FOOTHILLS GATEWAY, INC.

Case Management Monitoring
(HCBS-DD, SLS, CES)

POLICY:
It is the policy of Foothills Gateway, Inc. to execute Case Management services according to Health Care Policy and Financing (HCPF) rules and regulations.

PURPOSE:
Foothills Gateway, Inc. will monitor services and supports for individuals in services per HCPF rules and regulations. Monitoring and follow-up activities are necessary to ensure each individual's care plan is implemented and adequately addresses the health and safety and service needs of each individual documented in the annual service plan. The frequency and level of monitoring shall meet the guidelines of the program in which the person is enrolled.

The individual and the team should assess what is working and not working for the individual, what is truly important to versus important for the individual and integrate what has been learned in the prior six month in order to plan for the next six months. Everyone should be given the opportunity to share what has been learned and have an opportunity to help shape the next six months of services. The Case Manager will help facilitate the discussion, collect the information and make changes to the service plan and 100.2 as appropriate. The Case Manager will also summarize what is learned in a log note entered in the BUS.

At a minimum monitoring shall include for each person to assure:

1. Completion of Initial or Continued Stay Review of functional eligibility (LTC 100.2 Assessment).
2. The delivery and quality of services and supports identified in the Service Plan (SP), the prior authorization request (PAR), and the utilization of these services.
3. The health, safety and welfare of the individuals.
4. The Community Centered Board (CCB), and service agency practices promote a person's ability to engage in self- determination, self-representation, self-advocacy and person centered planning.

PROCEDURE:
- **Case Managers will meet Targeted Case Management requirements for all individuals enrolled in HCBS Medicaid waivers using Targeted Case Management.**
    1. Face-to-face contacts quarterly, at a minimum
    2. Documented contact every month

- Case Managers will:
    1. At a minimum, complete two face to face visits in the home situation per year. One to complete the 100.2 and one additional visit with the individual in services.
       * When informed of a change of address, the Case Manager will visit all homes of people enrolled in the HCBS-DD Waiver within 45 days.
    2. Complete at least two face to face visits per year at the work/day situation.

In gathering information, the Case Manager should have the full array of information available. The primary source of information should be from the individual in service and those closest to the individual.

In addition to personally discussing the prior six months with the individual in service, those people closest to the individual, the Case Manager should also review incident reports written on behalf of the individual in service. An electronic record of incidents are available through the Foothills Gateway Incident Report application. The Case Manager will use the individual's name and date range search criteria to sort incident reports for the six month review. The Case Manager can evaluate whether there was a pattern in the type of incident, timing of the incident or environment.

Provider notes:
The Case Manager will review provider notes to determine whether the services provided meet the stated goals of the service plan as well as the definitions established by HCPF rules. In addition to desk or office reviews, the Case Manager should review a sample of the notes with the individual in service to ensure that the services match what actually happened. Any concerns arising from the notes review should be documented and shared with the team.

Progress Summaries/Assessments:
Service providers should prepare progress summaries. The frequency of the summaries is determined by the team. If six month summaries are required, the Case Manager should integrate information from the summaries and gauge progress against the goals developed with the individual and recorded in the service plan. Any concerns or successes should be shared with the entire team in order to keep each team member apprised of all aspects of an individual's services.

Health and Safety Reviews:
Some individuals in service have periodic reviews of health and safety skills and emergency plans. Part of this review can include documentation of the individual's ability to respond to crises. If this information is completed by a provider, the Case Manager should use information to evaluate an individual's strengths and mark changes when compared to prior reviews. Health and safety plans can also be reviewed with the individuals at the individual's home or in the day program setting.

Quality of Services Review:

During each monitoring visit, the Case Manager will review the individual's overall satisfaction with their services and supports, satisfaction with their provider selection(s), and review the health, safety, and welfare provided to the individual where services and supports are received. The Case Manager will speak with the individual to ensure individual satisfaction with their provider selection(s), services, and supports being provided. Additionally, the Case Manager will review the nature and frequency of complaints regarding the individual's service agency. If any concerns are brought up or observed, the Case Manager will work with the individual and their Interdisciplinary Team to resolve any concerns with the individual's services and supports.

Utilization:

The Case Manager should use available information on units billed to evaluate the use of the services. The information is available through the Bridge or from PASA staff. The Case Manager should use this information as a discussion point in determining whether the scope of the services is appropriate going forward and to troubleshoot any service delivery issues that may have created a barrier to services in the prior six months.

Service Plan Review:

The Case Manager should review the most recent version of the Service Plan to ensure services are being delivered according to the most current Service Plan, to ensure services in the plan adequately meet the individual's needs, and revise the Service Plan if necessary adjustments are needed to meet the individual's current needs. The Case Manager should also use this as a reference in discussing with the individuals if the goals align with the individual's personal goals and whether there are any services which are not needed or which are newly identified needs. The Service Plan should be revised to reflect any changes in natural supports and Medicaid/LTHH/third party benefits. Additionally, the DD section may be amended to reflect the individual's supervision changes, work changes, living status or preferences, strengths and desires.

100.2 Review:

Six months after the Service Plan, the Case Managers should evaluate whether there have been any functional changes that would impact the ULTC 100.2 assessment. These changes may arise by an increase or decline in an individual's ability to complete activities of daily living or cognitive/behavioral state. These changes may be precipitated by change in medical status or integration of assistive technology or adaptive equipment and may reflect an individual's acquisition of additional activity of daily living skills, decreased supervision needs or increased cognitive processing through maturation or the learning process. Changes in the 100.2 should be incorporated into an unscheduled 100.2 assessment. While this assessment need not be completed face-to-face and in the individual's home, the reassessment should use a variety of sources as the basis for the new assessment.

Incident Report Trending:

Case Managers should pull a query of the last six months of incident reporting. The Case Manager can pull this information from FGI incident reporting database. The Case Manager

should read the incidents written within the six month period and evaluate whether there are any trends apparent. Trends can include type of incident, period of time, service provider. The Case Manager can use this information to gauge the wellness of the person in service over the past six months and drive discussions about how changes might be made in the next six months.

Home Visit:

Review the state of the home environment and whether the home is a safe residence given the individual's physical and social needs. It is especially important to assess the safety of the home if there have been additional medical needs or a general decline in the individual's health. The visit should consider the risk of falls present from stairs, uneven surfaces, rugs and pets. The Case Manager should also evaluate the accessibility of bathrooms, bedrooms and closets. As part of the health and safety review, the Case Manager should also assess the suitability of the living environment's emergency egress in light of potential fire emergencies as well as safety equipment including smoke detectors and carbon monoxide detectors. For individuals living independently, the Case Manager should evaluate whether existing supports (paid and unpaid) are sufficient to allow the individual to live safely in that setting.

Waiting List Review:

Case Managers should discuss whether the person should continue or be added to the HCBS-DD waiver Waiting List and what status should be reflected on the Waiting List (safety net, as soon as available). If the discussion leads to a need for a change in status, the Case Manager will complete a Waiting List change form. The Case Manager will document this discussion in the log notes.

Professional Services (SLS and CES only):

Case managers will ensure that individual therapeutic goals for professional services (Hippotherapy, Massage Therapy and Music Therapy) are reviewed and approved by a Medicaid medical provider on a quarterly basis. The Case Manager will send therapy notes and outcomes to the person's Medicaid medical provider. If the Medicaid medical provider does not find that the therapeutic outcomes are meeting the needs of the person, the case manager will work with the IDT to revise the therapeutic goal or discontinue the professional service.

Documentation

- The Case Manager will complete the Comprehensive or SLS person centered home-visit checklist form for each home visit.
- The Case Manager will complete the day/work checklist form for each work and day activity visit.
- The Division/Case Management Resource Technicians will enter all visits with the individual in the Case Management Service Plan database (home, work, day and community setting).
- Case Managers will document all monitoring activities as log notes in the Benefits Utilization System (BUS).

- The Division of Case Management Administrative Assistant will distribute all checklists to appropriate Program Approved Service Agency (PASA) Directors for follow-up.

Follow-up

- The Case Manager will identify if follow-up is needed and who is responsible.
    1. The Case Manager will refer to the SP to identify who is responsible for follow-up.
    2. The Case Manager will have the Data Technician identify in the SP database concerns and follow-up needed. The Case Manager will assure follow-up is completed.

- The Case Manager will document when follow-up is complete
    1. When an assigned follow-up has been completed, the PASAs will submit the follow-up form to the Case Manager.
    2. The Case Manager will have the Data Technician document that the follow-up is complete and assure the date of the follow-up is in the Case Management SP database.

- The Data Technician will compile the visit and follow-up data
    1. Home, day/work visits and follow-up needed reports will be completed quarterly.
    2. Reports will be distributed to PASA Directors quarterly.

6/03. . . . . 12/17; 4/19, 7/19