

Case Management Training: New Standards



Wyoming
Department
of Health
Commit to your health.

Behavioral
Health
Division

Presented by:
The Behavioral Health
Division, Developmental
Disabilities Section



welcome

Welcome to the Case
Management Training on
the New Waivers

Agenda

- CMS Rule Overview
- Conflict Free Case Management
- Ethics in Case Management
- Service Clarification and the POC
- Roles in Monitoring
- Case Management Documentation



This training is designed to meet the education and compliance needs of the:

- Comprehensive Waiver Case Manager
- Supports Waiver Case Manager



How to Involve Yourself in this Training

- Parts of this training may appear to repeat things you already know
- Take advantage of this opportunity to offer your expertise and provide insight and examples of real-life situations to the rest of the participants



Objectives



- Understanding of the application process to become a conflict free case manager
- Understanding of the new CMS rules and requirements
- Application of ethical principles in case management



Objectives



- Understanding of a case manager's role in monitoring
- Understanding of plan of care implementation and service clarification
- Thorough documentation of the case management monthly or 15 minute unit

Let's get started.....




CMS Rule Overview



CMS Rule Overview



A variety of settings have been developed over time to serve eligible individuals on these Medicaid programs
(some seem to be institutional or isolating)

The rule sets criteria for home and community based service settings

The process also gives CMS the opportunity to get to know the nature of service settings in each state

To enhance the quality of HCBS and provide protections to participants

Intent of the Final Rule



- To ensure that individuals receiving long-term services and supports through home and community based service (HCBS) programs under Medicaid have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate.
- To enhance the quality of HCBS and provide protections to participants

CMS Presentation Slides



- The next 7 slides are CMS presentation slides describing the new requirements and the reasoning behind some of them.

HCB Setting Requirements

- The home and community-based setting requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences
- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting



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HCB Setting Requirements

The final rule establishes:

- Mandatory requirements for the qualities of home and community-based settings including discretion for the Secretary to determine other appropriate qualities
- Settings that are not home and community-based
- Settings presumed not to be home and community-based



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HCB Setting Requirements

The Home and Community-Based setting:

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services



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HCB Setting Requirements

- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
 - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources



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HCB Setting Requirements

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them



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Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Additional requirements:

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law



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Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual



Requirements



- Establish an outcome oriented definition that focuses on the nature and quality of individual's experiences
- Maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting
- Person-centered planning
- Conflict free case management

What Wyoming Has Done So Far.....



- ✓ Developed a citizen Transition Taskforce
- ✓ Conducted research on topics within the new standards, such as informed choice
- ✓ Brainstormed with taskforce members on state standards that will align with the new federal rules
- ✓ Conducted a provider setting survey
- ✓ Developed draft transition plan and state standards
- ✓ Submitted a transition plan to CMS

How Does the Rule Impact the States?



All providers in the state will be affected by the rule change

After the transition plan is approved, states must:

- Comply with the Home and Community-Based Setting Requirements milestones/deadlines
- Assure that services and service settings meet CMS criteria for “the required qualities of home and community-based settings”
- Transition participants out of settings that do not end up complying

Rule Impact on States



States must assess their service systems to determine:

- What aspects of the programs are meeting requirements
- If conflict free case management is in place
- What services and/or aspects must be modified
- What settings won't meet criteria

How Will Rules Be Enforced?



- Monitor**
 - Using provider monitoring, on-site visits, incident/complaint follow up processes, representative sample case reviews, and Case Management reports
- Address**
 - Addressing areas of non-compliance with standards through our usual corrective action processes
- Evaluate**
 - Evaluating the transition plan milestones quarterly and annually to ensure everyone is making changes as required, adjusting as needed.

How Quickly Do States Need to Respond?



By the end of the first year of the effective date (3/16/2015)

Wyoming needed ours submitted in November, due to ABI renewals and amendments to the Comprehensive and Supports Waivers

What Must be Submitted to CMS?



- A Five-Year Transition Plan
- Preliminary State Assessment
- Summary and Proof of Public Hearings

Transition Plan



- Most changes will occur in year two
- Year 3 will be an implementation and evaluation year
- Year 3 -4, location issues must be addressed
- Providers will get a report where they are not in compliance
- Providers will need to submit a transition plan to fix the areas flagged by March 2019
- Providers must have annual progress made at the milestones in their plan

Timelines for Wyoming



- Once approved, the transition plan covers a 5 year period that ends 3/2019
- Draft transition plan for each waiver was posted to the Division's website on October 3 for a required 30 day comment period.
- Anticipated transition plan approval by the by February of 2015

How will Wyoming Respond to the Rule Requirements



- Informed choice must change
- Case manager roles in monitoring will change
- Providers will need to make adjustments to settings, characteristics, practices and in some cases, location
- Case managers will help monitor providers adherence to the requirements

Conflict Free Case Management Application



Conflict Free Case Management Model



- *Benefits to a conflict free case management model*
 - Case managers core responsibility becomes ensuring that what is important to and for a participant is addressed based on the individual's preferences and desired outcomes.
 - Case managers will have more authority to advocate for participants and participants will be given true choice in services and providers.

Timeline for Conflict Free Case Management Application



- Wyoming must be conflict free by July 1, 2015
- All applications must be received no later March 1, 2015 to ensure completion of the process by July 1, 2015

Application



- Your assigned Provider Support specialist will assist you through the entire process and be your contact person
- Must provide official education transcripts to their provider support specialist
- All questions must be answered, including the last page

Conflict Free Case Management Model Process



- Application is available online
 - <http://health.wyo.gov/ddd/prospectiveproviderinfo.html>
- Anyone wanting to continue case management after July 1, 2015 must complete the application and submit it to your provider support specialist
- Contact your provider support specialist to determine what steps you need to take next and to begin the process

Deadline



Case managers will not be reimbursed for services they provide after July 1, 2015 if they have not been approved as a conflict free organization by the deadline

Ethics in Case Management

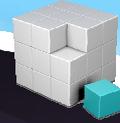


Ethics in Case Management



Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health and service needs.

Primary Goals of Case Management



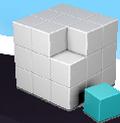
The primary goal of case management is to optimize participant functioning and well-being

What are the Basic Principles of Ethics?



- To do good
- To do no harm
- To respect individuals rights to make their own decisions
- To treat others fairly
- To follow through and keep promises

What are the Guiding Principles of Ethics in Case Management



- Strengthening
- Enhancing
- Linking
- Increasing

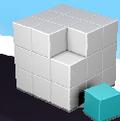
How are Ethics Applied?



- A case manager's primary obligation is to his or her participant
- Maintenance of respectful relationships
- Advocacy

**It's easy
to stand with
the crowd.
It takes COURAGE
to stand alone**

Chapter 1 Rules Section 16



Unethical Conduct.

- (a) Persons who provide services to vulnerable populations incur special responsibilities.
- The more dependent the population, the greater the responsibility.
- ISC's (case managers) are expected to support the choices and preferences of the person served unless doing so is either illegal or clearly not in the best interests of the person served.

Unethical conduct includes but is not limited to:

Ethics Applied



- Home Visits
- Team Meetings
- Documentation
- Service Observation
- Reporting
- Abandonment of Services

Conflicts of Interest



- Case managers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment.

Reporting and Ethics



- Any person believing that unethical conduct has occurred, should report the alleged misconduct immediately to the Division and, as appropriate, to the Provider Support Specialist

Service Clarification and the Plan of Care



Service Clarification and the Plan of Care



- Plan of Care
- Supervision Needs Section
- Employment/Employment Training Section
- Day Services
 - Adult Day Service
 - Community Integration
- Adult Day Services – Locations
- Community Integration

Plan of Care



- Person-Centered Planning
- Detailed and Descriptive of participant's goals, wants, needs, risks, etc.

IPC Meetings



The case manager shall facilitate the Individualized Plan of Care (IPC) team meetings, with the applicable members of the team, for the following events:

- An annual meeting
- A review meeting
- A special meeting
- A transition meeting

Plan of Care Team Meeting Requirements



- Notifying all individual plan of care team members of the scheduling of the meetings
- Notifying the local Division PSS of the date, time, and place of a team meeting
- Following the Division requirements for facilitating team meetings
- Documenting minutes of the team meetings in the form and manner prescribed by the Division in provider manuals and bulletins issued by the Division.

Supervision Needs



- This section replaces the old Habilitation Supports section.
- Focus on level of service score and description of participant supervision in various waiver settings.
- What is written needs to be observable and measurable.
- This section provides direct support staff and providers with specific instruction on the support and supervision specific to the participant.

Supervision Needs



- Assistance during times of more intensive needs:
 - Cover: Medical, Behavioral, ADL's
 - Cover: Specific Settings – residential, community, other locations.

Examples



- I need more intense care when I am sick. I usually need to stay at my residence when I am ill or when the weather is very cold outside. I **need staff to stay with me at all times** while I am at home. I need total assistance when I have to evacuate a building during an emergency.

Example



- I need more help when doing my ADL's. I can't do these on my own and must have help. I need help with mobility as I am in a wheelchair and can't wheel myself. I need **total assistance** at mealtime. I need help with all my toileting needs. I will also need more support when I am upset. Please read my behavior plan so you know how to best assist me. I need providers to make sure I am positioned in my wheelchair properly when transporting.

Example



- I need assistance bathing, brushing my teeth and with peri-care. When in the community, I need staff to be ***within eyesight*** as I don't understand traffic and I lack safety skills. In case of an emergency, I need total assistance from staff to respond

Supervision Needs



- Staffing patterns for habilitation services:
 - Cover: Specific Settings – residential, community, other locations.

Example



- In my home, I need ***30 minute visual checks*** when I am in my bedroom awake, ***10 minute visual checks*** when I am in the bathroom, and I need to be ***within eyesight*** of staff if I go outside. I need to be ***within arms reach*** of staff in the kitchen when the stove or oven is on or when there are sharp objects or appliances out.

Example



- I require ***staff to be available to me at all times during waking hours***. I need immediate/direct assistance during meal times, hygiene and showers, and my toileting needs. I need assistance walking as I cannot safely do this on my own.

Example



- I need ***help with all of my ADL's*** with hand-over-hand assistance.
- I need help with all of my feeding and drinking as I can't feed myself. Make sure to keep my hydrated. I have a colostomy and wear depends so I will need assistance with changing my depends and maintaining my colostomy bag. I would ***need total assistance in the case of emergency or evacuation***.

Supervision Needs



- Supervision while sleeping
 - Cover: Visual Checks, Assistance with Medical Equipment

Example



- I need **staff to be awake and within hearing range**. If there is an emergency, I would need total assistance from staff to evacuate due to my anxiety.

Example



- I need **life checks every 15 minutes** while receiving residential habilitation. My parents choose not to do life checks while I am home because they feel my independence is important.

Example



- I receive **15 minute life checks during the night**. My staff also get me up to use the bathroom once in the middle of the night.

Example



- When I am at the residential habilitation agency, I **receive 1 hour life checks**. When I am at my regular residential habilitation home, my provider can hear me during the night due to her bedroom being close to mine so she checks on me when I need assistance.

Supervision Needs



How to assist the person in this area

- Allow me to do as much as I can independently
- I am in need of help with all my ADL's
- **I cannot be left alone at all in the community**
- **I can be left alone in my apartment up to 2 hours**. I enjoy this alone time. I have my own phone for emergency
- **I need assistance and supervision for most of my ADLs**

Employment and Employment Training



- Expectations for this section
 - Under 16 – okay to explain they are too young to work
 - 16 – 21 – Include the transition plan that is being addressed in the person's IEP.
 - *Could include: work experiences, interest assessments, volunteering, formal vocational training, preparation for college, etc.*

Employment and Employment Training



- Over 65 – okay to write retired
- Medically Fragile – okay to put as long as this matches what is in the plan of care
- 21-64 – explain what is being done to look for employment and what accommodations are needed.
 - Information from the Employment Pathway Planning Packet
 - Could include: Volunteer services, job shadowing, work experiences, etc.

Employment and Employment Training



- Examples:
 - The work I do or would like to do is _____
 - The average hours I can work are _____
 - Currently I work at _____
 - My work is considered _____ (Independently Employed, Community Integrated Employment, Group Supported Employment, etc.)
 - The supports or accommodations I need to work in the community are _____

Employment and Employment Training



Medically Fragile

- I do not work due to my fragile health.
- I am at high risk of injury while working due to my seizures, therefore, I have staff with me at all times and I can not work at this time.

Employment and Employment Training



Under 16

- I do not work. I am 10 years old.
- I do not work. I am 13 years old. I do help my dad with chores on the farm.
- I do not work. I am 12 years old. I do help my family with chores around the house.

Employment and Employment Training



Ages 16-21

- I am 17 years old. Currently I am in the IDEAL program at high school working on my career portfolio, work skills, and soft skills to prepare me for job placement.
- I am 18 years old. Currently I am in a work experience through the high school at the local grocery store. I continue to also work on work skills and soft skills through the IDEAL program.

Employment and Employment Training



Over 65

- I am retired. I worked at the grocery store for ten years before retiring last year.
- I have retired! I am going to sell my candy machine business to my friend. I am excited to teach her how to run the business.

Employment and Employment Training



Ages 21-64

- I **work at the local grocery store**. I have been employed there for ten years. I am currently a **bagger** but I have also worked other positions within the store.
- I would **require a job coach** on the job when I am learning a new task or job position at work.

Employment and Employment Training



Ages 21-64

- I do require **a job coach to check in with me monthly** to make sure I am doing okay and to help me with my paychecks and making sure I am reporting to Social Security.

Employment and Employment Training



Ages 21-64

- I **work at the recycling center an average of 7 hours a day, 5 days a week**. I sort a variety of recycling materials and go on community pickups.
- My **provider is within eyesight or hearing distance**. I **receive visual checks every 15 minutes**. Closer supervision is needed when learning a new task, changing job tasks, during time studies, and sometimes is needed to complete a task. When doing pickups in the community, I choose to stay close to my staff.

Employment and Employment Training



Ages 21-64

- I **need the following accommodations**: I receive job coaching and time studies.
- I do enjoy working at recycling. I don't like it when it is too hot. I do like sorting the plastic bottles and going for rides in the recycling pickup and picking up cardboard and recycling at other places.
- My guardian has advocated for me to work in an agriculture job, even if it is temporary or periodic in order to utilize some of the skills that I possess.

Employment and Employment Training



Ages 21-64

- I am not interested in employment at this time but will remain active in the community by exploring volunteer options.
- I am not interested in employment at this time but my team will keep me involved in community activities and help me identify ways I can volunteer within my community that might lead to employment.

Day Services



- Community Integration
- Adult Day Services
- Goals cannot reflect employment

Community Integration



- What is Community Integration?
- Expectation of the 50% and how documentation supports this

Community Integration Schedule



Participant Name: _____ Community Integration Services T2021/ T2021 TF/ T2021 TG Provider: _____

Average time in service: _____ Supervision: _____ Week Start Date: _____ Week End Date: _____

Services should be furnished in any of a variety of settings in the community and are not limited to fixed-site facilities. Services may be provided up to five days a week. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

Date	Day 1	Day 2	Day 3	Day 4	Day 5
Beginning Time	AM PM				
End Time	AM PM				
Time in and out for other services	Out: _____ In: _____				
Meals Taken	Time _____ Meals _____				
Meals Taken	Time _____ Meals _____				
Planning Activity	Amount of time _____				
Location/Activity (Community setting/program/agency)	Amount of time _____				
Location/Activity (Community setting/program/agency)	Amount of time _____				
Location/Activity (Community setting/program/agency)	Amount of time _____				

Community Integration Schedule



Describe in brief (one sentence) about the participant's appearance, support, and behavior from 1st interview to subsequent. Things to note: medication, positive behavior incident plan details, last medical exam, and important things the person does to help, places to visit, regular events/activities, etc. List support needs as in table, where specific comments should be noted and plan to help address them. Do address 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

Objective Setting Use relationship, behavior, or skill map to assess and determine measurable	Only across items addressed today							
Score	Success (0-100%)	Score	Success (0-100%)	Score	Success (0-100%)	Score	Success (0-100%)	Score
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