

	DIVISION OF CHILD AND FAMILY SERVICES Children's Mental Health
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ATTACHMENTS:	Attachment A: Children's Uniform Mental Health Assessment Attachment B: Targeted Case Management Assessment Attachment C: Strengths, Needs and Culture Targeted Case Management Assessment Questions, Early Childhood Attachment D: Strengths, Needs and Culture Discovery, Children Above Early Childhood Age Attachment E: Targeted Case Management Care Coordination Plan Attachment F: DCFS Freedom of Choice Documents

I. POLICY

It is the policy of the Division of Child and Family Services Children's Mental Health Services to accurately document targeted case management activities, including assessment and care coordination planning.

II. PURPOSE

The purpose of this policy is to describe the requirements for documentation of targeted case management activities, including assessment; strengths, needs and cultural discovery and care coordination planning.

III. DEFINITIONS

Assessment: Activity to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social or other services. Includes: Taking client history, identifying the needs of the individual, completing related documentation, gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual and family. Must include:

1. A comprehensive identification of the individual's strengths and preferences, and consider the individual's physical and social environment

2. Periodic reassessment to determine whether an individual's needs and/or preferences have changed

Care Coordination Plan: A written individualized plan developed jointly in a Child and Family Team that specifies the goals of providing case management to the child and actions to address the medical, social, educational and other services needed by the child including:

- Ensuring the active participation of the child (as developmentally appropriate) and family
- Working with the child, family and others to develop such goals and identify a course of action to respond to the assessed needs of the child

Case Management: An activity that assists individuals in gaining access to necessary care and services appropriate to their needs. It is the individual's access to care and services that is the subject of case management, not the individual.

Case Management Services: Services that assist individuals in gaining access to needed medical, social, educational and other services. Case management services include:

- Assessment
- Development of a specific care coordination plan
- Referral and related activities
- Monitoring and follow-up activities

Case management services do not include the direct delivery of underlying medical, educational, social or other services to which an individual has been referred.

DAP: A form of case notation by policy description to include:

- Data (observable, concrete, what was said by the client)
- Assessment (conclusions, analysis of the data)
- Plan (the intervention agreed upon by the case manager and the client and parent/guardian)

Documentation: Providers must maintain case records that document, for each individual receiving case management services, the following:

- Name of the individual
- Dates of case management services
- Name of the provider agency
- Person chosen by the individual to provide the case management services
- Nature, content, units of case management services received
- Whether the goals specified in the care plan have been achieved
- Whether the individual has declined services in the care plan
- Timelines for providing services and reassessment
- Need for, and occurrences of, coordination with case managers of other programs

Freedom of Choice: The individual's right to choose freely among those individuals or entities that the state has found qualified and eligible to provide targeted case management services in a community setting. An individual has the right to decline services in the care plan.

Health Insurance Portability and Accountability Act (HIPAA): Federal regulation addressing healthcare issues related to the standardization of electronic data, the development of unique health identifiers, and security standards protecting confidentiality and the integrity of health information.

Monitoring and Follow-Up Activities: Activities and contacts that are necessary to ensure that the care coordination plan is effectively implemented and adequately addresses the needs of the eligible

child. Monitoring and follow-up activities may be with the child, family members, providers or other entities. These activities may be conducted as frequently as necessary to help determine matters such as:

- Whether services are being furnished in accordance with the child's care plan
- Whether the services in the care plan are adequate to meet the needs of the child
- Whether there are changes in the needs or status of the child. If there are changes in the needs or status of the child, monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers

Reassessment: Assessment activity to review and re-determine service needs including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Includes: updating client history, identifying the needs of the individual and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete updated assessment of the individual and family. A reassessment must include a comprehensive identification of the individual's strengths and preferences, and consider the individual's physical and social environment. Complete assessments must be completed at least annually to maintain eligibility for targeted case management services

Referral and Related Activities: Activities that help an individual obtain needed services, including:

- Activities that help link the eligible individual with medical, social, educational providers
- Activities that help link the eligible individual with other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Severe Emotional Disturbance (SED): The determination made by a Qualified Mental Health Professional within the scope of their practice and further defined as:

- Persons from birth through 48 months who currently or at any time during the past year (continuous 12-month period) have a:
 1. DC: 0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or
 2. DC: 0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or
- Persons from 4 to age 18 who currently or an any time during the past year (continuous 12-month period) have a:
 1. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the DSM (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and V codes, unless they co-occur with a serious mental disorder that meets DSM criteria); and have a
 2. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however, may vary in terms of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefits of treatment or other support services are included in this definition.

Targeted Case Management Services: Case management services furnished to particular defined target groups or in any defined locations without regard to requirements related to statewide provision of services or comparability. The DCFS target group includes children and adolescents with a determination of a severe emotional disturbance.

IV. PROCEDURES

General Procedures for Assisting Children and Families Accessing Targeted Case Management from DCFS Children's Mental Health Programs

A. Screening

1. DCFS Children's Mental Health Intake Coordinator or other qualified professional screens the family's or custodial case manager's request for services and matches the family with a Targeted Case Manager.
2. Targeted Case Manager:
 - a. Ensures child meets eligibility requirements for targeted case management services by recording a Severe Emotional Disturbance determination made by a Qualified Mental Health Professional;
 - b. Reviews clinical assessment if available;
 - c. Completes a Strengths, Needs and Culture Targeted Case Management Assessment, utilizing the Strengths, Needs and Culture Case Management Assessment Questions; and
 - d. Includes demographic information as part of the assessment, and makes entries into the case record as prescribed by agency policy and protocol, including the use of the DAP format for case/progress notes.

B. Clinical Assessment

1. All children and youth must have a clinical comprehensive assessment by a DCFS or community Qualified Mental Health Professional. DCFS QMHPs will utilize the Children's Uniform Mental Health Assessment. Community providers may use the Uniform Mental Health Assessments or their own assessment documents and procedures.
2. The clinical assessment will generate the identification and documentation of client history, present concerns, a mental status examination, diagnoses and recommendations. A determination of severe emotional disturbance will be made.
3. The clinical assessment information will be placed in the medical record by entering the information into Avatar with a brief corresponding progress note.
4. If a recommendation is made for targeted case management services and the family chooses to receive these services, either the clinician or a targeted case manager will complete a Strengths, Needs and Culture Targeted Case Management Assessment.

C. Targeted Case Management Assessment

1. Targeted case manager interviews the child and family to complete the Targeted Case Management Assessment including the following elements:
 - a. Family demographics
 - b. Family strengths
 - c. Social Life Domain
 - d. Emotional Life Domain
 - e. Medical Life Domain
 - f. Educational Life Domain
 - g. Other Domain to include child/family resources and needs in any other areas not previously addressed
 - h. Summary to include child and family preferences for outcome of services
 - i. Must be completed within ten days of the first case management contact and prior to the completion of the Care Coordination Plan

D. Strengths, Needs, Cultural Discovery

1. The Strengths, Needs and Cultural Discovery may be guided by the Strengths, Needs and Culture Questions that include the following areas for each domain:

- a. Social Life Domain – child/family living situation; family/friends/informal supports; family dynamics; financial, legal, spiritual well-being; and any relevant child and family history
 - b. Emotional Life Domain – child/family emotional and behavioral life; family relationships; peer interactions; emotional/behavior concerns; spiritual well-being; and any relevant child and family history
 - c. Medical Life Domain – child/family medical and health concerns, medical needs and resources and any relevant child and family history
 - d. Educational Life Domain – education/vocational needs and resources
 - e. Other Domain – child/family resources and needs in any other areas not previously addressed, especially their perception of immediate safety issues, including any relevant child and family history.
2. Each of the Life Domain elements will yield a description of the child and family’s needs and the care coordination recommendations for their particular situation. This will provide a basis for the completion and documentation of Targeted Case Management Care Coordination Plan.
 3. Must be completed by all facilitators that provide high fidelity wraparound case management and reviewed by the child and family prior to the initial Child and Family Team meeting.

E. Targeted Case Management Care Coordination Plan

1. The designated targeted case manager completes the initial Targeted Case Management Care Coordination Plan with the child as age and developmentally appropriate, the family and other identified support members of a Child and Family Team. Included are the following elements:
 - a. Child and family name
 - b. Team facilitator name
 - c. Child and family perception of current status
 - d. Goals based upon case management needs for the child and family
 - e. Criteria for discharge defined as the family’s preference for outcomes of service
 - f. Measurable objectives and the action steps toward the achievement of Social, Emotional, Medical, Educational and Other specific objectives
 - g. Progress toward each objective, including a rating of Active, Postponed, Achieved or Discontinued
2. The targeted case manager will enter the Care Coordination Plan into the child’s electronic record.

F. Freedom of Choice Form

1. The child’s parent/guardian signs a Freedom of Choice form thereby indicating their choice to receive or decline targeted case management services and their choice of case managers and their consent to receive these services.
2. The Freedom of Choice form will be entered into the child’s record.