



Using Wraparound to Provide Intensive Case Management:

Tips for Your
Consideration

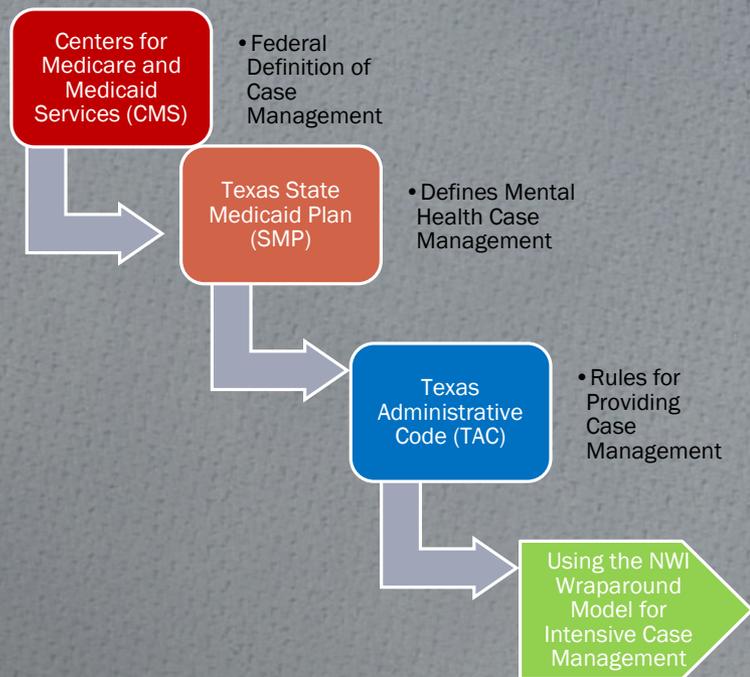
Billing Medicaid for Case Management Encounters

- o Texas Administrative Code §412.414
 - o In accordance with §412.407 of this title (relating to MH Case Management Services Standards), a billable event is a face-to-face contact during which the case manager provides an MH case management service to an:
 - (1) individual who is Medicaid eligible; or
 - (2) LAR on behalf of a child or adolescent who is Medicaid eligible.

https://info.onsiteinteractive.com/pub/readthebest/DocPage?id=R&app=9&ip_dir=&ip_sdir=&ip_tdir=&ip_plac=&ip_pg=1&ip_tas=&itc=25&ipst=1&ch=412&cl=414



Defining Case Management



- Centers for Medicare and Medicaid Services (CMS)
 - <http://www.cms.gov/>
- Texas State Medicaid Plan (SMP)
 - <http://www.hhsc.state.tx.us/medicaid/StatePlan.html>
- Texas Administrative Code (TAC)
 - Recovery Plan (*formerly treatment plan*)
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=322](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=322)
 - Case Management
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sc_h=I&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=412&sc_h=I&rl=Y)
- National Wraparound Initiative (NWI)
 - <http://www.nwi.pdx.edu/>

What is the Federal Definition of Case Management

The term case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. Such term includes the following:

- o **Assessment** of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:
 - o Taking client history.
 - o Identifying the needs of the individual, and completing related documentation.
 - o Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.
- o **Development of a specific care plan** based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.
- o **Referral and related activities** to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- o **Monitoring and follow-up activities**, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—
 - o whether services are being furnished in accordance with an individual's care plan;
 - o whether the services in the care plan are adequate; and
 - o whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

http://www.thenationalcouncil.org/catargeted_case_management_cms_int.htm
erim final rule



How Does the State Medicaid Plan (SMP) Define Case Management?

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services and supports. Case management includes the following assistance:

- o **Comprehensive assessment and periodic reassessment**, as clinically necessary, of individual needs to determine the need for any medical, educational, social, or other services. These assessment activities include:
 - o (1) taking a client's history;
 - o (2) identifying the individual's needs and completing related documentation; and
 - o (3) 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.
- o **Development (and periodic revision, as clinically necessary) of a specific care plan that:**
 - o (1) is based on the information collected through the assessment;
 - o (2) specifies the goals and actions to address the medical, social, educational, and other services and supports needed by the individual;
 - o (3) includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized healthcare decision maker) and others to develop those goals; and
 - o (4) identifies a course of action to respond to the assessed needs of the eligible individual.
- o **Referral and related activities** to help an eligible individual obtain needed services and supports, including activities that help link an individual with:
 - o (1) medical, social, and educational providers; and
 - o (2) other programs and services that provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- o **Monitoring and follow-up activities** and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.
 - o (1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:
 - o (a) services are being furnished in accordance with the individual's care plan;
 - o (b) services in the care plan are adequate in amount, scope and duration to meet the needs of the individual; and
 - o (c) the care plan and service arrangements are modified when the individual's needs or status change.

<http://www.hhs.state.tx.us/medicaid/StatePlan.html>

What Does the Texas Administrative Code (TAC) Say About Intensive Case Management (ICM)?

The following has been paraphrased:

A case manager for a child/youth receiving Intensive Case Management must:

- o Meet face-to-face with the child/youth and their LAR/primary caregiver under the following circumstances or document why the meeting did not occur.
 - o (1) within 7 days of assignment or d/c from inpatient setting;
 - o (2) according to the MH CM plan (created using Wraparound);
 - o (3) if there is a clinically significant change
- o Develop an intensive case management plan based on the child's or adolescent's needs that may include information across life domains, including: the child or adolescent; the LAR or primary caregiver; other agencies and organizations providing services to the child or adolescent; the individual's medical record; and other sources identified by the individual, LAR, or primary caregiver
- o Incorporate wraparound process planning in developing a plan that addresses the child's or adolescent's unmet needs across life domains, in accordance with the department's utilization management guidelines and subsection.
 - o (A) a prioritized list of the child/youth's unmet needs which includes a discussion of the priorities and needs expressed by them and their LAR
 - o (B) a description of the objective and measurable outcomes for each of the unmet needs as well as a projected time frame for each outcome;
 - o (C) a description of the actions the child/youth, the case manager, and other designated people will take to achieve those outcomes;
 - o (D) a list of the necessary services and service providers and the availability of the services;
 - o (E) a description of the MH case management services to be provided by the case manager; and
 - o (F) max period of time between face-to-face contacts with the child/youth, and their primary caregiver, in accordance with the UM guidelines;
- o Wraparound process planning model may include, but is not limited to:
 - o (1) a list of identified natural strengths and supports;
 - o (2) a crisis plan developed in collaboration with the LAR, caregiver, and family that identifies circumstances to determine a crisis that would jeopardize the child's or adolescent's tenure in the community and the actions necessary to avert such loss of tenure;
 - o (3) a prioritized list of the child's or adolescent's unmet needs that includes a discussion of the priorities and needs expressed by the child or adolescent and the LAR or primary caregiver;
 - o (4) a description of the objective and measurable outcomes for each of the unmet needs as well as a projected time frame for each outcome;
 - o (5) a description of the actions the child or adolescent, the case manager, and other designated people take to achieve those outcomes; and
 - o (6) a list of the necessary services and service providers and the availability of the services.
- o Assist the child/youth in gaining access to the needed services and service providers (including: making referrals to providers; initiating contact with potential providers; arranging, and if necessary, accompanying the individual to initial meetings and non-routine appointments; arranging transportation; advocating with providers; and providing relevant information to providers;
- o Monitor the child's or adolescent's progress toward the outcomes set forth in the plan, including:
 - o (A) gathering information from the child or adolescent, current service providers, LAR, primary caregiver, and other resources;
 - o (B) reviewing pertinent documentation, including the child's or adolescent's clinical records, and assessments;
 - o (C) ensuring that the plan was implemented as agreed upon;
 - o (D) ensuring that needed services were provided;
 - o (E) determining whether progress toward the desired outcomes was made;
 - o (F) identifying barriers to accessing services or to obtaining maximum benefit from services;
 - o (G) advocating for the modification of services to address changes in the needs or status of the child or adolescent;
 - o (H) identifying emerging unmet service needs;
 - o (I) determining whether the plan needs to be modified to address the child's or adolescent's unmet service needs more adequately;
 - o (J) revising the plan as necessary to address the child's or adolescent's unmet service needs;
 - o (K) a description of the intensive case management services to be provided by the case manager; and
 - o (L) a statement of the maximum period of time between face-to-face contacts with the child or adolescent, and the LAR or primary caregiver, determined in accordance with the utilization management guidelines



http://info.sos.state.tx.us/pls/pub/road/tacDest.TacPage?sl=R&app=9&sp_dir=&sp_slcc=&sp_tloc=&sp_ploc=&sp_pg=1&sp_tac=&ti=25&pt=1&ch=412&sl=407

Key Definitions for the Next Section

Recovery (formerly treatment) Plan, using provisional language:

- o Developed following authorization within 10 days (according to TAC)
- o Must include services (i.e. Intensive Case Management) prior to billing for these services
- o Based on existing services and services available in the Level of Care-YES (LOC-Y). Notations/provisional language may be made on the recovery plan that some/all of the individual services will not be provided until they are identified through the Wraparound planning process as “strategies”
- o Should be amended as the Wraparound Plan/ICM plan is developed as Wraparound process planning identifies TRR services/“strategies” to implement. At this point it would no longer need to be called “provisional” and would be a complete “Recovery Plan”

Intensive Case Management Plan, using provisional language:

- o Describes what CM activities will be completed by wraparound facilitator until the ICM/Wraparound Plan is fully developed with the team. (i.e. Will facilitate Wraparound process planning at least monthly to first create and then carry out an ICM/Wraparound plan)

Wraparound Plan/Individual Plan of Care (IPC)/ICM Plan/Recovery (formerly treatment) Plan:

- o After the Wraparound Plan is developed during the 1st Family Team Meeting the Facilitator/Intensive Case Manager should be able to use the plan as the IPC, ICM plan, and recovery plan.
- o Should be complete and comprehensive enough to not only inform updates to the Recovery Plan, it may be able to be synonymous with the Recovery Plan.

State Medicaid Plan (SMP) Requirements for Community Based CM	TAC Requirements for the Provision of ICM	ICM Activities Within the NWI Wraparound Model
<p>Face-to-Face Meetings: “Community-based –face-to-face contact with the Medicaid-eligible individual provided primarily at the consumer’s home, work place, school, or other location that best meets the consumer’s needs with telephone or face-to-face contacts with community based agencies, support groups, providers, and other individuals as required to meet the needs of the individual.”</p>	<ul style="list-style-type: none"> • 1st face-to-face meeting with the child/youth within 7 days (where “recovery plan using provisional language” may be developed) 	<p>During Engagement Phase:</p> <ul style="list-style-type: none"> • 1st <i>family</i> meeting within 7 days. Initial Crisis/Safety plan is developed. Initial referral and linkage based on the crisis plan to crisis lines, etc. must happen at this time. (All other linkages and referrals occur with the team in Child and Family Team meetings.)
	<ul style="list-style-type: none"> • According to the CM Plan 	<p>Family Meetings /Engagement Phase:</p> <ul style="list-style-type: none"> • 1st <i>Child and Family Team</i> meeting occurs within 30 days of Enrollment in YES Waiver • Likely 2-3 hour meeting during Initial Individual Plan of Care (IPC) Development Phase • At least monthly during Implementation Phase (implementation of the Individual Plan of Care) • Monitor/adjust Crisis/Safety plan
	<ul style="list-style-type: none"> • Upon clinically significant change • Upon notification that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis 	<ul style="list-style-type: none"> • Between Child and Family Team meetings, follow-up with the family and providers to monitor activities. • In addition to monthly team meetings the team may need to meet when requested by any team member, when the child/youth’s situation warrants, and/or to address crisis situations (crisis defined by the child/youth and family). • If the child/youth is in crisis (crisis as defined by the family) the Child and Family Team will meet within 72 hours. The Child and Family Team, including the Wraparound Facilitator will monitor the IPC and crisis plan and adjust as necessary.
	<ul style="list-style-type: none"> • When requested by the child/youth and/or primary caregiver 	<ul style="list-style-type: none"> • When requested by any Child and Family Team member, including the child/youth and family as team members.



SMP Requirements for Community Based CM

“Case management may include contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.”

TAC Requirements for the Provision of ICM

- Gather information about the child/youth's strengths and service needs across life domains from relevant sources. (including: the child/youth; the primary caregiver; other involved agencies; their clinical record; and other sources identified by the LAR/primary caregiver)

ICM Activities Within the NWI Wraparound Model

Family Meetings:

- Wraparound facilitator **assesses** for and identifies strengths during 1st *family* meeting while getting the family story in the Engagement Phase
- Engagement of Child and Family Team Members
- Meet face-to-face with Child and Family Team members for Team Preparation Phase (before 1st *team* meeting and ongoing as team members are added) **assessment**.

Child and Family Team Meetings:

- **Assess** for needed support for any school or court issues, mental health appointments; make referrals
- Strengths are reviewed and expanded upon when **assessed** for by soliciting input from team members during 1st Child and Family Team meeting during the Initial IPC Development Phase.
- Functional strengths are continually identified and expanded upon and called upon to potentially function as **referral** sources, as appropriate, during the life of the IPC to be used to resolve challenges throughout the Implementation Phase.
- Family and team members able to **link** to, elicit, mobilize, and reinforce identified strengths during Transition Phase.
- Review the IPC and make adjustments as necessary, i.e. adding Specialized Services, Minor Home Modifications and/or Adaptive Aids and Supports.



SMP Requirements for Community Based CM	TAC Requirements for the Provision of ICM	ICM Activities Within the NWI Wraparound Model
<p>“Comprehensive assessment and periodic reassessment as clinically necessary, of individual needs to determine the need for any medical, educational, social, or other services. These assessment activities include: (1) taking a client's history; (2) identifying the individual's needs and completing related documentation; and (3) 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.”</p>	<ul style="list-style-type: none"> • Gather information about the child/youth’s strengths and service needs across life domains from relevant sources. (including: the child/youth; the primary caregiver; other involved agencies; their clinical record; and other sources identified by the LAR/primary caregiver) 	<p>Prior to face-to-face contact:</p> <ul style="list-style-type: none"> • Read referral and any related documents, including uniform assessment. <p>Family Meetings:</p> <ul style="list-style-type: none"> • Create a family timeline and identify needs from gathered information. • Assess how comfortable family feels advocating for themselves, assess level of supports needed. <p>Child and Family Team Preparation:</p> <ul style="list-style-type: none"> • Gather information from other sources by eliciting team members’ assessment of participant and family’s needs/strengths <p>Child and Family Team Meetings:</p> <ul style="list-style-type: none"> • Identify additional needs if appropriate and prioritize identified needs • Gather information from team members regarding needs and strengths of the Waiver participant & family
	<ul style="list-style-type: none"> ○ determining if progress toward the desired outcomes was made; 	<ul style="list-style-type: none"> • Create outcomes that are measurable that are tied to the initial reason for referral and behaviors • Assess progress towards family vision and outcomes at ongoing meetings
	<ul style="list-style-type: none"> ○ identifying barriers to accessing services or to obtaining maximum benefit from services; 	<ul style="list-style-type: none"> • Specifically assess for and address barriers to all prioritized strategies chosen by the family. • Assess accomplishments at ongoing meetings, adjust the plan, address barriers, and adjust strategies accordingly.
	<ul style="list-style-type: none"> ○ identifying emerging unmet service needs; 	<ul style="list-style-type: none"> • Use the family story to assess for underlying needs. Continue to assess for underlying needs as they present throughout the Wraparound process.
	<ul style="list-style-type: none"> ○ determining if the MH case management plan needs to be modified to address the individual's unmet service needs more adequately 	<ul style="list-style-type: none"> • Assess progress towards outcomes and family vision to determine if IPC needs to be updated accordingly.

SMP Requirements for Community Based CM	TAC Requirements for the Provision of ICM	ICM Activities Within the NWI Wraparound Model
<p>Development (and periodic revision as clinically necessary) of a specific care plan that:</p> <p>(1) is based on the information collected through the assessment;</p> <p>(2) specifies the goals and actions to address the medical, social, educational, and other services and supports needed by the individual;</p> <p>(3) includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized healthcare decision maker) and others to develop those goals; and</p> <p>(4) identifies a course of action to respond to the assessed needs of the eligible individual.</p>	<ul style="list-style-type: none"> Utilize wraparound process planning to develop an MH case management plan that addresses the individual's unmet needs and that includes: <div data-bbox="620 268 842 475" data-label="Image"> </div> a prioritized list of the child/youth's unmet needs including a discussion of the priorities and needs expressed by them and their LAR a description of the objective and measurable outcomes for each unmet need as well as a projected time frame for each outcome; a description of the actions the child/youth, the case manager, and other designated people will take to achieve those outcomes; a list of the necessary services and service providers and the availability of the services; a description of the CM services to be provided by the case manager; max period of time between face-to-face contacts with the child/youth, and their primary caregiver, in accordance with the UM guidelines; 	<p>A good Wraparound Plan is a product resulting from the team process that represents the best fit between all of the activities of the process including: family story, vision, team mission, strengths, needs, and strategies that move a family close to their vision</p> <ul style="list-style-type: none"> 1st <i>family</i> meeting within 7 days (where recovery plan & ICM plan (using provisional language) and crisis /safety plan are developed.) Initial referral and linkage based on the crisis plan to crisis lines, family partners etc. happens at this time. (All other linkages and referrals occur with the team in Child and Family Team meetings.) 2nd <i>family</i> meeting monitor “recovery plan using provisional language” & crisis plan, revise if necessary. During first <i>team</i> meetings the Individual Plan of Care is created (Initial Plan Development Phase). The 1st Child and Family Team meeting occurs within 30 days. In monthly team meetings monitor and revise plan as necessary. <ul style="list-style-type: none"> Bring prioritized list of Waiver Participant and family needs to Child and Family Team meeting gleaned from family history. Child and Family Team chooses top three underlying needs to address at a time and addresses them on IPC. <ul style="list-style-type: none"> Outcome statements outlined in on the plan are measurable, targeted to identify when the need has been met, and are tied to the initial reason for referral and behaviors. <ul style="list-style-type: none"> Assign tasks to team members based on strategies and adjust plan as necessary. Monitor completion of tasks and success of plan. <ul style="list-style-type: none"> Develop strategies (unique interventions and supports) to meet the prioritized needs of the family & outline the strategies agreed upon by the family in IPC. <ul style="list-style-type: none"> Wraparound Facilitator (Intensive Case Manager) facilitates the Wraparound process and Child and Family Team members will also have tasks (assessing needs/strengths, developing and documenting the IPC, making referrals, monitoring the IPC and referrals.) <ul style="list-style-type: none"> Per YES Waiver guidelines, the Child and Family Team must review and update the IPC every 90 days Best Practice: Meet at least monthly during Implementation Phase (implementation of the IPC) Less frequently until unnecessary during Transition Phase

SMP Requirements for Community Based CM

Referral and related activities to help an eligible individual obtain needed services and supports, including activities that help link an individual with:

- (1) medical, social, and educational providers; and
- (2) other programs and services that provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

TAC Requirements for the Provision of ICM

Assist the child/youth in gaining access to the needed services and service providers (including: making referrals to providers; initiating contact with potential providers; arranging, and if necessary, accompanying the individual to initial meetings and non-routine appointments; arranging transportation; advocating with providers; and providing relevant information to providers;



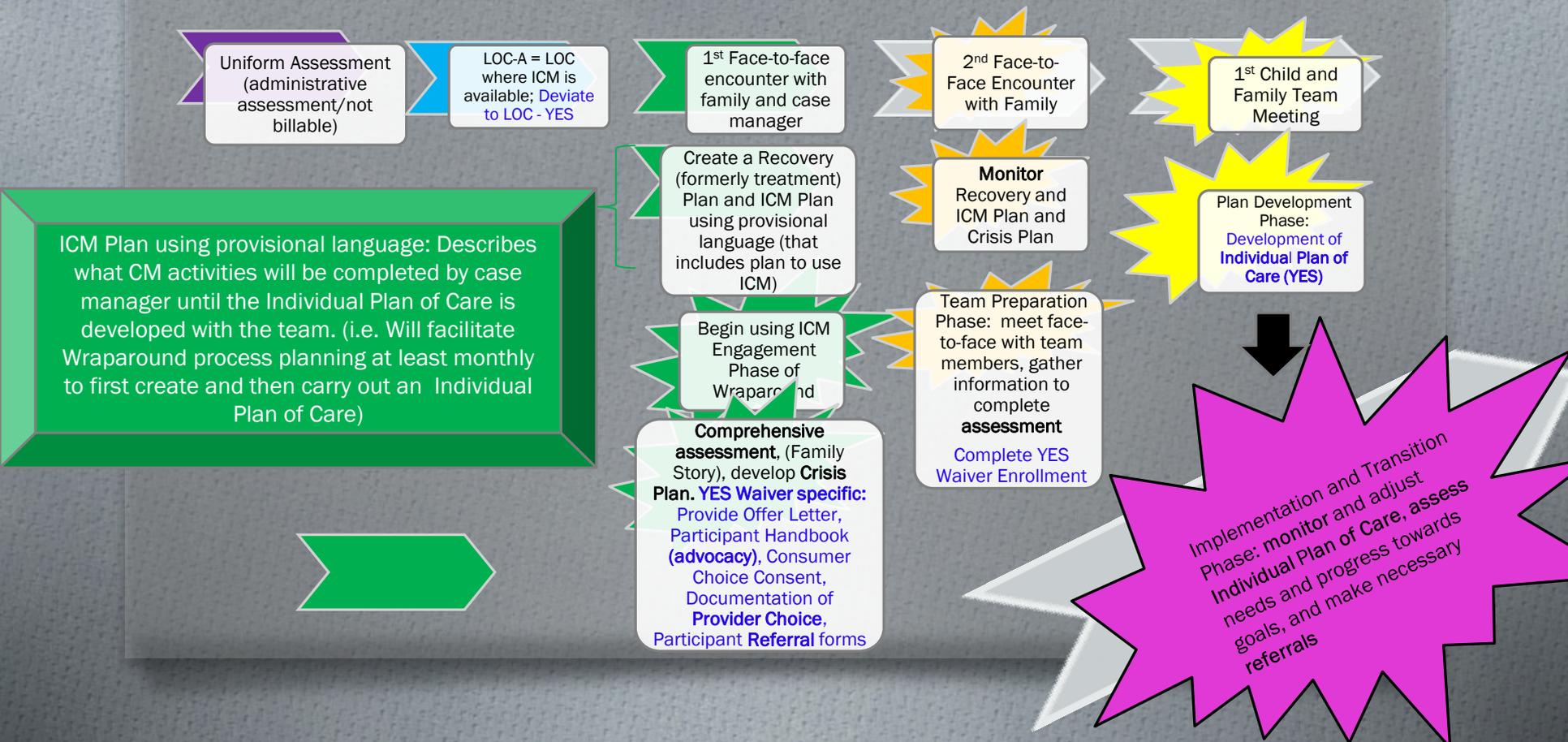
ICM Activities Within the NWI Wraparound Model

- 1st family meeting (where recovery plan & ICM plan (using provisional language) and **crisis /safety plan** are developed.) Initial **referral** and **linkage** based on the crisis plan to crisis lines, family partners etc. must happen at this time. (All other linkages and referrals occur with the team in Wraparound team meetings.)
- Team members will continue to be identified and necessary **linkages** will be made as these team members will be strengths that can be utilized as strategies during the Wraparound process.
- Functional strengths are continually identified and expanded upon
- During the Initial Plan Development Phase, the Child and Family Team identifies underlying needs and strategies to meet those needs and **refers** the Waiver participant and family as appropriate.
- Family and team members able to **link** to elicit, mobilize, and reinforce identified strengths during Transition Phase.
- Purposeful **connections/referrals** including aftercare options are negotiated and made based on family strengths and preferences and reflect community capacity.
- Specifically **assess** for and address barriers to all prioritized strategies chosen by the family and make **referrals** as necessary.
- **Lead the team in identifying progress toward achieving sustainability** after YES Waiver Services are no longer provided. Identify support in the following areas: formal services, community resources, naturally occurring relationships, develop individualized approaches to assure strong connections with after-wraparound supports.

SMP Requirements for Community Based CM	TAC Requirements for the Provision of ICM	ICM Activities Within the NWI Wraparound Model
<p>Monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.</p> <p>(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:</p> <p>(a) services are being furnished in accordance with the individual's care plan;</p> <p>(b) services in the care plan are adequate in amount, scope and duration to meet the needs of the individual; and</p> <p>(c) the care plan and service arrangements are modified when the individual's needs or status change.</p>	<ul style="list-style-type: none"> • Monitor the child/youth's progress toward the outcomes in the MH case management plan including; 	<ul style="list-style-type: none"> • During the Implementation Phase review accomplishments (things that have worked, went well, etc.), monitor progress, adjust the IPC (address barriers and adjust strategies accordingly), assign new tasks.
	<ul style="list-style-type: none"> ○ gathering information from the individual, current service providers, and other resources; 	<ul style="list-style-type: none"> • Seek input from Child and Family Team members regarding what is working/needs to be modified
	<ul style="list-style-type: none"> ○ reviewing pertinent documentation, including the individual's clinical records, and assessments; 	<ul style="list-style-type: none"> • Monitor implementation of the IPC and assess input from Child and Family Team members and other resources, summarize data and empower the team to adjust the plan and modifying strategies based on facts and results.
	<ul style="list-style-type: none"> ○ ensuring the MH case management plan was implemented as agreed upon; 	<ul style="list-style-type: none"> • Document the process from a strengths perspective that clearly represents the family's perspective and choices. • Monitor and check-in regarding assigned tasks.
	<ul style="list-style-type: none"> ○ ensuring needed services were provided; 	<ul style="list-style-type: none"> • Check in on assigned tasks and assign new tasks (based on adjustments to strategies (including services listed in the recovery plan) or need for more formal assistance.
	<ul style="list-style-type: none"> ○ determining if progress toward the desired outcomes was made; 	<ul style="list-style-type: none"> • Assess progress towards outcomes and vision to determine if IPC needs to be updated.
	<ul style="list-style-type: none"> ○ identifying barriers to accessing services or to obtaining maximum benefit from services; 	<ul style="list-style-type: none"> • Manage the Child and Family Team over time to seek understanding of unmet needs and underlying conditions. • Monitor the IPC (if things did not happen or did not work, ask why; address barriers, and adjust strategies accordingly)
	<ul style="list-style-type: none"> ○ advocating for the modification of services to address changes in the needs or status of the individual; 	<ul style="list-style-type: none"> • Lead the Child and Family Team in assessing for and identifying potential unmet needs based on current & projected underlying conditions during all phases of Wraparound.
	<ul style="list-style-type: none"> ○ identifying emerging unmet service needs; 	<ul style="list-style-type: none"> • Assess for underlying needs as they present throughout the Wraparound process.
	<ul style="list-style-type: none"> ○ determining if the MH case management plan needs to be modified to address the individual's unmet service needs more adequately; and 	<ul style="list-style-type: none"> • Assess/monitor progress (check in for task completion, are we closer to needs met, family vision attained)
	<ul style="list-style-type: none"> ○ revising the MH case management plan to address the individual's unmet service needs; 	<ul style="list-style-type: none"> • Monitor plan implementation (did not work or did not happen); address barriers. and adjust strategies accordingly.



When Can You Start Submitting ICM Encounters?



1st Family Meeting

(TAC says must occur within 7 days)

What Happens According to the NWI Model
(may be broken up into several contacts):

- Facilitator and Family Partner engage the family and explain the Wraparound process.
- Discuss reason for referral, review CANS/Uniform Assessment
- Develop Recovery (formerly treatment) Plan and ICM Plan using provisional language (see next slide for example)
- Gather comprehensive history/assessment to create a written family story
- Develop Family Vision and identify strengths to be used in the creation of ICM Plan/Wraparound Plan
- Create an initial crisis/safety plan and address any immediate crisis situation
- Make referrals necessary to implement recovery plan (in whatever phase of completion) and crisis plan.

ICM Begins!

Example Description of ICM Activities Provided



- Began comprehensive assessment to be used in the development of YES Individual Plan of Care (IPC) and identification of underlying needs and level of supports needed (when family first knew something was wrong, when they first sought help).
- Developed Family Vision and assess for strengths and resources to be used as part of ICM planning process.
- Develop Crisis & Safety Plan
- ICM completed referral to crisis hotline as part of Crisis & Safety plan.
- ICM completed necessary referrals to appropriate community resources, i.e. school program, and community food pantry to resolve emergent needs for youth.

Family Story

Recovery (formerly treatment) Plan

(According to the TAC, must be completed within 10 business days after authorization)

What Happens According to the TAC (Paraphrased):

A QMHP completes and signs recovery plan. The recovery plan reflects input from each of the disciplines of treatment to be provided. The recovery plan must include:

- description of the presenting problem;
- description of the child/youth's strengths;
- description of the child/youth's needs arising from the SED;
- description of the child/youth's co-occurring substance use or physical health disorder, if any;
- description of the recovery goals and objectives ;
- expected date for achievement of recovery goals;
- list of resources for recovery supports; and
- list of the type(s) of services within each discipline of treatment that will be provided. And for each type of service, provide:
 - a description of the strategies to be implemented by staff in providing the service and achieve goals;
 - frequency , number of units , and duration of each service to be provided; and
 - credentials of the staff providing each service.

The goals and objectives with expected outcomes must:

- specifically address the child/youth's unique needs, preferences, experiences, and cultural background;
- specifically address the individual's co-occurring substance use or physical health disorder, if any;
- be expressed in terms of overt, observable actions of the individual;
- be objective and measurable using quantifiable criteria; and
- reflect child/youth's self-direction, autonomy, and desired outcomes.

The individual and LAR must be provided a copy of the recovery plan and each subsequent recovery plan reviewed and revised.

Example of Recovery and Intensive Case Management Plan Using Provisional Language & Key Language to be Included to Submit ICM Encounter

Created on:
06/15/___

Strengths

- Strengths will continue to be developed through Wraparound Process Planning and documented on the Individual Plan of Care (IPC)
- Youth uses sports (basketball, &volleyball) as stress relief.
- Youth values and is able to develop/maintain healthy relationships with friends, Sarah and Rodrigo.

Presenting Problem (likely reason for referral)

- Youth diagnosed with Depression, has a history of psychiatric hospitalization and runs away from home often and was recently arrested for shoplifting...

Needs

- Needs will be identified throughout Individual Plan of Care
- Youth needs to know they are in control of their life
- Youth needs to feel that she can make good and safe decisions

Co-Occurring Disorder

- N/A

Recovery Goals and Objectives

- Recovery Goals and Objectives will continue to be developed through IPC , will assess for need for counseling/skills training. Assessment anticipated by 07/15/___
- Youth will improve relationship with family evidenced by no longer running away
 - Family will develop a crisis plan with help of case manager to enact instead of youth running away (06/15___).

Resources

Debate coach, volleyball coach, church youth group, LMHA youth support group, certified family partner, therapist (Case Manager will make necessary referrals)

Services (will continue to be identified through Wraparound Process)

Intensive Case Management: Over one year, Intensive Case manager will facilitate the Wraparound process at least monthly to create and carry out an Individual Plan of Care. Will assist in development of a crisis plan.

Counseling and/or Skills Training: May be provided after needs are further identified and clearly defined during planning process.

Family Partner Supports: Certified Family Partner will meet with LAR for a frequency TBD throughout the IPC and provide supports as identified.

2nd Family Meeting

What Happens According to the NWI Model:

- Continue to listen to the family's story
- Discuss possible team members to identify and include natural supports
- Set location, date, and time of Team Meeting
- Monitor crisis plan and adjust if necessary
- Present needs list that facilitator developed/gleaned from the family story
- Have family prioritize needs to be presented at team meeting

Example Description of ICM Activities Provided



- Continued ongoing comprehensive assessment of underlying treatment needs by gathering more details of family story and adjust (monitor) the recovery plan accordingly.
- Identified community members (counselor, teacher, probation officer, etc.) with whom ICM agrees to link and advocate (referral) for their participation in the Child and Family Team and development of the IPC.
- Monitored effectiveness and outcomes of implementation of Crisis & Safety plan.
- Family prioritized needs to be utilized in the development of the IPC.

Should Occur
Within First
30 Days of
Authorization

1st Child and Family Team Meeting

What Happens:

Creation of the Wraparound Plan

- Share family vision with team and make any changes the family suggests
- Develop a team mission statement
- Review functional strengths already discovered and add to the list as discovered and include strengths of team members
- Identify and prioritize needs (starting with needs related to referral and crisis plan).
- Brainstorm and choose interventions for the initial needs to be addressed (should be related to strengths of family and team).
- Review crisis plan.
- Assign tasks to team members

Example Description of ICM Activities Provided



- As part of comprehensive assessment CM gathered information from team regarding underlying needs and strategies to meet those needs during creation of Individual Plan of Care (IPC)
- Monitored and adjusted Crisis & Safety plan accordingly based on creation of IPC
- CM and team referred youth to sports facility where part-time job may be available, and animal foster program per youth's interests, and ...
- Assigned tasks to be completed by each Child and Family Team member, in accordance with IPC.
- Team agrees to meet at least monthly in accordance with Wraparound (protocol for the provision of ICM).

Follow Up Wraparound Team Meetings

TAC says shall happen when: requested by child/youth or LAR/primary caregiver, in accordance with UM Guidelines and Individual Plan of Care, or if there is a clinically significant change

Potential Happenings and Case Management Activities According to the NWI Model:

- Team continues to identify and make meaningful use of strengths
- Deepens understanding of underlying needs and needed strategies
- Delivers and modifies strategies that align with chosen outcomes and reflect family perspective
- Family perspective is used in modifying the mix of strategies & supports to assure best fit with family preferences.

Example Description of ICM Activities Provided



- Monitored IPC and reviewed accomplishments, and made adjustments to strategies as appropriate
- Specifically assessed for and addressed barriers to all prioritized strategies chosen by the family.
- Assessed accomplishments at ongoing Child and Family Team meetings, monitored the plan, address barriers, and adjust strategies accordingly.
- Monitored progress towards outcomes and family vision to determine if IPC needs to be updated
- Assessed for additional functional strengths
- Expanded upon necessary referrals (transportation, special education, etc.) to resolve challenges of successful implementation of IPC.
- Followed up on previous tasks and assign new tasks as appropriate.

Highlights

- o DSHS has identified the NWIC model of Wraparound process planning for the provision of ICM and coordination of YES Waiver services. Providers must facilitate the Wraparound process to bill for the provision of ICM.
- o Definitions of CM include: comprehensive assessment (not the uniform assessment), development of plan (not the treatment/recovery plan), referral and related activities, and monitoring and follow-up. Other associated activities are incidental and not billable.
<http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=35712&id=8589961742&terms=Billing+Guidelines>
- o The ICM Plan, using provisional language, should outline what the case manager will do until such time that the ICM Plan is fully developed in accordance with TAC. (The provisional language on the ICM plan is not expected to be the individualized plan that is expected to be developed at the first Family Team Meeting).
- o The IPC should be completed at the 1st Child and Family Team Meeting which should occur within the first 30 days of authorization into LOC-YES.
- o When completed, the IPC can fold seamlessly into the ICM Plan and can easily be incorporated into the recovery plan. If done appropriately, these three plans could potentially be the same plan.
- o Documentation should be completed in accordance with the TAC.

A photograph showing several hands of various skin tones (light, medium, and dark brown) reaching towards the center, symbolizing unity, support, and community. The hands are arranged in a circular pattern, with some fingers overlapping. The background is a plain, light color. The entire image is framed by a white border and mounted on a grey surface with four silver corner fasteners.

Thanks for all that you do.
Please let us know how we can
support the important work
you are doing for YES Waiver
Participants and their families.