual Service Plan

What are the necessary steps to complete?

- 1. ULTC 100.2 prior to Service Plan (not a TCM activity)
- 2. Service Plan Meeting

NOTE: The only required participants for either of these meetings are the individual receiving services and/or the parent or guardian with the appropriate authority, and the case manager.

## Completion of annual Service Plan

1. Personal Goal: Get a job near home.

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- 2. Change to Services: Reduction of days attending Day Program
- 3. Referral: Division of Vocational Rehabilitation
- 4. Natural Support: Mother providing Medication Management

## REFERRAL AND RELATED ACTIVITIES TO HELP A CLIENT OBTAIN NEEDED SERVICES

#### Includes:

- Discussions with individual to determine preferences
- Referral distribution to identify provider

# REFERRAL AND RELATED ACTIVITIES TO HELP A CLIENT OBTAIN NEEDED SERVICES (cont'd)

Activities that help link an individual with providers:

- Referrals to providers for services
- Includes medical, social, and educational providers
- Other programs and services
- Includes scheduling appointments, as needed.

### Referral and related activities

SLS Waiver - Initial enrollment

Services / support needs identified:

- Vocational
- Personal Care
- Day Habilitation

## Referral and related activities

Services / support needs requiring referral:

- Vocational-Division of Vocational Rehabilitation (DVR)
- Personal Care-individual identified provider
- <u>Supported Community Connections</u>-all potential providers

#### MONITORING AND FOLLOW-UP ACTIVITIES

- Required to ensure:
  - Services are provided as specified in Service Plan
  - Services adequately address individual's needs
- Addresses individual's:
  - Health and safety
  - Services in Service Plan

## MONITORING AND FOLLOW-UP ACTIVITIES (cont'd)

- If services are not adequate or if needs change:
  - Necessary adjustments made
  - Revision to Service Plan

## MONITORING AND FOLLOW-UP ACTIVITIES (cont'd)

## Monitoring Requirements:

- Performed at least quarterly and when necessary
- Direct Contact (face-to-face) with the individual receiving services
- Observation occurs where services are being provided
- Completed for HCBS-DD, HCBS-SLS, and HCBS-CES

## MONITORING

#### At minimum shall include:

- Delivery and quality of services and supports
- Health, safety and welfare
- Satisfaction with services and choice in providers
- Practices promote ability to engage in selfdetermination, self-representation, and self-advocacy

10 CCR 2505-10, 8.607.6

## MONITORING FREQUENTLY ASKED QUESTIONS

Question: "How do I calculate the quarters for an individual for Monitoring?"

Answer: As long as a Monitoring activity is conducted at least once per three month period for an individual, the Case Manager is compliant with this requirement.

Question: "How will I know if Monitoring is required outside of the quarterly requirement"

Answer: Additional Monitoring would be conducted if concerns arise about an individual's health and safety or if the Case Manager observes trends or concerns that require direct contact to follow up and address. Also, at the individual/guardian's request due to a change in condition or support needs.

Question: "What if I see someone on my caseload when I am out in the community? Can I count that as a Monitoring activity?"

Answer: With the exception of a very small number of situations, you cannot treat incidental contact with an individual as a Monitoring activity. Monitoring must be purposeful and requires more than simply documenting that you have seen someone and commenting on their appearance.

Question: "Can I use video technology such as Skype or FaceTime to conduct my Monitoring activities?"

Answer: The requirements for Monitoring specify that it must be directly conducted face-to-face with the individual. At this time, no video options can be used to complete Monitoring activities.

Question: "What do I do if an individual or the guardian refuses to meet with me for quarterly Monitoring?"

Answer: Quarterly monitoring is a requirement of the HCBS-DD, HCBS-SLS, and HCBS-CES waivers. At the time the Service Plan was completed, the roles and responsibilities specified that the individual/guardian will participate in the coordination of services and agree to cooperate with the providers and Case Management Agency.

#### **EXAMPLE:**

#### Monitoring and follow-up activities

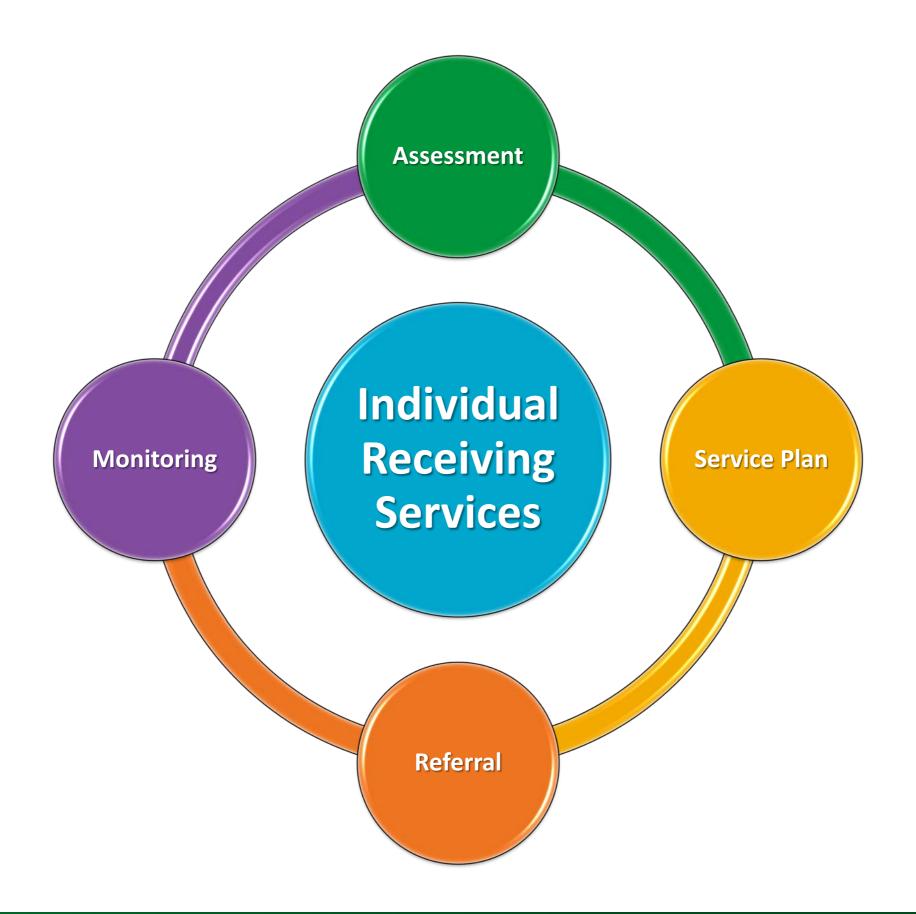
- Quarterly Monitoring due
- Case Manager schedules time with the individual to meet at his Day Program
- Prior to the Monitoring, Case Manager:
  - Checks utilization
  - Reviews information gathered during Assessment

#### **EXAMPLE:**

#### Monitoring and follow-up activities

At Monitoring meeting, Case Manager reviews:

- Individual's satisfaction with services
- Incident Report (IR) received
- Service provision is adequate to support needs
- Personal Goal



### ASSESSMENT

**Known History** 

Multiple Incident Reports

Activity: Assessment

### MONITORING

Face to Face visit at Day Program

Review of Day Program notes Phone call with Mother / Guardian

### REFERRAL

Review of preferences

Sending out of Referral

Follow up with responses received

### SERVICE PLAN / REVISION

Choice of Day Program Service Plan Revision Distribution of Service Plan Revision

#### **DOCUMENTATION**

How must Targeted Case Management activities be documented?

- Must be entered on the BUS
- Travel time in individual log note
- Units are calculated in 15 minute increments
- Units reflect actual duration of activity

#### **EXCLUSIONS**

- Incidental contact (e.g. social events)
- Filing / administrative tasks
- ULTC 100.2
- Supports Intensity Scale (SIS) assessment
- Intake
- DD Determination
- Investigations
- Appeals

(Note: This is not an exhaustive list of what is not considered a Targeted Case Management activity.)

#### **EXCLUSIONS**

Not enrolled HCBS-CES, SLS, and DD

Resides in Class I nursing facility

Resides in ICF-IID

#### **SUMMARY**

Four components

Overlap between components

**Exclusions** 

Familiarization of Regulations

# Questions or Concerns?



### Contact Information

Leila Norden

DIDD Case Management Training Coordinator
Leila.Norden@state.co.us

# Thank You!