

TARGETED CASE MANAGEMENT
Substantial Draft of the policy developed by the Services Definition Committee
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TARGETED CASE MANAGEMENT

1.0 Description of Targeted Case Management

Case management is an activity that assists recipients in gaining access to necessary care and medical, behavioral, social, and other services appropriate to their needs. Case management should be individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include assessment, care planning, referral/linkage, and monitoring/follow up.

1.1 Assessment

Comprehensive and culturally appropriate assessment should determine a recipient's service needs, strengths, resources, preferences, and goals to develop a care plan. Assessment should address all aspects of the recipient, including medical, physical/functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational/educational areas. Assessment should include early identification of conditions and needs for prevention and amelioration. Assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators to form a complete assessment. Assessment should include periodic reassessment to determine whether a recipient's needs or preferences have changed.

1.2 Care Planning

Care Planning is the development and periodic revision of a specific care plan based on the information collected through an assessment or reassessment. The care plan should be comprehensive and address the recipient's identified needs, strengths, resources, and preferences. The care plan specifies the recipient's goals and the actions necessary to address the medical, behavioral, social, and other service needs of the recipient. Care planning should include the active participation of the recipient and the recipient's natural and paid supports. The goal of care planning is to develop an appropriate and fiscally responsible plan of care that enhances quality and access outcomes.

The care planning process should ensure the active participation of the recipient and his or her caregivers and promote self-direction and self-management. The care planning process involves information sharing with the recipient and his or her supports in order to help the recipient make informed decisions. A recipient's care plan should be revised as his or her needs, preferences, and goals change.

1.3 Referral/Linkage

Referral and related activities link a recipient with medical, behavioral, social and other programs, services, and supports to address identified needs and achieve goals specified in the care plan. Referral and linkage activities include:

- Coordinating the delivery of services to reduce fragmentation of care and maximize mutually-agreed upon outcomes.
- Facilitating access to and directing recipients to services and supports as identified in the care plan.

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- Making referrals to providers for needed services and scheduling appointments for the recipient.
- Assisting the recipient as he or she transitions through levels of care.
- Facilitating communication and collaboration among all service providers and the recipient.

1.4 Monitoring/Follow-up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the recipient. Monitoring activities may involve the recipient, his or her supports, providers, and others involved in care delivery. Monitoring activities should help determine whether:

- Services are being furnished in accordance with the recipient's care plan;
- Services in the care plan are adequate and effective;
- There are changes in the needs or status of the recipient; and
- The recipient is making progress toward his or her goals.

2.0 Eligible Recipients, Categories of Service and Access

2.1 Recipient Eligibility

Recipients of Medicaid are eligible for Targeted Case Management services if medically necessary (i.e., in a covered population the entrance criteria establishes medical necessity) for the covered populations, with the following exceptions:

1. Medicaid Qualified Beneficiaries (MQB)
2. Family Planning Waiver (FPW) recipients
3. Medicaid Recipients residing in a Nursing Facility, Inpatient or Intermediate Care
4. Facility for persons with Mental Retardation (ICF-MR) unless specifically approved by the designated Care Management Oversight Agency for the last 90 days of residency, with exceptions for more as authorized, based on medical necessity.
5. Medicaid Recipients who are inmates of public correctional institutions or
6. Adults age 21 and older in facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMD).

2.2 Covered Populations

Covered Populations for Targeted Case Management are:

Target Group	Recipient and Description
Target Group 1	Adults and children with developmental or intellectual disabilities (including TBI)
Target Group 2	Children and adults with serious emotional disturbance, or severe and persistent mental illness, or substance abuse disorders
Target Group 3	Individuals enrolled in Home and Community Based Waiver programs (CAP);
Target Group 4	Pregnant and postpartum women who meet risk criteria
Target Group 5	Children birth to age 3 who have developmental disabilities or delays or established health conditions leading to a developmental delay
Target Group 6	Children birth to age 5 who are at risk for or have a medical, behavioral, social or environmental related problem

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Target Group	Recipient and Description--continued
Target Group 7	Children birth to 21 with special health care needs meeting EPSDT criteria
Target Group 8	Individuals with HIV who meet clinical criteria
Target Group 9	Children and adults who are at risk for abuse, neglect or exploitation

2.3 Categories of Service

There are four categories of Targeted Case Management which dictate the recipient's Clinical Home provider: Behavioral Health, Intellectual/ Developmental Disability, At Risk and Public Health (medical/social). In situations where the recipient has multiple needs, these agencies will coordinate and determine the lead status. Regardless of the designated clinical home provider, that provider must address all the identified needs.

2.4 Access to Targeted Case Management

- 2.4.1 Authorization for Targeted Case Management services will be obtained as specified by the LME, DPH/LHD, CCNC or other CAP designee as determined by the Division of Medical Assistance in accordance with the Memorandum of Agreements/Contracts.
- 2.4.2 The recipient may request services directly from the LME, DPH/LHD, CCNC or other CAP designee as determined by the Division of Medical Assistance in accordance with the Memorandum of Agreements/Contracts. Or the LME, DPH/LHD, CCNC, or other CAP designee as determined by the Division of Medical Assistance in accordance with the Memorandum of Agreements/Contracts may offer services through outreach to eligible recipients. The recipient may request assistance from any person, agency or provider to assist them in this process.
- 2.4.3 If Targeted Case Management services are denied, appeal of the decision will follow requirements of Recipient Notices and Fair Hearing Procedures.

3.0 When the Service is Covered

3.1 Entrance and Continuation Criteria

1. Recipient has difficulty, independently or with family (caregiver) support, in obtaining or maintaining basic needs including safe and adequate housing, food, health care or transportation for necessary services.
 - Pregnant and postpartum women : inadequate prenatal care. Pregnant and postpartum women and children: Inadequate or unsafe housing; nutritional concerns or lack of sufficient food; lack of ability to pay for needed healthcare; transportation needs.
 - I/DD - Recipient has significant functional impairment leading to inability to function independently in community in at least 2 of following domains: basic needs (self-care, food, housing, clothing), communication, educational, vocational, medical, social, transportation, AND the recipient is experiencing difficulties in at least one of the following risk criteria under the IDD heading.
2. Recipient has care giving or support needs including adequate parenting of a child or adequate parent child bonding.

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- Children birth to age 3: Maternal age < 15 years*; Parent-infant bonding*; Family and social support/stressor*; basic parenting issues.*
3. Recipient, family or parent of a child has, or has been unable to address, one or more conditions that present risk to the identified recipient, OR presents risk of functional loss; OR presents risk of placement in a more restrictive setting.
- Pregnant and postpartum women: Unintended pregnancy; plan for adoption; communication barriers due to disability or language limitations; lack of social support; tobacco use; stress; previous preterm delivery (<37 completed weeks); previous preterm labor resulting in a term birth; previous low birth weight baby (5.5 lbs or less); previous miscarriages (2 or more); previous stillbirth; previous neonatal or infant death; short interconceptional interval (<18 months); multiple pregnancy; hypertension or pre-eclampsia; diabetes; gestational diabetes; asthma; preterm labor; age 35 or older; age 17 or younger; pre-pregnant body mass index below 19.8 (underweight), 26.1-29.0 (overweight) or above 29.0 (obese).
 - Children birth to age 5: Other family health problems*; Fetal exposure to potentially harmful drugs during pregnancy; Other specified family circumstances*; Birth weight less than 1500 gms*; Gestational age less than 32 weeks*; Potential for perinatal asphxia*; Hypoglycemia*; Hyerbilirubinemia*; Intracranial hemorrhage*; Neonatal seizures*; Suspected visual impairment*; Suspected hearing loss or risk factors for hearing loss*; Well care*; Chronic lung disease*; Developmental delay*; Atypical development*; Chromosomal anomaly/genetic disorder*; Metabolic disorder*; Infectious disease*; Neurologic disease*; Congenital malformation*; Toxic exposure, lead *; Visual impairment*; Hearing impairment*; Other medical condition*
 - I/DD - At risk for institutionalization, hospitalization, or placement in a more restrictive residential setting, i.e. group home, adult family care home, assisted living facility, rest home or nursing home
4. Recipient is residing in an institutional setting and needs support to return to a less restrictive setting.
- I/DD - Up to 90 consecutive days prior ***This should be expanded to allow CM according to DRA & Olmstead requirements of a 180 days.*** to discharge from Institution or Hospital, (or Substance Abuse/Rehab facility, ICF, nursing home) for the purposes of transition to the community
5. Parent or provider has significant concerns related to a potential developmental delay or disability of a child or other recipient under their care.
- Children birth to age 3: Significant parental concern*;
6. Recipient has experienced or is at risk for (based on family or situational history or reporting) domestic partner or family violence, abuse, neglect or exploitation.
- Pregnant and postpartum women: Domestic or intimate partner violence; sexual abuse.
 - Children birth to age 3: Potential for child maltreatment/potential for atypical development*;
 - I/DD - DSS has substantiated abuse, neglect, or exploitation, or person is at risk of abuse, neglect, or exploitation

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7. Recipient presents with known or possible symptoms of a mental illness or chronic substance use, or the recipient has been prescribed psychotropic medications
- Pregnant and postpartum women: Substance use; mental health concerns;
 - I/DD recipients with a dual diagnosis (either DD/MH or DD/SA) or receiving psychotropic medications.
 - Axis I or II MH/SA diagnosis as defined by DSM-IV-TR other than a sole diagnosis of I/DD
 - Recipients with a SA diagnosis that meets American Society for Addiction Medicine (ASAM) criteria. AND
 - Documented need in at least two of the following life domains: financial/ access to benefits, social, emotional, safety, housing, medical/health, legal, vocational, educational; AND
 - Experiencing significant functional impairments in any of the following areas:
 1. Has demonstrated difficulty in meeting or maintaining basic needs in the areas of safety, housing, food, healthcare or transportation
 2. Has unmet identified needs, related to MH/SA diagnosis, for multiple services that require service coordination
 3. Resides in an institutional setting and needs assistance to return to less restrictive setting
 4. Unable to independently access and sustain involvement with needed services
8. Recipient has multiple service needs or stressors indicating a need for coordination, advocacy and monitoring.
- I/DD - Has unmet need for coordination and monitoring of needed medical, social, educational, or other service(s)
 - I/DD - Needs advocacy, service coordination, and monitoring of direct service provisions from multiple agencies

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* Definitions for DPH Family Case Management entrance criteria included in appendix..

3.2 Early Periodic Screening, Diagnostic and Treatment (EPSDT) Special Provision

EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions above and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination by a physician or other licensed clinician. This documentation shows how the Targeted Case Management service will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed

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practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice.

4.0 When the Service is Not Covered

4.1 Prohibited Service Activities for Payment

Service Activities that are not billable as Targeted Case Management are:

1. Direct Treatment – provision of direct therapeutic, medical or clinical services are not reimbursed. Educating recipients about their disease or disability is considered treatment.
2. Administrative Functions – provision of required administrative functions associated with the delivery of the service such as referral and linkage to services, required documentation, and recruiting staff.
3. Writing service plans, progress notes or any other documentation of activities.
4. Travel .
5. Missed appointments, attempted contacts or leaving messages.
6. Time spent in staff training, clinical supervision or case reviews
(All of the above items are considered in determining the rate except for direct tx and transportation. Direct tx and transportation are not case management functions.)

4.2 Exit Criteria for Targeted Case Management Services

1. Recipient or family refuses case management services.
2. Care plan goals have been achieved. and other concerns that meet need for ongoing case management do not exist.
3. Family of referred child or recipient refuses or wishes to discontinue case management services.
4. Recipient "ages out" of case management services. (For children in Family Care Coordination)
5. Recipient has transitioned to another program, has moved out of state or is deceased.
6. Recipient is admitted to a facility for more that 60 **consecutive** days, or is permanently placed in ICF-MR residential facility.
7. CAP services are terminated.
8. Recipient is no longer eligible for Medicaid.
9. Admission to a nursing facility or hospitalization for 30 **consecutive** days or more.
10. Health, safety and wellbeing cannot be maintained in a home.
11. Recipient is no longer at risk for harm.
12. Psychotropic medication or other multiple medications are terminated and recipient is no longer in need of a medication evaluation.
13. Recipient is incarcerated.
14. Progress is no longer being made and additional actions to meet the needs cannot be identified.

5.0 Service Requirements and Limitations

5.1 Non-Duplication of Services

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1. An individual can receive Targeted Case Management services from only one provider organization at a time. If an individual meets more than one target population, case managers from case management agencies should coordinate their efforts to decide which case management agency should be the identified case manager. Recipient's choice is a primary consideration in determining active agency. Consultation between the agencies should be encouraged to ensure that all of the recipient's needs are met appropriately (for example, a recipient with mental illness and HIV, or high risk pregnancy).
2. An individual may receive Targeted Case Management services while receiving Department of Social Services At-Risk of Abuse, Neglect and Exploitation Case Management services, for a period of time not to exceed six months.

5.2 Limitations

An individual can not receive separate Behavioral Health Targeted Case Management with any of the following services:

- Intensive In-Home Services (IIH)
- Multisystemic Therapy (MST)
- Assertive Community Treatment Team (ACTT)
- Community Support Team (CST)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)

5.3 Maximum Units

This service will be reimbursed at one unit per recipient per month following the delivery of services. This unit rate will cover all Targeted Case Management services for that individual for that month. An accurate audit trail must be maintained between the medical records documentation of all contacts and associated units of service for cost reporting. Recipients must receive a minimum of one contact per month to bill, quarterly face-to face contact and an annual assessment or reassessment.

6.0 Provider Requirements

6.1 Provider Types

Three types of providers may offer Targeted Case Management services: 1) Integrated TCM Providers (such as CABHAs, LMEs or Public Health; 2) Home and Community Based Waiver TCM Providers; and 3) Division of Social Services. These are defined as follows:

1. Integrated Targeted Case Management Providers include CABHAs, Public Health, and LMEs.
 - a. Integrated Targeted Case Management Providers (agencies) must:
 - i. Provide Medication Management, if applicable;
 - ii. Outpatient Treatment; and
 - iii. Clinical Assessment
 - b. For Target Populations of Pregnant Women and Children with Special Health Care Needs, the following applies:
 - i. Public Health Agencies or their designees who have demonstrated direct experience in the delivery of maternal and child health services (ie. prenatal, family planning, immunization, children with medical or social health issues below 21 years of age, children with special health care needs or WIC

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- ii. The Division of Public Health, through its MOA with the Division of Medical Assistance will implement methods and procedures to certify providers of case management services for target groups who can demonstrate:
 1. Their capacity to provide case management services;
 2. their experience with delivery and coordination of services for persons described in the target groups above;
 3. Their capacity to assure quality; and
 4. Their experience in sound financial management and record keeping.
 - iii. Children's Developmental Services Agencies are designated the sole providers of targeted case management services to infants and toddlers birth to age 3 who are enrolled in the NC Infant and Toddlers Program under Part C of IDEA.
2. Home and Community Based Waiver (CAP Programs) Providers of Targeted Case Management .
- a. For persons with developmental disabilities who are not CAP MR/DD recipients, either an integrated or single service TCM provider, providing only TCM to the individual, may offer these services, depending on the recipient's overall service needs.
 - b. For current providers of Targeted Case Management, a one year sunset clause will be allowed to meet the minimum standards of an Integrated Case Management Provider, based upon the date of provider enrollment and the development and implementation of standards.
 - c. Policies for inclusion of out-of-state or border providers do not apply to Targeted Case Management Providers.
3. Department of Social Services (At Risk Populations)

6.2 Certification

Providers must be certified through the appropriate process, when it becomes available by the designated DHHS Division or designee prior to enrollment with Medicaid (e.g., for PH case management (PH processes), for CABHAs (LMEs), etc.). The certification process must be one approved by the Division of Medical Assistance. For providers currently approved to offer case management services, deemed status will be given for a period of no more than two years from the implementation of certification procedures. State Certification must be achieved by current providers within 1 year from the date the certification process is developed and implemented. Thereafter, all providers must achieve Certification for continuous enrollment.

DHHS or its designee is responsible for certifying qualified Targeted Case Management providers to render services in accordance with professionally recognized standards and as specified by this policy, and also for decertifying those Targeted Case Management providers that fail to render services in accordance with professionally recognized standards and as specified by this policy.

The DHHS Division or designee will be responsible for:

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1. Provider Agency Certification, Re-certification, and De-certification
2. Provider Expansion Requests
3. Provider Agency Monitoring and Evaluation, including plans for correction
4. Provider Agency Technical Assistance, Guidance, and Support
5. Regional Training, and
6. Reporting and Notifications.

The process for Certification will entail a review of required program materials, an on-site visit for validation and approval of documentation systems, including electronic data processing, within 90 days of receipt of all required information from the provider agency. Certification shall be provided for a maximum of three years.

A condition of continuing enrollment is Provider Certification, following the initial three year phase-in period. The Certification Agency will have authority to:

- Require plans of correction which must be submitted within 30 calendar days following the request.
- Conduct quality assurance visits, upon review of the corrective plan of action, which will be scheduled as deemed necessary to determine if corrective action has taken place and the service is compliant with all of the program's requirements.
- Provide the primary training and technical assistance necessary to improve any deficiencies however the responsibility for all recommended corrections, changes or improvements remain with the provider.

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Full resolution of all issues must be achieved in no greater than six months.

A condition of certification is the employment of a full time equivalent Certified Professional (a certified case manager) by the organization which is relevant to the category of Targeted Case Management services. This person will be responsible for the clinical oversight of service delivery. The provider may not subcontract to another company, however one public health agency may subcontract to another public health agency or they may contract with individuals.

The Division of Public Health, through its MOA with the Division of Medical Assistance will implement methods and procedures to certify providers of case management services for target groups who can demonstrate:

1. Their capacity to provide case management services
2. Their experience with delivery and coordination of services for persons described in their target population groups
3. Their capacity to assure quality, and
4. Their experience in sound financial management and record keeping.

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6.3 Certification Measures:

1. **Organizational Design** – The provider must be established as a legally recognized entity and have a physical business site at the time of application. This site cannot be in a private residence or vehicle. A program description must identify counties to be served, hours of operation, emergency after-hour response plan (if applicable), ability to coordinate with other providers of case management, ability to provide non duplicated

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- services, management authority, continuity of operations, organizational structure, communications, organization code of ethics and conflict of interest.
2. Business and Financial Practices - descriptions of internal controls, internal auditing, annual cost reporting, liability and malpractice insurance and lines of credit, performance bond or sufficient reserves for continuous operations;
 3. Human Resource Policies unique to the organization - process for validation of credentials, continuing education requirements, training in fraud detection, and procedures for employee performance appraisal and disciplinary action.
 4. Quality Improvement Systems - monitoring and evaluation of case management services, plans for measuring recipient outcomes, data reporting and analysis, recipient rights, indicators for tracking and reporting complaints and how they are resolved, systematic response to lapses in service delivery, conducting statistical studies including cost and utilization studies and monitoring for accuracy of claims and service records.
 5. Regulatory Compliance – plan for meeting federal, state rule and DHHS policy requirements, policies for incident reporting, quality assurance plans for all documentation standards and use of standardized forms without alteration.
 6. Clinical Services – descriptions of clinical and administrative staff supervision, caseload and staff vacancy management, after hours responder operations (if applicable), recipient transfer and discharge policy with procedures for referring recipients to specialty care/services or transfer to another TCM provider (including when the service is provided without a referral), development and maintenance of community resource information, community collaboration and conflict resolution, role of volunteers and natural supports and use of clinical consultation and clinical best practice programs, protocols and guidelines.
 7. Recipient-Provider Relationships - guidance for professional relationships with recipients, supports for self-reliance, application of person centered thinking, and measures of person centered outcomes, foster recipient-provider relationships without creating dependency and, prohibition of relationships that could compromise professional objectivity.
 8. Customer Service – policies and procedures for recipient grievance, non-discrimination, recipient rights, informed consent, freedom of choice of providers, identification and referral for evaluation of abuse, neglect or exploitation, conflict resolution, recipient advocacy, due process implementation, recipient satisfaction surveys and recipient feedback about organizational effectiveness.
 9. Information Management – policies and procedures for confidentiality, HIPAA compliance, safety and security including transporting of PHI, back-up of operating systems and record retention, generation of reports, communication with the Care Management Oversight Agency (LME or CCNC) and electronic records.
 10. Interpretive Services - make interpretation services available free of charge to each current and potential recipient of services based on Title VI requirements. This applies to all non-English languages. and ASL (American Sign Language).

6.4 Measure of Recipient Outcomes

As pertinent to the care plan and identified needs:

1. Recipients physical and psychosocial health needs are addressed".

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2. Recipients will have integrated and coordinated management of their physical and psychosocial needs.
3. Recipients will have timely and uncomplicated access to case management via "no wrong door" policy.
4. Recipients will have reduced out of home placements where possible/appropriate (including hospitalizations, incarcerations, residential, etc.).
5. Recipients will have improved ability to live independently.
6. Recipients will receive assistance to obtain safe and stable housing.
7. Recipients will have improved ability to achieve and maintain employment.

7.0 Staff Requirements: Staff Case Management Certification will be explored, if no national curriculum is identified, develop a State certification.

7.1 Minimum Staff Qualifications:

1. Bachelor's degree in human services or related field from an accredited college or university, or an RN and one (1) year of directly related (pre-degree or post-degree experience; or
2. Bachelor's degree in non-human services (or unrelated) field from an accredited college or university,; AND completion of a DMA approved curriculum or certification in case management.
3. A Master's degree and one year related experience.

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All case managers must meet qualifications, competencies, and fulfill required trainings.

Directly related experience is defined as: human services experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy, treatment planning, teaching, or providing direct service supports to people. No trainee appointments are eligible.

For current employees on the effective date of provider enrollment, a 5-year sunset clause will be allowed to meet the minimum experience. For any individual acting as a Case Manager under this condition, direct administrative and clinical supervision must be provided by a Certified Case Manager.

New hires must meet minimum qualifications at the time of hiring.

In addition, Case Managers for Early Intervention must become certified as an Infant, Toddler and Family Specialist within 3 years of employment.

7.2 Competencies

All Case Managers must complete a DMA approved curriculum within 90 days of employment or from date curriculum is developed and implemented. The Curriculum will meet the standards for the Knowledge, Skills and Abilities identified below:

1. Assessment
Knowledge of:

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- Formal and informal assessment practices.
- The population/disability/culture of the recipient being served.
- Skills and Abilities to:
 - Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and provision of appropriate options
 - Develop a trusting relationship to engage recipient and natural supports
 - Engage recipients and families to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions
 - Recognize indicators of risk (health, safety, mental health/substance abuse)
 - Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and recipient preferences
 - Consult other professionals and professional and natural supports in the assessment process
 - Discuss findings and recommendations with the recipient in a clear and understandable manner.

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2. Care Planning

Knowledge of:

- The values that underlie a person-centered approach to providing service to improve recipient functioning within the context of the recipient's culture and community
- Models of wellness-management and recovery
- Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines.
- Processes used in a variety of models for group meetings to promote recipient and family involvement in case planning and decision-making
- Services and interventions appropriate for assessed needs.

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Skills and Abilities to:

- Identity and evaluate a recipient's existing and accessible resources and support systems
- Develop an individualized care plan with a recipient and his or her supports based on assessment findings that include measurable goals and outcomes.

3. Linkage/Referral

Knowledge of:

- Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources
- Current laws, regulations, policies surrounding medical and behavioral healthcare.

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Skills and Abilities to:

- Research, develop, maintain, and share information on community and other resources relevant to the needs of recipients
- Maintain consistent, collaborative contact with other health care providers and community resources
- Initiate services in the care plan in order to achieve the outcomes derived for the recipient's goals
- Assist the recipient in accessing a variety of community resources.

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4. Monitoring & Follow-Up

Knowledge of:

- Outcome monitoring and quality management
- Wellness-management, recovery, and self-management
- Community recipient-advocacy and peer support groups

Skills and Abilities to:

- Collect, compile and evaluate data from multiple sources
- Modify care plans as needed with the input of recipients, professionals, and natural supports
- Discuss quality-of-care and treatment concerns with the recipient, professionals, formal and natural supports
- Assess the motivation and engagement of the recipient and his or her supports
- Encourage and assist a recipient to be a self-advocate for quality care.

5. Professional Responsibility

Knowledge of:

- Importance of professional ethical standards and the consequences of violating ethical standards
- Quality assurance practices and standards
- Confidentiality regulations
- Required performance standards and case management best practices
- Definitions and fundamental concepts of culture and diversity
- Origins and tenets of one's personal value system, culture background, and beliefs; and understand how this may influence actions and decisions in practice
- Recipient differences in culture and ethnicity

Skills and Abilities to:

- Use critical thinking skills and consultation with other professionals to make ethical decision and conduct ethical case management
- Use initiative and creative problem solving to support people in accessing the community and developing socially valued roles
- Form constructive, collaborative relationships with recipients of various cultures and use effective strategies for conducting culturally-competent case management.
- Form constructive, collaborative relationships with medical and other service providers
- Discern with whom protected health information can be shared
- Communicate clearly, both verbally and in writing
- Discern when the severities of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary
- Identify areas for self improvement, pursue necessary education and training, and seeks appropriate supervision.

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7.3 Continuing Education

Continuing Education is required minimally on an annual basis to update knowledge, skills and abilities in competencies and categories: Assessment, Care Planning, Linkage/Referral, Monitoring and follow-up and professional responsibility. In addition, the case manager must participate in training of best practice interventions specific to the population served. The DHHS approved staff certification program may substitute for the continuing education requirements.*

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Case Managers will complete at least 12 credit hours of continuing education per year after completing initial training upon hire. Training may be related to

1. Case management practice, such as:
 - Assessment
 - Planning
 - Referral/linkage
 - Monitoring, or
2. State and federal regulatory requirements, such as:
 - HIPAA
 - DRA
 - Cultural diversity
 - Crisis management
 - Legal and ethical issues
 - Prevention of abuse, neglect and exploitation
 - Person-centered thinking and planning, etc., or
3. Best Practice Interventions, such as:
 - Self-determinaiton
 - Empowerment and advocacy
 - Positive Behavioral Supports
 - Essential Lifestyle Planning and Tools
 - Circles of Support
 - Supported employment
 - Least restrictive approaches
 - Community living
 - Pharmacology
 - Dual diagnosis
 - Autism Spectrum Disorders
 - Substance Abuse in People with I/DD
 - Etc.

Sources for training and providers' training related costs will be included in the case rate. Training for providers could occur through AHECs, DDTI, Community Colleges, Universities, LMEs, conferences, on-line training organizations, provider collaboration or other comparable sources.

8.0 Documentation Requirements

Each provider must be compliant with the relevant standards issued by DHHS and additional requirements prescribed by the certifying Division or designee.

1. NCAC Title 10A, Health and Human Services Chapter 69, Confidentiality and Access to Client Records
2. Applicable DHHS General Administration Policies are Sections IV, Record Retention, Section VIII, Privacy and Security and Section IX, Transportation Services;
3. Non-Profit Organization must have knowledge of Guidelines from the Office of the Controller issued in the Fiscal Non-Profit Administration Manual;

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4. Division of Medical Assistance's Basic Medicaid Billing Guide and Confidentiality Regulations incorporated in the Family and Children's Medicaid Manual and Adult Medicaid Manual.

8.1 Access to Clinical Records

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid Program. Records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements as referenced in 10A NCAC 22F .017 and 10A NCAC 22F.0601. The provider shall promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for claims review, audit, medical record review, or other examination during the retention period specified above. Should a case management provider close a recipient to services, the agency shall provide the following information in writing to DMA's designee within 30 calendar days of the closing date: physical location of the records (hard copy and electronic); name of contact person and means for communication.

8.2 Electronic Records

A case management provider may store clinical records electronically (i.e., on disk, microfilm, or optical imaging systems). Providers using electronic storage systems are subject to the same recordkeeping requirements identified in this policy. **Current rule, specified in MH/DD/SA records and documentation manual, requires record retention for much longer, regardless of whether or not it is electronic.** Providers unable to maintain the historical documentation electronically shall maintain hard copies for the specified retention period. Disaster recovery systems must be in place to assure daily back-up of clinical records. With respect to claims review, audit, or other examination, the provider shall present clinical records along with the equipment necessary to read them. The provider shall ensure that all documentation with electronic signatures is consistent with state regulations (GS §66-58.5).

8.3 Electronic Mail

The provider must send all recipient related e-mails using a secured, encryption enabled e-mail method, approved by the HIPPA guidelines. To reduce unauthorized access to (e-mail) systems all e-mail services must adhere to the security requirements G.S. §147-33.110.

8.4 Clinical Record Specifications

The clinical record serves as a formal and systematic accounting of an individual's need for services and creates a written record which demonstrates over time, the effectiveness of service delivery. The service record holds vital information and is a primary means for communication between service providers.

1. Qualities of Clinical Records

- The medical record must be complete and legible to someone other than the writer.
- The documentation must support the intensity of treatment, including specific reasons for selecting specifics in the care plan.
- The rationale for diagnostic tests, ancillary services and referrals must be documented or apparent in the medical record.

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- Reasons for any atypical treatment/ habilitation utilized or apparent contradictions between information sources.
- Documentation that reflects individualized care and treatment.
- Recording information in a timely way, to avoid inaccurate or incomplete information; Documentation that is objective, and factual. Documentation to indicate coordination with other services and providers.

2. Components of Clinical Records

Each page or electronic file in the record contains the patient's name and Medicaid identification number. If the documentation originates from another, that provider must be identified on each page.

Application or intake forms which includes the recipient's biographical data

- Assessments and diagnostic test results;
- Care plans with documented timelines for obtaining services;
- Progress notes;
- Medication sheets (a copy of medication sheets should be obtained from the pharmacy and coordinate any changes in medications);
- Medication allergies and adverse reactions, as well as the absence of allergies, are prominently noted and easily identifiable.
- Contact sheets for resource development and coordination of service delivery, including disclosure of information.
- Discharge summaries are included as part of the medical record for all hospital admissions, crisis services or institutionalizations that occur while in service delivery as applicable.
- Recipient consent form(s) that address release of information, consent for case management, and recipients' rights and responsibilities;
- Past and present diagnoses and risk factors must be identified; these must be accessible to other treating and/or consulting practitioners. Reasons for diagnostic revision must be documented.
- Medical history, including serious accidents,
- Complete immunization record. For pediatric recipients (age 12 and under) there is a complete record with dates of immunization and administration as applicable.
- Emergency care is documented in a record and includes crisis plans, emergency back-up plans and advance care directives as applicable.
- Areas of risk and factors that initiated case management services.
- Clear reasons for continuation of or exit from case management.

Not all items listed here are appropriate for all types of CM. The Division of MH/DD/SA already has a records and documentation manual that specifies documentation requirements.

3. Progress Notes

Progress notes document case management activities that directly foster achievement of goals identified in the care plan. More than one intervention, activity, or goal may be reported in one service note, if applicable. Progress notes shall contain: ***With efforts to decrease costs and paperwork requirements, is a CM log like we used to be able to use being considered rather than a full service note?***

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- The place of service delivery;
- The date of service;
- The type of contact (face-to-face, phone call, collateral);
- The purpose of the of the contact as it relates to the goal(s) in the Care Plan
- A description of the case management activity
- A description of the result or outcome of the case management activity
- The duration of service per day;
- The case manager's legal signature, including first and last name with title or initials (if applicable) indicating credentials;
- Documentation of all contacts, both direct and indirect, with the recipient, the recipient's support network, providers, and other participants in the plan of care;
- Documentation indicating if the recipient has declined services specified in the care plan.
- Documentation regarding achievement of care plan goals
- Documentation of progress and reasons for continuation of case management.

4. Additional Requirements

- Only standardized forms for Service Plans and Case Management Assessments, without alteration, may be used. ***I/DD already has the standard Person-centered Plan format that is required. Are we also to use a standard CM Assessment form? We suggest that providers continue to develop their own assessment form to meet the standards set in the Division's records and documentation manual.***
- The Targeted Case Management billing code reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

5. Documentation Time Frame Requirements

- Minimum requirements for recipient interaction are: Service contact once per month; Quarterly face-to-face contacts; and an annual assessment or reassessment. More frequent contacts will occur to address the recipients care plan, needs and monitoring services.
- For recipients of Home and Community Based Waivers (CAP Programs), the timeframes for documentation will follow the requirements listed in the Community Care Manual for CAP-Disabled Adults, CAP-Choice or CAP-Child and the CAP Manual for CAP-MR/DD recipients.
- The initial assessment shall be completed within 10 business days of the referral date or documentation must indicate a clear reason for delays.
- The care plan shall be completed within 10 business days of the assessment and reassessment completion date or the delay beyond this period must be clearly documented.
- Progress notes shall be documented within 24 hours of contact. The progress note must be timed and dated as to the time of the contact.

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- The contact sheet, which details a list of all service providers, family contacts, and other informal support persons, shall be completed with the care plan and reviewed and updated as needed, at least every three months.

What is the contact sheet? Will this be a standard new form? Why every 3 months?

- The recipient shall be contacted within 30 calendar days of the care plan completion date to monitor the recipient's progress.
- ***90 day reviews are not necessary in the DD world, and is one of the mandates that needs adjusting. We would suggest moving to 6 months at a minimum.***
- A written notice of termination or change in case management services shall be forwarded to the recipient at a minimum of **thirty calendar days** prior to termination or change. ***Increasing this timeframe would prevent people with I/DD from being "dumped" by CM providers abruptly, especially in the current environment where some providers could provide CM up to the allowed limit and then terminate.***
- The provider shall document any deviations from the above in the progress notes.
- At the time of discharge, the agency shall complete a discharge summary within **thirty calendar days** of discharge.

9.0 Conditions for Enrollment

9.1 Enrollment Agreement

Providers must meet the conditions defined in the Targeted Case Management Enrollment Agreement with DMA that includes:

1. List of persons who have five percent or more ownership in all or any one agency
2. Be owned and operated by individual(s) that have not been convicted of a felony charge related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
3. Be owned and operated by individual(s) that have not been convicted of a felony charge related to the neglect or abuse of a recipient in connection with the delivery of health care services.
4. Certification as a Targeted Case Management provider.
5. Effective management of the medical and/or behavioral health care needs of recipients.
6. Compliance with electronic billing requirements
7. Compliance with requirements for Electronic Funds Transfer (EFT)

9.2 Decertification and Breach of the Enrollment Agreement

If any one of the following conditions is substantiated, the provider may be de-certified by DMA or its designee and enrollment status with DMA cancelled. This list is not all inclusive.

1. Failure to provide core service components
2. Fraudulent billing practices
3. Owner(s) being convicted of a felony charge
4. Failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by DMA or its designee; to make recommended corrections; or both within 30 calendar days
5. Falsification of records
6. Violation of a recipient's confidentiality
7. Employment of staff who do not meet the stated criteria.

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8. Failure of staff to complete the DMA or its designee's mandatory basic training within 90 days of their employment date
9. Failure of staff to obtain required continuing educational units (CEU).
10. Failure to provide case management staff with supervision to meet the recipients' needs
11. Failure to provide documentation that is sufficient to support the provider's billing
12. Failure to implement and enforce a quality improvement program
13. Failure to notify DMA or its designee, within 30 calendar days of proposed changes or five business days of actual changes, of any changes in agency name, director/ownership, mailing address, and telephone number(s), resulting in the designee's or DMA's inability to contact the provider
14. Failure to comply with applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program
15. Failure of a provider to achieve and or maintain the requirements for certification as defined in this policy.

When a provider is de-certified by DMA's designee, due process/appeal rights shall be issued to the provider in accordance with NCGS 150B-23(a) and 130A-24. Following the exhaustion of an appeal and potential disenrollment, the provider must wait for no less than one year to reapply for certification as a Targeted Case Management provider.

9.3 Sanctions: Debbie is going to check this out!

Failure to meet the terms outlined in the provider agreement may result in the imposition of one or more of the following sanctions:

1. A limit may be imposed on the number of recipients the provider may serve.
2. Suspension of new admissions for a period of no more than 6 months;
3. Requirement for pre-payment reviews if documentation is found to be significantly out of compliance; **what does this mean? Debbie will check on wording.**
4. The Care Management Oversight Agency may investigate or refer the provider to DMA Program Integrity (PI) for investigation of potential fraud or for quality-of-care issues.
5. The Provider may be terminated from this enrollment category.

DMA makes the determination to initiate sanctions against the provider and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of a recipient is endangered; or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

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Appendix A: 3.1 Definition of Public Health Entrance and Continuation Criteria

1. Recipient has difficulty, independently or with family (caregiver) support, in obtaining or maintaining basic needs including safe and adequate housing, food, health care, transportation for necessary services,

Providing Basic Parenting – Definition: Primary care-giving parent is unable to protect the child from injury and/or abuse, provide physical care and food, form an ongoing stable relationship with the child, or perceive or respond to the child's changing needs. **Rationale:** The absence of consistent, supportive relationships to help the child cope is an essential feature in Toxic Stress.ⁱ

Stable Housing – Definition: Lack of stable residence or homelessness, indicating a disruption in family life. For example, child's family lives on the street or in a vehicle, or moves from 3.1 Entrance and Continuation Criteria

2. Recipient has difficulty, independently or with family (caregiver) support, in obtaining or maintaining basic needs including safe and adequate housing, food, health care, transportation for necessary services,

Providing Basic Parenting – Definition: Primary care-giving parent is unable to protect the child from injury and/or abuse, provide physical care and food, form an ongoing stable relationship with the child, or perceive or respond to the child's changing needs. **Rationale:** The absence of consistent, supportive relationships to help the child cope is an essential feature in Toxic Stress.ⁱⁱ

Stable Housing – Definition: Lack of stable residence or homelessness, indicating a disruption in family life. For example, child's family lives on the street or in a vehicle, or moves from one dwelling to another with no permanent shelter.

Rationale: Extreme poverty in conjunction with continuous family chaos is a major contributor to Toxic Stress.ⁱⁱⁱ

3. Recipient has care giving or support needs including adequate parenting of a child or adequate parent child bonding.

Maternal Age < 15 years - Definition: Maternal age less than age 15 at the time of delivery. **Rationale:** All children born to adolescent mothers, including healthy term infants, are more likely to have developmental and behavioral problems.^{iv} Parenting adolescent females experience a high rate of depression, tend to their children's needs inconsistently and less effectively compared to older mothers which increase the potential of disorganized attachment and ultimately poor child outcomes.^v

Parent-Infant Bonding - Definition: Primary care-giving parent shows ongoing substantial lack of attention and interest in infant, withdrawal from, avoidance of or over-stimulation of the infant/child associated with misreading the infant's early communication/cues; or parent does not give clear cues to the child. **Rationale:** The absence of consistent, supportive relationships to help the child cope is an essential feature in Toxic Stress.^{vi}

Family and Social Support/Stressor - Definition: Family experiences physical or social isolation, many unsolved concerns, and/or lack of or limited use of social support. For example, they have no family, friends, or other means of support to

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whom they may turn in a crisis, or to meet routine needs. **Rationale:** The absence of consistent, supportive relationships to help the child cope is an essential feature in Toxic Stress.^{vii} Having a network of support helps to strengthen families, and having support from others is associated with positive outcomes for both parents and children.^{viii}

4. Recipient, family or parent of a child has, or has been unable to address, one or more conditions that present risk to the identified recipient, OR presents risk of functional loss; OR presents risk of placement in a more restrictive setting.

Other Family Health Problems – **Definition:** Other family members with diagnosed health issues that negatively affect the infant/child. These include Parental Mental Retardation and Parental Mental Illness. **Rationale:** Parental Mental Illness is a major factor that negatively impacts brain development.^{ix}

Fetal Exposures to Potentially Harmful Drugs During Pregnancy - **Definition:** Maternal use of medications / drugs / substances during pregnancy that are known to adversely affect a child's growth and development, such as anticoagulants, anticonvulsants, alcohol and other recreational drugs. **Rationale:** The fetus is impacted by antineoplastics, anticonvulsants,^x and anticoagulants.^{xi}

Other Specified Family Circumstances - **Definition:** Alcohol or substance abuse, parental history of abuse-neglect, or living with ongoing domestic violence. **Rationale:** The specified family circumstances are major identified factors that negatively impact brain development.^{xii}

Birth Weight 1000-1500 grams – **Definition:** Infant's birth weight is 1000-1500 grams. **Rationale:** Birth weight < 1500 gms is associated with abnormal neuro development.^{xiii}

Gestational Age 28-32 weeks - **Definition:** Infant's gestational age is 28-32 weeks. **Rationale:** Gestational age < 32 weeks is associated with motor impairment.^{xiv}

Potential for Perinatal Asphyxia - **Definition:** Five (5)-minute Apgar score between 0 and 3. **Rationale:** An Apgar Score between 0-3 could be associated with poor neuro outcomes.^{xv}

Hypoglycemia - **Definition:** Infant had serum glucose levels under 25 milligrams per 100 milliliters (25 mg/dl) in the first week of life. **Rationale:** Hypoglycemia has been associated with developmental delays.^{xvi}

Intracranial Hemorrhage - **Definition:** Grades II-IV Intracranial hemorrhage including subdural, subarachnoid, intracerebral, periventricular-intraventricular, and periventricular cystic leukomalacia. **Rationale:** Greater than 30% of ICH are associated with motor or cognitive delays.^{xvii}

Neonatal Seizures - **Definition:** Child has had non-febrile seizures-single, prolonged, or multiple. **Rationale:** Mortality and neurologic sequelae in newborns with seizures remain high.^{xviii}

Suspected Visual Impairment - **Definition:** Infant is not able to make eye contact or to track visually after the first few weeks of life; infant has abnormal eye/eye muscle movements; failed vision screening; or parental or provider concern. **Rationale:** Research on the plasticity of the brain related to hearing and visual perception strongly supports the need for early identification and early provision of services.^{xix}

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Suspected Hearing Loss or Risk Factors for Hearing Loss - **Definition**: Child fails a hearing screening; presents with diagnosed chronic otitis media; physical abnormality of the ear, or oral-facial anomalies; genetic condition with increased risk for hearing loss; parent or provider expresses concerns regarding the child's hearing or other risk factors as per AAP list (see list). **Rationale**: Research on the plasticity of the brain related to hearing and visual perception strongly supports the need for early identification and early provision of services.^{xx}

Well Care - **Definition**: No prenatal care prior to the end of the first trimester of pregnancy for mother, or no more than 1 well visit (including immunizations) during the infant's first six months of life. **Rationale**: Having at least the recommended number of EPSDT visits may shift some health provision from the ED to physicians' offices.^{xxi}

Chronic Lung Disease – **Definition**: Children diagnosed with Bronchopulmonary Dysplasia who present with developmental implications. **Rationale**: At high risk for learning and related developmental difficulties.^{xxii} Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxiii}

Developmental Delay: Developmental Delay - **Definition**: Children whose development is delayed in one or more of the following areas:

- Cognitive Development
- Physical development including fine and gross motor function
- Communication Development
- Social-Emotional Development
- Adaptive Development

The specific level of delay must be:

a. For children from birth to 36 months:

- 1) documented by scores of at least – GM one and one-half standard deviations below the mean of the composite score (total test score) on standardized tests (Check I-TP Eligibility); or
- 2) documented by at least a -GM 20 percent delay on instruments which determine scores in months in at least one of the above areas of development (Check I-TP Eligibility).

b. For children from 36-60 months:

- 1) documented by a 30 percent delay using assessment procedures that yield scores in months, or test performance of two standard deviations below the mean on standardized tests in one area of development; or
- 2) documented by a 25 percent delay using assessment procedures that yield scores in months, or test performance of one and one-half standard deviations below the mean on standardized tests in two areas of development.

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxiv}

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Atypical Development: Atypical Development - Definition: Children who demonstrate significantly atypical behavioral, social-emotional, motor or sensory development, such as:

1. Diagnosed conditions such as :
 - Fluency disorders, such as stuttering. (These are speech disorders characterized by deviations in continuity, smoothness, rhythm, and/or effort with which phonologic, lexical, morphologic, and/or syntactic language units are spoken.)
 - Developmental speech or language disorders that do not meet EI
 - Failure to Thrive of either non-organic (psychosocial) or organic (biological) origin. This is the clinical term applied to an infant or young child who is failing to meet the standards for age.
 - Hyperactivity
 - Attention Deficit Disorders
 - Autism Spectrum Disorders (Check I-TP Eligibility)
 - Severe Attachment Disorders (Check I-TP Eligibility)
 - Other Pervasive Developmental Disorders (Check I-TP Eligibility)
 - Other Behavioral Disorders (Check I-TP Eligibility)
2. Indicators of Social-Emotional and Behavioral Disorders: (Check I-TP Eligibility)
 - Delay or abnormality in achieving emotional milestones such as attachment, parent-child interaction, pleasurable interest in adults and peers
 - Difficulty in communicating emotional needs, or inability to tolerate frustration
 - Persistent failure to initiate or respond to most social interactions
 - Fearfulness or other distress that does not respond to comforting by caregiver
 - Indiscriminate sociability, for example , excessive familiarity with relative strangers
 - Self-injurious or aggressive behavior
3. Environmental situations that raise significant concern regarding the child's emotional well-being, such as exposure to abusive relationships or violence or confirmed abuse, neglect, exploitation or sexual abuse.

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction. ^{xxv}

Chromosomal Anomaly/Genetic Disorders - Definition: Children diagnosed with one or more chromosomal abnormalities or genetic disorders with developmental implications, such as:

- Down syndrome
- Fragile X Syndrome
- Klinefelter Syndrome
- Turner Syndrome
- Cri-du-chat Syndrome

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- familial retardation syndromes

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs and improving family satisfaction.^{xxvi}

Metabolic Disorder - Definition: Children diagnosed with one or more familial disorders with developmental implications, such as:

- PKU
- Diabetes
- Cystic Fibrosis
- Chronic Renal Failure
- Short Bowel Syndrome
- Lysosomal Storage Disorders, such as:
 - Tay Sachs Disease
 - Hurler Syndrome
 - Gaucher Syndrome
 - Metachromatic Leukodystrophy

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxvii}

Infectious Disease - Definition: Children diagnosed with an infectious disease that interferes with daily functioning for greater than three months a year or is likely to require hospitalization of more than one month a year. This may include such diseases as:

- Human Immunodeficiency Virus/AIDS
- Cytomegalovirus (CMV)
- Herpes
- Rubella
- Bacterial Meningitis
- Viral Encephalitis/Meningitis
- Toxoplasmosis
- Syphilis

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxviii}

Neurologic Disease/Central Nervous System Disorders - Definition: Children diagnosed with a disease/disorder known to affect the nervous system, with developmental implications, such as:

- Cerebral Palsy
- Spina Bifida
- Anencephaly
- Myelomeningocele
- Microcephaly
- Macrocephaly
- Hydrocephalus
- Recurrent seizures or Epilepsy

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- persistent Hypertonia
- persistent Hypotonia
- Tuberous Sclerosis
- Neurologic Syndromes such as, Lennox-Gastaut or Sturge-Weber
- Traumatic Brain Injury
- Plegias and Pareses, such as:
 - Triplegia
 - Hemiparesis
- Strokes

Rationale: The health care needs among CSHCN with multiple neurologic conditions may be better served by targeted efforts to improve care coordination.^{xxix}

Congenital Malformation - **Definition:** Children diagnosed with any congenital disorder with developmental implications, such as:

- Congenital Heart Disease
- Certain disabilities requiring orthopedic treatment
- Orthopedic birth defects
- Perthe's Disease
- Certain disabilities requiring plastic surgery
- Repair of Cleft Lip and Cleft Palate
- Tracheoesophageal Fistula
- Missing or Deformed limbs
- Anatomic malformations involving the head and neck
- Fetal Alcohol Syndrome/Alcohol-Related Birth Defects

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxx}

Toxic Exposure, Lead - **Definition:** Children with a confirmed venous blood lead level of 20 micrograms per deciliter (20ug/dl) or greater. **Rationale:** Case finding, case management, and prevention of additional exposure will still be required.^{xxxi}

Visual Impairment - **Definition:** Children diagnosed with a visual impairment that is not adequately corrected with treatment, surgery, glasses, or contact lenses and still impairs daily functioning. **Rationale:** Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxxii}

Hearing Impairment - **Definition:** Children with any loss in hearing, whether permanent or fluctuating, bilateral or unilateral, sensory or conductive that impairs daily functioning. **Rationale:** Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxxiii}

Other Medical Conditions - **Definition:** These medical conditions may affect the child's development and developmental monitoring is appropriate. Examples include:

- Rheumatic Heart Disease
- Scoliosis
- Nephrotic Syndrome

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- Malignancies
- Hemoglobinopathies such as: Sickle Cell Disease or Thalassemia
- Conditions requiring extensive surgery and/or recovery, e.g.
- Bladder Tumor
- Facial Dysostosis Restructure
- Burns (rehabilitative stage, for grafting and associated care)
- Seizures

Rationale: Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing health care costs while improving family satisfaction.^{xxxiv}

5. Recipient is residing in an institutional setting and needs support to return to a less restrictive setting.

No DPH FCM Entrance Criteria.

6. Parent or provider has significant concerns related to a potential developmental delay or disability of a child or other recipient under their care.

Significant Parental Concern - Definition: Parent expresses concern about the child's developmental competence, health or emotional well-being, for which extended follow-along will be essential to address the present problem. Rationale: Research shows that parents' concerns are as accurate as quality screening tests and that parents are equally able to raise important concerns regardless of differences in education and child-rearing experience.^{xxxv}

7. Recipient has experienced or is at risk for (based on family or situational history or reporting) domestic partner or family violence, abuse, neglect or exploitation.

Potential for Child Maltreatment/Potential for Atypical Development - Definition: A child is at risk for child maltreatment/atypical development when there is evidence that the family system is stressed by a combination of risk factors (child and/or family) outweighs the protective factors.

Child Risk Factors include:

- Difficult temperament/behavior disorders
- Disabilities

Family Risk Factors include:

- Single Parent
- Young/Adolescent Parent
- Low Educational Level
- Limited Cognitive Skills
- Childhood history of Maltreatment
- Foster care
- Negative Perception of Children

- Negative Affect
- Lack of Empathy

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- Depression
- Personal Stress/Distress
- Substance Abuse
- Social Isolation
- Lack of Resources (e.g., childcare, financial resources)
- Instability/Disruptions
- Large number of children
- Family Conflict
- Domestic Violence
- Problematic Parent-Child Interactions

Rationale: Strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.^{xxxvi} Recurrent physical or emotional abuse and/or chronic neglect is a major contributor to Toxic Stress.^{xxxvii}

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