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Case Management Operational Guidelines 2023

People with developmental disabilities who are most at risk benefit from more frequent case manager/support coordinator face-to-face visits due to the complexity of their support needs. The "Case Management Operational Guidelines" were developed by a committee of Community Services Boards (CSB), DD Waiver staff, and advocacy community representatives. The guidelines provide historical information, including two additional updates from April 2014 and January 2017. This document is designed to incorporate past guidance in a simplified, redesigned format.

These operational guidelines are intended to assist CSB DD case managers (hereafter referred to as support coordinators or SC/CM) in implementing the case management requirements of enhanced case management (ECM). Enhanced case management requires the following:

1. For individuals receiving case management/support coordination services, the individual's SC/CM shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.

2. At these face-to-face meetings, the case manager/support coordinator shall:

    - Observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status;
    - Assess the status of previously identified risks, injuries, needs, or other change in status;
    - Assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and
    - Ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated settings appropriate to the individual's needs.

If any of these observations or assessments identifies a previously unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, the SC/CM shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.

To **"report and document the issue**" and meet requirements, the SC/CM must take the following actions:

a. Document in the record the specific unidentified or inadequately addressed risk, injury, need, or change in status, including the report to and the response of the designated provider(s).

b. Convene and mobilize Person-Centered Planning (PCP) team members needed to address the issue and revise the ISP as needed. The meeting will include the individual, guardian/authorized representative (AR), if applicable, case manager/support coordinator, and applicable providers. The meeting can be in person, a video meeting, a formal scheduled conference call, and/or an informal SC/CM initiated telephone call with the relevant parties.

c. Report suspected abuse, neglect, or exploitation to Adult Protective Services or Child Protective Services and the DBHDS Office of Human Rights (OHR) according to agency policies and regulations.

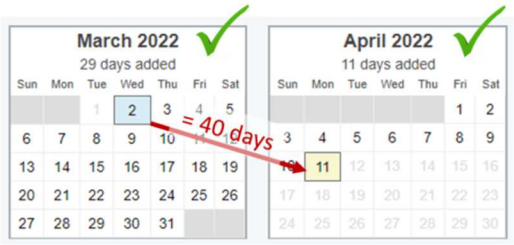
d. Report to the DBHDS Office of Licensing (OL) serious incidents or injuries as defined in licensure according to agency policies and regulations.

e. Report the individual's PCP team's inability to achieve resolution within a reasonable time (2 weeks) by following SC/CM agency policies and by contacting the CRC and the DBHDS Office of Licensing as needed.

f. Document the issue and resolution of the issue in the case manager/support coordinator record.

g. When an issue is related to a health or crisis event, the SC/CM monitors implementation of the ISP (including safety and risk mitigation protocols) to ensure the ISP is implemented as written to reduce the potential of a future crisis event. Any crisis event includes the need for the SC/CM to document the issue, convene relevant team members, revise the ISP, report suspected abuse, neglect, and/or exploitation to APS/CPS/OHR/OL as defined in regulations, and document the resolution. SC/CMs also communicate concerns to their supervisors and follow their agencies' policies and procedures in responding.

3. The individual's case manager/support coordinator shall meet with the individual face-to-face every 90 days. For individuals that are receiving ECM, these visits must occur **at least one time per calendar month, with no more than 40 days between visits.** For example, if an ECM visit occurs on March 2, the next visit is due on or before April 11th. There are 40 days from March 2nd to April 11th and this timeframe enables one visit to occur in both calendar months.



At least one such visit every two months must be in the individual's place of residence for any individuals who:

1. Have transitioned from a Training Center within the previous 12 months;
2. Receive services from providers having conditional or provisional licenses;

3. Have an interruption of service greater than 30 days (excludes a break in employment when the individual is in Supported Employment and remains with the same supported employment provider);
4. Have an inability to access needed therapeutic services, assistive technology, environmental modification, or behavioral consultation;
5. Encounter the crisis system, criminal justice system, or have APS involvement;
6. Reside in congregate settings of 5 or more individuals**;
7. Have any items under 1a or 1b scored with a 2 on the Supports Intensity Scale ® (SIS ®)**

** exceptions described in the chart below

To assist with determining when to intiate and cease the provision of ECM, DBHDS developed, in collaboration with CSBs, an automated **ECM Worksheet** that is available on the DBHDS website at https://dbhds.virginia.gov/wp-content/uploads/2022/09/CM-Worksheet-FINAL-11.3.21-1.xlsx.

The **On-site Visit Tool (OSVT)** must be completed at one face-to-face visit monthly for people receiving ECM and once quarterly for people receiving Targeted Case Management (TCM) and uploaded into the Waiver Management System under the Person's Information attachments section. This form provides a means to ensure that consistency is applied when assessing for any "change in status" and to confirm that the services are "implemented appropriately." Based on observation and report, include specific, detailed notes in the person's record about the findings and any actions that will be taken (including the need for any additional assessments, such as behavioral and/or medical reviews, or root cause analysis, to understand and address identified concerns). If the person has lost a service as a result of behavioral or medical issues or a provider's perception of increased needs, additional assessment from a qualified professional or the exploration of alternate services/providers are necessary to determine how the individual's needs can met.

Case managers/support coordinators must ensure that there is a corresponding note in the individual's record that includes additional actions or follow-up as identified on the OSVT. When scoring each section (Change in Status and Services Implemented Appropriately), if there is a concern noted on any of the questions in each of these two sections, this affects final scoring. For example, if there is an answer of 'yes' to any of questions 1 - 5 in "Change in Status," this indicates a change in status. Similarly, an answer of 'no' to any of questions 7 – 13 under "Services Implemented Appropriately" indicates services are not appropriately implemented. Information from the completion of the OSVT should be incorporated into the quarterly Person-Centered Review.

Explanation of Population Served

All individuals with developmental disabilities who receive HCBS waiver services and who meet the criteria established in this guidance require more frequent face-to-face visits at least every thirty (30) days.

Individuals receiving HCBS waiver services include Building Independence (BI), Family and Individual Support (FIS), Community Living (CL) Waiver recipients, as well as people receiving Commonwealth Coordinated Care (CCC) Plus Waiver who are on the DD Waiver Wait List and have Targeted Case

Management. Thus, the CSB DD case manager/support coordinator must provide the more frequent face-to-face visits at least every thirty (30) days to individuals who are on the DD waiver or the DD waiver wait list with Commonwealth Coordinated Care (CCC) Plus Waiver, AND meet any of the criteria 1 - 7 above.

Table 1 below shows which groups must receive face-to-face visits at least every (30) days, if they meet any of the criteria.

Inability to Complete Required Visits

Table 1: Population	**30 day visists required IF any of the criteria of are met**
BI Waiver Recipients	Yes
FIS Waiver Recipients	Yes
CL Waiver Recipients	Yes
Individuals on DD Waiver Wait List who are receiving CCC+ Waiver Services and who have Targeted Case Management	Yes
Individuals on the DD Waiver Wait List who do not have CCC+	No
Individuals in Training Centers	No
Individuals in Community-Based ICFs	No
Individuals in NFs	No

If the case manager/support coordinator cannot complete the required face-to-face contact, all attempts and reason(s) must be documented. After two consecutive 30-day periods of no contact, the CSB case manager/support coordinator will notify their supervisor to determine if further steps are needed (such as contacting the Licensing Specialist, DMAS, CRC, etc.). The CSB case manager/support coordinator must also comply with the established Waiver "Request to Retain Slot" process, as appropriate.

Compliance with these standards will be through routine Licensing reviews of case management services, Quality Service Reviews, and as part of the investigation review process for both OL and OHR.

Exceptions

The following chart provides a description of the removal of ECM criteria to include exceptions where applicable.

Enhanced Case Management Criteria and Considerations

	When to Begin ECM	When to Stop ECM	Considerations
A.	The person left a training center in the last 12 months.	The person has been stable in the new home for at least 12 months.	SC/CMs can complete a post-move monitoring report or send theirnotes from the visits that occur at 30, 60, and 90 days detailing their review of the provision of essential supports and notes for the first year to the Post Move Monitor. The Post Move Monitor should be notified of a change in provider if it occurs during the first year for individuals with SIS level 1-4 or during the first 2 years for individuals with a SIS level of 5-7 because that is how long DBHDS actively follows people who are discharged from a training center.
B.	The person receives services from any provider with a conditional or provisional license.	90 days have passed since the removal of the conditional or provisional status.	License type can be located through the OL Provider Search, by selecting License Type from the drop down menu here.
C.	An interruption of 30 days or longer for any DD waiver service (excludes a break in employment when the individual is in Supported Employment and remains with the same supported employment provider).	When services have resumed.	An individual choosing not to attend or participate in a service is not considered an interruption. This means a break in an authorized service due to factors beyond the individual's control such as programmatic issues, staffing, or medical events that led to the break in services for any of the following waiver services: i. Congregate Residential (including supervised [group home] and sponsored residential). ii. In-home Residential. iii. Personal Assistance (agency-directed or consumer-directed). iv. Supported Employment (A change in SE job site but not provider does not constitute interruption in service.) v. Day Services (e.g. group day support, community engagement, community coaching, and workplace assistance)

D.	There is an inability to access needed therapeutic services, adaptive equipment, or environmental modification that was recommended by a professional.	Needed services were identified/obtained.	N/A
E1.	The person encounters the crisis system and/or the medical health system for admission or assessment (for unplanned and emergency related events).	When the person has recovered from the crisis and/or medical concerns and has been stable† for at least 90 days or there are unique circumstances that a supervisor confirms* warrants an exception to ECM.	Crisis Services include: REACH Crisis Therapeutic Home (CTH), Adult or Child Crisis Stabilization Unit (CSU), unplanned crisis stabilization services (if Mobile Crisis comes out once and doesn't refer to consultation or other REACH services, then ECM is not required), Emergency Services, Children's Crisis or REACH services, hospital (other than for routine or elective procedures) and ER visits, hospitalization followed by an admission to a Long Term Rehabilitation or skilled nursing facility or unplanned stay, ECM is initiated upon admissionto the facility. A stay in a state facility such as Central State Hospital is different and ECM would not be provided during this stay. SC/CM must document the reason ECM is not provided in any instance. Some known causes of unplanned medical emergencies: the diagnosis of aspiration pneumonia, bowel obstruction, seizures, decubitus ulcer (pressure sore), UTI, seizure, falls, and sepsis.
E2.	There has been Adult or Child Protective Services involvement.	The APS/CPS case was closed without further risk to the person for at least 90 days or there are unique circumstances that a supervisor confirms* warrant an exception to ECM.	N/A
E3.	The person encountered the criminal justice system or was incarcerated.	Criminal charges were resolved with no additional concerns for at least 90 days or there are unique circumstances that a supervisor confirms* warrant an exception to ECM.	ECM is not reuired during periods of incarceration other than for the 60 days immediately prior to release to assist with reintegration efforts.

F.	The person lives in a group home with 5 or more beds.	This the only ECM criteria met and the person was medically and behaviorally stable† with successful supports for the past 12 months with no new risks (medical and/or behavioral) identified in the last 12 months.	Safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are in place as evidenced by: 1.The ISP includes safety protocols and mitigation plans for identified intensive medical and behavioral needs.The ISP is updated appropriately. 2. Safety protocols/mitigation plans are followed by the provider. 3. SC/CM reviews provider documentation of safety protocols and mitigation plans to ensure they are implemented as written. 4.The safety protocols/mitigation plans (health and safety outcomes/risk protocols/behavior plans) are reviewed quarterly and revised as needed. If the individual were to meet any other ECM criteria, this exemption does not apply and ECM would continue. If someone moves from a 5 bed home to another 5 bed home and that person was stable before the move and remains stable for 12 months and no new risks are identified, then ECM is not required. Please note ECM criteria is based on the number of people for which the home is licensed and not the number of people actually living in the home. Licensed home size can be confirmed by contacting the DBHDS Office of Licensing.
G.	Any item(s) under 1a or 1b on the SIS® are scored with a 2.	There is clinical documentation that establishes that items no longer meet 1a or 1b since the completion of the SIS® and no new needs were identified that meet the same criteria **or** this the only ECM criteria met (from A through G) and the person experienced no	If the individual experienced an injury as a result of an adverse event in the context of lifting or transferring in the past 90 days, then ECM is required and will continue for 90 days after the individual is stabilized.

		concerns related to the identified health conditions in the past 12 months. **or** the person only receives Therapy Services as identified on 1a of the SIS® with no other items under 1a or 1b scored a 2 **or** the only item identified is "Fall Risk" with no injury in the last 90 days.	

*It is expected that these situations will be infrequent and should clearly document supervisory review and why an exception is being made. If an exception is appropriate, the SC/CM must still review all criteria before determining if the individual qualifies for ECM.

†Stability is defined as pre injury/illness condition/functioning or the individual reached post injury/illness, condition or optimum functioning as determined by a licensed medical professional (primary care provider (PCM), nurse practioner (NP), registered nurse (RN), physician assistant (PA)). While documentation in writing from the professional would be preferable, documentation by the support coordinator/case manager is sufficient when it includes the details of the conversation with those involved and confirms that a professional made the determination.

DBHDS has a training video available at https://vimeo.com/manage/videos/673185115/22a1ae3289, as well as a Frequently Asked Questions document to assist with specific scenarios that were encountered. This document is available online at https://dbhds.virginia.gov/wp-content/uploads/2022/09/ECM-Question-Answers-Final-9.26.22-1.pdf. Additional guidance is available in the DD Support Coordination Handbook at https://dbhds.virginia.gov/assets/doc/sccm/dd-sc-manual-12202021-rev-2-final.pdf or by contacting your provider development system team community resource consulant (CRC). CRC contact information is available online at https://dbhds.virginia.gov/developmental-services/provider-development/.