

PRTF ALTERNATIVE CHANCE WAIVER OVERVIEW

Case Management Training
2012

This training will answer the following:

- ▣ What is the PRTF Alternative CHANCE Waiver
- ▣ How do youth and family gain entry into the Waiver
- ▣ What services are available under the Waiver
- ▣ What is Case Management
- ▣ Who can provide Case Management
- ▣ What does the Service Plan Development Team do and who are it's members

This training will answer the following:

- ▣ What is a Plan of Care
- ▣ What information is required to be included in the Plan of Care
- ▣ How do services get authorized
- ▣ Who does the plan need to be shared with
- ▣ What does the Case Manager do when they aren't writing developing a Plan of Care
- ▣ What services are billable under Case Management

The CHANCE Waiver

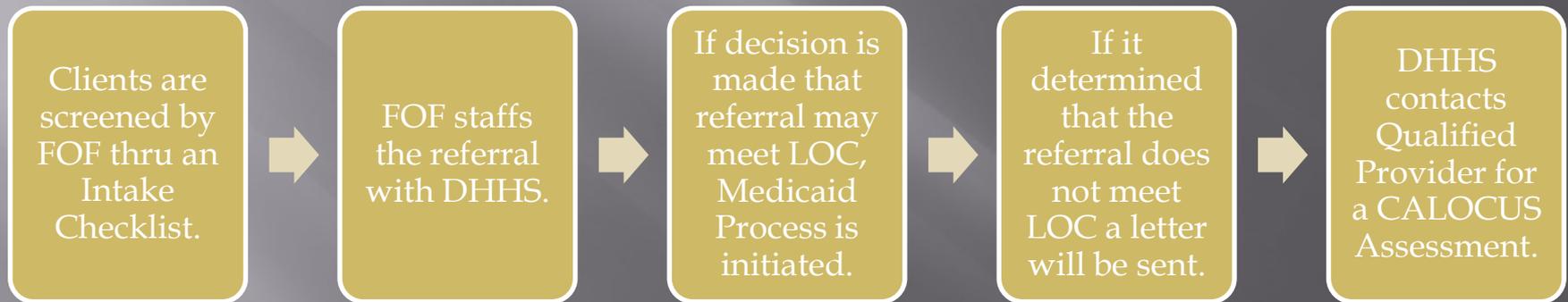
The purpose of this waiver is to provide home and community-based supports and services to children who have been diagnosed with Serious Emotional Disturbance (SED) and/or mental illness who would otherwise be served in Psychiatric Residential Treatment Facilities (PRTF)

Freedom of choice

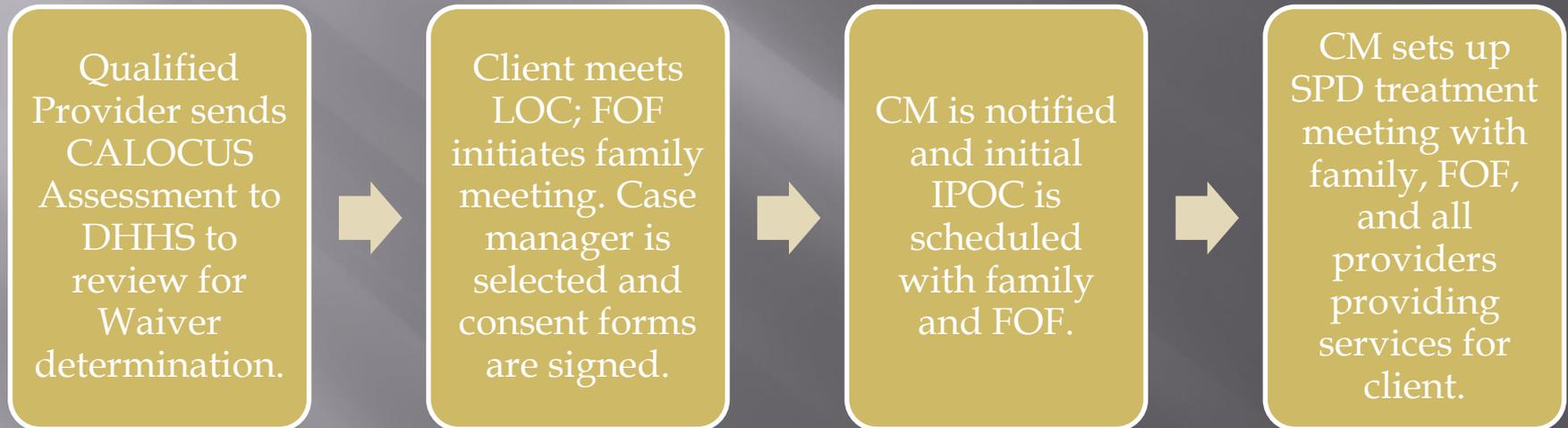
Youth and families have the choice of placing youth who meet Level of Care in a PRTF or electing to participate in Home and Community based services through 1915(c) of the social security act.

If Home and Community Based services are selected, youth and families have services provided to them by the qualified Waiver provider of their choice

Enrollment Process



Enrollment Process



Enrollment Process

CM completes POC budget and all necessary authorization forms.



CM submits all authorization forms to DHHS for approval. Client begins waiver services.



All providers for a client will meet every 90 days to review the POC, budget and crisis plan.

Referral and Intake

- ▣ Referrals are sent to Federation of Families (FOF), the CHANCE Waiver's family advocacy organization
- ▣ FOF contacts the family and asks intake questions so a determination can be made regarding the need for services under the waiver

Referral and Intake

- ▣ Intakes are sent to DHHS for review – if the individual appears to have a need for services they will continue on to the Medicaid Eligibility process
- ▣ Once eligibility notifies the CHANCE Waiver staff that the youth is eligible for Medicaid the Level of Care assessment is scheduled with a qualified clinician of the families choice

Referral and Intake

- ▣ Once the Level of Care is completed the recommendations are sent to DHHS
- ▣ DHHS will determine if the youth is appropriate for the waiver based on the recommendations of the clinician who performed the Level of Care assessment
- ▣ DHHS will grant the youth a waiver slot and services can begin

Current Waiver Services

- ▣ Case Management – required for all Waiver participants
- ▣ Pre-Vocational Services
- ▣ Respite
- ▣ Diagnostic/Therapeutic Services
- ▣ Psychiatric Medical Assessment
- ▣ Customized goods and services
- ▣ Youth and Caregiver Peer support services
- ▣ Wraparound Para-professional services
- ▣ Customized goods and services
- ▣ Service Plan Development

Case Management Service Definition

Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring and the coordination of the provision of services included in the participant's plan of care.

Case Manager Staff qualifications:

- ▣ A master's degree in social work, psychology, counseling, special education, or in a closely related field
- ▣ A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities; or
- ▣ A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities; or
- ▣ A registered nurse licensed to practice in South Carolina and have at least three years of experience performing clinical or case work activities

The Service Plan Development Team

- ▣ Consists of the youth, family, case manager, all waiver service providers and anyone else who the family chooses to participate
- ▣ Meets every 90 days or more as needed
- ▣ Facilitated by the Case Manager with input from family

The Service Plan Development Team

- ▣ Discusses progress or lack of progress towards goals
- ▣ Collaborates to determine support needs and appropriate services to keep the youth in the least restrictive environment
- ▣ Is vital to the success of person centered approach

The Plan of Care

- ▣ Is developed every 90 days following the Service Plan Development meeting
- ▣ Is based on the recommendations from the Level of Care and the Service Plan Development team
- ▣ Is written by the Case Manager in collaboration with the Service Plan Development team
- ▣ Is the map for services that the providers use to drive supports and services to Waiver participants

Plan of Care requirements

- ▣ The Plan of Care includes appropriate identifying information: the participant's name, Medicaid number, date of birth and date of the plan.
- ▣ Identifies strengths and support needs for the waiver participants.
- ▣ Identifies the Provider of the service, type of service, frequency and duration of the service.

Plan of Care requirements

- ▣ Identifies goals for each service type that the youth, their family and the service plan development team have identified through the service plan development process
- ▣ Has Case Manager signature, title and date as well as signature of the youth and family
- ▣ The Plan of Care must be distributed to the family and service providers once it has been approved by DHHS

Plan of Care requirements

- ▣ The POC will include a Crisis Plan that will clearly state the protocol and responsibility for handling crises, including after-hour calls.
- ▣ A budget that reflects the amount that will be spent to provide the services listed.

Authorization to provide services

- ▣ The signed POC, budget and authorization forms must be submitted to DHHS
- ▣ DHHS will review to ensure required elements of the POC are included
- ▣ DHHS will authorize the provision of services based on the needs of each individual child

Distribution

Once the plan has been approved by DHHS it must be distributed to the family and the service providers.

- ▣ Checks and balances system to ensure that what was agreed upon at the Service Plan Development meeting was appropriately included in the updated POC.
- ▣ If a provider determines that their section of the POC is not what was agreed upon at the meeting they should get in contact with the Case Manager as soon as possible to discuss the issue and have any errors corrected. Failure to do so may result in being held accountable to the error/misstatements in the final POC.
- ▣ Youth and families should know and understand what is in their Plan of Care to improve treatment outcomes and improve buy in from families

Case Manager Responsibilities:

- ▣ Educating families about available services
- ▣ Tracking and documenting the family's progress on treatment goals
- ▣ Keeping track of due dates for the Plan of Care and Level of Care to ensure that they are completed within the time frames
- ▣ Coordinating and facilitating the Service Plan Development team meetings

Case Manager Responsibilities:

- ▣ Writing the Plan of Care based on the Service Plan Development Team meeting and LOC recommendations
- ▣ Relationship building with the youth and family to develop trust and better meet the needs of the family
- ▣ Advocate on behalf of the youth and the families
- ▣ Coordinating needed services to meet the needs of the youth and the family

Case Manager Responsibilities:

- ▣ Collect and report all follow up minimum data set requirements
- ▣ Contact the family at least twice a month to monitor and oversee that the supports and services in place are meeting the needs of the youth and the family – **one of these contacts MUST be face to face**
- ▣ Support the family to schedule appointments related to supports and services for the youth

Service Provision

- ▣ Services are provided pursuant of the Plan of Care – billable service time addresses goals from the Plan of Care
- ▣ **Not all Case Management activities are billable activities**

Service Provision

Allowable/billable Case Management services include activities in which the Case Manager has a direct interaction with the youth/family that address one of the following:

- ▣ Educating families on available services;
- ▣ coordinating services;
- ▣ referral/linkage to supports;
- ▣ monitoring/follow up on services

Billable services: Case Management

To bill for Case Management services there must be documentation of at least one face to face contact and at least one phone contact. Case Management services are billed in 15 minute units.

Billable services: Case Management

Billable services include face to face contact, phone conversations or other direct interaction with the youth and/or their family member. Other required case management activities are built into the Case Management rate and are not billable activities. These other required activities can be important to the treatment of the child and should be documented as part of treatment progress.

**Proposed change, if approved
would go into effect on 1/1/13
Billable services: Case
Management**

Individuals providing case management services to a child may not provide other waiver services to that same child so long as they are the case manager for that child. Case Managers may provide other waiver services to children who are **not** on their caseloads.

Resources

- ▣ South Carolina Department of Health and Human Services website:
<http://www.scdhhs.gov/>
- ▣ **PRTF Alternative CHANCE Waiver website:**
<https://msp.scdhhs.gov/chance/>
- ▣ Federation of Families website:
<http://fedfamsc.org/>
- ▣ Center for Medicaid and Medicare services website: <http://www.cms.gov/>

Resources

- ▣ South Carolina Legislature website:
<http://www.scstatehouse.gov/code/statmast.php>
- ▣ Electronic Code of Federal regulations website:
<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=eabc498daa8a3a2689db074a01bdb045&c=ecfr&tpl=%2Findex.tpl>
- ▣ The Social Security Act website:
http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm

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