Division of Disability and Rehabilitative Services
Bureau of Developmental Disabilities Services

# Quality Guide

## for Case Managers and Case Management Organizations

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# Introduction

Case management is the foundational service on which all other supports and services are coordinated. Case managers are tasked with getting to know an individual, parent(s) of minor children, or legal representative(s), as applicable, and supporting them to navigate complex systems, connecting them to community resources, exploring opportunities for supports through technology, assisting in building relationships, and leveraging the personal strengths of the person and those who support them. We offer this quality guide to assist case managers in knowing and understanding the intricacies of providing quality case management.

# Acronyms in the Quality Guide

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| BDDS | Bureau of Developmental Disabilities Services |
| BMR | Budget Modification Request – Short Term |
| BQIS | Bureau of Quality Improvement Services |
| BRQ | Budget Request Questionnaire – Long Term |
| BSP | Behavior Support Plan |
| CAP | Corrective Action Plan |
| CFR | Code of Federal Regulations |
| CIH | Community Integration and Habilitation Waiver |
| CMO | Case Management Organization |
| CMS | Centers for Medicare and Medicaid Services |
| CRR | Case Record Review |
| CRMNF | Comprehensive Rehabilitative Management Needs Facility |
| CtLC | Charting the LifeCourse |
| DDB | Disability Determination Bureau |
| DDRS | Division of Disability and Rehabilitative Services |
| DFR | Division of Family Resources |
| EMN | Extensive Medical Needs |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment |
| ESN | Extensive Support Needs |
| FSSA | Family and Social Services Administration |
| FSW | Family Supports Waiver |
| HCBS | Home and Community Based Services |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| IAC | Indiana Administrative Code |
| IC | Indiana Code |
| ICMO | Initial Case Management Only Service Plan |
| I/DD | Intellectual/Developmental Disability |

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|---|---|
| IFUR | Incident and Follow-Up Reporting Tool |
| IHCP | Indiana Health Coverage Programs |
| IIDC | Indiana Institute on Disability and Community |
| IOT | Indiana Office of Technology |
| IR | Incident Report |
| IRUA | Indiana Resource Use Agreement |
| IST | Individualized Support Team |
| MAPS | McGill Action Planning System |
| MFP | Money Follows the Person (in conjunction with CIH waiver) |
| MI | Mental Illness |
| NF | Nursing Facility |
| OBA | Objective Based Allocation |
| OMPP | Office of Medicaid Policy and Planning |
| PA | Prior Authorization |
| PATH | Planning Alternative Tomorrows with Hope |
| PCISP | Person-Centered Individualized Support Plan |
| PDSA | Plan, Do, Study, Act |
| POCOS | Provider Owned or Controlled Setting |
| PRE-ETS | Pre-Employment Transition Services |
| RFA | Request for Authorization |
| RHS | Residential Habilitation and Support |
| RID | Recipient Identification Number |
| SDM | Supported Decision Making |
| SFC/AFC | Structured Family Caregiving / Adult Foster Care |
| SFL | Substantial Functional Limitation |
| SGL | Supervised Group Living |
| SPD | State Personnel Department |
| SPH | State Psychiatric Hospital |
| SSA | Social Security Administration |
| VR | Vocational Rehabilitation |

## *A Word about Words*

*Words are singularly the most powerful force available to humanity.... Words have energy and power with the ability to help, to heal, to hurt, to harm, to humiliate, and to humble.*

*~Yehuda Berg*

Providing person-centered and strengths-based case management, including the use of respectful language, is essential to supporting individuals with intellectual and developmental disabilities with dignity and recognizing their many abilities. The words we use to talk about individuals should emphasize their capacity for self-determination and communicate respect, dignity, empowerment, and a supportive environment. Individuals should never be defined by their disability, but by their accomplishments and contributions to their communities. The use of outdated or inaccurate descriptors can perpetrate negative stereotypes and make it difficult to build trust and craft a meaningful Person-Centered Individualized Support Plan (PCISP) that details the individual's hopes, dreams, and desires for their best life.

There are words and phrases our community has traditionally used in everyday language that are offensive to the individuals we support. They want to be seen and spoken to/spoken of just like individuals without disabilities. When we talk about them, we should use their names or use the word "individual" if speaking generically. The term "individual" recognizes that everyone is different and has unique abilities, preferences, goals, and needs. The individuals we support should never be referred to as "client", i.e., my client needs help with transportation." Instead, we should use the individual's name and say, "Robert needs help with transportation." Words like clients, consumers, or patients are used to describe specific relationships between people. For example, if you get services from an attorney, you are typically described as a client. When you go shopping, you are described as a consumer. And, when you go to your doctor, you are described as her patient. Each of these terms used in context and applied based on activity and relationship is acceptable language. The problem arises when these terms are applied to individuals without connection to what they are doing or as a general description. Instead of a description of activity or relationship, the terms are being used to describe who people are, and it labels them as being different than other people. No one is a "consumer" 24 hours a day! Think before you describe someone.

Individuals are supported by case managers and providers, but they do not belong to them. Terms like "my people" denote ownership and property, rather than valued community members.

The individuals we support have an "Individualized Support Team" not an "interdisciplinary team." The concept of an interdisciplinary team originated at a time when people with intellectual disabilities lived in institutions. It was believed that individuals required many clinicians and professionals to help them. Thinking on this has evolved over time and we now customize support to each individual's needs and preferences. Using the term "Individualized Support Team" describes the role and recognizes that there are a wide range of people – not just paid professionals – who provide support, including family, friends, and community members.

The individuals we support live in houses and apartments – homes – just like everyone else. And just like us, people with disabilities live by themselves, with their friends, roommates, or with their families in an apartment or a house. Using the term "supported living setting" to mean a house or apartment that is shared with other individuals indicates it is not the individual's home, but one specific to a funding stream for supports.

Using person first language means applying the same social rules of language that we use with everyone else when we are talking with and about individuals with intellectual and developmental disabilities. By challenging ourselves to use these same traditional patterns in our everyday interactions, we will naturally become more respectful and supportive of people with disabilities.

Identity first language emphasizes that the disability plays a role in who the person is and reinforces disability as a positive culture identifier. It is important to note that whether a person with a disability prefers person first or identity first language is not universal. It is important to be respectful and individualized therefore the best thing to do when you are unsure is to ask the person what they prefer.

## *Core Competencies*


As part of the Case Management Innovation project, BDDS has adopted core competencies to enhance the provision of quality case management throughout the state of Indiana. All case management organizations will align their training and performance measures with these core competencies to ensure person-centered, strength-based, and consistent case management services are provided to all individuals.

### Why Core Competencies?

The Indiana BDDS Core Competencies for case managers were developed to:

- Ensure quality case management;
- Define foundational competencies to clarify the role and purpose of case managers;
- Develop certification examination by competency area; and
- Enhance consistency statewide in the professional development of case managers and the delivery of case management services.

The core competencies should set the tone, expectations, and provide the foundational aspects and values that drive case management. They are ***not*** a quality measurement tool, nor are they intended to change the core functions of case management.

### CORE COMPETENCY: FOUNDATIONAL VALUES, BELIEFS, AND SKILLS

Case managers are knowledgeable and adaptable professionals, demonstrating ethical behavior and professionalism across all core competency areas.

#### Case Manager Requirements:

The single most important element of quality case management is building relationships. When strong relationships are developed and trust exists between all people involved with the individual supported,

the quality of supports and services improves. Yet, building relationships is not a separate and distinct activity; it is integral to each function the case manager performs.

### Sub-Categories:

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| Disability Values and Knowledge: | Understands and articulates the philosophies and practices related to supporting individuals with intellectual and/or developmental disabilities, *and* the various systems that establish and ensure services and supports align with these paradigms. |
| Self-Awareness: | Recognizes and responds to any personal or professional values or behavior that may interfere with the ability to provide supports in an ethical, unbiased, and culturally competent manner. |
| Professionalism: | Continually develops and utilizes personal and professional skills in a responsible and responsive manner to meet both regular and unexpected work tasks. |

### Knowledge, Skills, and Attitudes:

- Disability Values/Paradigms: Integrates the philosophical values related to supporting individuals with intellectual and/or developmental disabilities into all core competency areas.
- Disability Service Infrastructure: Understands the formal services and service structures at federal, state, and local levels, including both internal agency and external service delivery practices and standards.
- Best Practice: Identifies and implements evidence-based intervention approaches to promote well-being in all life domains.
- Ethics: Behaves and practices ethically, adhering to all relevant laws and regulations and respecting the rights of the individual supported.
- Cultural Competence: Respects the cultural needs and preferences of each individual, to include the use of verbal and written communication that is understandable to all.
- Self-Awareness: Recognizes personal biases and prevents them from interfering with work tasks or relationships.
- Professional Judgement and Critical Thinking: Utilizes personal strengths and decision-making skills to prioritize work tasks, seeking feedback and assistance from appropriate others when needed.
- Professional Development: Maintains qualifications and develops additional capacities through accessing opportunities for personal and professional growth.
- Personal Professionalism: Demonstrates the qualities of a responsive and responsible employee in personal appearance, work behavior, task completion, and team collaboration.

## CORE COMPETENCY: ENGAGEMENT

The case manager develops and maintains a relationship with the individual and their IST that facilitates effective communication and collaboration to promote well-being.

### Case Manager Requirements:

Case management services include comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

- Taking the individual's history;
- Identifying the needs of the individual, and completing required documentation; and

- 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.

### Sub-Categories:

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| Relationship-Building: | Establishes collaborative, professional relationships that are built on mutual respect and trust with the individual and others on the IST. |
| Communication: | Uses positive and respectful verbal, non-verbal, and written communication in a way that can be understood and facilitates coordination between all members of the team. |
| Holistic Perspective of the Individual: | Identifies and addresses the physical, social, emotional, behavioral, and spiritual well-being of the individual across all life stages and quality of life areas. |

### Knowledge, Skills, and Attitudes:

- Understands and effectively communicates with the individual and IST the roles and responsibilities of the team.
- Shows genuine concern for the individual's welfare and future.
- Continuously demonstrates personal integrity, honesty, and sincerity.
- Demonstrates respect for individual's perceptions, learning style, personal being, and culture.
- Possesses confidence in working with strong emotions and the ability to self-manage to facilitate a collaborative team and mediate potential disagreements.
- Accurately interprets and utilizes tone of voice and body language.
- Uses language appropriate and respectful to the individual and team (non-technical, non-jargon).
- Demonstrates effective communication skills, including active listening (summarizing, paraphrasing, reiterating, etc.) and conveying accurate information in a manner that can be understood.
- Demonstrates basic professionalism and courtesy – such as timeliness, responsiveness, and follow through.
- Utilizes basic team facilitation skills, including problem solving, action planning, and leading a meeting.
- Utilizes technology to accommodate individual needs and ensure efficiency.
- Facilitates meaningful conversation through awareness and utilization of a variety of tools and strategies and relevant language supports (accessible language, adaptive communication, use of interpreter, etc.).
- Understands and uses person first language in all interactions.

## CORE COMPETENCY: EMPOWERMENT

The case manager enhances the individual's capacity for self-direction through ensuring awareness of rights and responsibilities and facilitating access to resources.

### Case Manager Requirements:

The case manager develops and periodically reviews/revises the PCISP based on the information collected through the assessment, which includes the following:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual.

- Includes activities such as ensuring the active participation of the eligible individual and working with the individual and the individual's authorized health care decision maker, if applicable, and others to develop those goals.
- Identifies a course of action to respond to the assessed needs of the individual.

### Sub-Categories:

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| Advocacy: | Supports the individual to continually increase self-direction by equipping him/her to speak for himself/herself with providers, family members, community, and others *and* by promoting systems change that removes barriers to self-determination. |
| Education: | Educates the individual and all IST members regarding individual rights and responsibilities *and* resources and options, including their related benefits and risks. |
| Capacity Building: | Increases the individual's autonomy, resiliency, and skill sets by identifying and providing the appropriate level of support in each circumstance. |

### Knowledge, Skills, and Attitudes:

- Identifies and builds upon the strengths and resources of the individual and support team.
- Possesses a basic understanding of various systems, and applicable policies and procedures.
- Understands developmental stages and the life cycle and applies knowledge to normalize experiences and educate regarding life possibilities.
- Bridges and connects to resources across all life stages and quality of life areas.
- Advocates on behalf of the individual with the IST or other stakeholders when necessary.
- Facilitates self-exploration and self-advocacy to enhance skills of self-determination.
- Assesses the specific information needed and provides education that is culturally and developmentally appropriate and sensitive to learning style.
- Understands and clearly articulates individual rights and acts when rights are infringed upon.
- Understands and clearly articulates resources a person has when rights are violated, or a person is dissatisfied with the quality of services (i.e., complaints and appeals).
- Provides impartial information about the array of options and ensures informed choice.
- Identifies social, political, economic, and cultural factors that affect the individual, and assists the individual to identify external barriers that may affect their ability to live a self-directed, self-determined life and/or access needed resources.
- Promotes the individual's self-advocacy skills and links to opportunities for enhancement.
- Develops alliances with groups working for change.

## CORE COMPETENCY: EXPLORATION AND PLANNING

The case manager engages the individual and their IST in a person-centered planning process that results in an integrated and comprehensive plan that is reflective of and responsive to the strengths, interests, needs, and desired outcomes of the individual in all areas of their life.

### Case Manager Requirements:

The case manager develops and periodically reviews/revises the PCISP based on the information collected through the assessment, which includes the following:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual.
- Includes activities such as ensuring the active participation of the eligible individual and working with the individual and the individual's authorized health care decision maker, if applicable, and others to develop those goals.
- Identifies a course of action to respond to the assessed needs of the individual.

## Sub-Categories:

| | |
|---|---|
| Exploration and Assessment: | Facilitate identification and articulation of personal goals, as well as supports and services that will assist the individual to achieve those goals. |
| Plan Development: | Collaboratively develop a person-centered plan that is a comprehensive reflection of the individual with a related plan for services and supports. |
| Implementation: | Assist the individual to set goals, and to identify and make informed choices regarding strategies to achieve their goals. |

## Knowledge, Skills, and Attitudes:

- Facilitates collaboration and discussion.
- Identifies trends in observations and conversation.
- Utilizes informal assessment techniques, such as asking open-ended questions, reviewing case notes, etc. to gather meaningful information.
- Utilizes formal assessment tools to gather information.
- Identifies strengths, interests, needs, and areas for learning and growth.
- Consolidates collected information and collaboratively establishes a plan that addresses major concerns and major areas for learning and development.
- Facilitates the planning process so that an integrated plan that encompasses the family context, relevant history, current situation, future goals, etc. results.
- Facilitates planning for both the long-term and the short-term.
- Designs plans that meet regulatory requirements but remain relevant and sensitive to the individual.
- Utilizes and reflects the individual’s voice when articulating meaningful, attainable, measurable, and specific goals and outcomes.
- Identifies integrated resources, supports, and/or services and facilitates the development of goal to help the individual to achieve identified resources.
- Monitors for progress, reassessing, and responding as necessary.
- Understands awareness of circumstances necessitating revisions to the plan, such as changes in the individual’s condition, lack of response to the plan, preference changes, transitions across settings, etc.
- Presents anticipatory guidance by facilitating a proactive conversation related to the potential experiences and related expectations, needs, and desired outcomes at each stage of life.

## CORE COMPETENCY: CONNECTING TO INTEGRATED SUPPORTS AND SERVICES

The case manager assists the IST to cultivate an array of resources, including paid and non-paid supports that provide the individual opportunities for integrated supports that address both what is important to and important for the individual.

### Case Manager Requirements:

The case manager completes referral and related activities to help the individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the PCISP.

### Sub-Categories:

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|---|---|
| Navigate: | Supports the individual to identify and access needed resources, supports, and/or services relevant to the current and upcoming life stage and the cultural context of the individual. |
| Inform: | Explains services and service terms to the individual being supported and the IST. |
| Network: | Develops and leverages personal and professional knowledge and relationships that will facilitate opportunities for the individual to make connections and access integrated supports. |
| Negotiate: | Assists the individual to overcome barriers to receive needed services. |

### Knowledge, Skills, and Attitudes:

- Demonstrates an awareness of a variety of resources available, including eligibility, relevant policies, and procedures, the "right" contacts, etc.
- Provides multiple options for resources whenever possible to ensure individual choice.
- Models strategies for and supports the individual/family to make informed choices.
- Assesses the level of support needed and enhances the capacity of the individual (or family) to avoid creating dependence.
- Demonstrates the ability to look forward and prepare for life stage transitions by anticipating and identifying expectations, needs, and desired outcomes during each stage of life and during transitions.
- Researches, locates, and refers to resources.
- Connects the individual and stakeholders to other organizations and groups.
- Develops a system for remaining aware of changing resources.
- Encourages and assists the individual in connecting with others in a valued social role.
- Supports the individual to identify, connect to, and access recreational, social, and learning opportunities valued in his/her culture.
- Supports the individual to connect to friends and live included in the community of their choice.
- Acts as mediator or liaison when necessary.
- Demonstrates an ability to problem solve and resolve conflict.
- Demonstrates an awareness of technological supports.
- Demonstrates networking skills and builds relationships in the community that can be leveraged to enhance the resources available to (or experiences of) individuals and families.
- Facilitates access to an array of identified resources and supports to meet the individual's needs and personal outcomes, prioritizing the use of resources available to any individual in the community prior to state and federal disability specific funding.

## CORE COMPETENCY: FACILITATATION OF LONG-TERM SERVICES AND SUPPORTS

The case manager facilitates the exploration and acquisition of paid supports from a variety of funding sources and monitors for quality services that maximizes the use of support dollars to meet identified goals and minimize risks.

### Case Manager Requirements:

Case managers monitor and perform follow-up activities, including activities and contacts that are necessary to ensure that the PCISP is effectively implemented and adequately addresses the needs of the eligible individual, and which may be, with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's PCISP.
- Services in the PCISP are adequate.
- There are changes in the needs or status of the eligible individual.
- Monitoring and follow-up activities include making necessary adjustments in the PCISP and service arrangements with providers.

### Sub-Categories:

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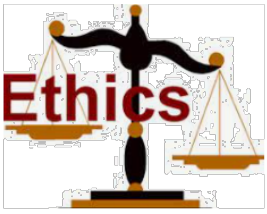
|---|---|
| Gather and Assess Information: | Formally and informally gathers, reviews, and analyzes information from a variety of sources, utilizing the results to track progress and collaboratively guide support work. |
| Monitor and Manage Risk: | Objectively identifies potential for positive and negative outcomes, working to maximize individual progress and satisfaction and minimize/prevent abuse, neglect, exploitation, or other negative outcomes. |
| Resource Management and Stewardship: | Facilitates the utilization of available support dollars from a variety of funding sources to allow for timeliness of service delivery in accordance with an individual's justified needs and identified goals. |

### Knowledge, Skills, and Attitudes:

- Understands and explains disability specific funding mechanisms and eligibility for federal, state, and local resources and how to integrate with other community supports.
- Understands and explains types of long-term service and supports, and the role of providers in supporting an individual throughout the lifespan.
- Explains roles, expectations, rights/regulations, and responsibilities governing the relationship between the disability service providers and the individuals receiving supports and ensures understanding between parties.
- Interprets information from formal and informal assessments to justify services and supports needed to reach identified outcomes.
- Demonstrates objectivity and discernment that facilitates unbiased provider relationships to facilitate informed choice regarding services and supports received and from whom.
- Monitors progress toward personal outcomes and quality of life in all domains, quality of service, and environments/settings through regular observation, conversation, documentation review, and formal monitoring.
- Identifies, communicates, documents, and responds appropriately to issues found during monitoring and/or reported by the individual or team members.
- Recognizes the signs of abuse, neglect, and exploitation, reports incidents according to applicable regulations and procedures, and completes appropriate actions to ensure immediate health and safety.
- Identifies serious events and completes appropriate follow-up action.

- Accurately and thoroughly completes all documentation that includes, but is not limited to, eligibility, monitoring, and resolution of identified issues, etc.
- Facilitates authorization of paid services according to specified time frames.
- Ensures availability of service provision through completion of authorization processes according to specified time frames.

## *Ethical Case Management*




Legal and ethical principles, although often similar, can at times conflict. Legal duties are the minimal acceptable standards. Ethical standards exceed legal duties and represent a professional standard. In this section case managers will learn the ethical practices to be followed in the provision of BDDS HCBS waiver case management.

### What are the Ethical Practices of Case Managers?

#### Beneficence

Always do good. Treat individuals, parents of minor children, legal representatives, providers, and all others with dignity, respect, and cultural sensitivity without regard to race or ethnicity, gender identity, religion (or no religion), or socioeconomic status. Case managers are to support individuals and their Individualized Support Team to identify, select, obtain, coordinate, and utilize paid services, and natural and integrated supports in a manner that enhances their independence and integration into community life in a manner consistent with their lifestyle preferences and needs.

#### Non-malfeasance

Do not purposefully do harm. Avoid any conflict of interest that would result in putting the individual's needs and desires after others'. Do not give or receive gifts of any kind from the individual, parent(s) of minor children, legal representatives, or a provider; express religious, social, or political beliefs. Case managers should never act unethically out of fear of being "fired" by an individual, parent of a minor child, or legal representative, as applicable.

#### Autonomy

Promote the rights of the individual in their efforts to identify and clarify their good life and related outcomes regardless of their disability or support needs. When there is disagreement between the individual and parent(s) of minor children or legal representative, as applicable, the case manager must be able to balance the needs of both. *Additional guidance is available under Balancing Competing Priorities.*

#### Justice

Assist individuals to obtain what they deserve, in a good way. Case managers are responsible for learning and maintaining knowledge of BDDS HCBS waiver services and community resources as well as facilitating informed choice, consent, and decision making.

#### Fidelity/Veracity

Do not make promises you cannot keep and always tell the truth. Case managers shall not falsify documentation or violate Federal regulations, Indiana Code, Indiana Administrative Code, FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals, including written agreements and the HCBS Provider Reference Module.

### Solicitation

Providers, including providers of case management services, shall not engage in uninvited solicitation of potential clients, who are vulnerable to undue influence, manipulation, or coercion. When a case manager decides to separate from their current employer, he or she may share that information with the individuals they support. **If asked** (uninvited) by an individual, parent(s) of a minor child, or legal representative(s), as applicable, where they are going to work, the case manager may share the name of their new employer without it being viewed as solicitation in violation of 460 IAC 6-36-2(15). Case managers are encouraged to follow up with their employers regarding any company policies on this issue.

Separating case managers may not take any individuals' files, protected health information, or personal identifying information with them when they leave, whether or not the individual, parent(s) of a minor child, or legal representative, as applicable, has indicated an interest in transferring to the case manager's new case management organization.

### Employment by Other Waiver Provider Agencies

Case managers are discouraged from working as a case manager and for a provider of other BDDS HCBS waiver services. In doing so, the case manager may be influenced, intentionally or otherwise, to make referrals to the provider agency based on his or her employment.

## *Professionalism*


Professional case managers prepare themselves to meet their professional standards and obligations, and actively develop and enhance their professional expertise. They prepare and obtain supervisor support to ensure competence as they build their own skills. Professional case managers ensure they understand their duties, how to carry out those duties, and provide their services in an effective and efficient manner.

### Interactions with Individuals, Parents of Minor Children, and Legal Representatives

Case managers demonstrate professionalism in working with individuals, parents of minor children, and legal representatives through:

Commitment to Individuals: Case managers have a responsibility first and foremost to the interests and well-being of the individuals they support.

Empowerment for Individuals: Case managers have a responsibility to help empower individuals to explore options that promote movement toward their self-identified good life.

Cultural Competence and Social Diversity: Case managers will respect, support, consider, and be sensitive to, cultural differences at all times. Case managers will strive to become knowledgeable about each individual's culture and respect the strengths in all cultures.

Respect: Case managers have a responsibility to assure that all verbal or written communication with or about an individual is strengths-based and guided by the understanding that all people have the right to be treated with dignity and respect.

Person-Centered Practices: Case managers must protect an individual's right to participate in decision making and that information is presented in the individual's primary language or communication method. This includes participation in IST meetings and face-to-face visits. When a conflict exists between the

individual and parent(s) of a minor child or legal representative, as applicable, the case manager will work to resolve the conflict in a manner that balances the individual's rights and interests with the desires of the parent or legal representative.

Informed Choice: Case managers must provide comprehensive, accurate information that provides the individual, parent(s) of minor children, or legal representative(s), as applicable, with the knowledge to make decisions for themselves and be supported in that decision.

Privacy and Confidentiality: Case managers must protect the individual's right to privacy at all times. Release of information and documentation to potential providers requires written authorization of the individual, parent(s) of a minor child, or legal representative(s), as applicable, dated within one year. Requests for the production of documentation must be forwarded to FSSA BDDS Documentation Requests.

## Interactions with Individualized Support Teams (ISTs)

Case managers demonstrate professionalism in working with ISTs through:

Cooperation: Case managers shall treat other service providers and members of individuals' ISTs with respect and fairness. They should interact with the IST effectively and actively participate with the IST, using their knowledge and expertise to contribute to the development of services and supports that are meaningful to the individual and move them toward their vision of a good life.

Conflicts or Disputes: In the event a case manager has a conflict or dispute with another IST member, the case manager must ensure the individual is not brought into the dispute, is not put to any disadvantage, and is not used to advance either position in the conflict.

Case Noting: When case noting interactions with IST members, case managers must demonstrate fairness and respect. Case notes should never include the case manager's negative personal opinion, or derogatory comments, when describing an IST member or interactions with them. Remember – just the facts.

## Interactions with BDDS

When questions arise, case managers will work within the structure of their case management organization to obtain the needed information. If the question cannot be addressed through use of the Quality Guide or it's addenda, supervisors may contact the BDDS Case Management Organization Liaison with case management questions, email BQIS.Help@fssa.in.gov with general policy questions or submit a Jira ticket for technology systems questions. Case management organizations will have the opportunity to address global issues during their meetings and touchpoints with BDDS. Case managers and case management supervisors are strongly advised against answer shopping with the same questions to various sources when an answer has been given.

## Standards for all Professions

In addition to the standards listed above, there are basic standards of professionalism for all employee types. Adherence to these standards can help create better relationships between case managers and the individuals they support and their ISTs.

Rules and Expectations: Understand what is expected of you, follow the rules, and complete all tasks timely.

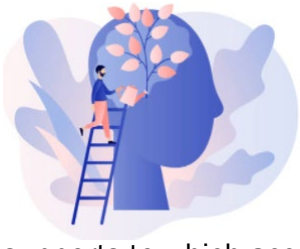
Personal Responsibility: Take credit for successful activities, admit your mistakes, and follow-through on promises made and tasks assigned.

Ethics: Follow DDRS/BDDS/BQIS policies, your case management organization's policies, and ask for help when needed. *For more information on the practice of Ethical Case Management, see the section on Case Manager Activities.*

Appearance: Clothing and personal hygiene should be work appropriate. Remember, you represent BDDS as well as your case management organization.

Language: Avoid swearing or the use of trendy words that may be misunderstood. Keep topics work appropriate.

# *Knowledge Development*



Case management is the foundation which all other supports and services are built upon. Case managers are tasked with getting to know an individual and the parents of a minor child or legal representatives, as applicable, and provide an array of services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services or community supports to which access is gained. Case managers advocate alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment. By establishing a good relationship with the individual, and having the knowledge and tools necessary, the case manager can effectively help build a strength-based, person-centered, Person-Centered Individualized Support Plan (PCISP) inclusive of integrated supports that will support the individual in achieving their good life.

## Why is Knowledge Development Important?

The case manager is the ongoing, primary contact for the individuals they support. When questions arise or the individual's situation changes, the case manager facilitates the team's involvement as needed. Individuals, parents of minor children, and legal representatives will also have differing needs based on the life stage of the individual and the natural and integrated supports they have in place. Case managers should have a broad knowledge base of both paid and non-paid supports. Knowledgeable and effective case managers can facilitate discussion, problem solve, and support an exploration of integrated supports. Case managers should also have knowledge of guidance and reference materials that can be utilized in discussions with the team and be able to explain it to the individual, parent(s) of minor children, and/or legal representative(s), as applicable. Additionally, a knowledgeable case manager will keep up with updates to policy or and waiver services so that the individual and team have the most accurate program information when making decisions.

## Knowledge Changes Lives

A PCISP that is centered on the individual's strengths, preferences, and needs will guide the team in support of the individual to ensure what is important to and for the individual is in place. When focusing on the individual's goals, dreams, and aspirations, the plan must not be "cookie cutter" in nature and the team will avoid making assumptions about what the individual wants or needs.

When working with minor children, case managers are to ensure the parent(s) is aware of the full array of services available to then. If music therapy, recreational therapy, and respite are the only services offered, they may miss out on a meaningful service for the child. Services and supports should be based on the

individual's needs and desires and that will enhance the journey toward their preferred life through a combination of waiver services and integrated supports.

Knowledge of resources available based on the life stage of the individual is also important as it may allow the individual to access other paid and non-paid supports. Understanding that the individual's Medicaid waiver funding should always be the payer of last resort, case managers should be able to lead teams in consideration of all of the options available. The individual's life stage should be primary for the team. Based on life stage, there may be other programs, whether paid or non-paid, that could be accessed.

## What Knowledge Must a Case Manager Have?

Case manager knowledge should include, but is not limited to, the following:

- BDDS' Core Competencies
- Building relationships with individuals, parents of minor children, and/or legal representatives, as applicable. *See the training "Building relationships through face-to-face meetings" in the Case Management Training Series.*
- Balancing the competing priorities of individuals, parents of minor children, and legal representatives.
- Person-centered planning practices inclusive of person-centered and strength-based practices, and that enable them to offer opportunities to include integrated supports. *See the PCISP Guide and trainings available in the Case Management Training Series: "What does it mean to be person-centered?", "What does it mean to be strength-based?", and "What are integrated supports?".*
- Development of natural supports that align with the individuals needs and desires. *See the training "Developing Natural Supports" in the Case Management Training Series.*
- Knowledge of community resources.
- Cultural and linguistic competence. *See the training "Cultural and linguistic competence in developmental disabilities" in the Case Management Training Series.*
- Risk as it relates to person-centered planning. *Also see the Risk Assessment and Planning resources available on the BQIS website and the appendix on risk in the PCISP Guide.*
- Life stages and life domains as utilized in the PCISP. *See the PCISP Guide*.
- BDDS Home and Community Based Waivers and waiver services.
- DDRS/BDDS/BQIS policies, processes, and guidance.
- Case Management Waiver Service Definition.
- The role of the case manager in preventing, detecting, and remediating abuse, neglect, and exploitation. *See training available in the Case Management Training Series: "Abuse, Neglect and Exploitation".*
- The role of the case manager in protecting rights, what rights restrictions are, and rights restrictions vs lifelong support needs. *See training available in the Case Management Training Series in Canvas: "Human Rights".*
- Medicaid Prior Authorization (PA) services. *Go to the IHCP Prior Authorization module available for more information.*
- BDDS Portal functionality and related business processes and rules. *See training resources available in the course BDDS Portal 2.0 Training for Case Managers. Training and a complete user guide will be available to all users prior to go-live.*

# BDDS Home and Community Based Waivers

Home-and Community-Based Waivers (HCBS) provide person-centered individualized supports that assist individuals to live in their own home or family home and have full access to the benefits of community living.

## Goals and Objectives of BDDS HCBS Waivers

- Provide access to meaningful and necessary home and community-based services and supports;
- Implement services and supports in a manner that respects the individual's personal beliefs and customs;
- Ensure that services are cost-effective;
- Facilitate the individual's involvement in the community where he or she lives and works;
- Facilitate the individual's development of social relationships in his or her home and work communities; and
- Facilitate the individual's independent living.

## Family Supports Waiver (FSW)

The FSW provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual/developmental disabilities or related conditions. The FSW serves persons with intellectual /developmental disabilities or autism who have substantial functional limitations, as defined in 42 CFR 435.1010. Individuals may choose to live in their own home, family home, or community setting appropriate to their needs. Individuals develop a Person-Centered Individualized Support Plan (PCISP) using a person-centered planning process guided by an individualized support team (IST). The IST consists of the individual, parent(s) of minor children or legal representative(s), as applicable, the individual's case manager, and anyone else of the individual's choosing, but typically family and friends. The individual, with the IST, selects services, identifies service providers of the individual's choice, and develops a budget within the PCISP.

*FSW fact sheets for families are available in English, Spanish, and Burmese.*
*FSW checklists for families are available in English, Spanish, and Burmese.*

## Community Integration and Habilitation Waiver (CIHW)

The CIH waiver provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an ICF/IID. The CIH waiver serves individuals with an intellectual/developmental disability, autism spectrum disorder, or related conditions who have substantial functional limitations, as defined in 42 CFR 435.1010. However, entrance into services under the CIH waiver occurs only when an applicant has been determined by the DDRS to meet at least one of the federally approved priority criteria. Case managers may assist the individuals and families they support in applying for the CIH waiver.

### Priority Criteria

Individuals must meet and be approved for the specific priority criteria of at least one of the following reserved waiver capacity categories:

- Eligible individuals transitioning to the community from a nursing facility (NF), Extensive Support Needs Home (ESN), or a State Psychiatric Hospital (SPH)
- Eligible individuals determined to no longer need/receive active treatment in Supervised Group Living (SGL)

- Eligible individuals transitioning from 100% State-funded services
- Eligible individuals aging out of Indiana Department of Education facility/residential placement; the Indiana Department of Child Services foster care, facility, residential, or group home placement; or Indiana Medicaid Supervised Group Living
- Eligible individuals choosing to leave an ICF/IID
- Eligible individuals with caregivers over the age of eighty (80) years when no other caregiver is available
- Death of a primary caregiver when there is no other caregiver available
- Evidence of abuse or neglect in current institutional or Supervised Group Living placement
- Extraordinary health and safety risk as reviewed and approved by the DDRS Director

*CIH fact sheets for families are available in English, Spanish, and Burmese.*

### Money Follows the Person-Community Integration and Habilitation Waiver (MFP-CIH)

The Indiana Money Follows the Person program is an Indiana Medicaid demonstration project that assists people who live in qualified facilities in moving into their own community with needed funds, services, and supports. Qualifying facilities include nursing homes, hospitals, and other qualified facility-based settings. Money Follows the Person supports Hoosiers in having more choices about where they receive their long-term supports and identifies and addresses barriers to receiving quality, community-based, long-term care and supports. Participation in Money Follows the Person is voluntary and funded through a partnership between the Indiana's Family and Social Services Administration and the Centers for Medicare and Medicaid Services.

Individuals participating in Money Follows the Person receive funding for 365 participation days. On day 366, eligible individuals are transitioned seamlessly to services under one of Indiana's HCBS Medicaid Waivers. For BDDS, it is the Community Integration & Habilitation (CIH) waiver.

#### Qualifying Criteria

To qualify for MFP, the individual must:

- Currently reside in a hospital, skilled nursing facility, or an intermediate care facility for people with developmental disabilities and have resided in a qualified facility for at least 60 calendar days;
- Meet the eligibility requirements for the appropriate community-based long-term services;
- Receive Medicaid services before the transition; and
- Choose to move to a "qualified residence." A "qualified residence" is:
    - The person's own home or apartment;
    - A family member's home; or
    - A residential setting for no more than four (4) people,

## BDDS Waiver Services

The following list provides high level overview of waiver services provided by waiver type. Complete details, including reimbursable activities and activities not allowed, are available in Division of Disability and Rehabilitative Service Home and Community Based Services Waivers module available on the IHCP Provider Reference Module website under Program Specific Modules. Where additional resources are available, they are noted under the information provided for that waiver service.

## Family Supports Waiver Services

- **Adult Day Services**

  Adult day services are community-based group programs designed to support individuals as specified through the PCISP. These programs encompass both the health and social service needs to ensure the optimal functioning of the individual. Meals and/or nutritious snacks are required.

- **Behavioral Support Services**

  Behavioral supports are an array of services designed to assist individuals who are experiencing or are likely to experience challenges accessing and actively participating in the community as a result of behavioral, social, or emotional challenges. Behavioral support services are intended to empower individuals and families (by leveraging their strengths and unique abilities) to achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life, across all environments, across the lifespan.

  *For more information, please see the document Behavioral Support Services: Service Definition and Standards effective July 16, 2020.*

- **Case Management**

  Case management means services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services must be reflected in the PCISP which is developed using Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, Charting the LifeCourse, or an equivalent person-centered planning process.

- **Day Habilitation**

  Day habilitation are services that are specified in the PCISP and support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Day habilitation activities are intended to build relationships and natural supports. Services are provided in a variety of settings in the community or in a facility owned or operated by an FSSA/DDRS-approved provider. Settings are non-residential and separate from an individual's private residence or other residential living arrangements.

  *For more information, please see the document Day Habilitation: Service Definition and Standards effective July 16, 2020.*

- **Environmental Modifications**

  Environmental modifications are those physical adaptations to the home, required by the PCISP, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home. DDRS' waiver services staff must approve all environmental modifications requests prior to the service being rendered.

  *For more information, please see the Fact Sheet About Environmental Modifications.*

- **Extended Services**

  Extended services are ongoing employment support services which enable an individual to maintain integrated competitive employment in a community setting. Individuals must be employed in a community-based, competitive job that pays at or above minimum wage to access this service.

- **Facility-Based Support Services**

Facility based support services are structured, comprehensive, non-residential programs that provide health, social, recreational, and therapeutic activities, as well as optional educational and life skill opportunities as described in the PCISP. Individuals attend on a planned basis.

- Family and Caregiver Training

  Family and caregiver training services provide education and support directly to the family caregiver of an individual to increase the confidence and stamina of the caregiver to support the individual. Education and training activities are based on the family/caregiver's unique needs and must be specifically identified in the PCISP. Reimbursable activities include educational materials or training programs, workshops, and conferences for caregivers that are directly related to the caregiver's role in supporting the individual in areas specified in the PCISP

  *For more information, please see the Fact Sheet About Family and Caregiver Training*

- Intensive Behavioral Intervention

  Intensive behavioral intervention (IBI) services focus on developing effective behavior management strategies for individuals whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting. IBI services teach the individual, families, and other caregivers how to respond to and deal with intense and challenging behaviors. IBI services are designed to reduce an individual's behaviors and improve independence and inclusion in the community. The need for IBI services is determined by a functional and behavioral needs assessment of the individual. IBI services are specified in the PCISP.

- Music Therapy

  Music therapy is services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of non-musical skills and behaviors.

- Occupational Therapy

  Occupational therapy means services provided by a licensed/certified occupational therapist.
  If individuals under age 21 choose to utilize Occupational Therapy services, they should access Occupational Therapy services through EPSDT.

- Participant Assistance and Care

  Participant assistance and care (PAC) services are provided in order to allow individuals with developmental disabilities to remain and live successfully in their own homes, function and participate in their communities, and avoid institutionalization. PAC services support and enable the individual in activities of daily living, self-care, and mobility with hands-on assistance, prompting, reminders, support, and monitoring needed to ensure the health and safety of the individual.

- Personal Emergency Response System

  A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

- Physical Therapy

  Physical therapy means services provided by a licensed physical therapist.
  If individuals under age 21 choose to utilize Physical Therapy services, they should access Physical Therapy services through EPSDT.

- Prevocational Services

Prevocational services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in integrated community settings.

- Psychological Therapy

  Psychological therapy means services provided by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.

- Recreational Therapy

  Recreational therapy services are a medically approved recreational program to restore, remediate, or rehabilitate an individual to improve the individual's functioning and independence; and reduce or eliminate the effects of an individual's disability.

- Remote Supports

  Remote supports are a technology-based service that allows for trained remote support professionals (RSPs) to deliver live support to an individual at a remote location in place of onsite staffing. Remote Supports are delivered by awake, alert remote support professionals whose primary duties are to provide remote supports from the provider's secure remote supports facility.

  *For additional information, please see the Fact Sheet About Remote Support Services*

- Respite

  Respite Care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Respite Care can be provided in the individual's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS approved day habilitation facility, or in a non-private residential setting such as a respite home.

- Specialized Medical Equipment and Supplies

  Specialized medical equipment and supplies include:

  - Devices, controls, or appliances specified in the PCISP that enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
  - Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
  - Other durable and non-durable medical equipment not available under the State plan that is necessary to address individual functional limitations.

  DDRS' waiver services staff must approve all specialized medical equipment and supplies requests prior to the service being rendered.

- Speech/Language Therapy

  Speech-Language therapy means services provided by a licensed speech pathologist.
  If individuals under age 21 choose to utilize Speech/Language Therapy services, they should access Speech/Language Therapy services through EPSDT.

- Transportation

  Transportation services are services to transfer individuals in a vehicle from the point of pick-up to a destination point. Transportation services enable individuals to access non-medical community services, resources/destinations, or places of employment, as well as maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the PCISP.

- **Workplace Assistance**

  Workplace assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver individuals to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the individual) or cuing to prompt the individual to perform a personal care task. Workplace assistance services are services that are designed to ensure the health, safety, and welfare of the individual, thereby assisting in the retention of paid employment for the individual who is paid at or above the federal minimum wage.

## Community Integration and Habilitation Waiver Services

- **Adult Day Services**

  Adult day services are community-based group programs designed to support individuals as specified through the PCISP. These programs encompass both the health and social service needs to ensure the optimal functioning of the individual. Meals and/or nutritious snacks are required.

- **Behavioral Support Services**

  Behavioral supports are an array of services designed to assist individuals who are experiencing or are likely to experience challenges accessing, and actively participating in the community as a result of behavioral, social, or emotional challenges. Behavioral support services are intended to empower individuals and families (by leveraging their strengths and unique abilities) to achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life, across all environments, across the lifespan.

  *For additional information, please see the document Behavioral Support Services: Service Definition and Standards effective July 16, 2020.*

- **Case Management**

  Case management means services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case management services must be reflected in the PCISP which is developed using Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, Charting the LifeCourse, or an equivalent person-centered planning process.

- **Community Transition**

  Community transition services are specified in the PCISP and include reasonable, one-time set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move.

- **Day Habilitation**

  Day habilitation are services that are specified in the PCISP and support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Day habilitation activities are intended to build relationships and natural supports. Services are provided in a variety of settings in the community or in a facility owned or operated by an FSSA/DDRS-approved provider. Settings are non-residential and separate from an individual's private residence or other residential living arrangements.

  *For additional information, please see the document Day Habilitation: Service Definition and Standards effective July 16, 2020.*

- **Environmental Modifications**

  Environmental modifications are those physical adaptations to the home, required by the PCISP, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home. DDRS' waiver services staff must approve all environmental modifications requests prior to the service being rendered.

  *For more information, please see the Fact Sheet About Environmental Modifications.*

- **Extended Services**

  Extended services are ongoing employment support services which enable an individual to maintain integrated competitive employment in a community setting. Individuals must be employed in a community-based, competitive job that pays at or above minimum wage to access this service.

- **Facility-Based Support Services**

  Facility based support services are structured, comprehensive, non-residential programs that provide health, social, recreational, and therapeutic activities, as well as optional educational and life skill opportunities as described in the PCISP. Individuals attend on a planned basis.

- **Family and Caregiver Training**

  Family and caregiver training services provide education and support directly to the family caregiver of an individual to increase the confidence and stamina of the caregiver to support the individual. Education and training activities are based on the family/caregiver's unique needs and must be specifically identified in the PCISP. Reimbursable activities include educational materials or training programs, workshops, and conferences for caregivers that are directly related to the caregiver's role in supporting the individual in areas specified in the PCISP

  *For more information, please see the Fact Sheet About Family and Caregiver Training.*

- **Intensive Behavioral Intervention**

  Intensive behavioral intervention (IBI) services focus on developing effective behavior management strategies for individuals whose challenging behavioral issues put them at risk of placement in a more restrictive residential setting. IBI services teach the individual, families, and other caregivers how to respond to and deal with intense and challenging behaviors. IBI services are designed to reduce an individual's behaviors and improve independence and inclusion in the community. The need for IBI services is determined by a functional and behavioral needs assessment of the individual. IBI services are specified in the PCISP.

- **Music Therapy**

  Music therapy is services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors.

- **Occupational Therapy**

  Occupational therapy means services provided by a licensed/certified occupational therapist.

- **Personal Emergency Response System**

  A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

- **Physical Therapy**

  Physical therapy means services provided by a licensed physical therapist.

- **Prevocational Services**
  Prevocational services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in integrated community settings.
- **Psychological Therapy**
  Psychological therapy means services provided by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor.
- **Recreational Therapy**
  Recreational therapy services are a medically approved recreational program to restore, remediate, or rehabilitate an individual to improve the individual's functioning and independence; and reduce or eliminate the effects of an individual's disability.
- **Remote Supports**
  Remote supports are a technology-based service that allows for trained remote support professionals (RSPs) to deliver live support to an individual at a remote location in place of onsite staffing. Remote Supports are delivered by awake, alert remote support professionals whose primary duties are to provide remote supports from the provider's secure remote supports facility. To ensure safety and HIPAA compliance, this facility should have appropriate, stable, and redundant connections. This should include, but is not limited to, backup generators, multiple internet service connections, battery backups, etc.

  *For more information, please see the Fact Sheet About Remote Support Services.*

- **Rent and Food for Unrelated Live-in Caregiver**
  Rent and Food for Unrelated Live-in Care giver provides payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver individual. Payment will not be made when the individual lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.
- **Residential Habilitation and Support (RHS Hourly and RHS Daily)**
  Residential habilitation and support (RHS) services means individually tailored supports that are specified in the PCISP that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development that support the individual to live successfully in his or her own home.
- **Respite**
  Respite Care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Respite Care can be provided in the individual's home or place of residence, in the respite caregiver's home, in a camp setting, in a DDRS approved day habilitation facility, or in a non-private residential setting (such as a respite home).
- **Specialized Medical Equipment and Supplies**
  Specialized medical equipment and supplies include:
    - Devices, controls, or appliances, specified in the PCISP that enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

- Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items.
- Other durable and non-durable medical equipment not available under the State plan that is necessary to address individual functional limitations.

DDRS' waiver services staff must approve all specialized medical equipment and supplies requests prior to the service being rendered.

- **Speech/Language Therapy**

  Speech-Language therapy means services provided by a licensed speech pathologist.
- **Structured Family Caregiving**

  Structured family caregiving a living arrangement in which an individual lives in the private home of a principal caregiver who may be a non-family member or a family member who is not the individual's spouse, the parent of the individual who is a minor, or the legal guardian of the minor individual.
- **Transportation**

  Transportation services are services to transfer individuals in a vehicle from the point of pick-up to a destination point. Transportation services enable individuals to access non-medical community services, resources/destinations, or places of employment, as well as maintain or improve their mobility within the community, increase independence and community participation and prevent institutionalization as specified by the PCISP.
- **Wellness Coordination**

  Wellness coordination services means the development, maintenance and routine monitoring of the individual's wellness coordination plan and the medical services required to manage his/her health care needs. A comprehensive medical risk plan may substitute for the wellness coordination plan or individual risk plans. Wellness coordination services extend beyond those services provided through routine doctor/health care visits required under the Medicaid State plan and are specifically designed for individuals requiring the assistance of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to properly coordinate their medical needs.
- **Workplace Assistance**

  Workplace assistance services provide a range of personal care services and/or supports during paid competitive community employment hours and in a competitive community employment setting to enable waiver individuals to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a personal care task for the individual) or cuing to prompt the individual to perform a personal care task. Workplace assistance services may be provided on an episodic or on a continuous basis. Workplace assistance services are services that are designed to ensure the health, safety, and welfare of the individual, thereby assisting in the retention of paid employment for the individual who is paid at or above the federal minimum wage.

## Money Follows the Person Community Integration and Habilitation Waiver Services

*See Community Integration and Habilitation Waiver Services*

# *Meeting with Individuals and Families*

In this section, case managers will learn what Individualized Support Team meetings and face to face visits are, why they're important, how effective meetings and visits look in practice, and the requirements for each. Guidance on the meeting/visit requirements for IST meetings, face to face visits, unannounced visits, and the additional face to face interactions required for individuals with high risk or health needs (formerly known as Algo 6, is also provided.

## Individualized Support Team (IST) Meetings

### What are IST Meetings?

IST meetings are productive, collaborative discussions for the purpose of supporting an individual's movement toward their preferred life.

The key to building a relationship is the individual's knowledge that you care about them, that you want them to live their best life and are willing to act on their behalf.

### Why are IST Meetings Important?

IST meetings provide an opportunity for the Individualized Support Team to engage in meaningful discussion that results in a PCISP reflective of the individual's preferences and priorities. Having a conversation with the individual about supporting him/her in living their best life supersedes a discussion embedded in technical jargon and focused on completing procedural requirements.

### How do Effective Meetings Look in Practice?

Effective meetings cultivate the type of teamwork that makes great things possible. Two key things must happen to make a meeting effective. First, the individual and team members must feel a sense of progress. Progress can only be achieved through a shared focus, the second component of effective meetings.

Case managers must ensure the following are in place for facilitating effective meetings:

- Develop intent and clarify purpose
- Adhere to the three phases of meetings:
    - Preparation, planning, and organization prior to the meeting
    - Leading the meeting
    - Follow-up after the meeting

Effective meetings include the individual, parent(s) of minor children or legal representatives, if applicable, the case manager and anyone the individual wishes to have present (family members, friends, provider staff, etc.). The PCISP should be central to all team meetings. The individual and team members should be continuously evaluating progress towards identified outcomes and strategies, celebrating successes, and

working through challenges. Every discussion should focus on the individual's preferred vision of a good life.

*Note: for more information on facilitating team meetings, case managers may view the training "Facilitation 101" available in the Case Management Training Series in Canvas.*

## Face-to-Face Visits

### What are Face-to-Face Visits?

Face-to-face visits allow the individual, parent(s) of minor children, and legal representatives, as applicable, and their case manager to engage in an informal conversation that helps to develop their relationship and further develop support. It should be comfortable, relaxed, and easy.

### Why are Face-to-Face Visits Important?

Face-to-face visits give the case manager the opportunity to better understand, encourage and support the individual in the living their preferred life. Additionally, face-to-face visits allow the individual and other participants to discuss progress on the current PCISP, identify areas of the PCISP that are/are not working, and identify what, if any, changes are needed to enhance alignment with the individual's preferred vision of a good life.

The case manager should carefully prepare with the individual for a face-to-face visit that is comfortable, relaxed, and enjoyable.

It is important to be patient and adjust as needed before, during and after the face-to-face visit.

### How do Effective Face-to-Face Visits Look in Practice?

- The individual and case manager are present during the meeting. The parent(s) of a minor child, or legal representative, if applicable, are also present.
- Visits occur at a time and place recommended by the individual, and parent(s) of a minor child or legal representative(s), as applicable. A few things to note:
    - Avoid service settings.
    - Suggest locations that align with the individual's age, interests, etc.
    - Do an activity together.
    - Face-to-face visits in a variety of locations provides the case manager an opportunity to see how supports are implemented in varying settings, as well as to understand any differences in needs based on the various settings.
- It is NOT an IST meeting.
- Spend the time together getting to know one another.
- The gained insight is included in the PCISP, and the case manager and IST will be prepared to promote movement that allows the individual to experience more of the good life.

*For more information on facilitating team meetings, case managers may view the training "Building Relationships Through Face-to-Face Meetings" available in the Case Management Training Series in Canvas.*

## Requirements

Ongoing case management services are based on the principles of person-centered thinking and driven by the PCISP. Person-centered practices include:

- Convening Individualized Support Team (IST) meetings at least semi-annually. IST meetings may be held in a manner desired by the individual and parent(s) of a minor child or legal representative(s), as applicable. The individual and parent(s) of a minor child or legal representative(s), if applicable, must be present for all IST meetings.
- Conducting face-to-face visits with the individual, parent(s) of a minor child or legal representative(s), as applicable, for the purpose of relationship building and knowledge of individual at least once semi-annually and as needed.
    - At least one meeting or visit each year must be held in the home of the individual.
    - For individuals residing in provider owned and/or controlled settings (POCOS), case managers must ensure at least one visit each year is unannounced.
    - Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program.
    - IST meetings and face-to-face contacts are both required in a manner that ensures interaction at least every 90 calendar days.

## Example

The plan year used for this example is February 1 – January 31.

| Meeting Due | Meeting/Visit | Manner of Meeting | Participants | Purpose |
|---|---|---|---|---|
| April 30 | Non-Annual IST Meeting | As desired by the individual, parent(s) of a minor child, or legal representative(s), as applicable (i.e., in person or virtually.) | Individual and parent(s) of a minor child or legal representative, as applicable; case manager; service providers; others invited by the individual, et al. | See PCISP Guide: Non-Annual Team Meetings |
| July 31 | Face-to-Face Visit | In person | Individual and parent(s) of a minor child or legal representative, as applicable; others invited by the individual, et al. | See PCISP Guide: Face-to-Face Visits |
| October 31 | Annual IST Meeting | As desired by the individual, parent(s) of a minor child, or legal representative(s), as applicable (i.e., in person or virtually.) | Individual and parent(s) of a minor child or legal representative, as applicable; case manager; service providers; others invited by the individual, et al. | Annual Planning Meeting<br><br>See PCISP Guide: Annual Team Meetings |
| January 31 | Face-to-Face Visit | In person | Individual and parent(s) of a minor | See PCISP Guide: Face-to-Face Visits |

| | | | | |
|---|---|---|---|---|
| | | | child or legal representative, as applicable; others invited by the individual, et al. | |

- Conducting unannounced visits to individuals residing in provider owned and/or controlled settings (POCOS) at least once per year in the home. Unannounced visits are intentional interactions and are not completed by arriving at the home early for a planned meeting or visit. A provider owned or controlled setting is defined as:
    - Residential settings that are owned by a provider; or
    - Residential settings in which individuals, who are not living in their family home, and utilize:
        - Residential Habilitation and Support – Level Two;
        - Residential Habilitation and Support – Daily; or
        - Structured Family Caregiving
- Individuals with high risk or health needs, formerly known as Algo 6, require additional oversight and support. Case managers must have monthly face-to-face interactions with these individuals. Individuals in this category:
    - Require access to full-time supervision (24/7) and more than a 1:1 staff to individual ratio;
    - Have needs that are exceptional;
    - Require more than one (1) caregiver exclusively devoted to the individual for at least part of each day; and
    - Are in imminent risk of harming themselves or others, or both, without vigilant supervision.

## *Person-Centered Planning*

Quality person-centered planning begins with an individual's vision for a preferred life and takes the concept of self-determination from theory to practice. The person-centered planning process should create a supportive environment that encourages individuals and their families to engage in robust discussion to create meaningful plans that promote greater opportunities for individuals to exercise choice and self- determination. Further, the person-centered planning process should enhance and promote collaboration among (IST) members and lead to outcomes, strategies, and action steps that relate to the individual's vision for their preferred life.

**IMPORTANT**

*Content provided in this Person-Centered Planning section below does not replace the full guidance provided the PCISP Guide, PCISP Rubric, PCISP Rubric Interpretive Guidelines, and trainings available through the Case Management Training Series available in Canvas. These resources are available separately but are attached as addendums to the BDDS Quality Guide for convenience.*

# Developing a Person-Centered Individualized Support Plan

## Developing a Strength-Based Plan

Developing a strengths-based plan requires identifying the individual's strengths based upon their input along with the input of the entire team (i.e., parents of minor children, legal representatives, other family members, friends, case manager, providers, direct support professionals, etc.). It recognizes the strengths and assets of the family unit, if applicable. Outcomes are designed to foster skill building from a strengths-based perspective. The PCISP builds upon those strengths, desires, and needs leading to the development of comprehensive and integrated solutions which support the individual in living their vision of a good life within their community.

**Supporting information:**

- Being strength-based means that the PCISP identifies the support needs of the individual using language that is respectful and explains the need.
- Support needs should be identified using language that maintains the person's dignity and helps the reader to understand the purpose, function and/or approach necessary to support the need.
- Support needs identified should be age appropriate.
- Rubric scoring measures related to outcomes includes all outcomes. All outcomes must possess the criteria identified.

*For additional information on developing a strength-based plan, please see the PCISP Rubric Interpretive Guidelines. Case managers may also view the training "What Does it Mean to be Strength Based?", available through the Case Management Training Series in Canvas.*

## Developing a Person-Centered Plan

All team meetings should only occur when the individual is present and as applicable, the parent(s) of a minor child or legal representative(s). The PCISP is driven by the individual those closest to them. The outcomes, wants, and needs are centered on the individual's vision for a good life. Their desires, cultural beliefs, and values are recognized, respected, embraced, and reflective in outcomes, formal services, and community activities. The PCISP demonstrates the individual's informed choice and allows for opportunities for learning.

**Supporting information:**

- The individual does not have to be listed in the section "Individualized Support Team Members".
- Person centered language and outcomes should align with the life stage of the individual. For young children, the PCISP may be from the perspective and desires of the parents while still including the child's interests, likes and dislikes. For adults with legal representatives, the PCISP should provide a balance of perspectives and desires while also including the person's interests, likes and dislikes.
- Rubric scoring measures related to outcomes includes all outcomes. All outcomes must possess the criteria identified.

*For additional information on developing a person-centered plan, please see the PCISP Rubric Interpretive Guidelines. Case managers may also view the training "What Does it Mean to be Person-Centered?", available through the Case Management Training Series in Canvas.*

## Incorporating Integrated Supports

Integrated supports should be continuously developed and maintained as determined by the individual's interests and preferences. The full team is to support the individual in relationship development. The identified areas of integrated supports include personal strengths and assets, technology, community based, relationships, and eligibility specific/paid supports

**Supporting information:**

- Integrated supports may be identified throughout the PCISP and should also be leveraged to support the individual in their outcomes, strategies and/or action steps.
- Rubric scoring measures related to outcomes are specific to the number of outcomes and number of integrated supports as stated in the measure.
- The use of technology can be personal technology that anyone uses; assistive or adaptive technology or devices that support an individual in their daily tasks; environmental technology designed to help with or adapt to surroundings. Technology does not have to be electronic.
- Relationships are family, friends, and acquaintances.
- Personal strengths and assets are the skills, personal abilities, knowledge, belongings, resources of the individual, parents, and legal representatives, as applicable, as well as things they are good at.
- Community-based supports are places that are available to everyone such as businesses, parks, schools, faith-based communities, health care facilities; groups or membership organizations with shared interests; local services or public resources that everyone uses such as public transportation.
- Eligibility specific are those needs-based or government funded services that a person is eligible for based upon disability, age, income, geography, or employment status.

*For additional information on incorporating integrated supports, please see the PCISP Rubric Interpretive Guidelines. Case managers may also view the training "What are Integrated Supports?" available through the Case Management Training Series in Canvas.*

## Assessing Risk

Exposure to risk is part of life. It is only through making choices and developing good judgment that we all learn and mature. Risk management emphasizes instruction and the development of strategies and safeguards geared specifically to the individual to manage reasonable risk whenever possible. Identifying and addressing unreasonable risk should be respectful of the individual's rights while addressing competency and capacity to make informed choices. The determination of risk should include those who know the individual best and be based on the understanding of any cultural and linguistic issues. It is to be included in the PCISP in each domain as applicable.

For complete information on assessing and managing risk in the PCISP, please see Appendix A: Risk in the PCISP Guide.

## Balancing Competing Priorities

### Individual and Parent/Legal Representative Priorities

Case Managers are responsible for ensuring the individual's voice is clearly heard by the entire team, including the parent(s) of a minor child or legal representative(s), if applicable. While the parents of a minor child and legal representatives are afforded a number of rights and responsibilities by the courts, this should not replace the expectation that individuals are present for their meetings, have an opportunity to express their opinions and desires, and be a meaningful part of the discussions and decisions that impact their life.

## Adults and Minors are Different

Ensuring the individual's voice will look different based upon the life stage of the individual receiving waiver services. For instance, parents of young children will be the primary driver of all decisions and outlining the vision they have for their child as they grow into an adult. Even in this instance, case managers should be taking the time to get to know the child and their interests. Case managers should be supporting parents of young children to think about ways they are building their child's capacity to make decisions and modeling for the parents how to incorporate their child's interests and desires into their decisions. These conversations should grow as the child ages so that when the child becomes a young adult and adult, they are a partner in the process and have the opportunities to drive the decisions that impact them.

## Facilitating Conversations that Matter

Typically, parents of minor children and legal representatives make decisions based upon what they think is best for the individual. These decisions may be driven by past experiences, worry, concern, or fear. It is important to remember this when having conversations with parents or legal representatives who may be telling an individual no. When an individual wants something and the parent or legal representative doesn't agree, ask "why". By digging deeper into their reasons for saying no you may uncover what their worry, concern or fear is and be able to work with them to come up with a plan to address those feelings. For example, an individual may clearly articulate a desire to spend time alone yet be unsafe in crossing streets or assessing risks in the community. Parents of minor children and legal representatives may prefer that the individual be protected rather than taking a chance on something new that has a risk of failure. As the case manager, you should work with the individual and parents or legal representatives to build and explore integrated support options that will alleviate the fears that the individual could be hurt or exploited while also giving the individual the much-desired independence that comes with being home alone. Using an integrated supports star can help facilitate this discussion.

## Creating an Environment of Partnership

To create an environment of partnership between individuals and parents of minor children or legal representatives, as applicable, the following should be reinforced:

- Individuals must have the power to make informed decisions about their own lives and the services they receive.
- Individuals must have access to necessary accommodations and supports in order to meaningfully participate in meetings, conferences, and other forums when issues are important to them are discussed (the "nothing about us without us" principle). These accommodations include but are not limited to:
    - Extra time planned for meetings to ensure the participation of each person;
    - Enhanced and alternative communication methods, such as communication devices, sign language, or interpreters;
    - Availability of technology supports and access through technology to ensure participation;
    - Materials provided ahead of the meeting for review;
    - Meeting materials written in plain language;
    - Support from direct support professionals, when needed; and
    - Funding for transportation, including support staff.
- It is important to respect the way that people with disabilities prefer to be identified. In most circumstances, person-first language is most appropriate, e.g., person with IDD. However, some people

with IDD prefer identity-first language, e.g., autistic person. In addition, people's self-identified pronouns for gender identity must be respected.
- Individuals must be afforded the same dignity of risk that all people have to make informed decisions and learn from any mistakes that impact themselves and others in the community.

## Including Services in the PCISP

The person-centered approach enhances the way in which services and supports are explained to individuals, parent(s) of minor children, and legal representative(s), as applicable, so their needs, aspirations, and opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life can be identified and explored. The individual has the right and power to command and direct the entire person-centered planning process with focus on his or her preferences, aspirations, and needs. The process empowers individuals to create life plans and direct the planning and allocation of resources to move toward their self-identified best life.

### What is the Services Section of the PCISP?

The service section of the PCISP identifies those supports and services which are selected by the individual, parent(s) of minor children, or legal representative, as applicable and funded by their HCBS waiver. Services included, including the scope and duration, should be identified in the person-centered planning process to implement strategies and outcomes that support the individual's desired outcomes and ensure his or her health and welfare.

*Case managers are reminded that waiver funding belongs to the individual. Changes made based on provider requests are not permitted without the express permission of the individual, parent(s) of a minor child, or legal representative(s), as applicable.*

## Requirements

With the implementation of changes made in BDDS Portal 2.0 through the systems consolidation project, services are submitted and authorized through the PCISP. The following requirements apply to the Annual PCISP inclusive of the Services section.

### Family Supports Waiver (FSW)

For individuals utilizing the Family Supports (FS) waiver, Annual PCISPs, inclusive of services, may be submitted up to one hundred (100) calendar days before of the start of the plan year. At a minimum, the Annual PCISP must be submitted forty-five (45) calendar days prior to the start of the plan year. Initial PCISPs, inclusive of services, cannot be submitted for service authorization until the Intake initial contact is made and the Intake meeting is held. Newly onboarded cases utilizing the FS waiver will be in Active status and have a Case Management Only service plan with two (2) units of case management to fund case management services leading to the development, submission, and authorization of the Initial PCISP. Please note, individuals onboarded with Managed Care will receive the Case Management Only service plan that will be active upon disenrollment.

### Community Integration and Habilitation Waiver (CIH)

For individuals utilizing the Community Integration and Habilitation (CIH) waiver, Annual PCISPs, inclusive of services, may be submitted at the release of the Objective Based Allocation (OBA) ninety-five (95) calendar days of the start of the plan year. At a minimum, the Annual PCISP must be submitted forty-five (45) calendar days prior to the start of the plan year. Newly onboarded cases utilizing the CIH waiver may be in Active status and have a Case Management Only service plan with two (2) units of case management

to fund case management services until the Intake initial contact is made and the Intake meeting is held for development, submission, and authorization of the Initial PCISP. Exceptions to the allowance of a Case Management Only plan include onboards of:

- CIH waivers in Transitional status;
- Waiver starts or re-entries requiring a facility discharge date;
- Re-entries onboarded to the same case management organization; and
- Change waiver.

### Money Follows the Person-Community Integration and Habilitation Waiver (MFP-CIH)

For individuals utilizing the Money Follows the Person demonstration project funding in conjunction with the Community Integration and Habilitation (CIH) waiver. Newly onboarded cases utilizing the MFP-CIH, may have an Initial PCISP created, inclusive of services once the Intake meeting has been held. Plan services will be authorized following the entry of the facility discharge date. Case managers are to work directly with BDDS district staff to plan for conversion to a pure CIH waiver. The document Indiana Money Follows the Person is available as an addendum to this Guide.

### Service Costs Over the Objective Based Allocation

When an individual has a reduction in their OBA due to residential (living arrangement) change, the individual's service plan may be over the allowable allocation. In those cases, the case manager is notified of the overage on the Over Allocation grid on the PCISP tab of the Home page dashboards. Case managers must speak with the individual, parent(s) of minor children, or legal representative, as applicable, and their IST, to review the PCISP and services and make the changes necessary to bring the cost of services back within the allocation within thirty (30) business days. Allowing service costs to continue to exceed the OBA beyond this time frame may result in corrective action and/or sanction.

*Note: For complete information on translating Algo levels into an OBA, please see section 6.4 of the DDRS Home and Community-Based Services Waivers Module.*

## Sibling/Family Plan Year Alignments

PCISP plan years may be aligned for siblings and other family members (i.e., parents and children, spouses) when requested by the individual, parent(s) of minor children, or legal representative, as applicable. Plan year alignments include retaining the plan year of at least one of the individuals while re-setting the other individuals' plan year(s) in the next Annual PCISP. To align plan years prior to the start of the next Annual PCISP, the Monitoring Checklist schedule for the current plan year will also be adjusted.

Plan year alignments require that the individual(s) changing their plan year have a shortened plan year, with a prorated waiver cap (FSW) or allocation (CIH) to manage the alignment. No plan year can exceed a twelve (12) months. When the plan year alignment is requested, it is imperative for case managers to determine if there would be any negative impact to the way the individual uses services and share that information with them.

Beginning with systems consolidation in 2022, requests for sibling/family plan year alignments are to be submitted through Jira by the case manager's supervisor or other designated case management organization staff member. Requests must include the individuals' full HIPAA names, including the RID number, BDDS Portal ID, end date of their current plan year, and the requested plan year.

Example:

**Related Application:** BDDS Portal – General
**Service Request Type:** Data Change
**Summary:** Sibling/Family Plan Year Alignment
The individual, parent(s) of a minor child, or legal representative(s), as applicable, has requested a plan year alignment for the following individuals:

| Full HIPAA Name | Portal ID | Current Plan Year |
|---|---|---|
| SMITJOHD123456789999 | 12345 | 01/01 to 12/31 |
| SMITJANA124563789999 | 98765 | 06/30 to 05/31 |
| Retained Plan Year: | 01/01 to 12/31 | |
| Relationship: | Siblings | |

BDDS will process the adjustments to the Monitoring Checklist and adjust the Annual PCISP for the shortened plan year. The Jira ticket will be resolved once these activities have been completed.

***Until the system consolidation project release of the BDDS Portal 2.0, please follow the process outlined in the interim guidance released with this guide.***

# *Home and Community-Based Services Final Rule on Settings*

All states providing waiver services are required to follow and abide by federal laws and regulations set by the Center for Medicare and Medicaid Services (CMS). In this section, case managers will learn about the Home and Community-Based Services Final Rule on Settings, also known as the Settings Rule, issued in 2014.

## Why is the Settings Rule Important for Individuals?

In the settings rule CMS clarified expectations for person-centered planning and the things that need to happen when HCBS waivers are administered. This includes where and how support is delivered. These regulations enhance the quality of home and community-based services and provide additional protections to individuals that receive HCBS waivers and supports.

## Settings Rule Assurances

The homes of individuals receiving supports and services through HCBS waivers must be located in a setting that enables interaction with people without disabilities. Their home must provide access to the community and participation in community activities to the same degree as people without disabilities. Further, the settings rule requires specific questions to be asked at least annually but as often as the PCISP is updated and/or Monitoring Checklist completed for individuals who reside in provider owned or controlled settings (POCOS). Some of these questions appear within five (5) of the life domains of the PCISP while others are part of the HCBS Settings section of the Monitoring Checklist. *Please note, HCBS questions currently within the Monitoring Checklist will be relocated to the PCISP in 2022.*

PCISP – Community Living

- Does the individual have privacy in their sleeping or living quarters?

- Does the individual's living quarters have lockable entrance doors, with the individual and appropriate staff having keys to the doors as needed?
- Does the individual have the freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement?

PCISP – Safety and Security

- Is the individual's dwelling/unit owned, rented, or occupied under a legally enforceable agreement?
- Does the individual have the same responsibilities and protection from eviction as all tenants under landlord tenant law of the state, county, city, or other designated entity?

PCISP – Healthy Living

- Is the setting physically accessible to the individual?
- Does the individual have access to food at any time?

PCISP – Social and Spirituality

- Is the individual allowed visitors at any time?

PCISP – Citizenship and Advocacy

- Does the individual have the freedom and support to control their own schedules and activities?

Monitoring Checklist – HCBS Settings

- Is the individual's setting in and does it support access to the greater community?
- Does the individual's setting provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources?
- Does the individual's setting ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services?
- Was the individual's setting selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting?
- Does the individual's setting ensure their rights of privacy, dignity, respect, and freedom from coercion and restraint?
- Does the individual's setting optimize the individual's initiative, autonomy, and independence in making life choices?

## Remediation

When HCBS questions are answered no, additional questions must be discussed, and the required remediation information included within the HCBS section for that domain of the PCISP, or in the CAP in the Monitoring Checklist. When responding to the questions in the Monitoring Checklist, it is important for the case manager to ensure that these additional protections to individuals is properly documented.

Consistent with CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each HCBS required question that is answered "no"** by the IST:

- Identify a specific and individualized assessed need;
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;

- Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include informed consent of the individual; and
- Include an assurance that interventions and supports will cause no harm to the individual.

Remediation Example

In this example, we'll look at Mary, a 25-year-old woman diagnosed with Prader-Willi Syndrome. Due to her diagnosis, Mary is short in height, has low muscle mass and high body fat. Additionally, her mild to moderate cognitive impairment causes Mary to have issues with thinking, reasoning, and problem-solving. Mary is currently overweight and would like to lose weight.

Settings rule question: Does the individual have access to food at any time? NO

Remediation: Mary is currently overweight and would like to lose 25 to 30 pounds, but she is unable to resist cravings for sweets and starches. Mary, with the help of her direct support professional, developed a meal plan but was not able to stick to it. To achieve her goal, Mary engaged her team in a problem-solving discussion where it was decided that Mary would receive 3 meals from her meal plan and 3 healthy snacks per day at scheduled intervals. Food will not be available to her other than at these scheduled times. Mary's case manager will follow-up with her monthly to measure the effectiveness of the plan and ensure Mary wants to continue on this path.

## *Medicaid as Payer of Last Resort*


The role of the case manager includes care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each individual, and identifying resources and negotiating the best solutions to meet identified needs. Toward these ends, case managers must demonstrate a willingness and commitment to explore, pursue, access, and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the individual's local community, thereby enabling the Medicaid program to complement other programs and resources.

### What does it mean for Medicaid to be the "payer of last resort"?

The Centers for Medicare & Medicaid Services (CMS) requires an individual utilizing HCBS waivers to exhaust all services regardless of funding stream, including those on the Indiana Medicaid State Plan, before utilizing HCBS waiver services. Case managers must understand, maintain, and assert that HCBS waiver programs are considered funding of last resort and have a closed funding stream.

The following list shows the hierarchy of funding streams:

Because HCBS waiver programs are the funding stream of last resort, waiver teams must ensure that all other revenue streams are exhausted before utilizing HCBS waiver services.

The Indiana Medicaid State Plan services that must be accessed prior to the use of waiver-funded services include, but are not limited to:

- Home health
- Medical transportation
- Physical therapy
- Speech/language therapy
- Medicaid Rehabilitation Option (MRO)

### Why is it important?

It's imperative for case managers to have knowledge of resources, both paid and unpaid, to be able to lead teams to consider all available options. This includes age specific services such as EPSDT. All services and supports utilized should be based on the individual's needs and desires and enhance their journey toward their preferred life.

### How does this look in practice?

- Case managers provide an array of services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services or community supports to which access is gained;
- Case managers advocate alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment;
- Case managers lead ISTs to consider all available options relevant to the individual's needs and desires, and which enhance the journey toward their preferred life;
- Case managers are trained in the person-centered planning process that aligns with BDDS mission, vision, and values, including participation in any BDDS person-centered trainings; and
- Case managers demonstrate a willingness and commitment to explore, pursue, access, and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the individual's local community, thereby enabling the Medicaid program to complement other programs or resources.

## *File Management*

The File management section will introduce case managers, intake coordinators, and case management leadership to the movement of files through the processes of onboarding, including transfers between case management organizations, and intake, Changes in case manager due to a separation of employment and Medicaid loss are also included. Let's look at each process individually.

# Onboarding

## What is Onboarding?

Onboarding starts with the system process of referring an individual to their selected case management company. Through this process the BDDS District Office provides important information about the individual, including, but not limited to, contact information, relationships, the individual's current living arrangement, diagnoses, etc. The CMO onboarding process should include a review of:

- The individual's waiver type (FSW, CIH, MFP-CIH) and status (active, pending, transitional);
- Medicaid category, benefit plan, and status;
- Algo and allocation of individuals receiving the CIH or MFP-CIH waivers;
- Level of Care Screening Instrument (LOCSI) dated within 90 calendar days; and
- Provider choice list for case management.

When the above statuses or documentation are incorrect, the CMO should contact the district office immediately for resolution. If the issue can't be resolved quickly, the CMO may be instructed to reject the onboard.

| Compatible Medicaid Benefit Plans: MA and PKGA<br>Compatible Medicaid Categories: | | | |
|---|---|---|---|
| 2 | Child Aged 6 – 18 | DI | Working Disabled MEDWORKS Imp |
| 4 | Title IV-E Foster Child < 18 | DW | Working Disabled MEDWORKS |
| 8 | Child Receiving Adoption Assistance | F | Transitional Medical Assistance |
| 9 | Child Aged 1 – 18 | GF | Parent / Caretaker of Relative |
| 14 | Foster Care Independence Age 18 – 20 | SI | Social Security Income |
| 15 | Former Foster Child Aged 18 – 26 | X | Newborn – Born to Medicaid Member |
| A | Aged | Y | Child Aged 0 – 18 |
| B | Blind | Z | Child Aged 1 – 5 |
| D | Disabled | | |

## Why is Onboarding Important to Individuals and Families?

Families depend on case managers and their case management organizations for access to the services and supports they need and are entitled to through BDDS' waivers. Case management intake coordinators are tasked with the responsibility of ensuring their timely access.

## How and When does Onboarding Happen?

Each business day the intake coordinator will review of their dashboard, or the On-boarding/Intake grid located under Processing in the BDDS Portal. Following the file review, the intake coordinator will accept or reject the file(s). Accepted referrals must be assigned to a case manager within twenty-four (24) hours. Additionally, the process also allows BDDS service coordinators to see the progress and respond to the reason for the rejected referral.

# Intake

## What is Intake?

Intake is the process of contacting and having an initial meeting with individuals who are new or returning to waiver services. Through the intake process case managers will begin to develop a relationship with the

individual, parent(s) of minor children, or legal representative, as applicable, that results in a quality Person-Centered Individualized Support Plan.

## Why is the Intake Process Important to Individuals and Families?

Robust intake meetings give case managers, individuals, parents of minor children, and legal representatives, as applicable, the opportunity to identify the individuals' strength and assets, important relationships, what's important to and for the individual, and begin a conversation that will enable the individual and those closest to them to develop a vision for their good life. From this intake meeting, case managers can begin to assist them in determining the services and supports that will best meet their needs.

> REMEMBER, REJECTING A REFERRAL BASED ON AN INDIVIDUAL'S NEED FOR INTERPRETATION OR TRANSLATION IS DISCRIMINATION. CASE MANAGEMENT ORGANIZATIONS ARE REQUIRED TO ENSURE CASE MANAGERS HAVE THE ABILITY TO EMPLOY THE TOOLS NECESSARY TO COMMUNICATE EFFECTIVELY AND EFFICIENTLY WITH EACH INDIVIDUAL BY WHATEVER MEANS IS PREFERRED BY THE INDIVIDUAL.
>
> Case Management Waiver Service Definition

## How do Case Managers Facilitate Intake Meetings?

An intake meeting should include the following:

- Preparation by the case manager that will enhance their ability to facilitate the intake meeting. Planning for the meeting should include a review of the individual's profile, relationships, living arrangements, diagnoses, and interview guide;
- The individual, parent(s) of a minor child or legal representative, as applicable, and others important to the individual that they want included;
- Conversation that focuses on what the individual envisions for their good life. As mentioned above, this includes the individuals' strength and assets, important relationships, what's important to and for the individual, and begins to identify integrated supports.


Person-Centered Individualized Support Plans must be developed using Charting the LifeCourse, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning process.

CASE MANAGEMENT WAIVER SERVICE DEFINITION

Indiana's PCISP was developed based on Charting the LifeCourse principals, life stages, and life domains, therefore, the use of the Charting the LifeCourse tools is considered BEST PRACTICE.

### When do Intake Meetings Happen?

- For individuals onboarded in Pending status, regardless of waiver type, the intake process must be completed and an Initial PCISP, including the service plan, submitted within forty-five (45) calendar days of onboard. Two units of initial case management are provided at onboard for this purpose. When the individual is enrolled in Managed Care, assignment of the availability of the two units of initial case management immediately follows dis-enrollment.
- For individuals in Transitional status, the intake process must be completed and an Initial PCISP that includes the Initial service plan must be submitted, approved, and confirmed to activate the waiver. Initial case management units are not provided as payment is included through Transitional Case Management.
- For individuals onboarded in Re-Entry status, a Re-Entry PCISP that includes the Re-Entry service plan must be submitted, approved, and confirmed to activate the waiver. Initial case management units are provided only if the individual is onboarded to a case management organization who was not the most recent to support the individual.

**IMPORTANT**

- Intake case notes move the individual's record through the Intake process.
- An Intake/Initial contact case note must be entered once the case manager speaks with the individual, parent(s) of a minor child, or legal representative, as applicable.
- An Intake/Meeting Held case note must be entered to indicate the case manager has met with the individual, parent(s) of a minor child, or legal representative, as applicable. This closes the intake process and removes the individual's name from the Intake grid.

**The PCISP with embedded services cannot be created until the intake meeting has been held and case noted**

## Transfers Between Case Management Organizations

### What are CMO Transfers?

Transfers of individual's files from one case management organization to another are known as Change CMO transfers. As with any onboard, they populate on the Intake/Onboard processing page and are accepted or rejected in the same way new referrals are managed.

### Why are CMO Transfers Important?

Individuals, parents of minor children, or legal representatives, as applicable, may feel the need to select a new case management organization when they are not satisfied with the service delivery of their case manager. Any CMO receiving a request for a case management choice list will provide a blank choice list whether or not they currently support the requesting party.

When a choice list is received by the receiving CMO, they will contact the transferring CMO, providing a copy of the choice list, and the transferring CMO will process a Change CMO transfer from the individual's Manage page in the BDDS Portal within five (5) business days. When a current CMO receives a choice list for another CMO, they will notify the receiving CMO, providing a copy of the choice list, and process the transfer from the individual's Manage page in the BDDS Portal within five (5) business days.

### How are CMO Transfers Managed?

Case management organizations may refer individuals to a different provider of case management once a provider choice list is received and the file, including case notes and monitoring checklists, is up to date, but within five (5) business days. Transfers of this type are processed on the individual's Manage page. Individuals in the transfer process will remain on the roster of the transferring case management organization and assigned case manager until the file is accepted. Referrals must be accepted or rejected within five (5) business days. Throughout the transition to a new case management organization, all parties must continue to receive case management services in a manner that is respectful and meets their needs.

REMEMBER, CASE MANAGEMENT IS A REQUIRED SERVICE FOR ALL INDIVIDUALS UTILIZING BDDS' WAIVERS. THE CASE MANAGEMENT ORGANIZATION INITIATING THE FILE TRANSFER MUST CONTINUE TO SUPPORT THE INDIVIDUAL UNTIL THE FILE IS ACCEPTED BY THE RECEIVING CASE MANAGEMENT ORGANIZATION.

Case Management Service Definition

## Case Manager Reassignment Due to Separation of Employment

When a case manager separates from their employer, it is necessary for their case management organization to reassign their files to a different case manager. Once the case manager's access to the BDDS Portal is inactivated following the process outlined in the systems access guidance, the case management organization must reassign the file within seventy-two (72) hours.

## Loss of Medicaid

### What is Medicaid?

Medicaid is a joint federal and state program that provides health coverage to millions of Americans, including individuals with intellectual and developmental disabilities. While access to Medicaid is generally based on income, minors receiving waiver services may access Medicaid regardless of family income.

### Why is Maintaining Medicaid Important?

Medicaid is the funding stream for BDDS Home and Community Based Services waivers. Without active Medicaid with a qualifying benefit plan and category, providers of waiver services cannot be paid. This can result in a delay or gap in services and/or loss of medical coverage. Additionally, providers may bill the individual, parent(s) of a minor child, or legal representative(s), as applicable, for services provided if Medicaid is not reactivated.

Access to Medicaid services can be lost for the following reasons:

- Individual, parent(s) of a minor child, or legal representative(s), as applicable, missed the annual redetermination deadline. Medicaid redetermination is a necessary part of being a Medicaid beneficiary. The redetermination process ensures an individual is still eligible to receive Medicaid benefits and can continue to receive Medicaid-funded long-term services and supports;
- Documents not submitted timely for redeterminations;

- The individual was over resourced at the time of redetermination. Medicaid beneficiaries that receive assistance through a Medicaid HCBS waiver are permitted to keep their monthly income up to a certain amount. If income or assets (resources) exceed the required limits, they may be determined over resourced and will no longer be eligible for Medicaid benefits;
- Social Security Administration (SSA) determines individual not disabled or individual has not applied after age 19; and/or
- Change to 'non-compatible' waiver category.

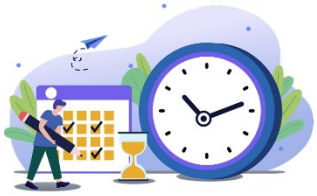
### When Medicaid is Lost

When Medicaid is lost, the case manager is to immediately contact the individual, parent(s) of a minor child, or legal representative(s), as applicable, to determine reason for loss of Medicaid and discuss steps to reactivate Medicaid. This may include a review of any letters they received from the Division of Family Resources (DFR).

If the individual, parent(s) of a minor child, or legal representative, as applicable, lists the case manager as an Authorized Representative (AR), the case manager can have direct contact with DFR. Case managers can then provide assistance as they navigate the Medicaid system. For some, the amount of information is overwhelming or misunderstood. Case managers who are Authorized Representatives can provide more comprehensive assistance.

If reinstatement is being actively pursued, the waiver should not be interrupted for sixty (60) calendar days to allow time for resolution. Medicaid is generally reinstated retroactively allowing all providers to be paid for services provided. Should the individual, parent(s) of a minor child, or legal representative(s), as applicable, choose not to pursue reactivation of Medicaid, case managers are to contact the district office for assistance and further guidance before terminating the waiver.

## *Waiver Management*



The Waiver Management section will provide case managers, case management supervisors, and case management leadership with the information needed to accurately utilize interruptions, extended interruptions, and waiver terminations when necessary.

## Interruptions

### What is an Interruption?

An Interruption is a break in waiver services for thirty (30) calendar days or less for a specific reason.

### What is an Extended Interruption?

An Extended Interruption is a break in waiver services for up to ninety (90) calendar days. The expectation is the individual will return to waiver services in ninety (90) calendar days or less.

### Why are Interruptions Important?

Interruptions allow the individual's waiver to be put on hold as needed and return to services, within the established time frames, without having the waiver terminated.

## When are Interruptions and Extended Interruptions Used?

Interruptions may be utilized to pause waiver services in the following situations:

- Facility placement;
- Incarceration, awaiting trial;
- Out of state travel that does not meet the standards for reimbursement of out of state home and community-based services;
- Refused services, pending receipt of BDDS signature page/freedom of choice; and
- Non-responsiveness (Note: see guidance on non-responsive individuals, parents, and legal representatives before submitting an interruption or termination for this reason.)

*Please note, interruptions are not submitted for individuals who desire to terminate their waivers. See Example 1 under Terminations.*

## How are Interruptions Used in Practice?

Example 1:

An individual enters a Medicaid-funded long-term care facility for thirty (30) calendar days or less for short term rehabilitation with the intention of returning to their waiver setting upon completion of rehabilitation. Because the individual is in a Medicaid-funded long-term care facility the case manager will:

- Document in case notes the individual's admission to the long-term care facility;
- Interrupt the waiver;
- Monitor progress to determine if the individual will return to the waiver setting within 30 calendar days;
    - If necessary, extend the interruption for a period up to a total of no more than ninety (90) calendar days;
- Document the individual's return to waiver services in case notes; and
- Restart the waiver when the individual returns.

Example 2:

An individual is arrested and remains in jail awaiting trial. The case manager will:

- Document in case notes the arrest and incarceration information received from the individual, legal representative, if applicable, and/or provider;
- Interrupt the waiver for a period not to exceed ninety (90) calendar days;
- Document the individual's return to waiver services in case notes; and
- Restart the waiver when the individual returns.

Example 3:

An individual receiving waiver services will be traveling to China for two months to visit family. The BDDS Policy Reimbursement of Out of State Home and Community Based Waiver Services covers only travel inside the United States, therefore it does not apply in this situation. The case manager will:

- Document in case notes the travel information received from the individual, parent(s) of a minor child, or legal representative(s) as applicable;
- Enter an extended interruption;
- Document the individual's return to waiver services in case notes; and
- Restart the waiver when the individual returns.

Example 4:

An individual receiving waiver services will be attending college in Texas for ten (10) months. He returns home during breaks and receives waiver service during that time. The BDDS Policy Reimbursement of Out

of State Home and Community Based Waiver Services only covers undergraduate and graduate programs in states contiguous to Indiana, therefore it does not apply in this situation. The case manager will:

- Document in case notes the individual's attendance at school as received from the individual, parent(s) of a minor child, or legal representative(s), as applicable;
- Enter an extended interruption;
- Document the individual's return to waiver services in case notes; and
- Restart the waiver when the individual returns.

# Terminations

## What is a Termination?

A Termination is the discontinuation of an individual's HCBS waiver.

## When is a Termination Used?

An individual's waiver services will be terminated due to:

- Voluntary withdrawal;
- Choice of institutional placement;
- Placement in a Medicaid-funded long-term care facility for more than 90 calendar days;
- Services required are so substantial that the total cost of Medicaid services for the individual would jeopardize the waiver program's cost-effectiveness. ***Only BDDS can make this determination;***
- ICF/IID LOC criteria is not met;
- Medicaid eligibility ends and is no longer pursued;
- Home and community-based services are no longer required;
- Individual is arrested, convicted, sentenced, and incarcerated for more than 90 calendar days; or
- Death.

REMEMBER, CASE MANAGERS ARE REQUIRED TO RE-START THE WAIVER TIMELY WHEN THE INDIVIDUAL RETURNS TO WAIVER SERVICES. INTERRUPTIONS MUST NEVER BE ENTERED WITH THE INTENT OF ALLOWING THE WAIVER TO AUTO-TERMINATE AFTER 45 CALENDAR DAYS (INTERRUPTIONS) OR 105 CALENDAR DAYS (EXTENDED INTERRUPTIONS).

Please see the BDDS Portal 2.0 User Guide for system instructions

## When does a Termination Require BDDS Prior Approval?

Case managers must contact the BDDS District Office for assistance and instruction before a waiver is terminated for non-responsiveness by the individual, parent(s) of minor children, or legal representative, as applicable. Pursuant to DDRS Policy: Individual/Parent/Legal Representative Responsibilities While Receiving Waiver Funded Services, written notice of the intent to terminate the individual's waiver services must be sent to the individual, parent(s) of a minor child, or legal representative, as applicable.

## How are Terminations Used in Practice?

Example 1:

When an individual, parent(s) of a minor child, or legal representative, as applicable, voluntarily chooses to withdrawal from services. The case manager will:

- Facilitate an Individualized Support Team meeting to discuss reasons for wanting to withdrawal from services. If, after discussion, the decision to proceed with withdrawing from services remains, the case manager should discuss other service options as appropriate. The case manager will also:
  - Explain the steps to take if they choose to return to the waiver program within the waiver year or in the future;
  - Obtain and upload a signed BDDS Signature Page documenting freedom of choice. *Please note, if the signature page is not returned within thirty (30) calendar days, the case manager may terminate the waiver at that time*;
  - Case note the individual, parent(s) of a minor child, or legal representative(s), as applicable, wishes to withdrawal from waiver services as well as any other related actions or activities.
  - Complete the waiver termination; and
  - Within three (3) calendar days of processing a termination, provide the individual, parent(s) of minor children, or legal representative, as applicable, with the Notice of Action (NOA), Appeal Rights as an HCBS Waiver Services Recipient instructions, and an explanation of the termination.

Example 2:

The parents of a minor child notify the case manager the family is moving out of state next month. The case manager will:

- Notify all waiver service providers of the impending move;
- Obtain and upload a signed BDDS Signature Page documenting freedom of choice;
- Case note the individual's move out of state as well as any other related actions or activities.
- Complete the waiver termination once all services have stopped and the individual has moved; and
- Within three (3) calendar days of processing the termination, provide the parents with a copy of the Notice of Action (NOA), Appeal Rights as an HCBS Waiver Services Recipient instructions, and an explanation of the termination.

Example 3:

An emancipated individual entered a Medicaid-funded long-term care facility for what was intended to be a stay of ninety (90) calendar days or less and their waiver was interrupted. If, upon ninety (90) calendar days in the facility, there is no immediate plan for discharge. The case manager will:

- Notify the district office of the impending waiver termination;
- Ensure the individual knows who to contact to re-enter waiver services if/when the individual is ready;
- Case note all activities with or on behalf of the individual;
- Terminate the waiver; and
- Within three (3) calendar days of processing the termination, provide the individual a copy of the Notice of Action (NOA), Appeal Rights as an HCBS Waiver Services Recipient instructions, and an explanation of the termination.

# Documentation Standards

There's an old adage that says, "If it isn't documented, it didn't happen." At any point in time, a case manager's supervisor and BDDS/BQIS staff should be able to review an individual's documentation with the assurance it is up to date within the time frames allowed. In this section case managers and case management organizations will be reminded of why it is important to complete documentation timely and accurately.

## Why is it Important to Adhere to Documentation Standards and Timeline Requirements?

Monitoring of the Home and Community Based Services (HCBS) waiver program is mandatory, and collection of timely documentation is essential in assuring the health, safety and welfare of individuals served. Without adherence to documentation standards and the established timelines for submitting documentation, individuals are at risk for negative, undetected, and/or undesirable consequences. Permission to operate HCBS waiver programs is granted by the Centers for Medicare and Medicaid Services (CMS) only when satisfactory assurances are made at the time of waiver application and ongoing compliance is demonstrated at prescribed intervals. Evidence proving compliance comes from data and documentation collected throughout the course of waiver operation.

Lack of appropriately documented and/or timely submission results in the assumption of lack of compliance. Additionally, when the state is unable to prove its compliance with these federal requirements, the state risks loss of federal matching funds essential to the successful operation of HCBS waiver services.

# Case Notes

This section on case notes provides the reader not only with BDDS' expectations for case note entries, including best practice, but why thorough and accurate case notes are important to the individuals receiving services and supports through BDDS' waivers.

## What are Case Notes?

Case note**s** are records that form the foundation of information needed by case management and BDDS staff, often at a moment's notice. These records, submitted for every interaction with or on behalf of individual, inform the reader of facts specific to an individual. Effective case notes employ strategic, insightful inquiry and understanding.

Case notes need to tell a story that any reader can appreciate. They can include, but are not limited to:

- Recounting conversations, including necessary follow-up activities or contacts;
- Recording team meetings and face-to-face visits; and
- Documenting case activities.

Basically, case managers should tell the reader what is happening with an individual without them having to ask for additional information. And remember case note lore "If it's not documented, it didn't happen." Keep in mind, case notes may be requested at any time by the individual, parent(s) of minor children, or legal representative, as applicable, and are also subject to subpoena for legal purposes. Case notes should *always* be professional.

## Why are Case Notes Important?

During times of great need or crisis, it is imperative that case management and BDDS staff understand the situation in real time. Without current, clear, concise, objective; and accurate details of the situation and what occurred (who, what, when, where, why, and how), important facts may be lost and have a detrimental impact on the individual. Accuracy in case noting also enhances the quality of case management provided, especially in crisis situations and for case managers with large caseloads.

## How are Quality Case Notes Written?

Let's look at some of the best ways to make your case notes more valuable to the reader. We'll begin with some basic Do's and Don'ts.

Do:

- Write in a style that is easily understood by all readers;
- Use professional language as well as correct spelling, capitalization, and punctuation;
- Include relevant details (who, what, when, where, why, and how);
- Base notes on the facts – first-hand observations are facts;
- Spell out acronyms before using them; and
- Say what you mean while refraining from criticism of the individual, parent(s) of minor children, legal representative(s), other providers, and/or State staff.

Don't:

- Include opinions and assumptions as they can result in bias;
- Use slang, clichés, or jargon;
- Use metaphors or similes;
- Include personal details that aren't relevant; or
- Include protected health information (PHI) or personally identifiable information (PII) beyond what is necessary. Never include PHI or PII of other individuals.

Additionally, case notes should be clear, concise, useful, relevant, and timely. Let's look at what each of those descriptors mean:

- **Clear** – Often, we are too close to what we are writing. We understand what we just said, but will any reader be able to understand it? If you are unsure, ask someone to read your case note to see if it makes sense to that person.
- **Concise** –Ensure that all relevant information included is in as brief of a format as possible.
- **Useful** – People who grew up watching Dragnet may remember the term "Just the facts ma'am". The phrase from the show is actually "All we want (or "know") are the facts, ma'am". This is the basis of useful case notes. They are the facts as we know them or have been told. To keep them useful, remember to include the 5 W's plus How and Next Steps.
- **Relevant** – This might be synonymous with useful. If something is mentioned in passing, it should not be recorded in a case note unless it is relevant to the situation at hand.
- **Timely** – Case notes should be written quickly or, at a minimum, within the required time frame.

Finally, the language used in case notes should reflect BDDS' mission and vision:

*The Bureau of Developmental Disabilities Services envisions a community where all people have equal access and opportunity to realize their good life. We are committed to partnering with individuals, parents of minor children, legal representatives, and professionals to ensure person-centered services that empower people with disabilities and their families by connecting them to the resources and supports to live their best life. Our core value is that all people have the right to live, love, work, learn, play, and pursue their dreams.*

*BDDS administers programs that support children and adults with intellectual and developmental disabilities to live their best life through community supports and residential options. Services are delivered using an individualized, person-centered approach where all people have equal access and opportunity to realize their good life.*

Case notes should use strength-based and person-centered language that reflects the development of comprehensive and integrated solutions which support the individual to live their best life. Their desires, cultural beliefs, and values should always be recognized, respected, embraced, and reflected.

Example 1

CM Smith received a call from Mary Greenway, guardian for Seth, informing her Seth would be traveling to Chicago for most of the month of September to spend the high holy days with family. Seth's faith is important to him and observance of the holidays as a family is part of their tradition. Seth will leave September 4, 2021 and plans to return to Fort Wayne September 30, 2021. Because Seth will be gone for more than 14 calendar days, his travel status was recorded in the BDDS Portal.

Example 2

CM Jones participated in face-to-face visits with Susie and her sister today. Susie and her sister prefer to have her team meetings and face-to-face visits at the same time and are members of each other's Individualized Support Team (IST). At their request, their father also participated. Susie is very social and reported being bored because she is home so much. Staff take Susie and her sister out shopping and to a movie weekly, but she is looking forward to returning to her day program next week and seeing everyone again. Susie also shared she is still working on finding a local dance club to join and has visited two clubs with her cousin this month. Susie's PCISP was updated to reflect this discussion.

Example 3

CM Smith contacted Sam and his mother to schedule the annual planning meeting due in September. An agenda for the meeting was discussed as well as who Sam and his mother would like invited to the meeting. Sam is enjoying camping with his family and would like to have the meeting in his backyard so he can show his team his new tent. The meeting will be held on September 20th at Sam's house. CM will share the time and location with the team and ask them to bring their own lawn chairs. Mom will contact Sam's aunt, as he would like her at his team meeting.

## When are Case Notes Required?

Case notes are required for every interaction with or on behalf of the individual within seven (7) calendar days, at a minimum, for compliance.

REMEMBER, CASE MANAGERS MUST HAVE AT LEAST ONE DOCUMENTED MEANINGFUL ENCOUNTER MONTHLY TO SUPPORT BILLING. SENDING A TEXT OR LEAVING A VOICEMAIL DOES NOT MEET THE STANDARD FOR A MEANINGFUL ENCOUNTER. ADDITIONALLY, CASE MANAGEMENT ORGANIZATIONS MAY NOT BILL IN A MONTH WHEN NON-CASE MANAGEMENT ACTIVITIES, SUCH AS MAILING GREETING CARDS OR SENDING HOLIDAY MESSAGES, FOR EXAMPLE, ARE THE SOLE ACTIVITY.

Case Management Waiver Service Definition


BEST practice is demonstrated by thoroughly and accurately case noting each encounter with or on behalf of the individual within 24 hours.

BETTER practice is demonstrated by thoroughly and accurately case noting each encounter with or on behalf of the individual within 72 hours.

Compliance requires thorough and accurate case notes to be entered to document each encounter with or on behalf of an individual within 7 calendar days at a minimum.

## *Monitoring Checklist*

The Monitoring Checklist section includes what the checklist is, why it's important to the individual, parent(s) of minor children or legal representative(s), as applicable, and case manager, and when it is completed. Additional information on the Monitoring Checklist is available in the Monitoring Checklist Interpretive Guidelines, available as an addendum to the Quality Guide.

### What is the Monitoring Checklist?

The monitoring checklist is a pre- and post-meeting and face-to-face visit checklist. It is **not** to be completed during team meetings or face-to-face visits. Use of the checklist pre-meeting will prepare the case manager for the meeting or visit. Information on the individual's environment, for those living in a provider owned or controlled setting (POCOS), staffing, and choice and rights will be recorded post-meeting or visit.

### Why is the Monitoring Checklist Important?

Completed as intended, the monitoring checklist supports the case manager in his/her quarterly review and management of the individual's annual planning documents, support and risk plans, health issues, staffing, choice and rights, as well as other issues. Accurate and correct completion of the monitoring

checklist is vital to meeting the needs and desires of all individuals. Further, it ensures the appropriate services and supports are being provided and correctly implemented in a timely manner.

## When is the Monitoring Checklist Completed?

Checklists are due on the last day of each Service Plan quarter. Case managers are allowed a "grace period" each quarter and may hold meetings and enter monitoring checklists 15 calendar days before or after that date.

| Service Plan Start | End | Quarterly Checklist | Mid-Year Checklist | Quarterly Checklist (Annual Planning) | Year End Checklist |
|---|---|---|---|---|---|
| Jan 1 | Dec 31 | March 31 | June 30 | September 30 | December 31 |
| Feb 1 | Jan 31 | April 30 | July 31 | October 31 | January 31 |
| Mar 1 | Feb 28 | May 31 | August 31 | November 30 | February 28/29 |
| Apr 1 | Mar 31 | June 30 | September 30 | December 31 | March 31 |
| May 1 | Apr 30 | July 31 | October 31 | January 31 | April 30 |
| Jun 1 | May 31 | August 31 | November 30 | February 28/29 | May 31 |
| Jul 1 | Jun 30 | September 30 | December 31 | March 31 | June 30 |
| Aug 1 | Jul 31 | October 31 | January 31 | April 30 | July 31 |
| Sep 1 | Aug 31 | November 30 | February 28/29 | May 31 | August 31 |
| Oct 1 | Sep 31 | December 31 | March 31 | June 30 | September 31 |
| Nov 1 | Oct 31 | January 31 | April 30 | July 31 | October 31 |
| Dec 1 | Nov 30 | February 28/29 | May 31 | August 31 | November 30 |

### Following the IST Meeting or Face-to-Face Visit

After the Monitoring Checklist review, Case Managers should ensure the following actions have been completed:

- Enter the Monitoring Checklist responses and any Corrective Action Plans (CAPs) prior to the checklist due date;
- Case note the meeting within seven (7) calendar days;
- Ensure all risks have a current risk plan in the document library;
- Update the PCISP, including services, following annual and non-annual team meetings, as needed after face-to-face visits, or as needed and desired by the individual, parent(s) of minor children or legal representative(s) as applicable;
- Ensure the Level of Care Screening Instrument (LOCSI) is current; and
- Upload all documents obtained at or after the meeting.
- The Annual BDDS signature page for the PCISP must be uploaded within thirty (30) calendar days following the start of the plan year.
- The BDDS signature page for the Initial PCISP must be uploaded within thirty (30) calendar days following the start of the initial plan year. *Note, the Initial Case Management Only (ICMO) service plan providing 2 units of case management does not require a signature page. The units of case management provided in the ICMO service plan will be included in the total number case management units in the Initial PCISP.*

*Please note, because the Monitoring Checklist is a pre- and post-meeting document, a signature page is not required. The document Monitoring Checklist Interpretive Guidelines is available as an addendum to this document.*

## *Fiscal Review*

A fiscal review is an evaluation of an individual's budget, control of assets, and allocation of funds. There is no "checklist" for fiscal reviews as in previous case management systems, but this section will guide you through the Why, When, and Next Steps of a fiscal review.

### Why are Fiscal Reviews Important?

Fiscal reviews of adults in waiver services can be important to increase person-centered practices around financial management for the individual, develop an understanding of an individual's assets, property, and expenses, implement reasonable safeguards against theft or mismanagement, support individuals to live within their means, and identify potential issues of financial mismanagement or exploitation that may require remediation or further investigation.

The financial review can be captured in the PCISP life domain of 'Safety and Security' if appropriate. The PCISP should capture the individual's financial needs and supports including, but not limited to, the individual's representative payee (if applicable), how the individual's finances are protected, if the individual earns their own income, how the individual accesses discretionary funds, how the individual is included in financial decisions including such things as groceries, and how leases, rent, and utilizes are handled.

Individuals should be supported to manage their money as independently as possible while supporting them at their level of need and mitigating any potential risks. The individual has the right to know how much money they have and how their money is being spent. When the individual's provider is the representative payee with the Social Security Administration, the PCISP should include how and the frequency in which the individual's financial status will be communicated with the individual and legal representative, if applicable.

### When Should Fiscal Reviews be Conducted?

A fiscal review should be conducted at least quarterly. However, finances should also be discussed and reviewed when there is suspected financial exploitation or when financial resources/expenses or oversight responsibilities change. When the individual's provider is the representative payee with the Social Security Administration, the individual's financial status should be discussed, reviewed, and communicated in the mode and the frequency identified in the PCISP.

### What are the Steps of a Fiscal Review?

Initially, the case manager should ensure the PCISP and individual's profile contain the necessary information regarding financial oversight (e.g., Rep Payee, individual's own income, financial status updates, etc.). General financial discussions should occur on an ongoing basis to guard against, or identify, financial exploitation.

**460 IAC 6-3-24 Exploitation**

- Unauthorized use of the personal services, the property, or the identity of an individual; or
- Any other type of criminal exploitation under IC 35-46-1-1; for one's own profit or advantage or for the profit or advantage of another.

At least quarterly, the case manager should discuss the following questions with the individual and their legal representative, if applicable, providers, and other team members.

| Discussion Question | Potential Documents for Review | Next Steps |
|---|---|---|
| If desired by the individual, has the identified provider ensured current insurance coverage at the individual's expense to protect assets and property? | • Insurance policy | • Document desire and outcome in PCISP<br>• Review policy<br>• Document in monitoring checklist |
| Does discussion with staff, the individual and legal representative, if applicable, confirm that a provider or provider's employees are not lending money to, or borrowing money from, the individual? | NA | • Document in case notes/monitoring checklist<br>• If not, file an IR for potential exploitation and ask the provider for an internal investigation |
| Has the individual avoided being charged for and/or paying for late fees and overdraft charges for the last 90 days? | • Bank statement<br>• Bills | • Document in case notes<br>• If not, file an IR for potential exploitation and ask the provider for an internal investigation |
| Does discussion with staff, the individual and legal representative, if applicable, indicate staff may be taking advantage of the individual (doing laundry, eating the individual's food, borrowing money, etc.)? | NA | • Document in case notes<br>• If yes, file an IR for potential exploitation and ask the provider for an internal investigation |
| If the provider is the SSA Rep Payee, has the provider communicated the financial information in the mode and frequency agreed upon? | • Bank statement<br>• Bills<br>• Financial reconciliation | • Document in case notes<br>• If not, follow-up with the provider on the provision of information |

## *Level of Care Screening Instrument*

This section on the Level of Care Screening Instrument, also known as the LOCSI, explains why it's important and how assessors are to be person-centered when determining level of care.

## What is a Level of Care Assessment?

The Level of Care Screening Instrument is the tool both BDDS service coordinators and case managers use to determine if an individual is eligible for admission to an intermediate care facility or for enrollment in a home and community-based services waiver. The LOC is not intended to be a comprehensive assessment of the person but serves as a foundation for other assessments and service planning.

## Why is the Completing a Person-Centered Level of Care Assessment Important?

The completion of a person-centered level of care assessment serves as a foundation for additional assessment needs and service planning. It will help the assessor to know the person and their valued social role by showing the person's interests and expectations as well as any substantial functional limitations (SFLs). Completing a person-centered LOCSI will provide one component for supporting the person in pursuing their good life. This LOCSI may provide the foundation for future teams to think about and remain focused on what it is the individual has identified as their good life.

## How are Person-Centered Level of Care Assessments Developed?

The assessor uses information gathered from a discussion with the individual and collateral documents to complete the screening. Participation from the individual, parent(s) of minor children or legal representative(s), as applicable, and key people in the person's life is fundamental to the development of a person-centered level of care assessment. LOCSIs should be thorough and focus on the individual's current status, wants, aspirations, needs, and services/assistance that are already in place. The assessor should ask person-centered, probing questions. This will help provide depth to the conversation. The focus of any discussion with an individual in preparation for the LOCSI should be on who this person is without the behavior or diagnosis which should result in a more positive, person-centered, strength based LOCSI. A finished LOCSI should give the reader a snapshot of the individual.

To qualify for HCBS waiver services an individual:

- Must meet both the State and Developmentally Disabled Eligibility requirements contained in Indiana Code 12-7-2-61 (a); and
- Meet the ICF/IID level of care (LOC) requirements contained within the Code of Federal Regulations (CFR) 42 CFR 435.1009 and 42 CFR 435.1010

To meet ICF/IID Level of Care a person must meet the following criteria:

- Have a confirmed mental and/or a physical impairment (other than a sole diagnosis of mental illness) that begins before the age of 22 years and is expected to continue indefinitely; and
- Have a substantial functional limitation (SFL) in at least three (3) of the following areas:
    - Self-Care
    - Learning
    - Mobility
    - Understanding and Use of Language
    - Self-Direction
    - Capacity for Independent Living

To meet State of Indiana Developmental Disability Eligibility requirements, a person must meet the following criteria:

- Have a confirmed mental and/or a physical impairment (other than a sole diagnosis of mental illness) that begins before the age of 22 years and is expected to continue indefinitely; and
- Have a substantial functional limitation (SFL) in at least three (3) of the following areas:
    - Self-Care
    - Learning
    - Mobility
    - Understanding and Use of Language
    - Self-Direction
    - Capacity for Independent Living
    - Economic Self-Sufficiency

The individual may not meet ICF/IID level of care but still meet the Indiana definition of a person with a developmental disability. For example, the individual has two substantial functional limitations in the areas of major life activities AND a substantial functional limitation in the area of Economic Self-Sufficiency. If the third substantial functional limitation is Economic Self-Sufficiency and the individual does not meet ICF/IDD level of care, they may be eligible for Stateline services.

## When are Level of Care Assessments Entered?

### Initial and Re-Entry

LOCSIs for individuals entering or returning to BDDS waivers are completed by BDDS district service coordinators and must be dated within ninety (90) calendar days of submission of the request for authorization of services in the individual's PCISP. Individuals receiving transitional case management or who are utilizing the MFP-CIH waiver, an update to the initial LOCSI by the BDDS district service coordinator may be required. In those instances, case managers must contact the service coordinator prior to the intended transition and start of the waiver.

*Please note, if the individual's waiver has a Transitional status, and more than ninety (90) calendar days will have passed before the Initial plan is confirmed, the case manager should request a new Initial LOCSI be completed by BDDS at the time of the pre-transition meeting.*

### Annual

Case managers and case management organizations are responsible for ensuring continued demonstration of eligibility through completion and review of a new LOCSI every three hundred sixty five (365) calendar days at a minimum. If the individual does not meet the level of care for eligibility, the reviewer is to assign the LOCSI to BDDS for a tertiary review. Once the review is complete the individual, parent(s) of a minor child or legal representative(s), as applicable, will be notified. If it is determined the individual does not meet level of care, the case manager will work with the BDDS service coordinator to ensure a smooth transition out of waiver services with the assistance of other available resources. In the event the decision is appealed, services will remain in place throughout the appeal process.

*Continued on next page.*

An individual's Person-Centered Individualized Support Plan should ***never*** include information solely for the purpose of documenting answers to questions in the LOCSI. Examples of ***improper*** practice include, but are not limited to, the following:

- Mary can walk for one city block without assistance.
- Tom can feed himself and does not need adaptive equipment.
- Jane can toilet independently.

## *Living Arrangements*

This section on Living Arrangements outlines what living arrangements are, why accuracy in documenting is living arrangements is important, and how they are applied in practice, including the use of the provider owned or controlled setting (POCOS) designation.

### What are Living Arrangements?

An individual's living arrangement reflects their choice of where they live, if they live alone or with someone else, or are in an institutional setting prior to transitioning to community living with a Home and Community Based Settings (HCBS) waiver.

### Why are Living Arrangements Important?

In addition to providing your case management organization and BDDS with important information, living arrangements play an important role in determining the funding available for individuals utilizing the Community Integration and Habilitation (CIH) waiver. Residential living arrangements, day services, and behavior scores are all components used to determine an individual's Objective Based Allocation. Correct living arrangements ensure the individual has the appropriate funding for their situation. Case managers must be diligent in entering living arrangement changes timely as they may only be back dated ten (10) calendar days. Failure to enter changes timely may have a negative impact on the providers' ability to accurately bill for services rendered.

*Continued on next page.*

### PROVIDER OWNED OR CONTROLLED SETTINGS (POCOS)

Individuals residing in provider-owned or controlled settings must be identified as such in the BDDS Portal. This notation prompts questions required by the Home and Community Based Settings Final Rule in the individual's PCISP and schedules the unannounced visit required annually. Further, the POCOS status will be reviewed as part of the Case Record Review beginning in 2022.

For the purposes of complying with these requirements, Indiana defines provider owned or controlled settings to include:

- Residential settings that are owned by a provider; or
- Residential settings in which individuals, who are not living in their family home, utilize:
  - Residential Habilitation and Support – Level Two (RH20);
  - Residential Habilitation and Support - Daily (RHS Daily - RD); or
  - Structured Family Caregiving (SFC).

## How are Living Arrangements Applied in Practice?

The following list of living arrangements includes examples of how each may be applied in practice:

- Living in Family Home (No shared RHS staff)

  Example 1: Adult siblings live in their family home. One receives supports through the CIH waiver, including RHS services, the other is supported through the FS waiver.

  POCOS: Because they reside in the family home, neither are designated as living in a provider-owned or controlled setting (POCOS) regardless of the type or amount of RHS received.

  Example 2: Siblings of any age live in their family home, both receiving services through the FS waiver through which RHS and SFC are not offered.

  POCOS: Because they reside in the family home neither is designated as living in a provider-owned or controlled setting (POCOS).

  Example 3: Individual lives in their family home and does not have another family member who receives waiver services.

  POCOS: Because the individual resides in the family home, s/he is not designated as living in a provider-owned or controlled setting (POCOS) regardless of the type or amount of RHS, if any, is received.

  Example 4: Married couple reside with the wife's parents. The husband receives RHS supports through the CIH waiver. The wife is supported through the FS waiver and therefore can't receive RHS or SFC services.

  POCOS: Because they reside in the family home, neither is designated as living in a provider-owned or controlled setting (POCOS).

- Living in Foster Home (SFC/AFC service)

Example 1: An adult individual is living in the private home of an unrelated caregiver utilizing the Structured Family Caregiving service.

POCOS: Because the individual resides with a non-family member and receives Structured Family Caregiving services, the individual is designated as residing in a POCOS.

Example 2: An adult individual is living in their family home and receiving Structured Family Caregiving from a parent.

POCOS: Because the individual is living in the family home, they are not designated as residing in a POCOS.

- Living with non-RHS sharing roommates (Not family)

  Example 1: Married individuals, one receiving RHS Level Two (RH20) through the CIH and one receives services through the FS, but they are of no support to one another.

  POCOS: Because they do not reside in the family home and one receives RHS Level Two (RH20), both are designated as living in a provider-owned or controlled setting (POCOS).

  Example 2: Individual with a CIH waiver, receiving RHS Daily (RD) services, lives with an individual currently waitlisted for a waiver who does not provide support to the individual receiving waiver services.

  POCOS: Because the individual receiving RD services does not live in the family home, s/he is designated as residing in a provider-owned or controlled setting (POCOS).

- Living with minors only

  Example 1: Individual receiving only PAC services through the FS waiver lives with his/her minor child who does not receive waiver services.

  POCOS: Because the individual does not receive RHS Level Two (RH20), RHS Daily (RD), or Structured Family Caregiving (SFC), the setting is not designated as a provider owned or controlled.

  Example 2: Individual receiving RHS Level Two (RH20) lives with his/her minor child who receives waiver supports through the FS waiver.

  POCOS: Because the individual is receiving RH20, both are designated as residing in a provider owned or controlled setting (POCOS).

- Living with caregiver (special consideration/BRQ needed)
- Living alone (Own home or apartment)

  Example: Individual lives alone and is not available for a housemate. They choose to live alone.

  POCOS: If the individual receives RHS Level Two (RH20) or RHS Daily (RD), they are designated as residing in a provider owner or controlled setting.

- Living alone (Not own home or apartment)

  Example: Individual lives alone but is available for a housemate. They are actively seeking a roommate due to someone recently moving out.

  POCOS: If the individual receives RHS Level Two (RH20) or RHS Daily (RD), they are designated as residing in a provider owner or controlled setting.

- Living with one housemate (sharing RHS staff)

  Example: Individual shares housing and RHS staff with another waiver individual.

POCOS: If either individual receives RHS Level Two (RH20) or RHS Daily (RD), both are designated as residing in a provider owner or controlled setting.

- Living with two housemates (sharing RHS staff)

  Example: Individual shares housing and RHS staff with two individuals.

  POCOS: If any of the individuals receive RHS Level Two (RH20) or RHS Daily (RD), all are designated as residing in a provider owner or controlled setting.

- Living with three housemates (sharing RHS staff)

  Example: Individual shares housing and RHS staff with three individuals.

  POCOS: If any of the individuals receive RHS Level Two (RH20) or RHS Daily (RD), all are designated as residing in a provider owner or controlled setting.

- Living in institutional setting (initials only)

  Example: Individual is currently living in a supported group living (SGL) home and transitioning to waver services.

  POCOS: All individuals living in institutional settings are designated as residing in a provider-owned or controlled setting (POCOS).

  Example: Individual is currently in a DCS funded residential facility, is aging out, and transitioning into waver services.

  POCOS: All individuals living in institutional settings are designated as residing in a provider-owned or controlled setting (POCOS).

- Not known at this time (initials only)

  Example: Individual left their previous residence, and their residential location is unknown.

The following living arrangements relate to sites that were previously supported group living sites that converted to waiver homes. These living arrangements cannot apply to new locations per IC 12-11-1.1-1:

- Living with four housemates (sharing RHS staff)
- Living with five housemates (sharing RHS staff)
- Living with six housemates (sharing RHS staff)
- Living with seven housemates (sharing RHS staff)

## Institutional Settings

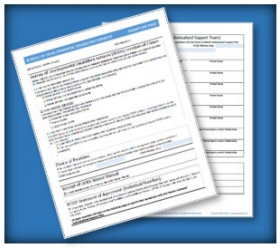
For minors residing in institutional settings and who will receive waiver services during visits home, the waiver may be continued. The waiver services provided may not duplicate services provided by the facility. For example, an individual may not receive Behavioral Support Services through the waiver if behavioral supports is provided by the facility. Additionally, Respite cannot be used as the service definition allows it only for the relief of those persons who normally provide care to the individual.

The individual's living arrangement will be Living in Institutional Setting and their address will be the address of the facility. Meetings/visits must continue to occur every ninety (90) calendar days and the individual must be present for their meetings.

The waivers of individuals who do not meet these requirements may be interrupted initially if they are expected to begin home visits or return home within ninety (90) calendar days. If they do not return home,

the waiver must be terminated. If the waiver year end (July 15) passes without the individual's return to the waiver, he or she should contact the BDDS District Office for assistance with waiver re-entry.

## *BDDS Signature Page*



The BDDS Signature Page is a single document that can be used for one or multiple purposes. In this section, case managers will learn how to accurately document Freedom of Choice, Choice of Providers, Receipt of the DDRS HCBS Waivers module, and PCISP Statement of Agreement for individuals, and parent(s) of minor children or legal representative(s), as applicable.

### What is the BDDS Signature Page?

The BDDS Signature Page (signature page) is a form that is used by individuals, parent(s) of minor children or legal representative(s), as applicable, and ISTs to acknowledge choice, receipt of waiver material, and/or agreement with other documents:

- Freedom of choice between waiver services, non-waiver services, and the choice not to receive ICF/ID Medicaid services;
- Choice of services included in the PCISP and who provides them;
- Receipt of the DDRS HCBS Waivers module or a link to the module;
- Participation in the development of the PCISP and agreement with the authorized plan by the individual, parent(s) of minor children or legal representative(s), as applicable; and
- Agreement of Individualized Support Team (IST) members responsible for implementing the finalized PCISP.

### How is the BDDS Signature Page Used?

- The individual's name and Medicaid Recipient Identification (RID) number must appear at the top of the document.
- Checkmarks indicating agreement must be included in each section covered by the signature(s) of the individual and parent(s) of minor children or legal representative(s), as applicable.
    - The Freedom of Choice section is used annually in conjunction with the annual service plan. Additionally, it is required documentation for transitions.
    - The Services section documents the agreement of the individual, parent(s) of minor children or legal representative, as applicable, with the services and service providers detailed in the Annual PCISP, and to acknowledge they have been informed of their right to choose any BDDS approved, certified waiver provider. When using the signature for this purpose, the PCISP Statement of Agreement (for the individual, parent(s) of minor children or legal representative(s), as applicable) and Freedom of Choice sections must also be completed.
    - Receipt of the DDRS HCBS Waivers module confirms receipt of the module or link to the module by the individual, parent(s) of a minor child, or legal representative(s), as applicable.
    - The PCISP Statement of Agreement is required to confirm participation in, development of, and agreement with a specific, finalized, PCISP by the individual and parent(s) of minor children or

legal representative(s), as applicable, Further it confirms their knowledge of how to appeal if they disagree with how the plan is implemented. Detailed information on the PCISP must be included in the section for IST member signatures (see next bullet point).

- The PCISP Statement of Agreement (Individualized Support Team) is signed by all team members responsible for implementation of a specific PCISP. When using the signature page for this purpose, the meeting date of the annual planning meeting, the effective date of the PCISP, and the PCISP serial number must be included. Please note, only one serial number may be referenced in the Service Plan and PCISP Statement of Agreement (IST) sections of the signature page (i.e., one service plan serial number, and/or one PCISP serial number).

- Both sides of the signature page must be uploaded, dated, and signed by the individual and parent(s) of minor children or legal representative, as applicable, to be valid.

*Please note, a new BDDS signature page will be released at implementation of the BDDS Portal 2.0 when service authorization becomes part of the PCISP.*

### When is the BDDS Signature Page Required?

The BDDS Signature Page must have the following sections completed annually:

- Freedom of choice;
- Services;
- Receipt of DDRS Waiver Manual;
- PCISP Statement of Agreement (Individual/Parent/Legal Representative); and
- PCISP Statement of Agreement (Individualized Support Team).

Required timelines:

- Annual BDDS Signature Pages must be uploaded within thirty (30) calendar days following the start of the plan year.
- Update BDDS Signature Pages must be uploaded within thirty (30) calendar days following the team meeting where changes were made. Note, when a PCISP or service plan is updated to include more than minor changes, a new signature page is required,

*Please note, BDDS does not require a signature page simply to document team meetings or face-to-face visits, but they must be case noted. Additionally, the Monitoring Checklist is a pre- and post-meeting document that is not to be completed face-to-face with the individual and parent(s) of minor children or legal representatives, as applicable. Therefore, a signature page is not needed or desired.*

## *Provider Choice*

Individuals receiving needed services and supports through Indiana's Home and Community-Based Waivers have the right to choose and change the services they receive, as well as who provides them, as required by 42 CFR §431.151. Demonstration of choice is documented using the Provider Choice List.

### What is the Provider Choice List?

The Provider Choice List (choice list) is a single use document that lists the names, contact information, and a description entered by the provider. Individuals and parent(s) of minor children or legal representative(s), as applicable, can use the choice list, with the assistance of their case manager, to determine what providers are available to provide a selected service within a specific geographic location.

### How is a Provider Choice List Obtained?

Case Managers or their CMO will provide an individual, parent(s) of a minor child, or legal representative(s) they support with a current, blank choice list for the service and location desired whenever asked. If a choice list is requested for case management services, regardless of whether the individual is currently served by the organization the request is made to, a current, blank choice list shall be provided.

When a choice list is received by the receiving CMO, they will contact the transferring CMO, providing a copy of the choice list, and the transferring CMO will process a Change CMO transfer from the individual's Manage page in the BDDS Portal within five (5) business days. When a current CMO receives a choice list for another CMO, they will notify the receiving CMO, providing a copy of the choice list, and process the transfer from the individual's Manage page in the BDDS Portal within five (5) business days.

### How is the Provider Choice List Used?

During the person-centered planning process, the case manager will discuss services and supports with the individual and parent(s) of minor children or legal representative(s), as applicable, that are most likely to fulfill the need or desire that will move the individual's trajectory toward their self-identified best life. Once a service and provider have been selected, their choice will be reflected in a signed and dated choice list.

### When is the Provider Choice List Required?

A choice list is required whenever a service is added to the services section of the PCISP, or in the event of a change in service provider. The choice list must be signed by the individual and parent(s) of minor children or legal representative(s), as applicable, dated, and uploaded to the individual's document library within thirty (30) calendar days of the start date of the service or change of provider documented in the Services section of the PCISP. Please note, choice lists are not required on an annual basis.

## *Data Management*

This section on data management includes information data security, quality oversight, and maintenance requirements. For the purposes of this guidance, BDDS' systems refer to the BDDS Portal, Level of Care Screening Instrument entry system, and the Incident and Follow-Up Reporting System.

### What is Data Management?

Data management is comprised of all information related to an individual applying for or receiving BDDS services. This encompasses collecting, entering, processing, storing, retrieving, and using data as well as validation and control of data according to established requirements to ensure the accessibility, reliability,

and timeliness of the data for all users. The data created and maintained by case managers and the case management company is an essential component of supporting individuals in BDDS services.

Data management includes the following:

- Data Security/Sharing – data must always be secured and shared according to HIPAA laws; Indiana Code (IC); Indiana Administrative Code (IAC) 460; and DDRS policy which includes, but is not limited to, electronic mail, computers, laptops, and electronic notebooks.
- Data Quality Management – case management companies must employ a quality audit process to validate that data is consistent, current, and complete.
- Data Requirements – maintenance of the individuals' records within the BDDS Portal including, but not limited to, all demographics (basic information, legal status, living arrangements, relationships, and diagnosis), other sections identified within the individual's record, and all required documentation.

## Why is Data Management Important?

The data collected and maintained by case managers is an essential component to providing services and supports to individuals that results in positive outcomes and the realization of the individual's self-identified good life. Effective data management ensures time and resources are utilized to collect and maintain information across BDDS' systems.

Data integrity is imperative. Data should correlate across all BDDS documents and system data fields. Case managers should strive to ensure the data in the individual's case file is free from inaccurate and/or duplicate information as well as poor data entry such as misspelling, mislabeling, typos, etc. By adhering to the established requirements, guidelines, and nomenclature, the integrity of the data within the systems is maintained. By ensuring data integrity the data within the systems can be used to drive data-decision making and identify individual and/or system trends.

## How do Case Managers Ensure Current, Consistent, and Complete Data?

- Current data requires case managers to ensure the data in the individual's case file is up to date. The data in the BDDS Portal should reflect the individual's current situation, including but not limited to, the individual's address, phone number, living arrangement, legal status and related documentation, housemates, as well as the PCISP, BSP, or other pertinent documents
- Consistent data requires case managers to ensure data in collected documents, data fields, and case files include the same information.
- Complete data requires case managers to ensure there are not gaps in data. Essentially, the data that is supposed to be collected, entered, and/or uploaded is present.

During the intake process, the case manager must be sure to obtain complete and comprehensive information, including any necessary documentation (e.g., legal representative paperwork). If the collected data is not current and comprehensive, it can have an impact on service planning, ensuring essential supports are in place, health and safety, and ultimately the individual's ability to pursue their best life. Case managers are the front-line to ensure current, consistent, and complete data is available for each individual served.

Ongoing, and as circumstances change, the case manager must ensure the required updates to BDDS systems and documents are made. Additionally, the case manager must ensure information collected from the individual's team is consistent with all other information for the individual. For example, if/when a provider uploads a risk plan for the individual, the case manager must ensure the risk plan reflects the team's decision and information on the risk included in the PCISP.

# *Timely Completion of Requirements*


Case managers are responsible for assisting individuals in living their good life. It is important that every individual has timely access to all supports whether paid or unpaid. Ensuring that the tasks assigned to case managers are completed in a timely manner will help guarantee that an individual's services and supports continue and allow for the individual to continue working towards their identified good life.

## IST Meetings and Face-to-Face Visits

Individualized Support Team (IST) meetings must be held at least semi-annually at the end of the first and third (annual planning) quarters of the individual's plan year. IST meetings may be held in a manner desired by the individual and parent(s) of minor children or legal representative(s), as applicable. The individual and parent(s) of minor children or legal representative, as applicable, must be present for all IST meetings.

Face-to-face visits must be held semi-annually at the end of the second and fourth quarters of the individual's plan year. Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program. The individual and parent(s) of minor children or legal representative(s), as applicable, must be present for all face-to-face visits.

IST meetings and face-to-face visits are required to be held in a manner that ensures interaction at least every ninety (90) calendar days. At least one IST meeting or face-to-face visit must be held in the home each year.

For individuals residing in provider owned and/or controlled settings (POCOS), case managers must ensure at least one visit each year in the home is unannounced. Unannounced visits are intentional interactions and are not completed by arriving at the home early for a planned meeting or visit.

REMEMBER, INDIVIDUALS WITH HIGH RISK OR HEALTH NEEDS, FORMERLY CATEGORIZED AS ALGO 6, REQUIRE ADDITIONAL OVERSIGHT AND SUPPORT. CASE MANAGERS MUST HAVE MONTHLY FACE-TO-FACE INTERACTIONS WITH THESE INDIVIDUALS WHO:

- REQUIRE ACCESS TO FULL-TIME SUPERVISION (24/7) AND MORE THAN A 1:1 STAFF TO INDIVIDUAL RATIO;
- HAVE NEEDS THAT ARE EXCEPTIONAL;
- REQUIRE MORE THAN ONE (1) CAREGIVER EXCLUSIVELY DEVOTED TO THE INDIVIDUAL FOR AT LEAST PART OF EACH DAY; AND
- ARE IN IMMINENT RISK OF HARMING THEMSELVES OR OTHERS, OR BOTH, WITHOUT VIGILANT SUPERVISION.

PCISP Guide

## Person-Centered Individualized Support Plan (PCISP)

### Initial / Re-Entry

An Initial / Re-entry PCISP must be developed and submitted for service authorization within forty-five (45) calendar days of BDDS on-boarding an individual's file to a case management company, even if Case Management is the only service at that time. Additional services may be added through updating the PCISP when other services and providers are selected.

### Update

An update to the PCISP is required when:

- The needs or circumstances of the individual changes;
- Services are added or removed;
- Requested by the individual, parent(s) of minor children, or legal representative(s), as applicable; or
- For non-annual team meetings to record team discussion on outcomes and any related plan changes.

PCISP updates must be documented within seven (7) calendar days at a minimum

### Annual

The Annual PCISP must be developed and submitted for service authorization a minimum of forty-five (45) calendar days prior to the end of the previous plan year.

When an annual PCISP is not submitted timely and the services authorized through the previous PCISP will expire without BDDS intervention, an extension PCISP will be created by BDDS. If this occurs, the case management organization will complete the Default Annual PCISP Remediation Report sent to them by BDDS within seven (7) calendar days and reflect the remediation specific to every individual for whom there was an extension created. Information must include:

- An explanation of why the PCISP was late; and
- Actions taken to complete the overdue PCISP.

Additional information may be requested in the quarterly Quality Training and Improvement Practices report.

### Important Note

Until the release of BDDS Portal 2.0, part of the BDDS systems consolidation project, Person-Centered Individualized Support Plans (PCISPs) and Cost Comparison Budgets (CCBs) will continue to be submitted separately. Please see the Interim Guidance for Timely Completion of Annual PCISPs and CCBs released with this guide and available on the resource page of the BDDS Portal.

## Budget Requests

### Short-Term Request (BMR)

A Short-Term Request (also known as a Budget Modification Request or BMR) must be filed by the case manager within sixty (60) calendar days of the event or status change. This submission extension from forty-five (45) to sixty (60) calendar days is in effect until further notice. For complete information on Short-Term Requests, please see the BDDS Policy: Budget Modification Timeline.

### Long-Term Request (BRQ)

A Long-Term Request (also known as a Budget Review Questionnaire or BRQ) means a set of qualifying questions to determine why a budget review is necessary that is submitted by the individual's case manager based on the information provided by the Individualized Support Team (IST). A BRQ is a request to review whether an individual has experienced a change in condition or status that is permanent in nature and, as such, requires the provision of additional services or supports for the individual to remain in the community such that the individual's budget needs to be increased. For complete information on Long-Term Requests, please see the BDDS Procedure: Budget Review Questionnaire.

## Monitoring Checklist

Monitoring checklists are due on the last day of each quarter of an individual's plan year. Case managers are afforded a "grace period" each quarter and may hold meetings and enter monitoring checklists 15 calendar days before or after that date. Complete requirements for the monitoring checklist, including a timetable, are available in the Monitoring Checklist section.

## Level of Care Screening Instrument (LOCSI)

Following onboard to a case management organization, the LOCSI must be completed by the case manager (assessor) and approved by a supervisor or other designated case management staff (reviewer) every 365 calendar days. When a LOCSI is not submitted timely, the case management organization will complete the Late LOCSI Remediation Report sent to them by BDDS within seven (7) calendar days and reflect remediation specific to every individual for whom a LOCSI was not submitted or was submitted late. Information must include:

- Why the determinations were completed late; and
- Actions taken to ensure completion of these determinations.
- Additional information may be requested in the quarterly Quality Training and Improvement Practices report.

## Case Notes

Case notes are required for each encounter with or on behalf of the individual within seven (7) calendar days at a minimum. Case managers must have at least one documented meaningful encounter monthly to support billing. For complete information on case notes, please see the Case Notes section.

## Incident Reporting and Management (IR)

An initial IR must be submitted within 24 hours of the incident or of receiving knowledge of the incident. The provider responsible at the time of the occurrence shall submit the IR, however if no provider is responsible at the time, the first provider who has knowledge of the occurrence shall submit the IR. All case managers, provider staff, BDDS staff, and BQIS staff are required to report any incident that meets the reporting criteria. Case managers are responsible for timely submission of IR follow-ups every seven (7) calendar days of the date of the initial IR until BQIS declares the incident to be closed.

Incident reports may be deemed critical events by BQIS if actual or alleged events jeopardize the health, safety, or welfare of the individual receiving services. This includes cases of abuse, neglect, and exploitation as well as significant injury. Once determined to be a critical event, the case manager must:

- Ensure the individual's immediate health and safety through live, person-to-person contact with the IST and the specific provider to create a plan of action within twenty-four (24) hours if protective measures do not appear to be in place;
- Request a full report of the provider organizations' investigation into the incident;
- And document all activities in case notes:
  - Contacts;
  - Scheduling information;
  - Requests for investigation reports;
  - Supporting documentation; and
  - All outcomes and supports discussed and implemented.
- Submit the initial follow-up report within seventy-two (72) hours.

*For complete information, see the trainings "Incident Reporting Process" and "Critical Events Process" available through the Case Management Training Series in Canvas.*

## *Transitions*

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that individuals with a developmental disability who are transitioning from one residential setting to another, or from one service provider to another, receive services and supports appropriate to their needs. It is the responsibility of the case manager and IST to support individuals and parent(s) of minor children or legal representative(s), as applicable, through what can sometimes be a stressful event.

### What is a Transition?

A transition is a change in an individual's physical residence and/or residential service provider that documents the actions and activities required when the individual receives, or will receive, residential supports through the CIH or MFP-CIH waivers.

### Why are Transition Activities Important?

Complete, accurate, and timely transition activities are important to ensure an individual's continuous receipt of services and supports appropriate to their needs. Prior to any transition, discussion should include the individual's vision of his/her preferred life, strengths, and achievements. Individuals must be able to choose the setting they want to live in from all options available and the setting must support full access to the community. Any setting must provide for maximum independence and opportunities to make life choices.


BEST practice is demonstrated by the submission of complete and accurate submission of the transition five (5) business days prior to the individual's move and/or change of provider for all transition types except Emergency Transitions.

BETTER practice is demonstrated is demonstrated by the submission of complete and accurate submission of the transition three (3) business days prior to the individual's move and/or change of provider for all transition types except Emergency Transitions.

Compliance requires submission of complete and accurate submission of the transition one (1) business day prior to the individual's move and/or change of provider for all transition types except Emergency Transitions.

## Transition Types

The type of transition documented is based on the change or changes the individual has chosen to make.

### Initial Transitions

- Community to Supported Living: Transitions from the family home, own home, or apartment.
- Other Setting to Supported Living: Transitions from Supervised Group Living (SGL), nursing facility, mental health facility, Extensive Supports Needs (ESN) facility, Comprehensive Rehabilitative Medical Needs Facility (CRMNF), and State Psychiatric Hospitals (SPH).

### Subsequent Transitions

- Change of RHS Provider and Change of Address: Transition from one residence to another that includes a change in the RHS provider.
- Change of RHS Provider with No Change of Address: Transition from one RHS provider to another without a chance in residence.
- Change of Address with No Change of RHS Provider or IST: Transition from one residence to another where the RHS Provider will continue to provide services.

### Emergency Transitions

An Emergency Transition may be utilized to protect the safety of an individual or when damage to the home (e.g., flood, fire, etc.) renders the save uninhabitable and it is unknown if the individual will be able to return to the home. In these cases, the provider and case manager need to do what is necessary for the safety of the individual while keeping BDDS informed of the situation. While recognizing there may not always be time for a team meeting. when time permits a team meeting for an Emergency Transition should be held. The individual, legal representative(s), if applicable, and team should discuss why the transition is needed, and how the move benefits all involved and promotes the safety of the individual or others. The team should further ensure staffing is in place and training has occurred prior to a staff working with the individual in the new setting. In an Emergency Transition it is the responsibility of the case manager and team to ensure the necessary supports are in place for the individual's safety. Emergency Transitions do not require the case manager to send BDDS staffing schedules and staff training. BDDS Service Coordinators will approve or deny an Emergency Transition based on the information provided.

### Temporary Relocations

A Temporary Relocation is not a transition but is used when it is necessary for the individual to leave the home for a short time but will be returning. A Temporary Relocation can be used:

- When a utility outage requires temporary relocation;
- When a home modification requires the individual to vacate the home for a short period of time;
- Due to COVID-19 staffing shortages. In these cases, the required activities in Appendix K and the guidance for use of case management flexibilities during the public health emergency must be followed; or for
- Extended visits to the family home due to COVID-19. Again, in these cases, the required activities defined in Appendix K and the guidance for use of case management flexibilities during the public health emergency must be followed.

There is currently no time limitation attached to a Temporary Relocation however it is only to be used when the individual will return home. An Incident Report (IR) is required when the reason for the Temporary Relocation meets the requirements of a reportable incident.

## When are Transition Activities Due?

Case managers are responsible for all pre- and post-transition monitoring activities. All pre- or post-transition actions or activities performed by the case manager will be documented in the transition in the BDDS Portal within three (3) business days.

### Pre-Transition Monitoring

- The case manager shall schedule a pre-transition meeting to facilitate person-centered transition planning with the current IST and the selected residential provider. A robust meeting includes the individual, their legal representative, if applicable, and anyone who is important to the individual that they want to include. The IST is not only comprised of waiver providers but may include other supports such as friends, family members, school personnel, and other paid or non-paid supports.
- Five (5) to seven (7) calendar days prior to the intended transition date, the case manager shall complete an Environmental Inspection Checklist (EIC) and Pre-Transition Checklist at the potential new

*When an emergency transition occurs and the individual does not return to their previous setting within five (5) calendar days, the System Initiated Transition (SIT) automatically populates to prompt the case manager to complete a full transition.*

home. The case manager will document findings in the individual's transitions within in the BDDS Portal. *Please note: An EIC is not required for family homes.*
    - For every 'no' on the Pre-Transition Checklist, the case manager will prepare a Corrective Action Plan (CAP) identifying the responsible entity and target date for completion and:
        - Forward a copy of the CAP to each identified responsible party;
        - Monitor the CAP to ensure completion by the identified completion dates;
        - Collaborate with responsible parties as needed to ensure completion of each corrective action; and
        - Update information as progress is made regarding issues requiring the CAP on the individual's Transitions page in the BDDS Portal.
- The case manager shall submit the transition in the BDDS Portal for BDDS approval one (1) business day prior to the planned move date at a minimum. *Please see best practice timelines above.*

- Except for Emergency Transitions, no move shall occur without BDDS approval.

Post-Transition Monitoring

- Seven (7) to fourteen (14) calendar days following the transition date the case manager must visit the home, complete a post-transition checklist, and document the findings in the individual's transition in the BDDS Portal.
    - For every 'no' on the Post-Transition Checklist, the case manager will prepare a Corrective Action Plan (CAP) identifying responsible parties and completion dates. Further, the case manager shall:
        - Forward a copy of the CAP to each identified responsible party;
        - Monitor the CAP to ensure completion by the identified completion dates;
        - Collaborate with responsible parties as needed to ensure completion of each corrective action; and
        - Update information as progress is made regarding issues requiring the CAP on the individual's Transitions page in the BDDS Portal.
- Thirty (30) calendar days following the actual transition date the case manager must visit the home, complete a post transition checklist, and document findings in the individual's transition in the BDDS Portal.
    - For every 'no' on the Post-Transition Checklist, the case manager will prepare a Corrective Action Plan (CAP) identifying responsible parties and completion dates. Further, the case manager shall:
        - Forward a copy of the CAP to each identified responsible party;
        - Monitor the CAP to ensure completion by the identified completion dates;
        - Collaborate with responsible parties as needed to ensure completion of each corrective action; and
        - Update information as progress is made regarding issues requiring the CAP on the individual's Transitions page in the BDDS Portal.
- CAPs unresolved sixty (60) calendar days following the actual transition date will automatically be referred to BQIS for resolution and only specific BQIS staff will be able to resolve the CAP.

## Required Documents and Activities by Transition Type

| | Community to Supported Living | Other Setting to Supported Living | Change RHS & Change Address | Change RHS, No Change of Address | Change of Address, No Change RHS/Team |
|---|---|---|---|---|---|
| Submission/approval of new CCB | X | X | X | X | X |
| Submission of PCISP | X | X | X | X | |

| | | | | | |
|---|---|---|---|---|---|
| Visits with potential housemates/to new address | X | X | X | | X |
| Transfer of Payee | x | X | X | X | |
| Representative Payee entered in BDDS Portal | X | X | X | x | |
| Confirm Medicaid status and Level of Care approval | X | X | X | X | |
| Community activities | X | X | X | X | |
| Day service program information | X | X | X | X | X |
| Family/guardian notification/contact information | X | X | X | X | X |
| Income and asset information | X | X | X | X | |
| Medications and prescriptions | X | X | X | X | |
| Notice of intent to change provider | | | X | X | |
| Supplemental Transition Information Form (STIF) | | X | X | X | |
| Lease | X | X | X | X | X |
| Individual's living expenses | | | X | X | X |
| Personal Inventory | | X | X | X | X |
| Medicaid card | X | X | X | X | |
| Social Security card | X | X | X | X | |
| Birth Certificate | X | X | X | X | |
| EBT card | X | X | X | X | |
| Other legal papers | X | X | X | X | |
| Risk issues | X | X | X | X | |
| Individual specific training for HRP | X | X | X | X | X |
| BSP and 60 days of progress notes, etc. | | X | X | X | |
| Individual specific training for BSP | X | X | X | X | X |
| Individual specific training for health/medical | X | X | X | X | X |
| Staffing appropriate to meet health and welfare needs of the individual | | X | X | X | X |
| Residential Placement form | | X | X | | |
| Freedom of Choice form | | X | X | X | X |

Emergency Transitions and Temporary Relocations do not require documentation. However, the BDDS District Offices retain the right to require documentation when appropriate.

REMEMBER, BDDS IS PLACEMENT AUTHORITY, AND NO TRANSITION SHALL OCCUR WITHOUT BDDS WRITTEN APPROVAL, WITH THE EXCEPTION OF EMERGENCY TRANSITIONS AS DEFINED IN POLICY. IN THE EVENT OF AN UNAPPROVED TRANSITION, AN INCIDENT REPORT MUST BE FILED.

BDDS Policy: Transition Activities

# *Documentation Requests*

In this section case managers will find the process for submitting documentation requests received from individuals, parents of minor children, or legal representatives, as applicable, and external entities. Additionally, guidance is provided for sharing documentation with BDDS waiver providers who do not currently serve the individual for whom the request is made.

With the exception of documentation case managers are specifically required to disseminate to individuals and parent(s) of minor children or legal representatives, as applicable (i.e., PCISPs and Notices of Action) as outlined in the Case Management Waiver Service Definition, documentation housed within an individual's document library is the property of the State of Indiana and may not be shared by case managers. Case managers must submit all requests as directed below.

## Eligibility Determination Requests

When documentation requests are received from the Disability Determination Bureau (DDB), Social Security Administration (SSA), Vocational Rehabilitation (VR), and attorneys representing individuals in SSA cases, the case manager shall:

- Review the BDDS Portal to ensure all profile information, including legal status, is correct and up to date.
- Submit the request documentation, including a release, to FSSA BDDS Documentation Requests BDDSdocumentationrequests@fssa.in.gov.

## Subpoenas

When subpoenas are received, the case manager shall:

- Review the BDDS Portal to ensure all profile information, including legal status, is correct and up to date.
- Submit the request documentation, including the subpoena, to FSSA BDDS Documentation Requests BDDSdocumentationrequests@fssa.in.gov.

## Individual/Parent(s) of Minor Children/Legal Representative(s) Requests

When an individual, parent(s) of a minor child, or legal representative(s) requests documentation, the case manager shall:

- Review the BDDS Portal to ensure all profile information, including legal status, is correct and up to date.
- Email the written request (email or letter) to the CMO Liaison, Beckie Minglin, at beckie.minglin1@fssa.in.gov.

### Centers on Medicare and Medicaid

- Case management organizations will respond to requests from the Centers on Medicare and Medicaid (CMS) consistent with the express language set forth in their provider agreement.

Provider referrals share protected health and personal identifying information as well as any documentation linked to the referral. The case manager must have a release signed by the individual, parent(s) of minor children, or legal representative(s), as applicable, and dated within the last year, to release this information to any provider not currently serving the individual.

## *Travel Status*

In 2019, BDDS implemented policy and provided guidance on the reimbursement of out-of-state home and community-based waiver services. In this section, case managers will learn what a travel status is and why it's important to individuals, parents of minor children, and legal representatives, as applicable. In addition to the information provided here, case managers must be familiar with the BDDS policy and related case management guidance, which includes examples.

### What is Travel Status?

Travel status is simply travel documented in the BDDS Portal when an individual, who meets the requirements of the BDDS Policy: Reimbursement of Out of State Home and Community Based Waiver Services, travels outside the State of Indiana for fourteen (14) calendar days or longer.

### Why is Having a Travel Status Important?

When travel meets the standards for reimbursement for out of state home and community-based waiver services, individuals have the opportunity to receive services when traveling outside of Indiana, if documented in the individual's PCISP. Providers may be reimbursed for:

- Day trip activities that cross Indiana's borders;
- Overnight trips within the United States and U.S. territories;
- Direct support staff accompanying individual's residing in border areas to appointments to receive Medicaid State Plan services outside of Indiana, if the medical service(s) is covered by Medicaid in accordance with 405 IAC 5; and/or
- Services to individuals who attend undergraduate and graduate programs in states contiguous to Indiana while remaining Indiana residents.

Case managers are required to complete the requirements outlined in guidance regardless of the length of time an individual will be traveling.

BDDS Policy: Reimbursement of Out of State Home and Community Based Waiver Services
Case Management Guidance: Reimbursement of Out of State Home and Community Based Waiver Services

# *Non-Responsive Individuals, Parents, and Legal Representatives*


BDDS requires that individuals, parents of minor children, and legal representatives, as applicable, participate actively and responsibly in the administration and management of their Medicaid-waiver-funded services. Non-responsiveness means they choose not to participate actively and responsibly in the administration and management of Medicaid-waiver-funded services.

## What Does it Mean for an Individual, Parent, or Legal Representative to be Non-Responsive?

Non-responsiveness is demonstrated when an intended lack of action, lack of response, lack of cooperation, and/or lack of communication by the individual, parent(s) of minor children, or legal representative, as applicable, when action has been requested by the state, the case manager, or the provider. It may also be demonstrated by not giving a response or not adequately addressing or meeting the requirements in a request.

Non-responsiveness may refer to a failure or refusal to acknowledge, respond to, or provide information requested via physical paper notes or mail, certified mail, phone calls, electronic texts, emails, or failure to attend previously scheduled meetings, or lack of cooperation with the case manager's attempts to schedule meetings.

## Why is Responsiveness Important?

Non-responsiveness can prevent the case manager and/or IST from moving forward with actions or activities that support the individual. These include, but are not limited to, person-centered planning, team meetings and face-to-face visits, evaluations, assessments, determinations, and risk plan or service plan development. Ultimately, non-responsiveness may impact and potentially become a barrier or prohibition to the individual's participation in HCBS waiver services.

## When Non-Responsiveness is an Issue

Case managers are required to meet with individuals and parents of minor children or legal representatives, as applicable, they support every ninety (90) calendar days. It is important for the case manager to document via case notes all actions and activities with or on behalf of the individual, including all attempts to contact and communicate with these persons.

If an individual, parent(s) of a minor child, or legal representative(s), as applicable, have been identified as non-responsive, case managers are to take the following steps before three (3) months have passed:

- Attempt all methods of contact you have information for: telephone calls, texts, email, mail, including certified mail.
- Attempt to complete an unannounced visit. If the individual resides in the family home, be sensitive to any reluctance to hold a meeting when you drop by. Instead, use the opportunity to let them know of your need to meet with them.
- Contact the BDDS District Office before taking additional action. Follow guidance provided by the service coordinator and do not terminate the waiver prior to their instruction. Never interrupt a waiver for non-responsiveness and allow it to auto-terminate.

- Case note all attempts to reach the parties, including contact with BDDS. Complete and accurate case notes will assist the help desk when requests are received to remove past due checklists due to non-responsiveness.

  Example
  CM Smith called Mary to schedule a face-to-face meeting but there was no answer. As case noted, the CM has tried to reach Mary for a couple of months, but Mary hasn't returned the calls, texts or emails sent. An unannounced visit was attempted on July 5, 2020, but no one was home. CM Smith will contact Supervisor Jones to see if a certified letter should be sent or the BDDS district office contacted for assistance in connecting with Mary.

Only BDDS can make the decision to terminate the individual's waiver services. If BDDS decides to terminate the individual's waiver services pursuant to the DDRS Policy: Individual/Parent/Legal Representative Responsibilities While Receiving Waiver Funded Services, BDDS must provide them with written notice of intent to terminate the individual's waiver services.

Should a termination occur, the individual and parent(s) of a minor child or legal representative, as applicable, have a right to appeal the State's decision. To file an appeal, they will follow the process outlined on the Notice of Action.

*Please note, the BDDS Policy: Individual/Legal Representative Responsibilities While Receiving Waiver Funded Services is under revision as of the date of Quality Guide publication but will be available soon.*

### How is Non-responsiveness Documented?

Case notes in the BDDS Portal must reflect efforts of the case manager to communicate with the individual and parent(s) of a minor child or legal representative, as applicable.

- Date and method(s) of each contact attempt.
- Date and time of each unannounced visit attempt.
- Date certified mail was sent, including receipts/tracking numbers information and follow-up documentation of response from postal service to certified mail delivery.
- Date and name of BDDS staff contacted as well as actions taken, or recommendations made.

## *Dispute Resolution*

In this section case managers will learn what dispute resolution is, why it's important to team dynamics, and how this looks in practice. For information on balancing the needs and desires of individuals and parents of minor children or legal representatives, as applicable, please see the section Balancing Competing Priorities.

### What is Dispute Resolution?

Dispute Resolution refers to a technique of settling the conflicts or claims between parties. The technique aims at achieving fairness for both the groups and arriving at an agreement between by consensus, often initiated by a third party.

### Why is Dispute Resolution Important to IST Dynamics?

Dispute resolution is essential to smooth interconnection processes**.** Resolving a dispute requires all parties to cooperate with an open mind and a willingness to communicate to reach a mutually agreeable resolution. Embracing disagreement is a valuable way of learning new ideas, tempering your own ideas into workable outcomes, and reaching solutions that everyone can benefit from.

### How Does Dispute Resolution Look in Practice?

When a dispute arises, an informal meeting should take place to allow the team a chance to resolve. The following steps provides opportunities for the exchange of information between IST members while focusing on the needs and desires of the individual. The process may include a review of any related documentation to ensure a full understanding of the facts and circumstances and to provide clarification on any issues.

The case manager will:

- Identify the issue and facilitate the conversation by establishing ground rules prior to discussion (no interrupting, staying respectful);
- Ensure the IST meeting remains focused on the individual's preferences and priorities;
- Allow each team member to explain their viewpoint;
- Identify and discuss options to resolve the conflict; and
- Come to an agreement on a solution.

If a disagreement persists, the dispute resolution process outlined in the Policy: Individualized Support Team shall be followed.

*Please note, the BDDS Policy: Individualized Support Team is under revision as of the date of Quality Guide publication but will be available soon.*

## *Appeal Process*


In this section, case managers will learn more about what an appeal is, why they are important, what information must be shared with individuals, parents of minor children, and legal representatives, as applicable, and what the process looks like in practice.

### What is an Appeal?

An appeal is any clear, written expression by the individual, parent of a minor child, or legal representative, as applicable, indicating disagreement with any adverse action taken by Division of Disability and Rehabilitative Services' (DDRS)/Bureau of Developmental Disabilities Services' (BDDS), including but not limited to, Waiver, OBA, Eligibility, RFA, PAS, State Line, or BMR.

### Why Appeals are Important

A fair hearing allows the individual, parent of a minor child, or legal representative, as applicable, an opportunity to present his/her grievance and to describe circumstances and needs in their own words. The individual may also be represented by legal counsel, relatives, friends, or any other individual that they choose. BDDS staff involved in the protested action also attend the hearing and present the facts on which the action was based.

## Information Case Managers Should Share with Individuals and Families

The case manager advises individuals and parent(s) of minor children or legal representative(s), as applicable, of their right to appeal and request a fair hearing. The case manager provides the individual and parent(s) of a minor child, or legal representative(s), as applicable, with a copy of the Notice of Action. Upon request, the case manager may provide advice on how to prepare the written request for appeal and fair hearing, the required time frames, and the address for submission of the appeal. The case manager can also provide an opportunity to discuss the issue being appealed.

## Case Manager Participation in the Appeal Process

Due to conflict-free case management requirements, the case manager may not file an appeal or appear at an appeal hearing on behalf of an individual unless the case manager is the Medicaid Authorized Representative noted on the individual's record with the Division of Family Resources (DFR). Case managers who are documented Authorized Representatives and will participate in an appeal hearing must take the following steps at least five (5) business days prior to the hearing:

- Upload the Authorized Representative documentation in the individual's document library; and
- Notify the case management liaison via email of their intent to participate in the hearing.

## What the Appeals Process Looks Like in Practice

Hearings provide impartial due process and are conducted before an Administrative Law Judge (ALJ). The ALJ's duty is to preside over the hearing and determine whether the agency's determination followed the law.

In preparing for a hearing, the BDDS representative should review the Denial Notice and appeal request to determine what the individual is appealing. The BDDS representative should also determine if the appeal was filed timely.

After an appeal is received by OALP and an ALJ is assigned to the case, the ALJ will issue a Notice of Hearing and Case Management Order. These notices inform all parties of the location of the hearing, the phone number to call into the hearing if scheduled as a phone hearing, the parties' rights, and what issues are being appealed. The notices will also inform the BDDS representative and appellant when to provide its Witness and Exhibit Lists to the ALJ and other party.

The BDDS representative will review the facts of the case to defend the state's decision to the ALJ. The BDDS representative should prepare exhibits that consist of specific documents that help explain the determination or disprove the individual's claim. Each exhibit should be labeled according to the system set by the ALJ in the Notice of Hearing and Case Management Order.

Once all parties have arrived or called in for the hearing, the ALJ reviews the hearing rules and procedure. The ALJ will begin a recording of the hearing stating the date, appeal title, and providing a brief summary of the issue. While the ALJ is recording, the hearing is "on the record". The ALJ will ask those present to state and spell their name for the record.

The ALJ will direct all possible witnesses to raise their right hand and repeat an oath to tell the truth. After administering the oath, the ALJ will afford both sides the opportunity to present their case. The BDDS representative typically presents first, though the ALJ may change this order when attorneys are involved.

Once both parties have presented their cases, the ALJ may allow each side to provide closing remarks. These are short, meant to summarize each party's position. This is the opportunity to make a final request

to the ALJ. Once the record is closed, neither party can speak to the ALJ about the case. If either party forgets an exhibit or if a question is asked that the BDDS representative does not know the answer to, the ALJ can be asked to keep the record open for a few days to allow time to submit the document or answer the question.

Following the hearing, the ALJ will issue a decision that can either uphold, change, or overturn the state's decision. Any party who disagrees with the ALJ's decision can file a request for Administrative Review.

After a request for Administrative Review has been filed, the Director/Ultimate Authority can uphold, or change the ALJ's decision. The Director/Ultimate Authority can also order the ALJ to conduct a new hearing or issue a new decision.

Any party who disagrees with the Director/Ultimate Authority's determination can request Judicial Review by filing a request with a court at their own expense.

A case can reach a settlement at any time. To settle a case, there must be a settlement offer that complies with the law. Once a written settlement offer is completed it is sent to the individual, parent(s) of a minor child, or legal representative(s), as applicable, for consideration of their withdrawal of their appeal request. If the individual, et al, accepts the offer and agrees to withdrawal their appeal, a copy of the signed withdrawal must be sent to OALP. If a case goes to Judicial Review, a settlement offer must be approved by the Attorney General's office and the Governor's office.

## *Case Record Review*

The Bureau of Quality Improvement Services (BQIS) maintains multiple quality and compliance measures to ensure that individuals utilizing supports and services through the Bureau of Developmental Disabilities Services (BDDS) receives person-centered services that support them and their families in living their defined best life. In this section, case managers will learn why Case Record Reviews (CRR) are important, the required activities for each section of the CRR, when CRRs are completed, and the case manager's responsibilities when the CRR demonstrates non-compliance.

### Why are CRRs Important for Individuals and the Indiana IDD System?

CRRs are completed to demonstrate compliance with the Home and Community Based Services (HCBS) Final Rule, Federal Code, Indiana Code (IC), Indiana Administrative Code (IAC), the Community Integration and Habilitation (CIH) waiver and Family Supports waiver (FSW), assurances, as well as requirements for case management established by the Bureau of Developmental Disabilities Services (BDDS). The information contained in this guide will provide case managers and case management entities with the information necessary to ensure compliance.

Case Record Reviews are also important to the individual as the CRR process ensures the individual's case file contains the necessary and appropriate information, the individual's needs and wants are clearly documented, and the individual is given appropriate choice. As BDDS continues with its internet technology modernization, the case file in the BDDS Portal will be transparent to all team members.

## What are the Required Activities by Section?

A CRR is conducted on a monthly basis utilizing a waiver-specific valid sampling methodology by the Bureau of Quality Improvement Services (BQIS). BQIS staff review waiver individuals' case files for case manager compliance with the HCBS Final Rule, Federal Code, Indiana Code, 460 IAC 6, 460 IAC 7, the CIH, FSW, and CIH with MFP funding waivers, and BDDS case management requirements. Case record reviews include: the Person Centered-Individualized Support Plan (PCISP), risk assessment (embedded in PCISP), identified risk plans, and signed choice lists for each service (provider choice form).

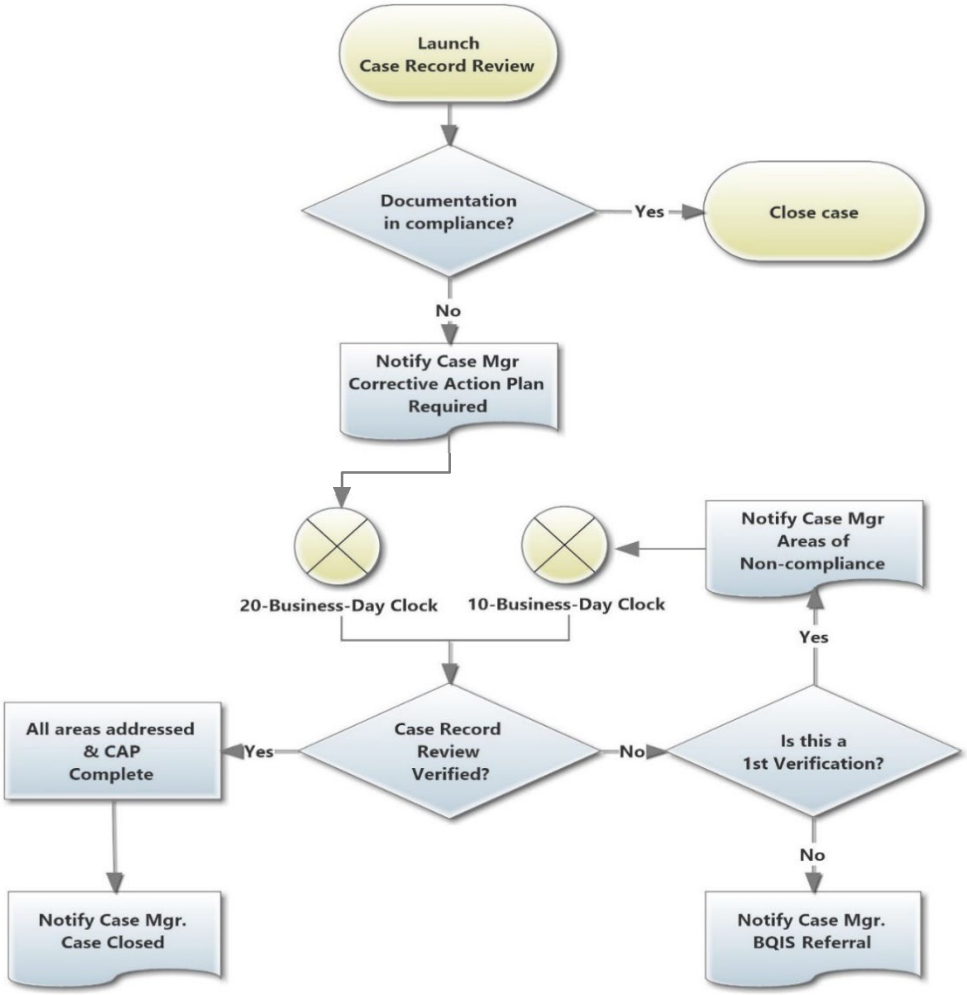
The PCISP is reviewed for compliance with the PCISP guide for the following:

- "Important To" and "Important For" is reflected in each completed Life Domain.
- A completed Risk Assessment.
- Identified risk plans have been reviewed/updated during the service plan year and are attached to the finalized/downloadable PCISP.
- The PCISP was updated when an individual's condition or circumstances changed.

Additionally, the current service plan is reviewed against provider choice lists uploaded in the individual's case file to ensure a completed provider choice list is present indicating the choice of provider by the individual, parent(s) of a minor child, or legal representative(s), as applicable.

## When are Required Activities Completed?

On an ongoing basis, Case managers should ensure all information in the PCISP and individual's case file in the BDDS Portal is current and compliant with requirements. Upon review of a case file during a CRR,



the case manager is sent an email with the required corrective action. The case manager must address the issue as indicated within twenty (20) business days. BQIS will re-review the case at that time. If the issue has not been addressed, the case manager will receive an email with the outstanding issues noted which must be addressed within ten (10) business days. BQIS will re-review the case and non-compliant issues will be referred to the BQIS Director for further action. Below is a process map of the timelines.

### How do Case Managers Complete the Required Activities?

When an item is found to be out of compliance, the CRR notification indicates the action required by the case manager.

For example, for the question "Does the PCISP include a completed Risk Assessment as demonstrated by information included in the appropriate Life Domain?" the following was noted in the PCISP:

> During the team meeting, the team discussed Individual A's difficulty with going up and down the step to enter and exit the home. They also discussed that Individual A has difficulty on some of the paths when they visit the nature preserve due to their unsteady gate. A risk plan would potentially reduce falls as staff will ensure Individual A has physical assistance when necessary and/or a person nearby to assist when walking on uneven terrain and by providing reminders to use the handrail when using the steps. If a risk plan is not in place, Individual A may fall and incur serious injuries.

How the required components of the risk assessment are identified by BQIS reviewer:

- **Identify the risk**
  The individual has an unsteady gait. Due to their unsteady gait, they have difficulty navigating uneven terrain and need support when going up and down stairs. A potential risk is that the individual may experience falls which may result in injury.
- **Clarify the problem they are trying to solve (with the risk plan)**
  Reduce falls by ensuring staff provide reminders and assistance on stairs and difficult terrain.
- **Describe what would happen if the risk plan were not in place (nothing was done)**
- Without the information provided in the risk plan, the individual may fall and experience a serious injury.
- **Identify the action the IST decided to take to manage this risk**
  If the PCISP does not indicate the team's decision, the case manager would receive a corrective action plan to update the PCISP to include the IST's decision regarding the risk plan.

## *Provider Corrective Action Plans*


In this section BDDS and BQIS outlines the expectations for corrective action plans and the remediation required for HCBS questions in the PCISP, monitoring checklists, transitions, risk plans, and behavior plans.

### Why are Corrective Action Plans Issued?

A corrective action plan (CAP) may be issued by BDDS/BQIS when a provider is found to be noncompliant with one or more requirements of BDDS Medicaid Home and Community Based waiver programs including, but not limited to, 42 CFR, Indiana code, Indiana Administrative Code, Community Integration and Habilitation and Family Supports waivers, DDRS Polices, and BDDS program requirements. Continued noncompliance of a provider may be indicative of a systemic issue within the provider's operations.

### Why is the Information Required Important for the Individual?

When a provider is noncompliant with established requirements, the individual may not be appropriately supported by the provider. The established requirements are in place to assure qualified providers are administering the supports and services to the individual. Noncompliance of a provider must be addressed through a corrective action plan by the provider to realign the business practices with the requirements.

### What are the Case Manager's Responsibilities?

Case managers facilitate an individual's team and must ensure the individual's documents align. Case managers are responsible for entering the PCISP, completing monitoring checklists, and facilitating transitions. These activities may identify an issue a provider needs to correct. The case manager must issue the CAP and follow-up with the provider in the established timeframes.

### BQIS Involvement in a CAP

When a provider does not resolve the CAP within the established timeframes, BQIS may become involved. In some cases, BQIS may become involved prior to the deadline of the CAP if there is an ongoing issue with the provider.

REMEMBER, A CORRECTIVE ACTION PLAN IS A METHOD OF DOCUMENTING A PROBLEMATIC SITUATION, IDENTIFYING ITS ROOT CAUSE AND CLEARLY LAYING OUT A WAY OF CORRECTING THE ISSUE. IN ADDITION, TO CHECK ON THE EFFECTIVENESS OF THE PROPOSED CORRECTIVE ACTION, IT SHOULD CONTAIN SOME METHOD THAT ALLOWS THE ORGANIZATION TO VERIFY THAT THE NEW ACTION WORKS APPROPRIATELY.

## *Legal Representation*


The term used by most courts that utilize a combination of medication and functional criteria to reach a determination that an individual cannot exercise specific rights is "incapacitated". Generally, a person determined by the court to be incapacitated is "unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care", and as such, are appointed a legal representative.

In Indiana, an incapacitated person is someone who cannot fully manage their property and/or provide self-care because of insanity, mental illness or deficiency, physical illness, habitual drunkenness, excessive use of drugs, incarceration, confinement, detention, duress, fraud, undue influence of others, or other incapacity or a person who has a developmental disability (IC 29-3-1-7.5). A protected person is someone who has a legal representative.

## Legal Representatives

When appointed by a court, a legal representative represents or stands in place of another under the authority recognized by law, especially with respect to the other's interests or property. A legal representative may be a personal representative appointed by the person, if the person is determined to be competent, or an agent appointed by the court.

## Types of Legal Representatives

### Guardianship

Guardianship is a legal proceeding to appoint a person who is responsible to the court to take care of an incapacitated individual or minor and/or manage that individual's property.

#### Types of Guardianship

- Guardian of the Person: Oversees the proper living condition and treatment for the protected person.
- Guardian of the Estate: Responsible to oversee and manage proper investment and financial affairs of the protected person.
- Guardian of the Person & Estate: Responsible for both of the above aspects of a protected person's life.

### Guardian Ad Litem

A guardian Ad Litem is appointed for the very specific purpose of representing a minor or someone who is allegedly incompetent during the course of a particular type of litigation. The authority of a guardian ad ends when the court releases the guardian ad litem.

### Co-guardianship

Co-Guardianship is where two people are appointed to act as guardian for someone at the same time. In other words, two people share the guardianship responsibilities.

### Limited guardianship

Limited guardianship allows the probate court to appoint someone as guardian over only the portion of a person's life where the person is both incompetent and has a need. Thus, there might be a limited guardian appointed for medical purposes only (i.e., to provide consent for medical procedures), or for placement purposes only, or for the limited purpose of approving behavior plans and/or psychotropic medications. This is the least restrictive form of guardianship and should be utilized whenever possible.

### Health Care Representative

An individual may appoint a health care representative if there are concerns that at some time, the individual may lack the ability to make decisions regarding his/her health. Under Indiana law the health care representative can then make these decisions on the individual's behalf. The appointment of a health care representative must be done when the individual is competent.

### Power of Attorney

A power of attorney, or POA, is a written notarized directive from one person to another delegating authority to make certain decisions. Attorneys who serve as a power of attorney are called attorney of fact.

### Temporary/Emergency Guardianship

Temporary/emergency guardianship can be ordered by a court without a hearing being held first, however it can last no longer than sixty (60) calendar days.

### Permanent Guardianship

Permanent guardianship requires a hearing first and continues for as long as it is needed.

### Guardianship of a Minor

Guardianship of a minor requires a hearing first and terminates when the minor reaches the age of eighteen (18).

## Legal Representative Documentation

Guardianship of any type requires a court order establishing the type of guardianship, name of appointed guardian, and effective date.

A power of attorney (POA) requires the person to have a notarized written directive appointing a personal representative. A POA can be revoked by the person at any time either orally or in writing. Additionally, the person may choose to not allow the POA to act on their behalf at any time.

A health care representative requires the person to have a written document which is signed by the appointer and witnessed by an adult other than the representative. The appointment does not commence until the appointor becomes incapable of consenting. The appointment of a health care representative may be revoked at any time by notifying the representative orally or in writing. (IC 16-36-1-7)

## Documenting Legal Representation

Case managers are charged with maintaining accurate information for an individual within the BDDS Portal, including documenting the individual's legal status. When an individual has a legal representative, the case manager must be careful to select, and keep current, the individual's status. Additionally, the legal representative must be identified in Relationships, and the legal documentation uploaded to the individual's document library.

# *Autonomy and Supported Decision-Making*


*All individuals with intellectual and/or developmental disabilities have the right to recognition as persons before the law and to enjoy legal capacity on an equal basis with individuals who do not have disabilities in all aspects of life.*

*United Nations Convention on the Rights of Persons with Disabilities*

To be person-centered, case managers and Individualized Support Teams must respect and support the personal autonomy, liberty, freedom, and dignity of the individuals they serve. Legally, each individual adult or emancipated minor without legal representation is presumed competent to make decisions for himself or herself, and should receive the preparation, opportunities, and decision-making supports to develop as a decision-maker over the course of his or her lifetime.

## What is Supported Decision Making?

Supported decision-making (SDM) is a way to support and accommodate the decision-making process. SDM is used by all people to make life decisions such as buying a house or choosing an education path. By using SDM individuals with disabilities who are capable of making decisions can be empowered to use available supports to make their own choices and live a self-directed, independent life. SDM is a less restrictive option that supports an individual with disabilities in making life decisions. An individual's right to make their own choices should not be taken away or restricted, such as through legal representation, without exploring all options and less-restrictive alternatives. In SDM, the individual retains all decision-making authority.

## What are Supported Decision-Making Agreements?

In 2019 Governor Eric Holcomb signed Senate Enrolled Act 380 into law. This law recognizes Supported Decision-Making Agreements as an alternative to legal representation and requires Less Restrictive Alternatives (LRAs) including Supported Decision Making to be considered before a legal representative is appointed by the court. As detailed in IC 29-3-14-2, a Supported Decision-Making Agreement means "a document that outlines the decision-making supports and accommodations the adult chooses to receive from one (1) or more supporters."

## What Does Supported Decision-Making Look Like in Practice?

SDM will look different for everyone. It includes finding tools and supports to assist the individual to understand, make, and communicate his or her own choices. Examples of these tools might be:

- Plain language materials or information in visual or audio form.
- Extra time to discuss choices.
- Creating lists of pros and cons.
- Role-playing activities to help the person understand choices.
- Bringing a supporter into important appointments to take notes and help the person remember and discuss her options.
- Opening a joint bank account to manage financial decisions together.

For more information on SDM, please see the resources available at https://www.in.gov/idr/sdm/files/7-Things-to-Know-about-SDM.pdf and https://www.arcind.org/future-planning/supported-decision-making/.

## *Supervised Group Living*

Supervised Group Living (SGL), also known as group homes, is a residential option available to eligible individuals with intellectual or developmental disabilities. The setting and services provided in an SGL placement can vary depending on the individual's age, support needs and interests.

### What is Supervised Group Living?

A group home, or Supervised Group Living (SGL), is a residential option and alternative to waiver placements for eligible individuals with intellectual/developmental disabilities needing services. SGLs provide twenty-four (24) hour residential supports and can vary depending on the individual's age, support needs and interest. There are typically four (4) to eight (8) individuals residing in each home. Homes are licensed and governed by state and federal regulations and have an annual recertification by the Indiana Department of Health (IDOH) to assure standards of care are met. SGL supports include residential supports, transportation, employment or education services, behavioral management, recreational activities, assistance with activities of daily living, person-centered planning, dietary services, psychiatric review, medical coordination, pharmacy review, individual program plan, nursing, medication administration, interpersonal skills, speech therapy, physical therapy, durable medical equipment, and occupational therapy consultation.

### Why is supporting individuals transitioning to or from an SGL important for a successful transition?

Case managers play a pivotal role in ensuring high-quality transitions both and to and from a supervised group living home. Case managers are an essential part of each individual's team and should be an advocate for the individuals they serve. Whether the person is going to or from an SGL setting the case manager should be working with this person to help determine what their good life looks like and assist in creating a path forward with those goals in mind. The case manager is a guide for these transitions and the goal should be to make it as seamless as possible for the individual.

### How do case managers support individuals transitioning to an SGL Setting?

Once an individual has chosen to live in an SGL setting the case manager should continue to provide support to the individual waiting to transition. The case manager should ensure that the supports being utilized currently remain in place until the move can occur. The case manager should be collaborating with the BDDS service coordinator assigned to the individual as well as the provider when needed. The BDDS service coordinator handles the transition process and will be responsible for gathering documentation and facilitating meetings. However, the case manager is still the primary contact for the individual or legal representative, as applicable, and should continue to provide that support in answering questions as they come up and ensuring they feel comfortable as they move forward with the process. Once an individual has been admitted to an SGL the waiver should be terminated by the case manager.

### How do case managers support individuals transitioning from an SGL setting?

Case managers are tasked with supporting each individual leaving an SGL by getting to know the individual and ensuring they understand the process moving forward, explaining services offered through the waiver and what those services might look like. CMs should assist by helping families connect with providers, offering choice every step of the way and making appropriate referrals as needed. Frequent communication with the individual and legal representative, if applicable, as well as the BDDS service coordinator for the home they currently reside in is vital. Case managers should be the guide through the transition process from SGL to waiver and should be following the transition plan in the BDDS Portal to ensure each step is covered and completed prior to the transition. This includes tasks such as completing a PCISP, understanding living expenses vs income, that a lease is in place and adequate staffing will be in place for the move-in date. The time frame for transitional case management is up to 180 calendar days and should be kept in mind when working with individuals and providers to establish a move-in date.

*For additional information see the Fact Sheet About Supervised Group Living.*

## *ESN and CRMNF Settings*

### What is an Extensive Support Needs (ESN) Setting?

An Extensive Support Needs setting is a four (4) person residential setting. Individuals are placed with the expectation that the placement is short-term for remediation and training for behaviors. This setting is meant to assist individuals with high assessed behavioral and supervision needs related to the safety of the individual and/or others. This is an intense level of support and structure in a more restrictive environment. The goal is to provide supports and services to stabilize an individual and prepare them for a less restrictive environment.

### What is a Comprehensive Rehabilitative Management Needs Facility (CRMNF) setting?

A Comprehensive Rehabilitative Management Needs Facility (CRMNF) is a residential setting is a secure facility for assisting individuals with assessed high-behavioral and supervision needs related to the safety of the individual and/or others. The CRMNF provides supports and services for adults who may have a dual diagnosis, have acute and high-risk challenges, and need comprehensive service delivery in the area of behavior and psychiatric supports and habilitation services. The CRMNF is a large ICF/IDD for more than eight (8) individuals. It is also intended to be a short-term placement.

### Why is supporting individuals transitioning to or from an ESN or CRMNF setting important for a successful transition?

Case managers play a pivotal role in ensuring high-quality transitions both and to and from ESN and CRMNF settings. Case managers are an essential part of each individual's team and should be an advocate for each individual they serve. Whether the individual is going to or from one of these settings the case manager should be working with them to help determine what their good life looks like and assist in

creating a path forward with those goals in mind. The case manager is a guide for these transitions and the goal should be to make it as seamless as possible for the individual.

### How do case managers support individuals transitioning to an ESN or CRMNF setting?

When an individual in the process of transitioning from a waiver setting to an ESN or CRMNF setting they are often in crisis and in need of a higher level of supports and services. It is important to understand that once a referral has been made to one of these settings the transition can happen quickly so keeping all documentation up to date is necessary. The case manager should be collaborating with the BDDS service coordinator assigned to the individual as well as the provider when needed. The BDDS service coordinator handles the transition process and will be responsible for gathering documentation and facilitating meetings. However, the case manager is still the primary contact for the individual and legal representative, if applicable, and should continue to provide that support in answering questions as they come up and ensuring they feel comfortable as they move forward with the process. The case manager should be working to help ensure that the new provider and team members are informed on the individual's needs so a plan can be enacted that will get the individual the support they need to be able to move on from this more restrictive setting.

### How do case managers support individuals transitioning from an ESN or CRMNF setting?

Case managers are tasked with supporting each individual leaving a SGL by ensuring they understand the process moving forward, explaining services offered through the waiver and what those services might look like. Case managers should assist by offering choice every step of the way and making appropriate referrals as needed. Frequent communication is vital with the individual and legal representative, if applicable, as well as the BDDS service coordinator and provider for the home they currently reside in. Case managers should be the guide through the transition process from SGL to waiver and should be following the transition plan found in the BDDS Portal to ensure each step is covered and completed prior to the transition. This includes tasks such as completing a PCISP, understanding living expenses vs income, that a lease is signed, and adequate staffing and behavioral supports will be in place for the move. Individuals coming from these more restrictive settings will likely still have higher needs and the case manager should be aware of what those needs are based on the recommendations from the discharge plan. Case managers should assist with advocating for the services needed so the continuity of care for the individual can continue to set them up for success based on what has been working in the ESN or CRMNF setting.

## *DCS / DOE Youth Facility Placements*

In this section on youth facility placements through the Department of Child Services (DCS) and the Department of Education (DOE) case managers will learn what DCS and DOE placements are and the use of waiver services while the child or youth is in a DCS and DOE placement.

## What Are DCS Placements?

The Department of Child Services (DCS) exists to protect children from abuse and neglect while partnering with communities. It was established as a stand-alone agency in 2005.

DCS can place a child or youth when that child is determined to be a Child In Need of Services (CHINS) by Juvenile Court. A CHINS case can be opened through DCS with court oversight. Children and youth may stay in the family home or be removed and placed with relatives, kinship, foster care, group homes, residential facilities, and/or State Psychiatric Hospitals (SPHs). CHINS cases may remain open until the Juvenile Court dismisses the case and the issues have been rectified and/or safe case closure can occur.

Placements of children and youth with relatives, kinship, and/or foster care homes that may need a safe placement placements are not considered institutional in nature. These placements are in the community with a family.

DCS can place children and youth in group home settings that assist with mental health and behavioral health needs. Group home settings are considered institutional in nature, however they are less restrictive than residential facilities and SPHs. Group home settings have eligibility requirements and those must be met for placement opportunities. Group home settings are institutional placements and should only be utilized if less restrictive settings have been unsuccessful with services and supports or there are safety issues.

DCS can assist families who may have a child or youth that need a restrictive setting for mental health or behavioral health treatment. These settings are also known as residential facilities and SPH's that utilize treatment goals and programming to help children and youth with their mental health or behavioral health needs. These facilities offer treatment and placement through funding from DCS. DCS can assist families to place a child or youth for short to long term stays depending on needs and programming requirements. Residential facilities and SPHs have eligibility requirements that must be met for placement opportunities. Residential facilities and SPHs are institutional settings and should only be utilized if restrictive settings have been unsuccessful with services and supports or there are safety issues.

## What are DOE Placements?

The Department of Education (DOE) offers resources, learning, programs, and teaching to students from Pre-K through College. These services are provided while also partnering with communities.

DOE can place children and youth when they are not safe, have exhausted all other community-based options, and determined no other community options are successful for the school setting. DOE works with the family to find appropriate treatment, programming, and placements that the child or youth needs to be successful and safe.

DOE can assist families who have a child or youth that needs a restrictive setting for mental health or behavioral health treatment. These settings are also known as residential facilities and SPHs that utilize treatment goals and programming to help children and youth with their mental health or behavioral health needs. These facilities offer treatment and placement through funding from DOE. DOE can assist families to place a child or youth for short to long term stays depending on needs and programming requirements. Residential facilities and SPHs have eligibility requirements that must be met for placement opportunities. Residential facilities and SPHs are institutional settings and should only be utilized if restrictive settings have been unsuccessful with services and supports or there are safety issues.

### Are Waiver Services Available to Children or Youth in DCS or DOE Placements?

Children and youth who are placed with relatives, kinship, and/or foster care may continue to receive waiver services in any of these community settings as they are not considered institutional in nature. However, children and youth are not able to utilize Respite or Structured Family Caregiving through BDDS waivers. These services should be terminated to avoid duplication of services.

Children and youth residing group homes who will receive waiver services during visits home, may continue to receive waiver services. However, group homes that are institutional settings, therefore if a child or youth is in a group home and not participating in home visits, the BDDS waiver must be terminated. This avoids duplication of services.

Children and youth residing in residential facilities or SPHs who will receive services during home visits, may continue to receive waiver services. However, residential facilities and SPHs are institutional settings, therefore if a child or youth is in a residential facility or SPH and not participating in home visits, the BDDS wavier must be terminated. This avoids duplication of services.

*For additional information on minors residing in institutional settings, please see the section on Institutional Settings under Living Arrangements.*

## *Nursing Facility Preadmission Screening and Resident Review (PASRR)*

The Preadmission Screening and Resident Review (PASRR) is a requirement under Title 42 of the Code of Federal Regulations (CFR), Section 483. It requires that every person be screened before they are admitted to a Medicaid certified nursing facility to see if they have a mental illness or intellectual disability and/or related condition. This screening ensures care in the nursing facility meets the individual's needs. It also helps to identify any specialized services that might be needed.

### What is the PASRR?

The Preadmission Screening and Resident Review identifies persons with mental health conditions or intellectual/developmental disabilities who can appropriately be diverted from nursing facilities, and those who would benefit from specialized services while in a nursing facility. PASRR assists with identifying services those individuals need as well as the most appropriate care setting in which to meet those needs. PASRR eliminates unnecessary segregation of individuals with disabilities and ensures that services are delivered in the most integrated and least restrictive setting possible.

### How is the PASRR completed?

Screening occurs prior to admission to a nursing home or when there is a significant change in the physical or mental condition of a resident (resident review).

The PASRR is a two-stage process. The first stage, a Level I, identifies individuals who have, or are suspected of having, a mental illness (MI) or intellectual/developmental disability (ID/DD), and need further evaluation.

The Level II, or second stage, is a more comprehensive evaluation to confirm whether the individual has MI/ID/DD, assess that individual's need for nursing facility services, and determine a person's service needs and the best care setting in which to meet those needs.

Maximus contracts to provide online PASRR Level I and Level II IDD screening and online Level of Care utilization review for long-term care populations.

The PASRR Level II evaluation process identifies rehabilitative or specialized services that an individual may require. PASRR Level II evaluations are conducted for the following entities:

- The Division of Disability and Rehabilitative Services (DDRS) Level II contractor for individuals with an ID/DD or MI/ID/DD diagnosis; and
- The Division of Mental Health and Addiction (DMHA) Level II for individuals with a diagnosis of MI only Level II evaluations must be completed prior to admission (when indicated by the Level I screen) and whenever a resident experiences a significant change in condition.

### Why is the PASRR important to/for individuals?

PASRR focuses on preventing inappropriate placement of individuals with MI/ID/DD or individuals of any age with physical disabilities also seek nursing facility placement. Frequently, individuals can be safely and successfully supported using home and community-based options appropriate to their needs and desires.

Nursing facilities are responsible for planning and arranging or delivering all required rehabilitative services identified through the PASRR Level II process. The nursing facility is required to:

- Determine the most appropriate setting for persons with MI, ID/DD, or MI/ID/DD; and
- Address both mental and physical health needs of residents.

## *FSSA Divisions, DDRS Bureaus, and Other State Resources*

Quality case management includes having knowledge of state and federal resources outside the waiver to live their best lives. This section is intended to help you connect with government systems that may be able to assist the individuals and families we support.

### Why is being aware of other resources important?

Knowledge is power and the more we know, the more we can contribute. Below is a list of systems that may be able to offer additional support or may already be involved with those individuals. Understanding other systems and how to nativize those systems is directly linked to problem solving, quality information, and making informed decisions for the people we support to live their best life. Below are resources, websites, and brief descriptions. This is not an exhaustive list, endorsement, or referral of any kind.

### FSSA/Division of Disability and Rehabilitative Services (DDRS)

DDRS supports a wide variety of Hoosiers with disabilities to create a vision for their future that uses paid and natural supports to build on and enhance their personal strengths and assets. DDRS provides continuous support and life-long commitment for citizens in need of disability and rehabilitative supports in the State of Indiana, today and in the future. https://www.in.gov/fssa/ddrs/about-ddrs/

### Blind and Visually Impaired Services

BVIS provides services to eligible Hoosiers that are blind or visually impaired. For information regarding Blind and Visually Impaired Services contact staff at: BVIS@fssa.in.gov or at 877-241-8144. https://www.in.gov/fssa/ddrs/rehabilitation-employment/blind-and-visually-impaired/

### Deaf and Hard of Hearing Services

Deaf & Hard of Hearing Services provides assistance to identify and find resources to meet the needs of deaf and hard of hearing individuals and their families, throughout the state of Indiana. https://www.in.gov/fssa/ddrs/rehabilitation-employment/deaf-and-hard-of-hearing/

### First Steps

Families with children ages birth to third birthday who are experiencing developmental delays and/or have a diagnosed condition that has a high probability of resulting in developmental delay may be eligible for First Steps service. https://www.in.gov/fssa/firststeps/

### Vocational Rehabilitation

Vocational Rehabilitation helps eligible individuals with disabilities to achieve their employment goals. We are taking steps to help current VR participants, new VR applicants, VR staff, and VR providers to remain safe and healthy during the current public health situation. This includes providing services in different ways, but please be assured that VR services are still available during this time. https://www.in.gov/fssa/ddrs/rehabilitation-employment/vocational-rehabilitation-employment/

## FSSA/Division of Aging (DA)

The Division of Aging is committed to helping Hoosiers find the information and resources they need. DA's goal is to put knowledge in Hoosiers' hands so they can make better decisions, not only for themselves but also for their loved ones. They strive to foster networks that provide information, access and long-term care options that enhance choice, autonomy, and quality of life for Hoosiers. They support the development of alternatives to nursing home care and coordinate home- and community-based services and funding through the statewide INconnect Alliance network. The INconnect Alliance is comprised of 15 Area Agencies on Aging/Aging and Disability Resource Centers. These local agencies cover 16 geographic regions (planning and service areas) within Indiana and are charged with the responsibility of providing a comprehensive array of services to, and advocating for, the needs of Hoosiers residing in their areas. https://www.in.gov/fssa/da/what-we-do/

## FSSA/Division of Family Resources (DFR)

The Division of Family Resources establishes eligibility for Medicaid, Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families benefits. The division also manages the timely and accurate delivery of SNAP and TANF benefits. DFR also provides employment and training services to some SNAP and TANF recipients. The division's overarching focus is the support and preservation of families by emphasizing self-sufficiency and personal responsibility. https://www.in.gov/fssa/dfr/

### Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program provides food assistance to low and no income people and families living in the United States. It is a federal aid program administered by the Food and Nutrition Service of the U.S. Department of Agriculture, however, distribution of benefits occurs at the state level. In Indiana, the Family and Social Services Administration is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. https://www.in.gov/fssa/dfr/snap-food-assistance/about-snap/

### Temporary Assistance for Needy Families (TANF)

Temporary Assistance for Needy Families is a program that provides cash assistance and supportive services to assist families with children under age eighteen (18), helping them achieve economic self-sufficiency. Children under age eighteen (18) who are living with their parent(s) or relative such as a grandparent, aunt, uncle etc., who meet specific nonfinancial criteria and whose countable family monthly income meets certain income guidelines are eligible. https://www.in.gov/fssa/dfr/tanf-cash-assistance/about-tanf/

## FSSA/Division of Mental Health and Addiction (DMHA)

The Division of Mental Health and Addiction sets care standards for the provision of mental health and addiction services to Hoosiers. DMHA is committed to ensuring that clients have access to quality services that promote individual, family and community resiliency and recovery. The division also certifies all community mental health centers and addiction treatment services providers. DMHA operates six psychiatric hospitals (Neuro Diagnostic Institute, Evansville Psychiatric Children's Center, Evansville State Hospital, Logansport State Hospital, Madison State Hospital and Richmond State Hospital). DMHA provides funding support for mental health and addiction services to target populations with financial need and administers federal funds earmarked for substance abuse prevention projects. https://www.in.gov/fssa/dmha/about-dmha/

## FSSA/Office of Early Childhood and Out of School Learning (OECOSL)

The vision of the Office of Early Childhood and Out-of-School Learning is that every Indiana community will have a strong network of Early Care and Education and Out-of-School Time programs that support the child, the family and local schools. Programs will be high quality, affordable and accessible to enable families to work effectively to obtain economic self-sufficiency. Children will thrive in programs that meet their developmental and educational needs and make them feel welcome, encouraged, and supported. Professionals teaching and caring for children will have the resources, including training and education, needed to operate and maintain high quality programs. https://www.in.gov/fssa/carefinder/

### Child Care Development Fund (CCDF)

The Child Care and Development Fund is a federal program that helps low-income families obtain child care so that they may work, attend training, or continue their education. The purpose of CCDF is to increase the availability, affordability, and quality of child care. https://www.in.gov/fssa/carefinder/child-care-assistance/

### Head Start

Head Start is a federal program that promotes the school readiness of children under five from low-income families by enhancing their cognitive, social, and emotional development. Head Start programs provide a learning environment that supports children's growth in many areas, including language, literacy, and social and emotional development. Head Start emphasizes the role of parents as their child's first and most important teacher. These programs help build relationships with families that support family well-being and many other important areas. https://www.in.gov/fssa/carefinder/head-start-and-early-head-start/

### Early Head Start

Early Head Start is a federal program that serves infants, toddlers, pregnant women and their families who have incomes below the federal poverty level. Early Head Start programs were established in recognition of the mounting evidence that the earliest years matter a great deal to a child's growth and development. https://www.in.gov/fssa/carefinder/head-start-and-early-head-start/

## FSSA/Office of Medicaid Policy and Planning (OMPP) / Other Health Plans

The FSSA Office of Medicaid Policy and Planning efficiently and effectively administers Medicaid programs for the state of Indiana. Medicaid is more than just health coverage, it provides a vital safety net to one in five Hoosiers. OMPP's suite of programs, called the Indiana Health Coverage Programs, includes traditional Medicaid, risk-based managed care and a variety of waiver services tailored to the needs of specific populations.

## Indiana Department of Child Services (DCS)

The Department of Child Services was established in January 2005 by an executive order of Governor Mitch Daniels. The department was charged with providing more direct attention and oversight of two critical areas: protection of children and child-support enforcement. DCS protects children who are victims of abuse or neglect and strengthens families through services that focus on family support and preservation. The department also administers child support, child protection, adoption and foster care throughout the state of Indiana. https://www.in.gov/dcs/

### Child Abuse and Neglect Hotline 1800-800-5556

The hotline serves as the reporting center for all allegations of child abuse or neglect in the state of Indiana. Indiana is a mandatory reporting state; anyone who suspects a child has been neglected or abused must by state law make a report. https://www.in.gov/dcs/hotline/

### Child Support Services

Child support services are available to both custodial and non-custodial parents. Even if the other parent is living in another state, you can enroll for services in Indiana. Caretakers or relatives who have custody of a child may also enroll for child support services. https://www.in.gov/dcs/child-support/enroll/

### DCS Prevention Programs

#### Community Partners for Child Safety (CPCS)

CPCS is a statewide prevention program. It is designed to strengthen the family unit and build support services. It is voluntary, free, and provides home-based services to connect families with resources. https://www.in.gov/dcs/prevention/community-partners-for-child-safety/

#### Family First Prevention Services

The 2018 Family First Prevention Services Act requires States to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families in order to prevent child abuse and neglect. https://www.in.gov/dcs/prevention/

### Healthy Families Indiana (HFI)

HFI is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. https://www.in.gov/dcs/prevention/healthy-families-indiana/

### Special Education

All students, including those with disabilities, are held to high expectations and have equitable access to educational opportunities that enrich their lives and prepare them for future success. The goal as educators is to improve outcomes for all students. This can be accomplished through a system that ensures equity and access. Equitable Access is the guarantee that all students are provided the necessary and individualized supplementary aids and services, accommodations, modifications, or supports to meaningfully participate in the general education curriculum. Equitable access must be accompanied by a school-wide acceptance or belief in shared responsibility, shared accountability, and high expectations.
https://www.in.gov/doe/students/special-education/

## *Medicaid Rehabilitation Option*

In this section case managers will learn what Medicaid Rehabilitation Option (MRO) is, why it's important, what it covers, and how it's accessed.

### What is the Medical Rehabilitation Option?

Medicaid Rehabilitation Option (MRO) includes community based behavioral health services for individuals with serious mental illness (SMI), youth with serious emotional disturbance (SED), and/or individuals with substance use disorders (SUD). This can include individuals with intellectual/developmental disabilities who have a co-occurring SMI, SED, or SUD diagnosis.

### Why are MROs Important?

MRO services are clinical behavioral health services are designed to assist in the rehabilitation of the individuals' functional ability in activities of daily living by:

- Assessing the individual's strengths and needs;
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how MRO services help the individual reach her rehabilitative and recovery goals; and
- Delivering appropriate services to the individual.

MRO services are designed specifically to provide supports related to an individual's behavioral health\mental health needs.

An individual may receive supports through a HCBS waiver program and also receive MRO services, however there can be no duplication of services. For example, the individual may not receive Behavioral Health Counseling and Therapy through the MRO and Behavioral Support Services through the waiver if

the purpose for both is the same. However, they can receive case management through both the MRO and waiver as the MRO case manager is providing services related to the MRO while the BDDS case manager is providing services related to the waiver. The case managers for both the HCBS waiver and MRO should coordinate supports to ensure a duplication of services does not occur.

## What do MROs Cover?

MRO services in Indiana include:

- Addiction Counseling
- Adult Intensive Rehabilitative Services (AIRS)
- Behavioral Health Counseling and Therapy
- Behavioral Health Level of Need Determination
- Case Management
- Child and Adolescent Intensive Resiliency Services (CAIRS)
- Crisis Intervention
- Intensive Outpatient Treatment (IOT)
- Medication Training and Support
- Peer Recovery
- Psychiatric Assessment and Intervention
- Psychosocial Rehabilitation (Clubhouse Services)
- Skills Training and Development

Individuals are assessed by the Community Mental Health Center (CMHC) to determine what MRO service package will meet the individual's behavioral health needs based on his or her functional assessment and resulting Level of Need (LON).

## How are MROs Accessed?

Community Mental Health Centers are the exclusive providers of MRO in Indiana.

An individual must have a qualifying diagnosis and qualifying LON as determined by the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment (ANSA). Children with an LON of 2 or higher are eligible for an MRO service package. Adults with an LON of 3 or higher are eligible for an MRO service package.

*For more information on MROs, please go to the Indiana Medicaid MRO page at https://www.in.gov/medicaid/providers/clinical-services/medicaid-rehabilitation-option-mro/ and/or the MRO Provider Reference Module available at https://www.in.gov/medicaid/providers/files/medicaid-rehabilitation-option-services.pdf.*

# *Beyond the Waiver*


Case Managers provide services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner. This includes assisting individuals in gaining access to needed waiver and other Medicaid State Plan services, as well as needed medical, social, educational, and other services and unpaid supports, regardless of the funding source. Beyond the Waiver is geared toward providing Case Managers with information that will inform and empower them to support families "beyond the Waiver".

## Understanding Trauma Informed Care

Research indicates that individuals with intellectual and developmental disabilities experience trauma at a much higher rate than the general population. There are several factors that contribute to this, and it is important that as paid professionals we are armed with the information and resources to appropriately respond when a person or family on your caseload may have recently experienced trauma or is continuing to deal with trauma that occurred in their past. Trauma is a broad term for an event or series of events that make a person feel threatened or victimized. Sources of trauma can vary and may include experiencing abuse and neglect, social trauma that would include things like bullying or verbal abuse or events that can feel traumatic such frequent changes in caregivers, being institutionalized or hospitalized and lack of choice and autonomy in one's life. Signs and symptoms of trauma in persons with intellectual and developmental disabilities can sometimes be misinterpreted as symptoms of their disability. These include but are not limited to challenging behaviors, avoidance of people or situations, loss of skills or physical illness.

It is likely that you are working with individuals and families who have experienced trauma throughout their life. As a case manager your role and guidance are a critical piece to supporting individuals and families live their best life. That is why learning about trauma informed care can help you in facilitating and coordinating services and supports that restore a person's sense of safety, power, and self-worth by not repeating or ignoring the trauma they have experienced. There are six key principles to the trauma informed care approach:

- Safety – ensuring that people feel physically and psychologically safe;
- Trustworthiness & Transparency – building and maintaining trust with the individual and family;
- Peer support – connecting with others who have the lived experience;
- Collaboration & mutuality – partnering and leveling the power differences between the individual and staff; and
- Empowerment, voice, and choice – individuals' strengths and experiences are recognized and built upon.

Cultural, historical and gender issues – moves past cultural stereotypes and biases; offers culturally responsive services that leverage the healing value of traditional cultural connection; recognizes and addresses historical trauma

To learn more about these 6 key principles and the concept of trauma and a trauma informed approach the Substance Abuse and Mental Health Services Administration has a free publication available for download.

To learn more about the importance of trauma informed care and addressing trauma in individuals with intellectual and developmental disabilities visit Relias website.

The Spokane Regional Health District has developed several resources and toolkits for caregivers of children who have experienced trauma which may be a valuable resource to the families on your caseload.

To learn more about trauma informed social work practice you can visit the Oxford Academic.

## Why Social Capital is Important

You may have heard the term social capital used in your education or professional development activities, but have you ever stopped to think about the role of social capital in the lives the individuals and families in waiver services? Social capital is defined as a set of relationships and social ties, with organizations and to individuals, which can expand one's choice-making opportunities, increase one's options, and lead to a more enriched quality of life. We are in a time where the attitudes and mindsets of professionals, individuals, families, and the community at large continue to progress towards true inclusion and community integration of people with all types of disabilities. The idea of inclusion and integration is no longer settling for being present but is expanding and at times, demanding, that not only are people with I/DD present, but that they are actively and meaningfully participating to the extent they desire. This shift in culture has challenged the traditional norms by forcing people, organizations, and disability systems to evaluate their own values, habits, and way of doing business. It is during these evaluations that we begin to see more clearly the disparities that exist between people with disabilities and people who do not have disabilities. It is well documented that people with disabilities, especially those with intellectual or developmental disabilities, have greater incidences of poor physical and mental health, are more likely to live in poverty, and are more likely to be the victim of abuse, neglect, and exploitation. When taking a closer look, you will find that the common dominator in reducing these poor outcomes and experiences is to increase a person's social capital. Having social capital reduces isolation, builds valued roles, and opens doors to opportunities and experiences that propel them towards their best life.

As a waiver case manager, you play an integral role in supporting, exploring, and building an individual and family's social capital. People develop their social capital at school, at work, in their faith-based organizations, at community events or clubs, through social media and anywhere that relationships are made. That social capital can then lead to getting a job, finding a roommate, securing transportation, falling in love, and having an enhanced quality of life. Think about your own life and how the people in your life have opened doors, brought you joy and provided support. Using the Integrated Supports Star is one way you can discuss what integrated supports the individual and family current possess and discover opportunities that they may be interested in exploring. It is through those opportunities that they will have the chance to build their skills and their social capital. These experiences and opportunities may include things like volunteering, joining a group or club that meets regularly based upon a shared interest, creating a social media account, being a mentor or mentee, and staying in touch with current relationships. Identify what the individual likes to do, is passionate about or has an interest in and then how can they use that interest or passion to become more involved in activities that build their social capital. Just as in our own lives, the individuals and families on your caseload may change their mind on what they like or want to be involved, have experiences that are not always successful or develop new interests to explore. All of which are okay and expected as part of life. What is important is that you are there to provide support, encouragement, and continue to assist them in building and maintaining their social capital.

## Mental Health

The public health emergency has caused increased stress and anxiety for everyone. For most, many aspects of our daily life look very different right now. The individuals and families on your caseload may be experiencing a loss of a job, disruption in their services and/or lack of formal supports. They may also be experiencing grief from the death of a family member or friend. All these feelings of isolation, worry, grief and frustration can result in increased mental health needs, especially for those individuals with an intellectual or developmental disability and their family.

As their case manager, individuals and families may be reaching out to you for help. There are a number of resources that you may want to explore with individuals and families.

- Be Well Indiana
    - Resources for COVID-19, Mental Health and Wellness, Substance Abuse and Recovery
- Child Mind Institute Supporting Families During COVID-19
    - Provides articles, resources, and tips on dealing with loss, discipline, and behavior, managing anxiety, remote learning, taking care of yourself, and much more
- National Alliance on Mental Illness Helpline: 800-950-NAMI helpline
    - Volunteers are available to answer questions, offer support and provide next steps
    - Crisis Text Line: Text "NAMI" to 741741 for 24/7 confidential free counseling
- SAMHSA Disaster Distress Helpline: 800-985-5990 or text TALKWITHUS to 66746
    - Provides 24/7, 365 day a year immediate crisis counseling and support to people experiencing emotional distress related to national disasters
- National Suicide Prevention Lifeline: 800-273-TALK
    - Feel and confidential support for people in distress, prevention, and crisis resources

## Chronic Medical Conditions

As you know, the Family Support Waiver and the Community Integration and Habilitation waivers are for individuals who have an intellectual or developmental disability who also meet level of care. The services are designed to meet the specific needs associated with having an intellectual or developmental disability. We all know that people are more than just their intellectual or developmental disability. We also know that oftentimes individuals on our waivers will have medical needs as well. So, what if the individual has extensive chronic medical needs? Do you know how to assist them in finding services and supports to meet those chronic medical needs?

First the individual or family may want to explore accessing home health services via Medicaid PA hours to receive the nursing level of supports they may need throughout their day if they qualify. Medicaid PA hours are one avenue of service available through their Medicaid state plan. To learn more about the eligibility and allowable activities of home health services available through Medicaid you can visit the Indiana Health Coverage Program, Home Health Services Module.

The individual and family may also want to explore if one of the waivers provided through the Division of Aging might better meet their needs if they qualify. The Division of Aging administers the Traumatic Brain Injury Waiver and the Aged and Disabled Waiver. The Aged and Disabled Waiver provides services and supports to individuals who would require care in a nursing facility if waiver or other supports were not available. The services available are different than those available on the BDDS waivers so it is important when individuals and families are trying to decide which waiver best meets their needs that they consider and explore what type of supports they need to live their vision of a good life. The Traumatic Brain Injury Waiver is available to individuals of any age who have experienced an external insult resulting in a traumatic brain injury diagnosis. If individuals are interested in learning more or applying for either of these

waivers, they should contact their local Area Agency on Aging. It is also important that families and individuals understand that they can only receive services from one waiver at a time.

Depending on their health condition there may also be ways technology can assist them in managing their care. From apps on their phone that track medications and symptoms that can be shared with health providers to ease of access to health records to electronic medical devices, advances in technology make it easier to manage symptoms, medications, and care.

Lastly, the individual and family may find it helpful to connect to groups that have similar medical conditions. These groups are often a great source of support, encouragement, and information when learning to manage their chronic health condition. A simple Google search of the health condition and city they live in can guide you towards groups that may exist in their area. Facebook has many private groups that individuals can join to learn from and talk to people all over the world. Using the search feature in Facebook will help you find those online communities. Local hospitals and clinics may also have information on formal and informal groups in the area.

At BDDS we strive to empower individuals and families in living their vision of a good life. Providing them with the information and resources on an array of integrated supports is one way that we can achieve this.

## Vocational Rehabilitation

Vocational Rehabilitation (VR) Services may be an option for individuals with disabilities who need assistance in preparing for, obtaining, or retaining employment. Individuals may self-refer, or the referral may be made by family members, physicians, educational institutions, or others. Once the VR office receives the referral and application a VR counselor will be assigned. The VR counselor will gather necessary information and evaluate all medical, educational, vocational, and other information supplied to determine eligibility. The eligibility determination must be made within 60 calendar days of the date on which the individual applies. An extension for the assessment period may be deemed necessary in certain circumstances and the individual must agree to the extension. An individual is eligible if a determination is made that:

- He or she has a physical or mental impairment;
- The physical or mental impairment constitutes or results in a substantial impediment to employment; and
- The individual requires vocational rehabilitation services to prepare for, enter, engage in, or retain an employment outcome consistent with his or her abilities, capacities, career interests, and informed choice.

Under the order of selection, once an individual is determined eligible for the VR program, VR completes an assessment to determine level of severity. Based on level of severity, an eligible individual will fall under one of three priority categories. Individuals determined to meet the criteria for priority category one, most significant disability (MSD), will work with a VR counselor to develop an individualized plan for employment and receive necessary services to achieve their employment outcome. Eligible individuals who do *not* meet the criteria for priority category one are then placed in category two or three and deferred for services through community resources that may be able to provide assistance. For more information on possible community resources visit the DDRS Community Resources webpage.

For students with disabilities who are between the ages of fourteen (14) and twenty-two (22) years of age, Pre-Employment Transition Services (Pre-ETS) may be an option. The five core services of Pre-ETS are job

exploration counseling, work-based learning experiences, counseling on postsecondary opportunities, workplace readiness training, and instruction in self-advocacy. Pre-ETS are not currently available in every school but is expanding all the time! For more information visit the Pre-Employment Transition Services webpage.

Project Search may also be an option if the individual you are assisting resides in one of the eight site areas. Project Search provides transition-age youth and young adults internship experiences in preparation for competitive employment. For more information visit the Project Search website.

*For more information about Vocational Rehabilitation or to find your local office visit the Vocational Rehabilitation Client Services webpage.*

*Publications, many of which are available in English, Spanish, audio file format, and large print are available on the VR Publications webpage.*

## Understanding EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

As more children are being served on the waivers, case managers find themselves having to learn about the services and supports available to children and their families. EPSDT is a benefit available only to children under the age of 21 years who are enrolled in a state Medicaid health plan.

EPSDT ensures comprehensive and preventative health care services for children and adolescents to receive appropriate preventative, dental, mental health, developmental, and specialty services.

**Early:** Assessing and identifying problems early
**Periodic:** Checking children's health at age-appropriate intervals
**Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
**Diagnostic**: Performing diagnostic tests to follow up when a health risk is identified
**Treatment**: Correct, reduce or control health problems that are considered "medically necessary"

Effective August 1, 2018, the following home and community-based waiver services administered through the Bureau of Developmental Disability Services will no longer be offered to children under the age of 21 years due to the ability to receive these services under the EPSDT benefit through the state Medicaid Health Plan:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Psychological Therapy
- Intensive Behavior Intervention

If a child is in need of these services parents should obtain a prescription from their physician and contact a pediatric rehabilitation clinic in their area to schedule an evaluation.

For more information on EPSDT visit the Medicaid Benefits EPSDT website.

For more detailed information visit the IHCP EPSDT/HealthWatch Services Module.

## Assisting Families with Medicaid

Families and individuals often find themselves struggling to understand and navigate the Medicaid system. Because having an appropriate Medicaid category is necessary to maintain their waiver it is important that they receive the guidance and appropriate assistance necessary to address any Medicaid issues to avoid an interruption in services. Here are some tips for you to help those you serve maintain their Medicaid:

### Division of Family Resources Benefits Portal

The benefits portal allows individuals to review case information, print proof of eligibility and report changes. Individuals will need to create an online account at the first login.

### Children under 18

Children under 18 years of age who have been approved for waiver services are eligible for Medicaid regardless of parental income. The child's income and assets are taking into consideration, so it is important for families to consider this when planning for their child's financial future. Families may consult with a financial planner or elder law attorney to discuss savings options for persons with disabilities that allow them to maintain their eligibility for government services.

### Adults 18 and over

Effective June 1, 2014, Indiana transitioned to a 1634 state. 1634 status refers to a state's method for determining Medicaid eligibility under the aged, blind, and disabled coverage category. 1634 is a section of the Social Security Act. In a "1634 state," the Medicaid agency uses the same definition of disability as the Social Security Administration (SSA) for the purposes of determining eligibility for the Medicaid disability coverage category. When determining Medicaid eligibility for the disabled, the 1634 state accepts and gives precedence to SSA disability determinations for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). With 1634 status individuals deemed eligible for SSI by SSA are automatically enrolled in Medicaid.

Because of this rule, INDIVIDUALS WHO ARE 18 YEARS AND OLDER MUST APPLY FOR SOCIAL SECURITY TO MAINTAIN THEIR MEDICAID ELIGIBILITY STATUS. For those individuals who are transitioning from child to adulthood and receive an initial denial from SSA they may MAINTAIN their Medicaid during the appeals process.

### How to contact Division of Family Resources

Individuals, parents of minor children, and legal representatives, as applicable, can contact their local DFR office with questions or problems associated with their Medicaid State Health Plan.

They may also call the member service line at: 1-800-457-4584

If they are unable to get a Medicaid issue resolved through DFR please call the local BDDS office who will work with the local DFR office to address the issue.

### Funding Opportunities

Individuals, parents of minor children, and legal representatives often incur expenses or have needs that formal supports and/or Medicaid are unable to provide. In your role as case manager, you work to find them community resources to meet those needs. Following is a list of possible resources as you assist individuals to live their vision a good life.

- **United Cerebral Palsy Association of Greater Indiana** provides financial assistance to individuals with Cerebral Palsy to have access to adaptive technology, medical equipment, and other items that will increase their independence, mobility, communication, or comfort. They also provide scholarships to graduating seniors with Cerebral Palsy to further their education or training. United Cerebral Palsy Association of Greater Indiana
- **Mark's Money** provides financial assistance to people with Down Syndrome to improve their quality of life. Mark's Money
- **The Danny Did Foundation** provides financial assistance for the cost of devices related to seizure detection and safety. Danny Did Foundation
- **Anna's Celebration of Life Foundation** provides life-enhancing gifts to Indiana children with special needs. Anna's Celebration of Life
- **Helping Challenged Children, Inc.** provides financial assistance for durable medical equipment to children with special needs. Helping Challenged Children
- **The Indiana University School Dept. of Pediatrics Safety Store** has high-quality, low-cost safety products and free injury prevention education that can be used for children and adults. The Safety Store
- **United Healthcare Children's Foundation** provides grants for medical services, treatments, and/or therapies to children under 16 years of age. United Healthcare Children's Foundation
- **National Autism Association** provides low cost/free materials and items through their Big Red Safety Shop. They will also provide the Big Red Box Safety Box free during various times of the year. Big Red Safety Shop
- **Hannah's Helping Hands Grants** provides quality of life grants for families that care for children and adults with special needs. Hannah's Helping Hands Grants
- **SAWs Inc.** builds wheelchair ramps to provide persons with disabilities and conditions of aging the freedom to remain in their homes and reconnect with their community. SAWs RAMPS
- Local community groups such as the Kiwanis and Optimist Clubs often will take on service projects to help families and individuals with a wide range of needs.

It is important to research the eligibility criteria for these and other programs to find out if the individual and/or family meets the organizations qualification requirements for assistance. This list should not be considered exhaustive nor an endorsement of any one organization or program. Rather it is intended as a starting point to assist you in helping the individuals and families you serve securing needed goods or services to live their best life.

## *Statewide and Community Resources*


As part of delivering quality case management services case managers advocate alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment.

## Statewide Resources

The following list is provided to connect you with organizations serving individuals with disabilities across the state that may be able to assist individuals in achieving their good life. This list is not exhaustive nor is it intended to be an endorsement or referral of any kind.

Aging and Disability Resource Centers 800-986-3505
Provides access to information, care options, and benefit enrollment as a single point of entry for individuals seeking assistance across a spectrum of long-term care services and supports.

Arc of Indiana 800-382-9100
Programs and services include: The Arc Advocacy Network provides information, referral, advocacy, and support regarding government programs, employment, health insurance, guardianship and alternatives and community living options; The Arc Master Trust offers special needs trusts administration for families and people with disabilities; and The Arc of Indiana Foundation works to create employment opportunities for people with disabilities, including opportunities through its vocational training program, Erskine Green Training Institute.

Autism Society of Indiana 800-609-8449
Provides guidance, resources, and individualized support. ASI has many programs that focus on individuals and families touched by autism along with providing direct care (respite), career services support and community events.

Centers for Independent Living (CIL) 800-457-8283
Promote the independent living philosophy to empower adults with disabilities. Services include peer counseling, information, and referral, individual and systems advocacy, independent living skills training, and services/assistance that facilitate transition from institutional settings or transition of youth to adult life.

Covering Kids and Families 317-222-1850
Helping Hoosiers apply for and obtain health insurance coverage, including Medicaid.

Down Syndrome Indiana 888-989-9255
Serves as a one-stop-shop for information and resources about Down Syndrome.

INDATA 888-466-1314
Indiana's resource for accessibility and assistive technology topics and information, including a lending library and funding assistance.

Indiana 211 211
A free and confidential service that helps Hoosiers across Indiana find the local resources they need.

Indiana Disability Rights 800-622-4845
Assures adequate legal and advocacy services for the protection, promotion, and empowerment of the rights and interests of individuals with disabilities.

Indiana Family to Family (844-323-4636)
Indiana Family to Family provides information, training, and one-on-one support to Indiana families of children and youth with additional health and education needs, and the professionals who serve them. They aim to provide families with tools to make informed decisions, advocate for improved systems and policies, and build partnerships between professionals and families https://www.inf2f.org

INSOURCE 800-332-4433

IN*SOURCE is here to help families with special needs who have educational concerns. We take the often complicated and overwhelming task of understanding special education law and break it down to help families apply it to their own unique and individual situation, with the hope of improving outcomes for children.

United Cerebral Palsy Association of Greater Indiana 317-871-4032
Assists those with Cerebral Palsy to gain access to adaptive technology, medical equipment and other items that will increase their independence, mobility, communication, or comfort.

## Community Resources

Community resources are assets in a community that meet specific needs for those around them. These assets can be people, places or structures, and organizations. Identifying and utilizing community resources can help the individual develop, enhance, and achieve the outcomes they desire and increase their social capital. By knowing what resources are available in an individual's community, the case manager is helping the individual live his or her best life.

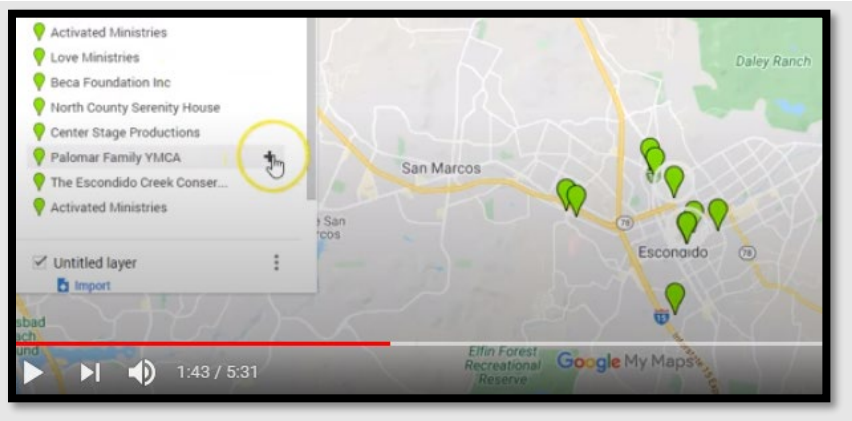
Community asset mapping is a method for identifying the assets of a community and looking at opportunities. It's not a new strategy or process – it's been in use for many years in varying forms.


Community asset mapping is about identifying and recording the people, places, businesses, organizations, and employment opportunities within a community. A community asset map should be a living document that can be added to over time to create a robust catalog of valuable community resources.

Community asset mapping can be completed by a case manager who is identifying the resources in the area s/he supports individuals or as an activity with an individual and their IST. For more information on community mapping, check out the videos below by pressing the Ctrl key and clicking on the title.

Community Asset Mapping – What is it?

[How to do Community Asset Mapping Using Google's My Maps]



# *Training Requirements*

## Case Management Training Series


BDDS is committed to practicing a culture of quality that results in the individuals we serve living their best lives. The Case Management Training Series was created to enhance the knowledge and abilities of providers of case management through skill and relationship development that supports individuals on a positive trajectory. Simply said, relevant and consistent training improves case management performance.

The Case Management Training Series is a series of online training modules for Bureau of Developmental Disabilities Services (BDDS) case managers, supervisors of case managers, and administrative staff of case management organizations. The modules are designed to provide education and training that assists with the day-to-day activities of working with individuals, parents of minor children, and legal representatives, while also meeting the training requirements set forth in 460 Indiana Administrative Code (460 IAC).

This series has been collaboratively developed by BDDS, the Bureau of Quality Improvement Services (BQIS), the Division of Disability and Rehabilitative Services (DDRS), and the Indiana Institute on Disability and Community at Indiana University (IIDC), Bloomington.

### Providers of Case Management Services

Providers of case management services are required to complete twenty (20) hours of training regarding case management services in each calendar year regardless of their date of hire. Ten (10) hours of this training shall be training approved by BDDS. BDDS approved training is provided through the Case Management Training Series in Canvas and achievement of the requirements is demonstrated by viewing the trainings taken in their entirety and the successful completion of the related quiz. Additionally, if BDDS identifies a systemic problem with a provider's case management services, the provider shall obtain training on the topics recommended by the BDDS.

Training available in the Case Management Training Series also includes training specific to the requirements set forth in 460 IAC 6-14-4 that apply to all providers, including providers of case management services.

As part of the ten (10) hours of training in the Case Management Training Series, the following trainings must be taken, and completion demonstrated, annually:

- Abuse, Neglect and Exploitation
- Human Rights
- Incident Reporting Process
- Critical Event Process
- BMR and BRQ Process

Further, new providers of case management services will take the required trainings prior to working with an individual.

## Case Management Administrative Staff

Administrative staff who do not provide direct case management services or support but may potentially have contact with the individual, parent(s) of a minor child, or the individual's legal representative, as applicable, through direct and/or indirect contact, must complete one and one-half (1 ½) hours of training annually. Indirect contact may include, but is not limited to, review of compliance and quality in case management documents and documentation, and internal processes that include input, discussion, and decisions made regarding the individual receiving case management services. These BDDS approved trainings are provided through the Case Management Training Series in Canvas and achievement of the requirements is demonstrated by viewing the trainings taken in their entirety and the successful completion of the related quiz. The one and one-half (1 ½) hours required must be comprised of the following trainings:

- Abuse, Neglect and Exploitation (460 IAC 6-14-4 a)
- Human Rights (460 IAC 6-14-4 a)
- Incident Reporting Process (460 IAC 6-14-4 a)

Further, per 460 IAC 6-14-4(d), administrative staff will take the trainings required in 460 IAC 6-14-4 prior to working with an individual.

*In addition to the information in this section, providers of case management services, case management administrative staff, and case management training liaisons must be knowledgeable of all requirements set forth in the Case Management Training Series Guidance for Providers of Case Management, Case Management Administrative Staff, and Case Management Organization Training Liaisons.*


BEST practice requires viewing the trainings taken in their entirety and the successful completion of the related assessment. While some assessments require a score of 100% to pass, for all others demonstration of best practice requires a score of 90% or above.

BETTER practice requires viewing the trainings taken in their entirety and the successful completion of the related assessment. While some assessments require a score of 100% to pass, for all others demonstration of better practice requires a score between 85 and 89%.

Compliance requires viewing the trainings taken in their entirety and the successful completion of the related assessment. While some assessments require a score of 100%, all others require only a score of 80% to pass and receive credit.

## Case Management Organization Training Requirements

To maintain BDDS' approval to provide case management services providers of case management services must complete ten (10) hours of training supplied by their case management organization.

Case management organizations are required to provide each case manager with ten (10) hours of comprehensive and competency-based training annually to ensure a consistently high standard of services. Case management organization provided training shall be structured around the curriculum developed by BDDS and must be in alignment with the State's 1915(c) Waiver Service Definition and FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals. Case management organization training is expected to go beyond minimum requirements and emphasize industry best practices for case management, with particular focus on the process outlined by the FSSA/DDRS/ BDDS/BQIS service standards, guidelines, policies and/or manuals. Training must be offered regularly and through various modalities, including but not limited to, in-person, on-demand, and web-based.

The subject matter of the training program shall include information on adjacent Medicaid services not covered by waivers that may be available to the Individual population as well as waiver services such as: localized resources or supports available in an individual's community; 211 access information; or national programs for specific diagnoses or conditions with specialized resources to support individualized needs. Additionally, the training shall include guidance on how to research and develop familiarity with potential community services available in a case manager's geographic area. The case management organization is responsible for notifying case managers of any new initiatives that are applicable and incorporating this information into training as necessary.

Documentation of case manager training and related assessments must be made available to BDDS/BQIS upon request.

## Indiana Office of Technology Training Requirements


Users of BDDS technology systems are required to complete regular training by the Indiana Office of Technology (IOT). In this section case managers will learn the requirements, why the IOT trainings are important, and when they are completed.

Additional information on obtaining and maintaining systems access is available in the Systems Access Guide.

### What are IOT Required Trainings?

IOT trainings have been developed to inform users on topics related to Indiana's systems policies and practices including, but not limited to, the Indiana Resource Use Agreement (IRUA) and CyberSecurity Onboarding. Monthly trainings address current security issues such as phishing, credential harvesting, mobile device security; and understanding link rewrites. Additionally, the State Personnel Department (SPD) may also enroll users in updated trainings such as, "Preventing Workplace & Sexual Harassment 2021 for Contractors". All enrolled trainings are found in the user's SAP SuccessFactors learning profile.

### Why are IOT Trainings Important?

To protect the integrity of state systems, it is important for users to be informed of security measures that must be taken while accessing BDDS systems, to boost awareness of potential cyber threats, and to ensure appropriate access and use of state systems.

### When are IOT Trainings Completed?

Employees of case management organizations are required to complete training prior to receiving access to BDDS systems, and monthly thereafter. Users who do not complete the required monthly training will lose access to the BDDS Portal until the training requirement has been met.

## *Case Manager Certification*


Case management organizations must ensure that each provider of case management services obtain proof of competency initially and annually demonstrated through successful completion of the DDRS/BDDS certification exam.

The Case Manager Certification exam is a series of assessments based on the Charting the LifeCourse Support Coordination Series and core competencies for all providers of case management services. The training materials provided will address each of the six foundational knowledge and skills areas:

- Recognizing Your Role
- Understanding Individuals & Families
- Engaging with Individuals & Families
- Facilitating Problem Solving & Decision Making
- Navigating Supports & Services
- Strategies to Achieve a Good Life

The exam is administered in six (6) assessments provided through the Certification module of the Case Management Training Series in Canvas. The assessments may be taken at different times, but all must receive a minimum score of 80% to meet the initial and annual requirements for certification. Providers of case management services will have three (3) attempts to successfully complete each assessment. If the provider of case management services does not successfully complete an assessment in three attempts, the supervisor or CMO leadership must contact BDDS for support to ensure success on the next attempt.

### Initial Certification Requirements

Case management organizations must ensure newly hired providers of case management services complete the certification exam within ninety (90) calendar days of the date they are hired. Case managers moving from one case management organization to another may transfer their initial certification if taken within the same calendar year.

### Annual Certification Requirements

Case management organizations must ensure all ongoing providers of case management services complete the certification exam within the first quarter of each calendar year. Case managers moving from

one case management organization to another may transfer an annual certification taken within the same calendar year.

For complete information on the certification exam, including exam materials, please see the Case Management Certification Exam document available as an addendum.


BEST practice requires a score of 90% or above on all modules.

BETTER practice requires a score between 85% and 89% on all modules.

Compliance requires a score of 80% on all modules for certification.

# *Case Management Organization Requirements*


Case management organizations (CMOs) are required to meet all standards set forth in the HCBS Case Management Waiver Service Definition for the Family Supports and Community Integration and Habilitation waivers as well as adhere to the terms of the contract allowing them to provide BDDS case management services.

Individuals receiving services through BDDS HCBS waiver programs deserve the opportunity to choose a case management organization capable of conducting accurate evaluations and assessments, facilitating development of Person-Centered Individualized Support Plans (PCISPs) that are strengths-based, person-centered, inclusive of integrated supports, and meet the needs and desires of the individual. Case managers are responsible for coordinating services among providers and monitoring the implementation of the services as well as the health and welfare of the individual. If problems arise, individuals deserve to have access to a case manager who can properly respond and assist individuals and their ISTs in finding and working toward solutions. The individual's experience will be maximized when their chosen case management organization is knowledgeable and properly equipped to support case managers in their support of individuals and Individualized Support Teams (IST).

As in most professional service industries, a certain level of applicable education, training, and acquired expertise is prerequisite for maximized results. The best case manager for the job is one who is well trained, knowledgeable, experienced, properly supported and equipped, skilled, and competent in their role. A case manager cannot succeed apart from a qualified case management organization.

## Case Manager Activities

### What are Reimbursable Activities?

Case management organizations are required to ensure case managers respond to individuals' needs and desires and complete all tasks accurately and timely. This includes, but is not limited to:

- Providing an array of services that assist individuals in gaining access to needed waiver and other Medicaid State plan services, as well as medical, social, educational, and other services regardless of the funding source for the services or community supports to which access is gained.
- Advocating alongside the individual to ensure their access and opportunities for participation in all paid and unpaid services, programs, and settings which allow for building social capital, skill development, and personal fulfillment.
- Initially and annually, completing Annual planning and assessment activities timely in support of the individual. This includes, but is not limited to:
    - Establishing a person-centered, strengths based, PCISP that supports the individual's vision of a good life through offering opportunities for integrated supports. The individual must be present and supported to facilitate development of the plan to the greatest extent possible;
    - Developing an annual budget in support of the PCISP; and

- Determining continued eligibility for services through completion of the Level of Care Screening Instrument (LOCSI).

- Ongoing case management services are based on the principles of person-centered thinking and driven by the PCISP. Person-centered practices include, but are not limited to:
  - Convening IST meetings at least semi-annually, and as needed. IST meetings may be held in the manner desired by the individual and parent(s) of minor children or legal representative(s), as applicable. The individual and parent(s) of a minor child or legal representative(s), as applicable, must be present for all IST meetings.
  - Conducting face-to-face, in-person visits with the individual and parent(s) of minor children, or legal representative(s), as applicable, for the purpose of relationship building and knowledge of the individual at least semi-annually, and as needed. Further:
    - Face-to-face visits must be intentional interactions and may not be held as drop-in visits at a day program.
    - At least one visit each year must be held in the home of the individual.
  - Case managers must ensure at least one visit each year is unannounced for individuals residing in provider owned or controlled settings (POCOS). Unannounced visits are intentional interactions and are not completed by arriving at the home early for a planned meeting or visit. Indiana defines a provider owned or controlled setting as:
    - Residential settings that are owned by a provider; or
    - Residential settings in which individuals, who are not living in their family home, and utilize:
      - Residential Habilitation and Support – Level Two;
      - Residential Habilitation and Support – Daily; or
      - Structured Family Caregiving
  - IST meetings and face-to-face contacts are both required in a manner that ensures interaction at least every 90 calendar days.
  - Regularly reviewing and updating the PCISP when:
    - The needs or circumstances of the individual have changed;
    - Services are added or changed
    - At the request of the individual, parent(s) of a minor child, and legal representative(s), as applicable;
    - Following non-annual IST meetings to record discussion on outcomes and any related plan changes.
  - Identifying, assessing, and addressing risks initially and as needed.
  - Updating PCISPs timely, including the submission of service changes and budget requests consistent with the individual's PCISP.
  - Monitoring service delivery and utilization to ensure that services are being delivered in accordance with the PCISP.
  - Monitoring individuals' health and safety.
  - Completing and processing the pre/post meeting Monitoring Checklist within the established timeline.
  - Completing, submitting, and following up on incident reports as established by BQIS.
  - Completing case notes and necessary PCISP revisions and documenting each encounter with or on behalf of the individual within 7 calendar days at a minimum. As a reminder, case managers must have at least one documented meaningful encounter monthly to support billing.

- Disseminating information including the PCISP, all Notices of Action and forms to the individual, parent(s) of minor children, and legal representative(s), as applicable.
- Disseminating Incident Reports (IRs) to all IST members.
- Maintaining files in accordance with State standards.
- Assessing the services outcomes and satisfaction of individuals, parents of minor children, and legal representatives, using the standardized survey developed in collaboration with BDDS/BQIS and sharing the results with BDDS/BQIS at least annually. At the case management organization's discretion, this responsibility may be assigned to a specific role within the case management organization (i.e., quality manager or organization leadership).

- Case management services may be available during the last one hundred eighty (180) consecutive dates of a Medicaid eligible individual's institutional stay to allow case management activities to be performed specifically related to transitioning the individual from an institutional setting to DDRS HCBS waiver setting. For the purpose of determining the availability of transitional case management services, institutional settings are limited to the following:
  - Nursing facility
  - Comprehensive rehabilitative management needs facility
  - State psychiatric facility
  - Supervised group living setting

## What Activities are Not Allowed?

In addition to defining the responsibilities of case management organizations for ensuring case managers complete specific requirements, there are also activities that are not allowed. Including these non-allowable activities in the waiver service definition, as well as in guidance, ensures case management organizations are knowledgeable of the level of support individuals, parents of minor children, and legal representatives must receive from their case manager, as well as identifying areas that would prevent the ethical delivery of case management services. Activities not allowed include:

- Case managers may not be contractors of the case management organization.
- The case management organization may not subcontract with another agency or case manager for the provision of direct case management services.
- Caseload average in excess of forty-five (45) across the case management organization's active, full-time case managers who carry caseloads. *See the section on Caseload Size for additional information.*
- The case management organization may not bill in a month for solely non-case management related activities or tasks such as mailing greeting cards or holiday text messages, for example.
- Reimbursement is not available through case management services for the following activities or any other activities that do not fall under the previously listed definition:
  - Services delivered to persons who do not meet eligibility requirements established by DDRS/BDDS.
  - Counseling services related to legal issues. Such issues shall be directed to the Indiana Disability Rights, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146.
  - Case management conducted by a legal guardian or person related through blood or marriage to any degree to the individual.
- The case management organization may not own or operate another waiver service agency, nor may the case management organization be an approved provider of any other waiver service or otherwise have a financial investment in any other waiver service.

## Conflict-Free Case Management

Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the individual being served. Conflict-free means:

- Case management agencies may not be an approved provider of any other waiver service.
- The owners of one case management agency may not own multiple case management agencies.
- The owners of one case management agency may not be a stakeholder of any other waiver service agency.
- There may be no financial relationship between the referring case management agency, its staff, and the provider of other waiver services.
- Case managers may not be financially influenced in the course of their service delivery. *Case management organizations are to be knowledgeable of the sections on Employment and Ethical Practices of Case Management Organizations included in this guide.*
- In addition, case managers must not be:
    - Related by blood or marriage to the individual;
    - Related by blood or marriage to any paid caregiver of the individual;
    - Financially responsible for the individual; or
    - Authorized to make financial or health-related decisions on behalf of the individual.

## Quality and Compliance

To ensure case management organizations, and the case managers they employ, are equipped to provide quality and compliant case management services, case management organizations must:

- Retain at least one full-time employee to actively monitor and ensure all areas of compliance and quality.
    - Persons in this role may not carry a case load of more than ten (10) cases.
    - Persons in this role may not do quality and compliance reviews on their own caseload.
    - Persons in this role will monitor and identity any violation of rules, regulations, or established requirements that are discovered and report them to BQIS through the incident reporting system as outlined in Indiana Administrative Code, Indiana Code and BQIS policy.
- Employ or contract with a Registered Nurse with valid Indiana nursing licensure.
- Have a mechanism for monitoring the quality of services delivered by case managers that aligns with BDDS practices; and addressing any quality issues that are discovered and reporting them to BDDS/BQIS.
- All DDRS-approved case management agencies specifically agree to comply with the provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq. and 47 U.S.C. 225).
- Case management entities must:
    - Ensure compliance with any applicable FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals, including policies, written agreements and the HCBS Waivers Provider Reference Module on the IHCP Provider Reference Materials webpage;
    - Ensure case managers meet with waiver individuals on a regular basis and as requested by the individual to develop, update, and support the execution of person-centered individualized support;

- Ensure case managers have the ability to employ whatever tools necessary to effectively and efficiently communicate with each individual by whatever means is preferred by the individual; and
- Ensure case managers meet with one or more of the following qualification standards:
  - Hold a bachelor's degree in one of the following specialties from an accredited college or university:
    - Social work, Psychology, Sociology, Counseling, Gerontology, Nursing, Special education, Rehabilitation, or related degree if approved by the FSSA/DDRS/OMPP;
    - Be a registered nurse with one-year experience in human services; or
    - Hold a bachelor's degree in any field with a minimum of one year full-time, direct experience working with persons with intellectual/developmental disabilities.
  - Holding a master's degree in a related field may substitute for required experience.
  - The case manager must meet the requirements for a qualified intellectual disability professional in 42 CFR 483.430(a).

## Training

- Require initially and annually, that each case manager employed by the DDRS-approved case management agency obtain proof of competency demonstrated through successful completion of the DDRS/BDDS case management training series curriculum and case management certification exam within the required time frames;
  - Ensure case managers complete and demonstrate competency of the BDDS required training;
  - Ensure case managers complete the required hours of BDDS approved, case management organization provided, training;
- Ensure that case managers are trained in the person-centered planning process aligned with BDDS and BQIS' mission, vision, and values, including participation in any BDDS person-centered trainings;
- Provide case managers with comprehensive and competency-based training to ensure a consistently high standard of Services.
  - Ensure CMO provided training shall be structured around the curriculum developed by BDDS and must be in alignment with the State's 1915(c) Waiver Service Definition and FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals.
  - Ensure the training program goes beyond minimum requirements and emphasizes industry best practices for case management, with particular focus on the process outlined by the FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals.
  - Ensure training is offered regularly and through various modalities, including but not limited to, in-person, on-demand, and web-based.
  - Ensure the subject matter of the training program includes information on adjacent Medicaid services not covered by waivers that may be available to the Individual population as well as waiver services such as: localized resources or supports available in an Individual's community, 211 access information, or national programs for specific diagnoses or conditions with specialized resources to support individualized needs.
  - Further topics to be included can be found in the training guidance, which the State reserves the right to periodically update and share with the Contractor
- Ensure the training program includes guidance on how to research and develop familiarity with potential community services available in a Case Manager's geographic area.

- The Contractor shall be responsible for notifying Case Managers of any new initiatives that are applicable and incorporating this information into the training as necessary.

## Technology

Individuals, parents of minor children, and legal representatives in crisis must have the ability to reach their case management organization for needed support in a crisis. To that end, case management organizations will:

- Provide and maintain a 24/7 emergency response system that does not rely upon the area 911 system and ensures assistance to all waiver individuals. Staff working the 24/7 must be capable of assisting individuals with addressing immediate needs and contact the individual's case manager to ensure arrangements are made to address the immediate situation and to prevent reoccurrences of the situation; and
- Ensure each case manager is properly equipped with a cell phone, smart phone, or similar device that allows the case manager to be accessible as needed to the individuals he or she serves

Further, case management organizations must ensure that case managers are knowledgeable and equipped with technology that is secure and allows them to protect the protected health information (PHI) and personal identifying information in alignment with the requirements outlined in the Information Resource Use Agreement (IRUA). Therefore, case management organizations will:

- Ensure the case management organization and each case manager maintains sufficient technological capability to submit required data electronically in a format and through mechanisms specified by the State in a manner consistent with the IRUA.

## Provider Qualifications

Providers of case management services must:

- Be enrolled as an active Medicaid provider.
- Be FSSA/DDRS-approved to provide contracted case management services.
- Provide case management services in every county.
- Comply with Indiana Administrative Code, 460 IAC 6, including but not limited to:
  - 460 IAC 6-10-5 Documentation of Criminal Histories;
  - 460 IAC 6-12-1 and 460 IAC 6-12-2 Insurance;
  - 460 IAC 6-11-1 to 460 IAC 6-11-3 Financial Status of Providers;
  - IAC 6-19-1 through 460 IAC 6-19-9 Case Management, and
  - 460 IAC 6-5-5 Case Management Services Provider Qualifications.
- Obtain/maintain accreditation (specific to Indiana programs) by at least one (1) of the following organizations:
  - The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.
  - The Council on Quality and Leadership in Support for People with Disabilities, or its successor.
  - The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.
  - The ISO-9001 human services QA system.
  - The Council on Accreditation, or its successor.
  - An independent national accreditation organization approved by the secretary.

- Develop and enforce a code of ethics aligned with 460 IAC 6-14-7 and BDDS policy, practices, and guidance. *See the section Ethical Practices of a Case Management Organizations for additional information.*
- Maintain a sufficient number of Case Managers to provide statewide coverage while maintaining an average caseload size of no more than forty-five (45) cases across full-time Case Managers who actively provide case management services to individuals receiving waiver services. A full-time Case Manager is defined as a Case Manager with a caseload of at least 21 cases. The State will monitor adherence to this caseload limit on a quarterly basis.
- Ensure, ongoing, that criminal background checks are conducted for every employee hired or associated with the case management organization as stated in Indiana Administrative Code, Indiana Code and BDDS policy.

## Case Management Organization Contract

In addition to the meeting the requirements outlined in the Case Management Waiver Service Definition and ensuring compliance with any applicable FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals, including policies, written agreements and the HCBS Waivers Provider Reference Module on the IHCP Provider Reference Materials webpage, case management organizations must adhere to the standards and requirements outlined in their BDDS case management contract.

## Additional Expectations and Responsibilities

The following expectations and responsibilities of all case management organizations (CMO) are in addition to those outlined above.

- The CMO shall participate in and collaborate with the State by staying informed of any and all updates, changes, and additions to BDDS/BQIS services, supports, policies, guidance, and procedures. This will be achieved through activities such as active participation in webinars, meetings, and by receiving and reading DDRS announcements.
- The CMO shall actively monitor and manage case managers in accordance with the specifications outlined by the State.
- The CMO shall be responsible for ensuring and demonstrating Case Managers are knowledgeable in accessing and connecting individuals to paid and nonpaid services and supports.
- The CMO shall provide support and supervision to case managers in the form of supervisory staff that are also available as a resource to case managers. Supervisory staff shall have a broad range of relevant experience and assist in ensuring statewide coordination.
- The CMO shall be responsible for reviewing and verifying the timely and accurate completion of required documentation.
- Regarding the assignment of case managers, the CMO shall:
    - Assign cases to case managers in accordance with the requirements set forth in the Case Management Waiver Service Definition and FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals.
    - Consider the complexity of individual cases when determining case manager caseload and capacity.
    - Ensure that, following assignment of a new case, the case manager initiates outreach to the individual in accordance with the FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals.

- Have a process by which individuals can request a specific case manager and change their case manager if and when desired by the Individual, parent(s) of a minor child, and/or legal representative, as applicable.

## *Ethical Practices of Case Management Organizations*

The ethical practices of a case management organization (CMO) are guided by the five basic principles outlined in the section on Ethical Case Management: Beneficence, Nonmaleficence; Autonomy; Justice; and Veracity. However, the ethical practices for CMOs go deeper. In this section, CMOs will find the requirements for all case management organizations as well as their responsibilities for oversight of the ethical practices of case managers.

### What Are the Ethical Practices of Case Management Organizations?

The code of ethics each case management organization is responsible for developing and enforcing in alignment with 460 IAC 6-14-7 and BDDS/BQIS policy, practices, and guidance shall include, but not be limited to, the following:

Beneficence: Always Do Good

- Ensure case managers are trained to treat individuals, parents of minor children, legal representatives, and providers with dignity, respect, and cultural sensitivity without regard to race or ethnicity, gender identity, religion (or no religion), or socioeconomic status.
- Ensure case managers are trained to recognize abuse, neglect, exploitation, and human rights violations and know their responsibilities for confirming the individual is safe, protected, and required steps are being followed to resolve the matter.

Nonmaleficence: Do not Purposefully do Harm

- Case management organizations must ensure case managers are knowledgeable of their organizations ethical standards and are aware of the potential harms that could occur when those standards are breached, even when it's unintended. The list of possible harms is lengthy and speaks to the sheer volume of ethical responsibilities the case manager assumes. For example, a case manager who does not know anything about confidentiality and privacy requirements, criminal behavior, informed consent, and ordinary professional courtesy would be seriously lacking in essential information, and therefore could potentially act in ways that violate the Federal, State, and/or Administrative Code as well as FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies and/or manuals, including policies, written agreements and the HCBS Waivers Provider Reference Module on the IHCP Provider Reference Modules webpage.
- A particularly trying situation invites maleficent behavior when a case manager becomes exasperated with or even comes to dislike a particular individual and/or their IST. In a situation such as this, the possibility of causing harm becomes quite real. Although understandable to want to be rid of this individual, this feeling can translate itself into any number of problematic behaviors on the part of the case manager such as: ignoring the individual's or IST's questions, lecturing, sermonizing, arguing, blaming, or feeling a strong aversion to communicating at all with the individual and his/her support system. These behaviors would hardly be conducive to a respectful, productive, or professional

relationship between the case manager and the individual, et al, and – ultimately – good case management outcomes.

- Case management organizations must avoid any conflict of interest that would result in putting individuals' needs and desires after their own or their case managers.
    - The employment model of the CMO must follow the requirements set forth in the Employment section of this guide. To practice case management ethically, case managers must be able to act in the best interest of the individual at all times. Payment based on assigned cases results in fear of losing income from being "fired" and can result in unethical practices.
    - Ensure case managers understand the conflict of interest that exists when gifts are given or received from providers, individuals, parents of minor children, or legal representatives.
    - Case management organizations must follow the conflict-free case management policy outlined in the Case Management Waiver Service Definition. This covers conflict of interest in terms of provision of services as well as in relationship to the individual being served. Conflict-free means:
        - Case management agencies may not be an approved provider of any other waiver service;
        - The owners of one case management agency may not own multiple case management agencies;
        - The owners of one case management agency may not be a stakeholder of any other waiver service agency;
        - There may be no financial relationship between the referring case management agency, its staff, and the provider of other waiver services; and
        - Case managers may not be financially influenced in the course of their service delivery.

Autonomy: Promote the Rights of the Individual

- Ensure case managers are trained to facilitate IST meetings, face-to-face visits, and assist with the development of a Person-Centered Individualized Support Plan (PCISP) in a manner that promotes the rights of the individuals in their efforts to identify and clarify their good life and related outcomes regardless of their disability or support needs. Case managers must be able to balance the needs of individuals, parents of minor children, and legal representative, as applicable, when there is a disagreement. *See Balancing Competing Priorities.*

Justice: Assist Individuals to Obtain What They Deserve

- Ensure case managers are trained to support individuals and their ISTs in person-centered planning and have the ability to identify, select, obtain, coordinate, and utilize paid services and natural and integrated supports in a manner that enhances their independence and integration into community life in a manner consistent with their lifestyle preferences and needs.
- Ensure case managers understand that waiver funding belongs to the individual. Changing the service type, number of units or how/when they are delivered without the informed consent of the individual, parent(s) of a minor child, or legal representative(s), as applicable, is prohibited.
- Ensure billing for case management services provided to an individual is for a meaningful, reimbursable, activity that has been documented in case notes as detailed in the Case Management Waiver Service Definition.

### Fidelity/Veracity: Always Tell the Truth

- Ensure case managers understand that falsifying documentation or violating Federal regulations, Indiana Code, Indiana Administrative Code, FSSA/DDRS/BDDS/BQIS service standards, guidelines, policies, and/or manuals including written agreements and the HCBS Provider Reference Module is prohibited. When issues are identified, the case management organization will follow the process outlined in the section on Investigations. Case management organizations are required to share validated complaint investigation results with BDDS/BQIS via email at BQIS.Help@fssa.in.gov.
- When reporting issues or responding to requests for information by BDDS/BQIS of any type and by any method, case management organizations must ensure the information included in the report or response is complete and accurate.

## Why are Ethical Case Management Organization Practices Important?

It is important that all CMOs demonstrate ethical practices that are aligned with the DDRS, BDDS, and BQIS Mission, Vision and Value statements and reflect the core belief and principles of LifeCourse Framework. These statements are:

### DDRS Mission

DDRS supports a wide variety of Hoosiers with disabilities to create a vision for their future that uses paid and natural supports to build on and enhance their personal strengths and assets.

### BDDS Mission

To connect people with disabilities and their families to resources and supports to live their best lives.

### DDRS Vision

All people have the right to live, love, work, learn, play, participate and pursue their dreams in their community.

### BDDS Vision

All people have equal access and opportunity to realize their good life.

### DDRS Values

- Dignity
- Strength-based
- Informed choice
- Supported decision-making
- Self-direction
- Self-advocacy
- Holistic support

### BDDS Values

- Person-Centered
- Inclusion
- Collaboration
- Commitment
- Empowerment

Along with the above statements, BDDS looks to case management organizations to have embraced the Charting the Lifecourse Framework (CtLCF) and fully promote the CtLCF core belief as the adopted vision

of DDRS, **"**all people have the right to live, love, work, play and pursue their life aspirations just as others do in their community"**,** as its vision.

## Incorporating the LifeCourse Framework in Ethical Practices

Adopting the following Life Course foundational statements below bring to life the ethical standards of beneficence, nonmaleficence, autonomy, justice, and fidelity/veracity.

### ALL People

ALL people, regardless of age, ability, or family role, are considered in our vision, values, policies, and practices for supporting individuals and families. All families have choices and access to supports they need, whether they are known to the disability service system or not.

### Family System and Cycles

People exist and have give-and-take roles within a family system, which adjust as the individual members change and age. Individuals and families need supports that address all facets of life and adjust as roles and needs of all family members change as they age through the family cycles.

### Life Outcomes

Individuals and families focus on life experiences that point the trajectory toward a good quality of life. Based on current support structures that focus on self-determination, community living, social capital and economic sufficiency, the emphasis is on planning for life outcomes, not just services.

### Life Domains

People lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life, including *daily living, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy.*

### Life Stages and Trajectory

Individuals and families can focus on a specific life stage, with an awareness of how prior, current, and future life stages and experiences impact and influence life trajectory. It is important to have a vision for a good, quality life, and have opportunities, experiences, and support to move the life trajectory in a positive direction.

### Individual and Family Supports

Supports address all facets of life and adjust as roles and needs of all family members change. Types of support might include *discovery and navigation* (information, education, skill building); *connecting and networking* (peer support); and *goods and services* (daily living and financial supports).

### Integrated Delivery of Supports

Individuals and families utilize an array of integrated supports to achieve the envisioned good life, including those that are publicly or privately funded and based on eligibility, community supports that are available to anyone, relationship-based supports, technology, and that consider the assets and strengths of the individual and family.

### Policy and Systems

Individuals and families are satisfactorily involved in policy making so that they influence planning, policy, implementation, evaluation, and revision of the practices that affect them. Every program, organization, system, and policy maker must always think about a person in the context of family.

By keeping in mind ethical practices, the mission, vision, and values held by DDRS and BDDS, and LCF principles, the case manager has a guidepost to assure the fair treatment and wellbeing of all they serve and provide to the individual a baseline expectation of the case manager's service delivery.

## *Monitoring and Quality Oversight*

In this section, BDDS will define the monitoring and quality oversight functions for case management organizations. Components include case management activities, investigations, and fraud.

### What Case Manager and Case Management Organization Functions are Included?

All case manager and case management organization functions are subject to quality oversight and monitoring by BDDS/BQIS as well as other regulatory entities. Quality oversight and monitoring employs a culture of quality such as the Plan-Do-Check-Act model. In this environment, a plan is developed and implemented, data is collected and reviewed, the plan is revised as needed, and the cycle continues. The goal is continuous improvement.

### Why is Monitoring and Quality Oversight Important for Individuals?

CMS requires assurance from states that all providers are qualified to fulfill their duty in supporting individuals. To effectively support individuals in BDDS services, providers and their staff must provide quality services and supports. To ensure quality services and supports, a case management organization must have a robust quality monitoring system that meets or exceeds BDDS/BQIS ongoing quality monitoring.

### How does Monitoring and Quality Oversight Look in Practice?

The case management organization shall have a comprehensive, two-pronged approach to quality assurance, actively conducting both prospective and retrospective quality assurance of the services provided by its case managers. A comprehensive quality assurance plan must include but not limited to:

- Delivery of statewide case management services
- Oversight of case managers
- Documentation verification
- Adherence to the 1915(c) Waiver Service Definition
- Any applicable FSSA/BDDS/DDRS/BQIS service standards, guidelines, policies and/or manuals, including written agreements
- Adherence to the IHCP Provider Reference Module for FSSA/DDRS HCBS Waivers

The case management organization's quality assurance plan must address:

- The case management organization's data-driven approach to decision making, including the approach to ensuring sufficient statewide coverage while balancing case manager capacity in relation to both geography and caseload.
- An approach to verifying employee qualifications.

- A detailed training plan, supplemental to any training provided by BDDS, which includes the proposed frequency, modality, and topics of these trainings.
- An approach to reviewing each case manager's activity and documentation at least annually. Findings from these reviews shall feed into case manager training and employee evaluations.
- Annual performance reviews and employee evaluations of case manager performance.
- Available feedback mechanisms, including the individual satisfaction survey and open feedback channel that the case management organization will make available to individuals receiving services.
- Investigation of and response to complaints. The case management organization shall outline an approach to investigating and responding to complaints received from individuals and all other interested stakeholders, including a mechanism to share with BDDS/BQIS upon request.

The case management organization shall provide periodic status reports within thirty (30) calendar days following the end of the calendar quarter, in a format provided by BDDS/BQIS, to BDDS/BQIS regarding their duties, including but not limited to the following:

- Quarterly Quality Training and Improvement Process. The case management organization shall collaborate with BDDS/BQIS in review of case management data each quarter. This review shall include a state data summary of the case management services, any identified quality assurance activities, random case audits, and outstanding issues and action items. This review should also highlight any notable trends for both the quarter and longitudinal. The final quarterly status update of each calendar year shall include an annual compilation of all quarterly status updates.
- The case management organization shall prepare, at no additional cost to BDDS/BQIS, any one-time report or new, ongoing report, at the request of BDDS/BQIS that may be necessary to address any concerning service delivery trends or quality assurance issues.
- On a semi-annual basis the case management organization shall participate in collaborative touchpoints with BDDS/BQIS. At the discretion of BDDS/BQIS, these touchpoints may be conducted in-person at the Indiana Government Center. BDDS/BQIS will prepare the agenda for these meetings and the case management organization shall be able to add items to agenda. Participation in the semi-annual touchpoints are limited to leadership staff and must include, at a minimum, a member of the executive staff and the Compliance Officer.
- The case management organization shall be available to attend additional meetings as requested by BDDS/BQIS.

On an ongoing basis, BDDS/BQIS will monitor case management activities, including but not limited to:

- PCISP and services contained within
- Level of Care
- Case records/documentation
- Meeting requirements
- Required training
- State system access

# *Quality Improvement*


A very wise man once said:

*Quality is not an act; it's a habit!*

We – individually and collectively – are what we repeatedly do, and don't do. Especially when no one is looking. *NASDDDS 2017 Directors Forum and Annual Conference*

This section on Quality Improvement will inform case management organizations and case managers about Case Record Reviews (CRR) the Quality Training and Improvement Process (QTIP), Quarterly Performance Reports, Semi-annual Collaborative Quality Touchpoints, Annual Summary Reports, and the annual Individual and Family Satisfaction Survey.

## Case Record Reviews

### What is a Case Record Review?

A Case Record Review is a systematic review conducted monthly utilizing a waiver-specific valid sampling methodology by the Bureau of Quality Improvement Services (BQIS). BQIS staff review waiver individuals' case files for compliance with the HCBS Final Rule on Settings, Federal Code, Indiana Code, 460 Indiana Administrative Code (IAC) 6, 460 IAC 7, the CIH and FS waivers, the MFP Demonstration Project, and BDDS case management requirements.

### What is Reviewed during a Case Record Review?

Case record reviews include:

- Review of the individual's profile information including, but not limited to:
  - Living arrangement;
  - Emergency contacts; and
  - Guardian information, if applicable.
- The Person Centered-Individualized Support Plan (PCISP);
- Risk assessment embedded in PCISP;
- Identified risk plans;
- Annual choice of waiver services, non-waiver services or to not receive ICF/IDD Medicaid services (BDDS Signature Page/Freedom of Choice Section); and
- Signed provider choice for each service.

### Why are Case Record Reviews Important?

Case record reviews are completed to demonstrate compliance with the Home and Community Based Services (HCBS) Final Rule on Settings, Federal Code, Indiana Code (IC), Indiana Administrative Code (IAC), the CIH and FS waivers, the MFP Demonstration Project, waiver assurances, and the requirements for case management established by the Bureau of Developmental Disabilities Services (BDDS).

### When a Case Record Review finds Non-Compliance

For any item reviewed that is not in compliance, a corrective action plan (CAP) is required. If corrective action is necessary, a secure email is sent to the responsible party noting the corrective action, steps to resolve, and due date. BQIS verifies implementation of the corrective action and either closes the CRR or issues a

second attempt for implementation by the responsible party. If the issue is not resolved by the responsible party, the case and responsible party are referred to the BQIS Director for further action.

The Case Record Review Interpretive Guidelines provides case management organizations and case managers with complete information and examples of how compliance is demonstrated.

## Monitoring and Reporting

### Quality, Training, and Improvement Practices (QTIP)

Each quarter, case management organizations will participate in review of case management data. This review will include a data summary for the case management organization's services, any identified quality assurance activities, random case audits, and any outstanding issues and/or action items from the previous quarter. This review should also highlight any notable trends for both the quarter and the lifetime of the contract. BDDS will collaborate with the case management organization each quarter to determine the content of the review.

### Semi-Annual Collaborative Quality Touchpoints

Semi-annually, all case management organizations will participate in collaborative touchpoints with BDDS/BQIS. The agenda for these meetings will be developed by BDDS/BQIS, but the case management organizations will have the opportunity to add items to the agenda. Participation in these touchpoints is limited to leadership staff and must include a member of the executive staff and the compliance officer at a minimum. At the discretion of BDDS/BQIS these touchpoints may be held virtually or in person at the Indiana Government Center.

The case management organization shall also make themselves available to attend additional meetings as requested by BDDS/BQIS.

### Annual Summary Reports

The annual summary report will include the information needed for the identified components of the quarterly report for the fourth quarter, as well as a compilation of all quarterly status updates for the calendar year.

### Additional Reporting

In addition to the required reviews detailed above, the case management organization may be required to prepare any one-time or ongoing report requested by BDDS/BQIS to address any concerning service delivery trends or quality assurance issues.

## Individual and Family Satisfaction Survey

Satisfaction surveys shall be solicited of all individuals and families at least annually and the findings detailed in the semi-annual survey summary. BDDS/BQIS is focused on data-driven decision making and will require that all case management organizations utilize a uniform satisfaction survey. BDDS/BQIS looks forward to working collaboratively with the contracted case management organizations to develop the survey questions.

# *Employment*

Case management organizations are required to actively monitor and manage case managers in accordance with the specifications provided in this section.

The quality of case management services that individuals, parents of minor children, and legal representatives have access to and receive is directly related to the employment models of case management organizations.

Case management organizations cannot contract out case management services, but instead must employ all case managers as W-2 employees. This enhances the case management organization's ability to provide consistent training and oversight of their case managers thus enhancing the quality of case management services provided.

Case managers may not be compensated by the case. An employee is someone who is guaranteed a regular wage amount for an hourly, weekly, or other period of time, even when supplemented by a commission or other incentive, and not a flat fee payment as defined by the Internal Revenue Service at https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation. This employee definition and pay structure is directly related to the ability of a case management organization to be conflict-free in the service provision of case management.

Caseload size limitations means that case managers will have more capacity to build relationships with the individuals they support. It allows for a more person-centered, strength-based approach in terms of identifying needed services and building on current supports. This also allows more time for the case manager to monitor the provision of services and facilitate IST discussions to ensure efforts are being made to support the individual on their journey to their preferred life.

## Employment Model

Case managers must be W-2 employees, not contractors. The State considers an employee as someone who is guaranteed a regular wage amount for an hourly, weekly, or other period of time, even when supplemented by a commission or other incentive, and not a flat fee payment as defined by the Internal Revenue Service. This employee definition and pay structure is directly related to the ability of a case management organization to be conflict-free in the service provision of case management.

## Employment Requirements – Providers of Case Management Services

BDDS defines providers of case management services as: case managers, case manager supervisors (whether or not they carry a caseload), and case management company leadership including quality assurance staff (whether or not they carry a caseload). Providers of case management services must meet one or more of the following qualification standards:

- Hold a bachelor's degree in one of the following specialties from an accredited college or university:
  - Social work;
  - Psychology;
  - Sociology;
  - Counseling;

- Gerontology;
- Nursing;
- Special education;
- Rehabilitation, or related degree if approved by the FSSA/DDRS/OMPP;
- Be a registered nurse with one-year experience in human services; or
- Hold a bachelor's degree in any field with a minimum of one year full-time, direct experience working with persons with intellectual/developmental disabilities.

- Holding a master's degree in a related field may substitute for required experience.
- The case manager must meet the requirements for a qualified intellectual disability professional in 42 CFR 483.430(a).
- Case managers may not be contractors of the case management organization.

Conditions for ongoing employment as a provider of case management services includes, but is not limited to, their ability to:

- Understand, maintain, and assert that the Medicaid program functions as the payer of last resort. This role includes care planning, service monitoring, working to cultivate and strengthen integrated and natural supports for each individual, and identifying resources and negotiating the best solutions to meet identified needs. Toward these ends, case managers are required to:
  - Demonstrate a willingness and commitment to explore, pursue, access, and maximize the full array of non-waiver-funded services, supports, resources and unique opportunities available within the individual's local community, thereby enabling the Medicaid program to complement other programs or resources.
  - Be a trained facilitator who has completed a training provided by a BDDS-approved training entity or person; observed a facilitation; and participated in a person-centered planning meeting prior to leading an IST.
- Complete ten (10) hours of training each year provided by BDDS regarding case management services.
- Complete ten (10) hours of training each year provided by the case management organization that aligns with the requirements outlined in Case Management Organization Training Requirements.
- Initially and annually, obtain certification through successful completion of the Case Management Certification Exam, attaining a test score no lower than 80%.

In the event a systematic problem with an employee's services is identified and remediation is needed, training will be obtained on the topics recommended by the BDDS.

## Employment Requirements – Case Management Organizations

Case management organizations must adhere to the requirements set forth in the Case Management Waiver Service Definition, Indiana Code (IC), Indiana Administrative Code (IAC), and the Code of Federal Regulations (CFR) including, but not limited to:

- Must develop and enforce a code of ethics aligned with 460 IAC 6-14-7 and BDDS policy, practices, and guidance.
- Maintain a sufficient number of case managers to provide statewide coverage while maintaining an average caseload size of no more than forty-five (45) cases across full-time case managers who actively provide case management services to Individuals receiving waiver services. A full-time case manager is defined as a Case Manager with a caseload of at least 21 cases. The State will monitor

adherence to this caseload limit on a quarterly basis. *For additional guidance and examples, please see the section on Caseload Size.*

- Must provide support and supervision to case Managers in the form of supervisory staff that are also available as a resource to case managers. Supervisory staff shall have a broad range of relevant experience and assist in ensuring statewide coordination.
- Ensure, initially and ongoing, that criminal background checks are conducted for every employee hired or associated with the approved case management organization as stated in Indiana Administrative Code, Indiana Code and BDDS policy.
- Retain at least one full-time employee to actively monitor and ensure all areas of compliance and quality.
    - Persons in this role may not carry a case load of more than 10 cases.
    - Persons in this role may not do quality and compliance reviews on their own caseload.
    - Persons in this role will monitor and identity any violation of rules, regulations, or established requirements that are discovered and report them to BQIS through the incident reporting system as outlined in Indiana Administrative Code, Indiana Code and BQIS policy.
- Retain or contract with a Registered Nurse (RN) with valid Indiana nursing licensure.
- The case management organization may not subcontract with another agency or case manager for the provision of direct case management services.

## Performance Evaluation

Case management organizations shall assess case managers, supervisors of case managers, and administrative staff on an annual basis at a minimum to ensure they demonstrate competence regarding best practices and subject matter knowledge, which will be verified by annual recertification with the State in accordance with the 1915(c) Case Management Waiver Service Definition. This shall be accompanied by an annual employee evaluation that assesses performance and includes personalized feedback. If significant competency or performance deficiencies are identified, the case management organization shall take action to ensure they are remedied.

## Conflict-Free Case Management

- Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the individual being served. Conflict-free includes, but is not limited to:
    - Case managers may not be financially influenced in the course of their service delivery.
    - There may be no financial relationship between the referring case management agency, its staff, and the provider of other waiver services.

*For additional information on conflict-free case management for CMOs, please see the Case Management Waiver Service Definition.*

## Solicitation

A successful case manager is one who building meaningful relationships with the individuals, parents of minor children, and legal representatives he or she supports. When changing case management organizations, it's natural for the case manager and the individual and their support network to want to continue that relationship. However, providers, including providers of case management services, shall not engage in uninvited solicitation of potential clients who are vulnerable to undue influence, manipulation, or

coercion. When a case manager decides to separate from their current employer, he or she may share that information with the individuals, parents of minor children, and legal representatives they support. **If asked** (uninvited) where they are going to work, the case manager may share the name of their new employer without it being viewed as solicitation in violation of 460 IAC 6-36-2(15).

The case manager's new case management organization must be aware that case managers may not take any individuals' files, protected health information, or personal identifying information with them when they leave their previous employer, whether or not the individual, parent(s) of a minor child, or legal representative has indicated an interest in transferring to the case manager's new case management organization.

## *Caseload Size*

Not all case manager capabilities are equal. Some case managers may flourish with a caseload of 50 individuals, while others will struggle to support 40. In this section, BDDS provides case management organizations guidance on caseload size, metrics to be considered, and how caseload sizes are calculated.

### Why is Caseload Size Important to Individuals Receiving Services?

Caseload size management is important to individuals receiving services because directly impacts the level of quality, time, and support case managers can provide to the individuals they serve. Quality case management is dependent upon case managers having the capacity to build meaningful relationships that allow for a more person-centered, strength-based approach and the facilitation of team discussions and activities to ensure efforts are being made by the IST to support the individual on their journey toward their good life. Managing caseload size is a key component to help ensure individuals are receiving high quality support from their case managers.

### What Performance Metrics Limit a Case Manager's Caseload Size?

Performance metrics can be used to measure the appropriateness of a case manager's caseload size to ensure that individuals are receiving quality support from their case managers. Collecting both qualitative (satisfaction of individuals, parents of minor children, and legal representatives with support from case managers, quality of PCISPs, etc.) and quantitative (average caseload size per case manager per month, case difficulty, number of meetings and touchpoints with individuals, parents of minor children, legal representatives, and ISTs, and completing PCISPs within the required timeline, etc.) should be combined to determine the appropriate caseload size for any given case manager.

### What is the Allowable Caseload Average Across the Case Management Organization?

The allowable caseload size across all active, full-time case managers of a case management organization shall not exceed forty-five (45) individuals. This average is calculated based on the total number of individuals a case management company supports, divided by the total number of full-time case managers.

BDDS calculates the allowable caseload size for each CMO in preparation for the quarterly, semi-annual, and annual quality reports and briefings. BDDS determines the date of calculation and does not give prior notice to CMOs of said date.

### Full-Time Case Manager

A full-time case manager is defined as a case manager who supports 21 or more individuals on the date of caseload calculation. This includes case management supervisors who do not carry a caseload but temporarily support 21 or more individuals on the date of caseload calculation. If for any reason a full-time case manager's caseload exceeds the maximum caseload size of 45 on day of calculation, the CMO must provide a corrective action plan that includes how individuals will be supported and a definitive timeline to return to the approved caseload size.

### Part-Time Case Manager

A part time case manager is defined as a case manager who supports 20 or less individuals on the date of calculation. This includes case management supervisors who do not normally carry a caseload but temporarily support 20 or less individuals on the date of calculation. If for any reason a part time case manager's caseload exceeds the maximum caseload size of 20 on day of calculation, the CMO must provide a corrective action plan that includes how individuals will be supported and a definitive timeline to return to required caseload size.

## Examples

### Example of Compliance

In this example, Case Management Company A employs a total of ten (10) case managers, nine of whom are full-time in that they have caseloads of 21 or more individuals. The total number of individuals supported by this case management company on the date of calculation is 396. The total number of individuals (396), minus the number of individuals supported by a part-time case manager (16), divided by the number of full-time case managers (9), equals an average caseload size of 42. While some case managers have caseloads that exceed 45, this case management company is compliant with the allowable caseload requirement.

| CMO | Case Manager | Case Load Total | Full Time |
|---|---|---|---|
| Case Management Organization A | CM 1 | 39 | Yes |
| Case Management Organization A | CM 2 | 41 | Yes |
| Case Management Organization A | CM 3 | 43 | Yes |
| Case Management Organization A | CM 4 | 29 | Yes |
| Case Management Organization A | CM 5 | 52 | Yes |
| Case Management Organization A | CM 6 | 49 | Yes |
| Case Management Organization A | CM 7 | 50 | Yes |
| Case Management Organization A | CM 8 | 32 | Yes |
| Case Management Organization A | CM 9 | 45 | Yes |
| Case Management Organization A | CM 10 | 16 | No |
| Total Individuals Supported | | 396 | |
| Total Individuals Supported by Part-Time Case Managers | | -16 | |
| Total Full-Time Providers of Case Management | | | 9 |
| Average Caseload Size (380 / 9 = 42) | | 42 | |

Example of Non-Compliance:

In this example, Case Management Company B employs a total of ten (10) case managers, eight (8) of whom are full-time in that they have caseloads of 21 or more individuals. The total number of individuals supported by this case management company on the date of calculation is 416. The total number of individuals (416), minus the number of individuals supported by part time case managers (31) divided by the number of full-time case managers (8), equals an average caseload size of 48. While case managers may have caseloads that exceed 45, this case management company's average exceeds the allowable caseload requirement and is non-compliant.

| CMO | Case Manager | Case Load Total | Full Time |
|---|---|---|---|
| Case Management Organization B | CM 1 | 47 | Yes |
| Case Management Organization B | CM 2 | 57 | Yes |
| Case Management Organization B | CM 3 | 46 | Yes |
| Case Management Organization B | CM 4 | 39 | Yes |
| Case Management Organization B | CM 5 | 12 | No |
| Case Management Organization B | CM 6 | 62 | Yes |
| Case Management Organization B | CM 7 | 56 | Yes |
| Case Management Organization B | CM 8 | 41 | Yes |
| Case Management Organization B | CM 9 | 19 | No |
| Case Management Organization B | CM 10 | 37 | Yes |
| Total Individuals Supported | | 416 | |
| Total Individuals Supported by Part-Time Providers of Case Management | | -31 | |
| Total Full-Time Providers of Case Management | | | 8 |
| Average Caseload Size (385 / 8 = 48) | | 48 | |

# *Mortality Review*


460 IAC 6-25-10 requires an investigation be conducted upon the death of an individual receiving BDDS HCBS waiver services. These investigations are called mortality reviews. In this section, case management organizations will learn what mortality reviews are, why they're important, when they're conducted, and their responsibility as a provider of case management.

## What are Mortality Reviews?

Mortality reviews are reviews of all deaths of individuals in BDDS services, regardless of service setting. These reviews are conducted by the BQIS quality vendor and may include review of the internal investigation conducted by the provider and additional requests for information which the provider shall comply with within a given time frame.

### Why are Mortality Reviews Important?

Information gathered through the mortality review process is used to address quality of care, identify trends, identify others who may be at risk of a negative outcome and recommend statewide action based on mortality information to systematically improve supports and services.

### When are Mortality Reviews Conducted?

The mortality review process begins upon the death of an individual receiving supports and services under the Community Integration and Habilitation (CIH) waiver, the Family Supports Waiver (FSW), Supervised Group Living (SGL), a Comprehensive Rehabilitative Management Needs Facility (CRMNF), and nursing facility (if less than ninety (90) calendar days). A death of person incident report is filed through the online incident reporting system (IFUR). Upon receipt of the incident report, the mortality review process begins which includes an 'Others at Risk Review', review of BDDS documentation, requesting documents from the responsible provider, and requesting the death certificate information from the Indiana Department of Health.

### What are the Case Management Organization's Responsibilities?

Upon the discovery of death, frequently the individual's case manager is notified. The case manager shall assure an incident report is filed no later 24 hours after notification of the death. The provider providing case management services to an individual shall continue to submit follow-up reports concerning any incidents that remain open on the BDDS's follow-up incident report form every seven (7) calendar days until the incident is resolved.

If the CMO is the primary provider, the CMO is responsible for conducting the mortality investigation. The BQIS quality vendor will request documentation from the CMO which may include, but is not limited to, the internal investigation treatment records, medication administration records, physician orders, dietary guidelines, risk plans, etc.

CMOs should include the investigation components outlined in the BDDS Policy, Mandatory Components of an Investigation.

## *Investigations*


This section on investigations will inform case management organizations and their leadership on the importance of investigations into Medicaid fraud and unethical practices for the purpose of prevention, as well as understanding their responsibility for sharing investigation outcomes with BDDS.

### Why are Investigations Important?

At some point, every case management organization will need to investigate the actions of a case manager. Conducting effective investigations demonstrates your company puts individuals first, takes the ethical provision of case management, as well as Medicaid fraud, seriously and sets the right tone.

Determining what occurred, and the "why" behind it, can be helpful. In fact, the immediate aim of all investigations should be to determine what exactly happened – even the bad – to be able to prevent future occurrences. Or, if nothing happened, to determine why an individual, parent(s) of a minor child, legal representative(s), a provider, or even other case management staff, made a complaint. A proper investigation will reveal issues one way or another, enabling case management leaders to create a plan for positive culture changes.

A thorough process, free from bias and prejudgment, and that delivers clarity, fairness, and conclusiveness is essential.

## What does an Investigation Look Like?

A successful investigation should begin with an open, transparent, and responsive complaint process, with the right staff members receiving and investigating complaints. Employees responsible for receiving, investigating, and resolving complaints:

- Are well-trained, objective, and neutral;
- Have the authority required to receive, investigate, and resolve complaints appropriately;
- Take all questions, concerns, and complaints seriously, and respond promptly and appropriately;
- Understand and maintain the confidentiality associated with the complaint process;
- Are properly trained in interview techniques; and
- Appropriately document every complaint, from initial intake to investigation to resolution.

Complaint investigators should make clear that they are neutral and are not advocates for the complainant or case management organization. Their conduct and questions should be matter of fact and non-confrontational, and they should demonstrate that they are actively listening to and interested in the comments of all parties. They are not to be judgmental. Copious and careful notetaking is also critical for a complete and accurate record.

Once the investigator has a complete picture of what occurred, they will need to determine where the truth lies. Whose story was more credible? Whose demeanor was more convincing? Were the claims supported or refuted by documentary evidence or statements made?

Prepare a written report documenting the allegations, the investigatory steps taken, the evidence gathered, the conclusion reached, and the next steps. Investigations that validate unethical behavior or Medicaid fraud are to be shared with BDDS via BDDS.Help@fssa.in.gov.

An investigation that finds credible evidence of unethical behavior or Medicaid fraud is of little use if it doesn't result in remedial action. Companies should act swiftly yet fairly if the conduct warrants termination or disciplinary action in accordance with company policy. Failing to respond appropriately to the evidence after an investigation is just as wrong as turning a blind eye to it in the first place.

## How is the Content of an Investigation Decided?

The two types of investigations covered in this section are around Medicaid fraud and the ethical provision of case management. Let's look at the two separately.

### Medicaid Fraud

Medicaid fraud is defined as the intentional provision of false information to get Medicaid to pay for services. An example would be documenting a meeting that didn't happen and submitting a claim to be paid for it. While the case manager's issue may be their inability to keep up with their workload rather than

an intentional attempt to defraud Medicaid, the result is the same. Regardless of whether the issue was identified through a file review or complaint, the components Medicaid fraud investigation must include:

- A review of all relevant documentation in the BDDS Portal for consistency of information. This may include:
  - Case notes;
  - Completed monitoring checklists and checklist reports;
  - Person-Centered Individualized Support Plans; and
  - Transitions, including follow-up activities.
- Discussion with the individual, parent(s) of minor children, or legal representative, as applicable, This contact should be non-confrontational and never leave them feeling they are the subject of the investigation.
- Discussion with service providers who support the same individual, when appropriate.
- Interview with the case manager. Allow time for a thorough discussion of the facts and provide the case manager the opportunity to share an explanation or their side of the story – after all, every story has two sides.
- Determine if there is a pattern of Medicaid fraud. Are there other individuals supported by the case manager who, upon file review, appear to have similar issues?
- Prepare a final report that encompasses the information gleaned from the steps above. Include the results, any corrective action, and Medicaid reimbursements related to the investigation.

Case management organizations are required to share these validated complaint investigation results with BDDS via email at BDDS.Help@fssa.in.gov.

Unethical Practices

Unethical practices in case management happen when a case manager's actions don't follow five simple standards:

- Beneficence: Always do good. Put the interests of the individual supported before all other concerns.
- Non-malfeasance: Do not purposefully do harm or allow others to.
- Autonomy: Treat each person as an individual. One size does not fit all.
- Justice: Assist individuals to obtain what they deserve. This includes access to the services and supports they are seeking, delivered in the manner desired, to achieve their self-identified good life.
- Fidelity/Veracity: Don't make promises you can't keep, and always tell the truth.

One example of unethical behavior would be to make changes to an individual's service plan without their consent. After all, waiver funding belongs to the individual. A case manager might not support the alteration, such as a change from RHS Hourly to RHS Daily knowing the individual intends to use the excess funds for other services, but there may a fear of being "fired" as the individual's case manager If the provider's request is not fulfilled. Regardless of the how the issue was identified, the investigation must include:

- A review of all relevant documentation in the BDDS Portal for consistency of information. This may include:
  - Case notes;
  - Completed monitoring checklists;
  - Person-Centered Individualized Support Plans;
  - Incident Reports, including all follow up; and

    - Risk and/or behavior support plans, including Human Rights Committee approval.
- Discussion with the individual, parent(s) of a minor child, or legal representative(s), as applicable. This contact should be non-confrontational and never leave them feeling they are the subject of the investigation.
- Discussion with service providers who support the same individual, when appropriate.
- Interview the case manager. Allow time for a thorough discussion of the facts and provide the case manager the opportunity to share an explanation or their side of the story.
- Determine if there is a pattern. Are there other individuals supported by the case manager who, based on the case manager interview, appear to have similar issues?
- Prepare a final report that encompasses the information gleaned from the steps above. Include the results, such as corrective action or termination.

Again, case management organizations are required to share the validated complaint investigation results with BDDS via email at BDDS.Help@fssa.in.gov.

## *Interpreters*


The Case Management Waiver Service Definition requires that case management organizations (CMOs) ensure their case managers have the ability to employ whatever tools necessary to effectively and efficiently communicate with each individual by whatever means is preferred by the individual. In this section, CMOs will learn the requirements for all recipients of federal funds.

Federal rules require that providers, including all IHCP providers, demonstrate such compliance by taking the following actions:

- All IHCP providers must prominently post notices that specify the following information:
    - The provider complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability.
    - The provider makes available free aids and services to people with disabilities to communicate effectively with the provider, including qualified interpreters, written information in other formats and free language services to people whose primary language is not English.
    - How to obtain the aids and services referenced previously.
    - The name and contact information of the provider's civil rights coordinator who handles grievances (if the provider employs 15 or more individuals).
    - The availability of a grievance procedure as well as how to file a grievance.
    - How to file an Office for Civil Rights (OCR) complaint.

## *LOCSI Reviewers*

The Level of Care Screening Instrument (LOCSI) is a tool used to determine eligibility for BDDS HCBS waiver services. It is a two (2) step process requiring the consensus of 1) an assessor and 2) a reviewer.

In this section, case management organizations are provided the process for requesting a supervisor or management staff as a LOCSI reviewer. Signatures of both the assessor and the reviewer must be included for the LOCSI to be finalized.

When a case management organization needs or desires to add a supervisor or management staff as a reviewer, they must submit a Jira ticket requesting the addition and attach a document that includes two (2) examples of the reviewer's signature. BDDS will review the request and, if authorized, facilitate the addition to the LOCSI system. The ticket will be resolved once all activities have been completed.

## *Jira Help Desk Support*

Jira is the Help Desk system utilized by BDDS to assist case management organizations, providers, and BDDS/BQIS to submit questions and report issues. Support tickets may be submitted for questions and issues related to account creation, billing, policy, security, and system issues. In this section, case management organizations will find information on Jira access, help desk ticket submissions, responding to requests for additional information.

### Jira Access

Case management organizations are responsible for training and supporting the case managers they employ. When questions or issues arise, they should first be addressed by the case manager's supervisor, compliance or quality assurance manager, or other case management organization leadership. When questions or issues remain, the case manager's supervisor may submit a Jira ticket. Therefore, access to Jira is limited to case management organization employees who are supervisory or management level staff.

When a case manager is promoted to supervisor, or new supervisory or management staff is hired, the case management organization should submit a request for Jira access via the Jira help desk support system. BDDS staff will review and approve or deny the request, as appropriate.

### Help Desk Ticket Submission

Jira help desk ticket submissions are entered via the Jira web-based platform. Instructions for submitting tickets, attaching documents, and responding to requests for additional information can be found in the Jira Help Desk User Guide available on the Resource page of the BDDS Portal under User Guides.

# *Systems Access*

Access to BDDS systems requires authorization from BDDS Account Management, the Indiana Office of Technology (IOT), and the State Personnel Department. Guidance obtaining and maintaining access, terminating access, initial and ongoing training requirements, and submission forms are available in the Systems Access Guide.

It's important to note that obtaining and maintaining access requires users to be identified by their full, legal names. The use of nicknames is not permitted.

# Addenda

Case Management Waiver Service Definition

PCISP Guide

PCISP Rubric Interpretive Guidelines

Case Record Review Interpretive Guidelines

Monitoring Checklist Interpretive Guidelines

Indiana Money Follows the Person

Case Management Guidance: Reimbursement of Out of State HCBS Waiver Services

Systems Access Guide

Case Management Training Series Guidance for Providers of Case Management Services

Case Management Certification Exam

Culture of Quality Tool Kit