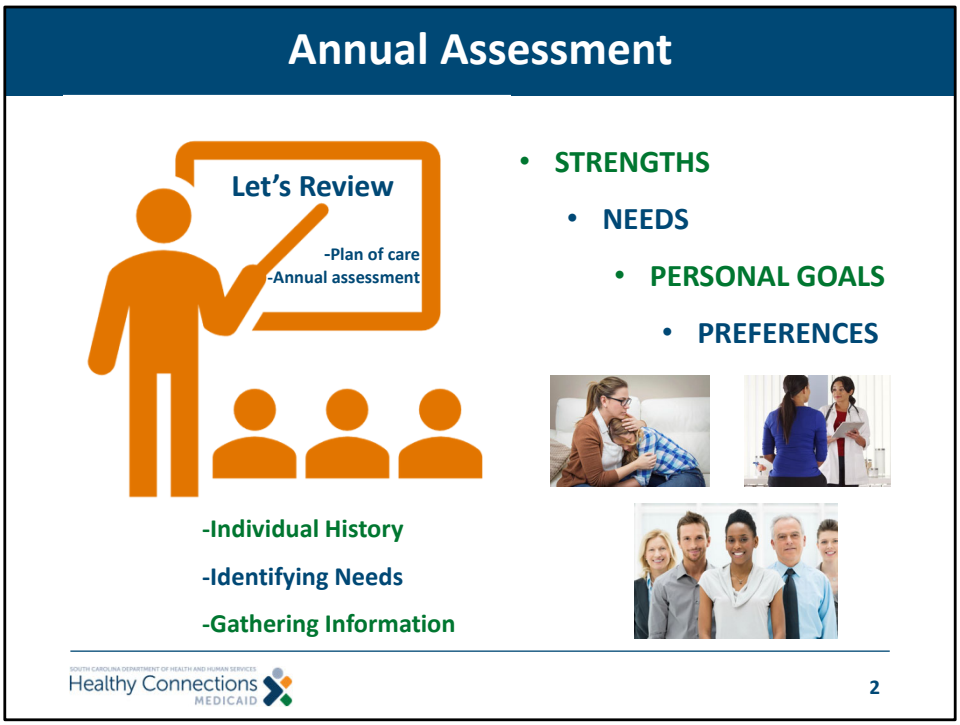
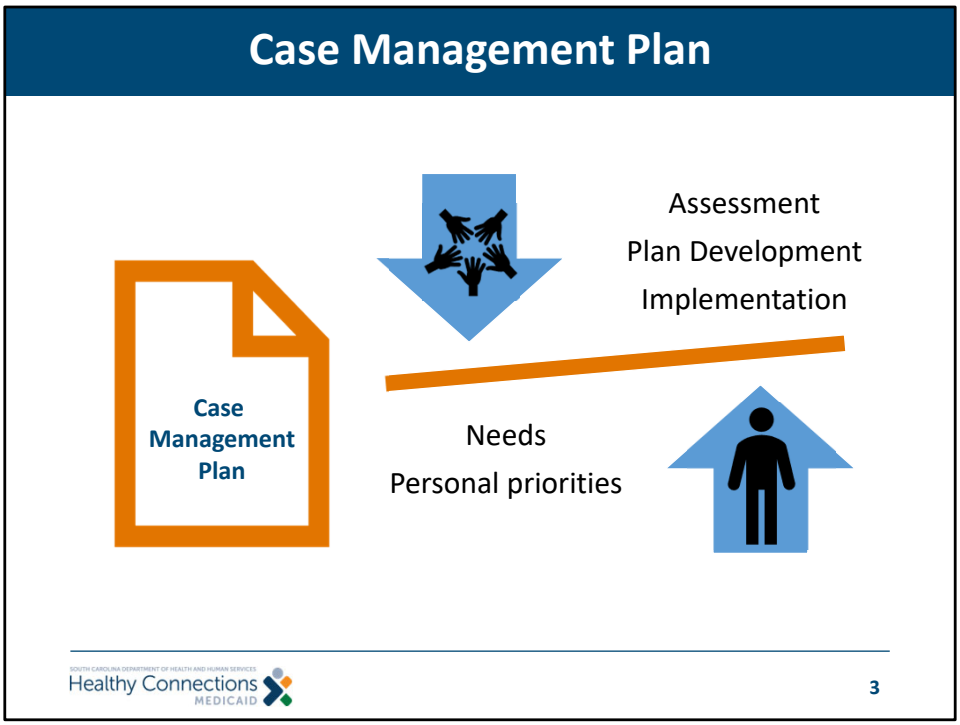
SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Assessment and Plans of Care

Version 1.0 (07/01/20)



The annual assessment and Case Management Plan is directed by the participant, legal guardian or parent and developed by the Waiver Case Management provider based on the comprehensive assessment of the waiver participant's strengths, needs and personal priorities and preferences. The participant, family, legal guardian, caregivers, professional service providers (including physicians) and others of the participant's choosing may provide input. Such assessment activities include:
-taking individual history,
-identifying the needs of the person supported and completing any related documentation, and
-gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment.



Case Management Plans are individualized for each waiver participant, stressing the importance of community support. The Plan is updated as needed, and an annual Plan is completed every 365 days. Participation in the planning process by the participant, parent or legal guardian, knowledgeable professionals and others of the participant, parent or legal guardian's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the person-centered service plan. All needs identified during the assessment process must be addressed.

Support Plan Development

Coordinated Care

Physician

Therapist

Other

- **STRENGTHS**
- **PRIORITIES**
- **PREFERENCES**

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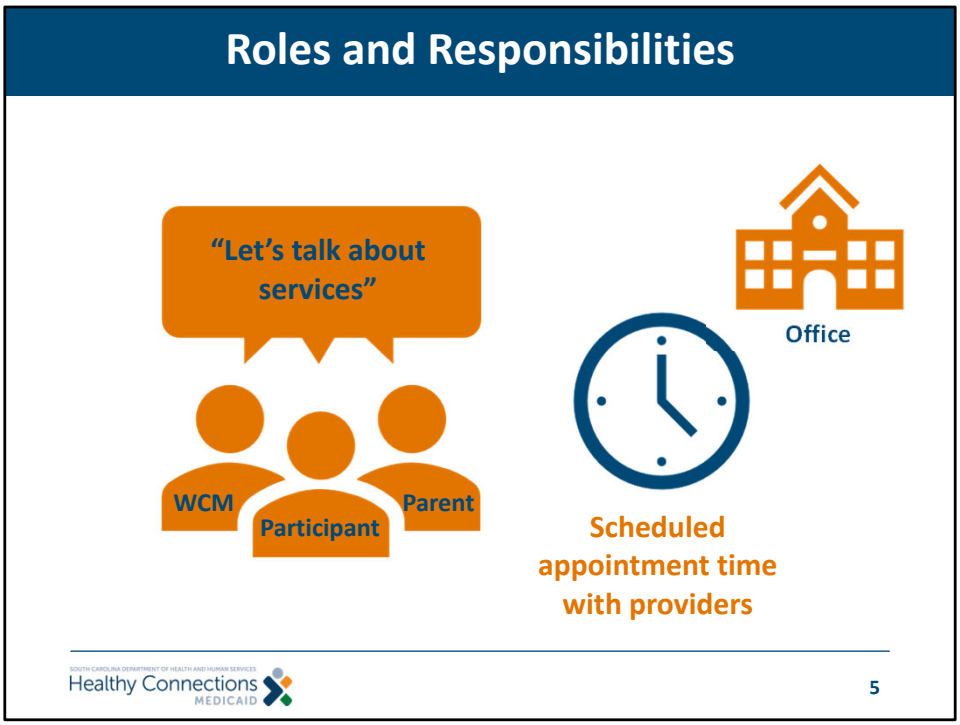
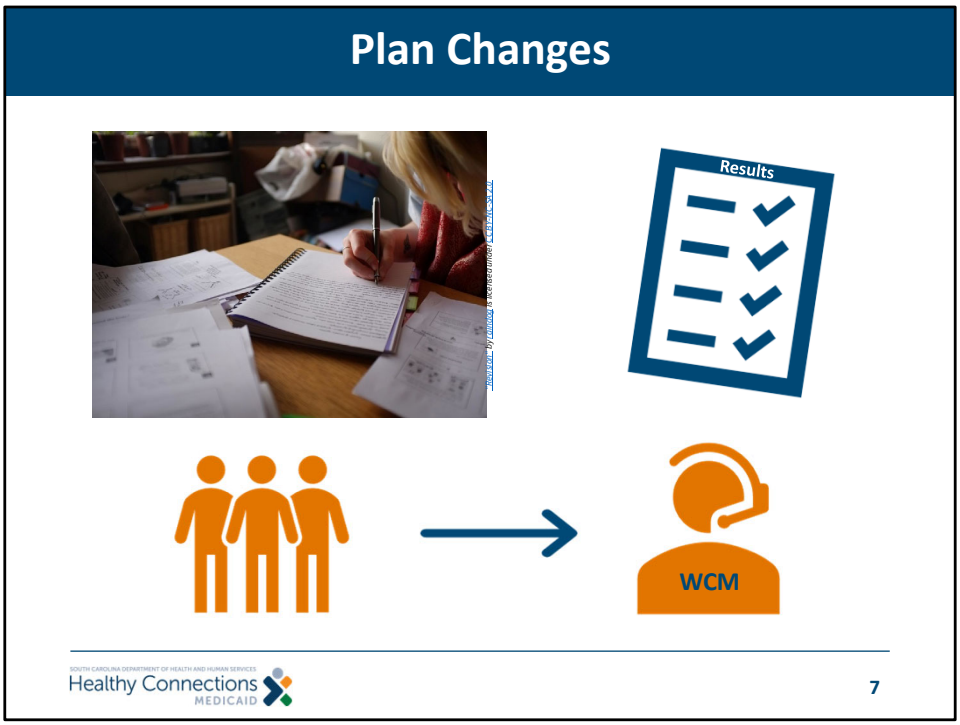
As part of the Case Management Plan development process, it is determined if the participant has health care needs that require consistent, coordinated care by a physician, therapist or other health care professionals. The Waiver Case Management provider must utilize information about the participant's strengths, priorities and preferences to determine how those needs will be addressed.



The roles and responsibilities of the Waiver Case Manager, participant, parent or legal guardian for each service will be discussed during planning. The Waiver Case Management provider will have primary responsibility for coordinating services but must rely on the participant, parent or legal guardian to choose a service provider from among those available and honor appointments that are scheduled with providers when needed for initial service implementation and ongoing monitoring of services. The appointments must be at convenient times and locations for the participant in order to coordinate an effort of collaborative cooperation with all parties involved with the development and ongoing monitoring of the plan.

Waiver Case Management providers are responsible for locating and coordinating other community or State Plan services. The objectives of Waiver Case Management are to counsel, support and assist participants and families with all activities related to the waiver program. Waiver Case Management providers must provide ongoing problem solving to address participant and family needs. They must also coordinate community-based support, provide referrals to other agencies and participate in interagency meetings as needed. These activities must be fully documented in the participant's waiver record.



Changes to the Plan will be made as needed by the Waiver Case Manager when the results of monitoring or when information obtained from the participant, parent or legal guardian, and/or service providers indicates the need for a change to the Plan.

Waiver Case Management Contact

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- **Meaningful Communication**
  - **WCM activities**

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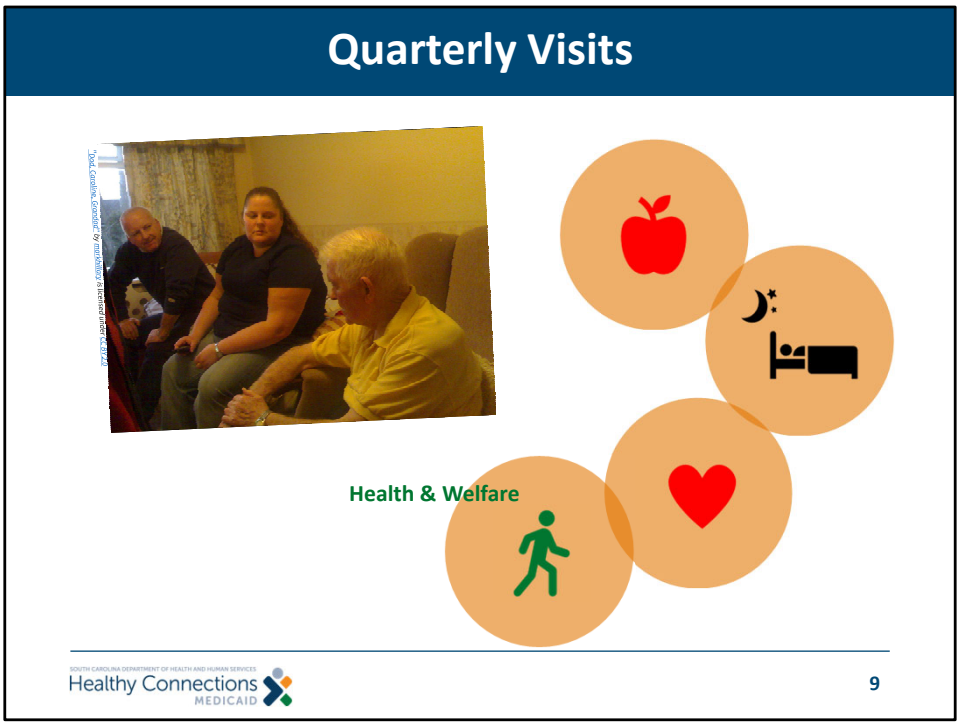
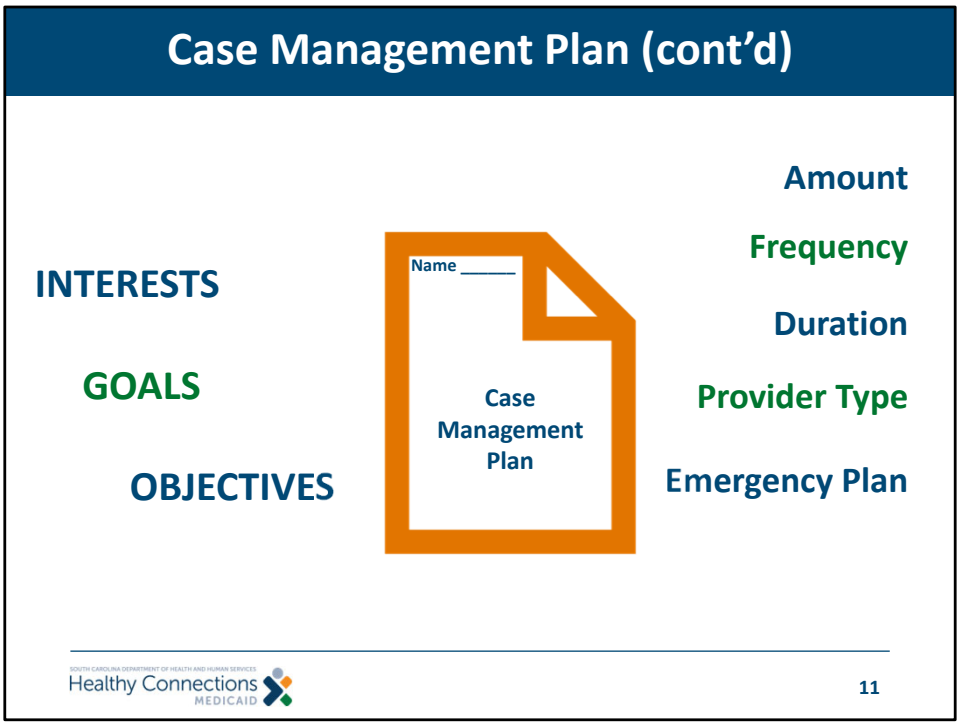
Monthly Waiver Case Management contact is required. A "Waiver Case Management contact" is defined as a meaningful communication exchange with the participant or his representative to provide one or more Waiver Case Management activities. Methods of contact include both face to face conversations and telephone calls, text messages, email messages, or written correspondence that are not face to face. Non face-to-face contacts are required during months in which a face-to-face contact is not conducted. Based on the results of the contact, amendments may be needed to update the Plan.

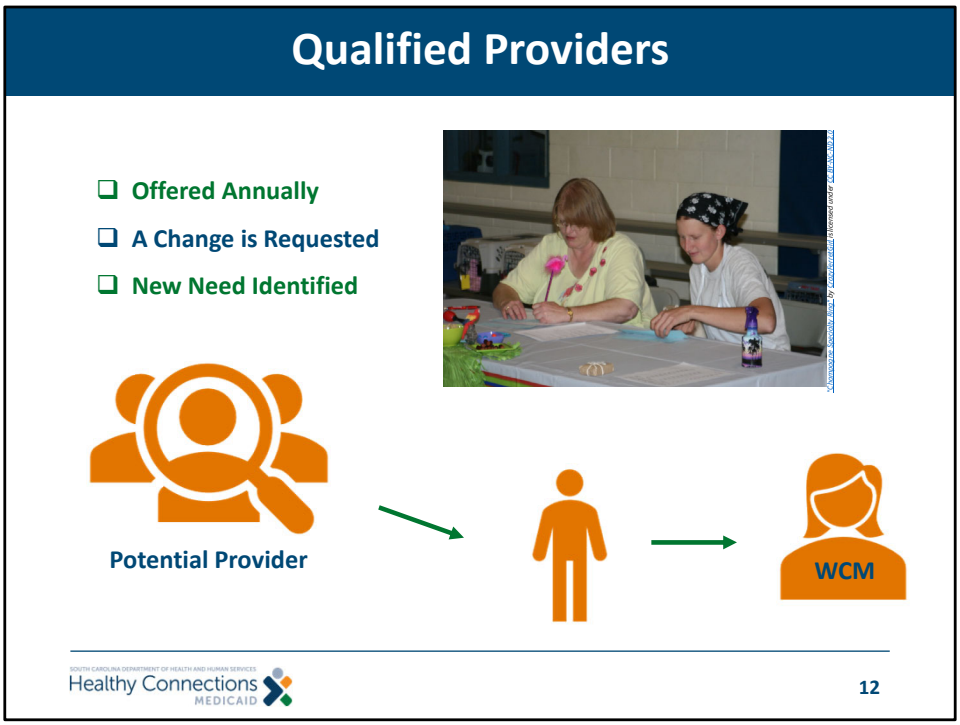


A face to face contact between the Waiver Case Manager and waiver participant is required at least quarterly. Included as part of the quarterly face to face contacts, a face to face contact must take place in the participant's home or natural environment every six months. The purpose is to monitor the health and welfare of the participant's living arrangements, as well as any changes in the family dynamics which might impact the needs of the participant.

The Case Management Plan includes a section for a description of the Plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver or supporter.

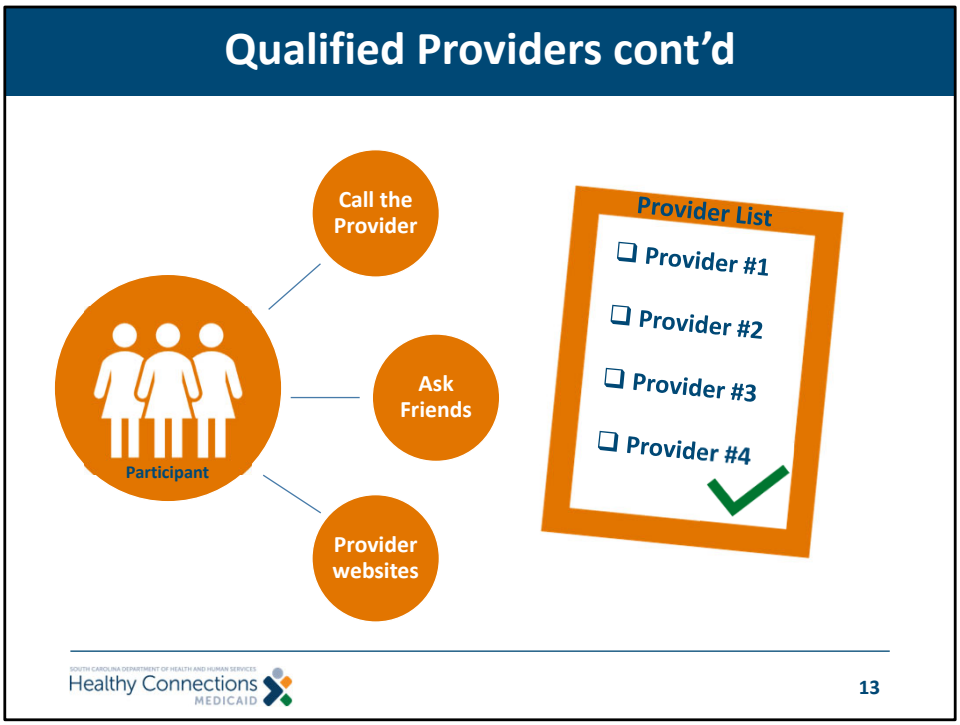


The Case Management Plan contains specific documentation such as the participant's name and demographic information. The Plan outlines the participant's individual strengths, interests, goals and objectives; amount, frequency, duration of services, type of providers performing the services, and includes an emergency plan. The Plan documents the evaluation of actual results and satisfaction of the services and supports the individual waiver participant is receiving.



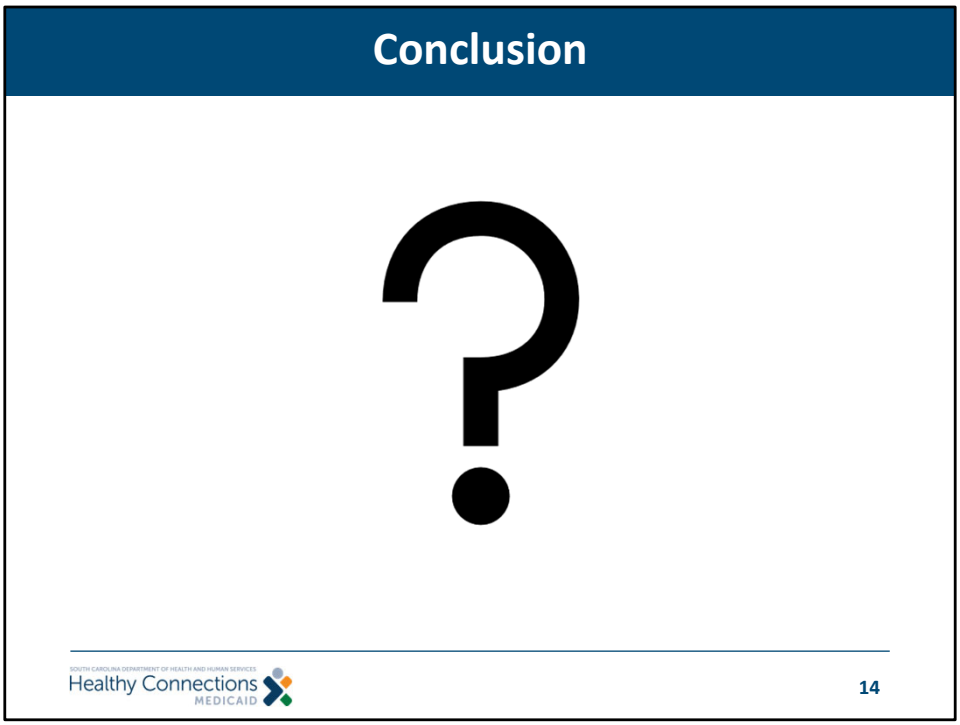
Waiver Case Management providers share information about available qualified providers of needed services to help participants make an informed choice. In order to select a provider, choice should be offered annually during plan development, anytime the participant or representative requests a change, or when an intervention or service to address a new need is identified.

The offering of choice must be documented in case notes along with the choice made by the participant or his or her representative. If only one potential provider is available, the participant or his or her representative must be informed and the Waiver Case Manager must document this discussion in a case note.



Participants, family and/or legal guardians are encouraged to phone providers with questions, ask friends about their experiences with providers, and utilize provider websites and other information sources in order to assist them in choosing a provider.

Additionally, participants, family and/or legal guardians are supported in choosing qualified providers by being encouraged to contact support and advocacy groups.



This concludes the Assessment and Plans of Care annual training. Please see your Supervisor for any additional questions or concerns.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