HCBS Quality

SOUTH CAROLINA'S CASE MANAGEMENT SYSTEM (CMS)

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Abstract

South Carolina relies upon an automated Case Management System (CMS) for the day-to-day management of three Medicaid HCBS waivers (Elderly/Disabled, HIV/AIDS, Ventilator Dependent). In addition to supporting intake, assessment, care planning and service initiation functions, South Carolina's CMS is also used to support quality management through its report-generation function (e.g., reports on timeliness of assessments/reassessments/care plan development; tracking missed provider visits; identifying participants at risk in the event of an emergency or natural disaster).

PRODUCT HIGHLIGHTS

- Key components of South Carolina's automated Case Management System (CMS) include:
  - → Intake and assessment information
  - → User access to information on up to five previous assessments
  - → Onscreen history of waiver participant's program history (initiation, changes, termination)
  - → Case manager record of contacts with the participant, including update of participant status
  - → Service Plan:
    - ⊙ Detailed information on current informal supports (relationship, visit frequency, contact information, supports provided)
    - ⊙ Detailed information on current formal supports (by service: initiation date, service type, provider name and contact information, number of service units per by day of week, termination date)
    - ⊙ Problems, Goals, Interventions: summarizes support needs identified in the assessment and how support needs are addressed
    - ⊙ Identifies problem group (e.g., medical, nutritional, functional status, etc.), problem, goal, time frame, and interventions to meet the goal
    - ⊙ PASARR identification module included
- CMS Utilities
  - → Password protection
  - → Participant selection and display criteria (e.g., display information for an individual participant, all of a case manager's participants, active or inactive participants only, etc.)
  - → Participant index in conjunction with search and/or display criteria
  - → Provider Resource Directory (name, address, counties served, services provided, waivers for which services currently being provided)
  - → User ID maintenance
- Automated Reports
  - → Reports on timeliness
    - ⊙ Pre-admission screening, initial assessment, reassessment(s)
    - ⊙ Verification of level of care
    - ⊙ Service plan completion
    - ⊙ Data entry of assessment
  - → Other reports to support business processes
    - ⊙ Generation of waiver and nursing home waiting lists
    - ⊙ Cost reports by area, case manager, or service—assist state in completing HCFA 372 reports and in providing information to state legislature
    - ⊙ Demographic summary reports →

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- → Report to identify people whose health and safety is at risk if an emergency or disaster occurs
- → Report to identify missed provider visits reported by provider and/or by participant
- → Report to identify all participants served by a particular provider
- → Capability to fax reports to providers, instead of mailing them; reports on timing and content of information sent to providers

- Future Plans
  - → Create a single database accessible through Internet, providing state staff real time access. Currently each area office has a database and data is transferred to the state's central Community Long Term Care (CLTC) office nightly
  - → Integrate CMS with a web-based information and referral system to be developed as part of a 2001 Real Choice Systems Change Grant
  - → Integrate with system used by the State Unit on Aging for in-home services
  - → Integrate with CareCall, a system South Carolina plans to develop in 2003. CareCall would require aides providing in-home services to call a central phone number when they arrive at the home and when they leave. The phone call, along with codes the aide would enter, will:
    - ⊙ Record the type of service provided
    - ⊙ Record the time the aide was at the participant's home
    - ⊙ Act as a billing invoice for the provider
- Lessons Learned
  - → Important to involve local staff in development of automated systems
  - → Make decisions about content (e.g., assessment) before automating
  - → Ensure a link with claims data
  - → Review software requirements and capabilities before committing resources Ñ make sure the software is compatible with your data and policy needs
  - → Have one or more staff/contractors who can communicate between software designers (programmers) and end-users of the system
  - → Sell the system's advantages to end-users
  - → If possible, don't make the system optional for end-users, but give end-users input into system design and implementation
  - → Invest in up-front training of end-users. Also, build instructions and help screens into the design of the system
  - → A stable workforce of end-users (i.e, low staff turnover) increases the reliability with which staff interact with the system, and minimizes the need for new-user training

PROGRAM CONTEXT

Program:

Elderly/Disabled Program Medicaid HCBS Waiver, HIV/AIDS Medicaid HCBS Waiver, and Mechanical Ventilator Dependent Medicaid HCBS Waiver. Administered and operated by South Carolina Department of Health and Human Services, Office of Senior and Long Term Care Services, Bureau of Community Long-Term Care.

Services Covered:

Traditional HCBS waiver services

Persons Enrolled:

- 11,000 on Elderly/Disabled Waiver
- 1,100 on HIV/AIDS Waiver
- 35 on Ventilator Dependent Waiver

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ADDITIONAL PROGRAM INFORMATION

- South Carolina's oldest HCBS Medicaid waiver is the Elderly/Disabled waiver—in operation statewide since 1984.
- Community Long Term Care (CLTC) oversees and operates the Elderly/Disabled, HIV/AIDS, and Ventilator Dependent waivers. CLTC sits within the state's Medicaid agency, the Department of Health and Human Services.
- CLTC has 14 area offices throughout the state. The offices assess eligibility for nursing facility and home and community-based services, and offer case management for the waivers.
- The state designates slots to each area CLTC office for each waiver. The Elderly/Disabled waiver and the Ventilator Dependent waiver have waiting lists. Approximately 3,500 people are on the waiting lists. Wait times vary according to area CLTC office. An Elderly/Disabled waiver participant typically receives services approximately six months after his or her first application.
- Case management is provided by area CLTC state staff, as well independent contractors and one case management agency.
- For Elderly/Disabled and HIV/AIDS waivers, RNs employed by the state conduct assessments and social workers (state employees or contract employees) provide ongoing case management.
- For Ventilator Dependent waiver, state-employed RNs provide ongoing case management as well as assessments.
- All registered nurses and social workers telecommute. They work from home if they are not at a participant's home or in transit. They visit the CLTC area office weekly to upload participant information into the Case Management System (CMS) and to download information from CMS.
- CLTC also provides oversight to the Department of Developmental Disabilities and Special Needs (DDSN), which operates two waivers, the Mental Retardation or Related Disabilities Program and the Head and Spinal Cord Injured Program, through contracts with 46 county boards.

QUALITY MANAGEMENT SYSTEM

South Carolina's Community Long Term Care (CLTC) quality management system for the Elderly/Disabled, HIV/AIDS and Ventilator Dependent Medicaid HCBS waivers largely relies on process measures. South Carolina conducts a series of record reviews to ensure case managers and other providers are serving participants according to the minimum standards set in administrative rule. The Case Management System (CMS), helps South Carolina perform these reviews because the CMS contains much of the case managers' documentation of their work. South Carolina acknowledges the potential for using CMS data for measuring system and participant outcomes, but currently the state has not had the resources to develop such applications for the system.

Local staff at South Carolina's 14 Area Community Long Term Care Offices are responsible for conducting the first level of review. On a monthly basis, case management supervisors review two participants' records for each case manager, and rely on a standard tool for performing these reviews. The reviews include verification that 1) the participant requires the level of care necessary for the waiver, 2) the assessment and service plan are current, 3) the service plan addresses identified needs, and 4) the case manager contacted the participant monthly and conducted quarterly in-person visits. Senior case managers also conduct a "quick review" of ten percent of participant records to ensure that basic elements of case management are documented; they utilize a seven-item tool to ensure case managers completed and documented monthly contacts with participants. One month in each year case management supervisors visit one or two participants per case manager in person instead of conducting record reviews. Each area office summarizes its findings and reports them to the central office quarterly.

State central office staff conduct additional record reviews at each area office each year. A three-person team—a registered nurse, a social worker, and the head of South Carolina CLTC's quality management unit—reviews a random sample of up to five percent of participants' records. The central office team review covers some of the same processes reviewed by area supervisors. The central office team also follows up with the area offices to ensure complaints

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were handled appropriately and that the office followed state policies and procedures (e.g., that case managers and assessors meet state standards). Each year the central office distributes findings to all area offices, so the area offices are aware of each others' performance. For case managers that are not state staff, but have a contract with the state, the team reviews whether the case manager or agency fulfills contract requirements. If a private case management provider or area office is compliant with a given standard less than 80% of the time, the area or provider must develop a corrective action plan subject to central office approval.

CLTC also conducts an onsite annual provider compliance review. Registered nurses review waiver providers to ensure the waiver's provider standards are met. This includes verifying that staff meet qualification standards, background security checks have been completed, up-to-date drivers' licenses are on file, tuberculosis tests are current, and that a liability insurance policy is in force. If a provider does not meet standards, CLTC may require a corrective action plan, prohibit the provider from serving new waiver participants until problems are addressed, or terminate the provider's contract, depending on the potential harm to participants due to the deficiency.

CLTC also reviews new providers before they start serving waiver participants. First, CLTC reviews required documents (e.g., financial information) submitted by the provider. Then CLTC performs the same on-site review conducted annually for current providers. If a new provider exhibits deficiencies, it must address them before CLTC will offer a contract. A second on-site review occurs within 30 days after the provider serves its first waiver participant.

Most recently, CLTC has added an external review function to its quality management approach through a contract with the University of South Carolina (USC). USC staff review compliance to policies and procedures at area CLTC offices and at the county boards that operate waivers for the Department of Developmental Disabilities and Special Needs. Reviews are conducted by a registered nurse, a licensed social worker, or someone with a Bachelors' degree in a health or social related field with two years professional experience. The state expects the methods and scope of the external review to expand over time to include the measurement of participant outcomes.

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