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The Process of planning and coordinating care and services to meet individual needs of a youth and to assist the youth in obtaining necessary medical, social, educational and other services.

Case Management provides coordination among agencies and providers in the planning and delivery of services.

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YCM Billable Activities:

- ✓ Assessment
- ✓ Case Planning
- ✓ Service Coordination
- ✓ Monitoring/Follow-up

Time Requirements:

- 8 minutes or more=Billable
- Less than 8 minutes= Non-Billable

Exclusions:

- Cannot bill for inputting of notes
- Youth with CHIP or Private Insurance unless contracted with a Service Agreement
- Youth receiving Youth Case Management from another provider
- 2 YDI employees CANNOT bill for the same Youth Case Management activity for the same time, same day, and same meeting

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Case Planning:

- Every 90 days complete Treatment Plan in Aura. TYH (TGH) are completed every 30 days
- Schedule Treatment Team Meeting
- Complete Family Engagement Checklist
- Complete ITP Meeting Invite List
- Gather all signatures for review by Lead Clinical or ACD
- Note: Independent Living skills goals and assessment are required for youth 14.5 years of age or older.
- *Start the "Transition Toolkit" Assessment (14.5 years or older)

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Required Contacts:
Legal Guardian- 1x per month
Youth-1x per month
Best Practice 1 hr for each

Types of contact:
1.Face to face (Best Practice)
2.Phone
3.Emails

This includes the following:
other agencies, medication providers, state, tribal, educational entities, JPO's and others regarding the youth's needs, services, discharge planning etc.

Documentation is required with a billable appointment and progress note.

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Assessments required for YCM

ECSII is for clients 3-6 years old-every 90 days
CASII is for clients 6 and older -every 90 days

CARR (Case File Review) is completed for YCM- Quarterly

YCM Monthly Placement Status-Monthly (last Tuesday of the month)

Medical Needs Assessments required every 180 days for TFC, FST, FSA

Transition Toolkit for youth 14.5 years and older

Client Incident Reports (as needed)

Complete STDS for Discharge of Programs and or Services

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Service Coordination

Referral to other services: medical, dental, vision, hearing, speech, neuro psychological, educational, housing and food insecurities

a) Explaining services, resources, and referral process with caregiver/Legal guardians

b) Looking for and coordinating transportation for family for appointments (Medicaid Travel)

c) Monthly follow-up with providers

d) Referral to a Higher Level of Care

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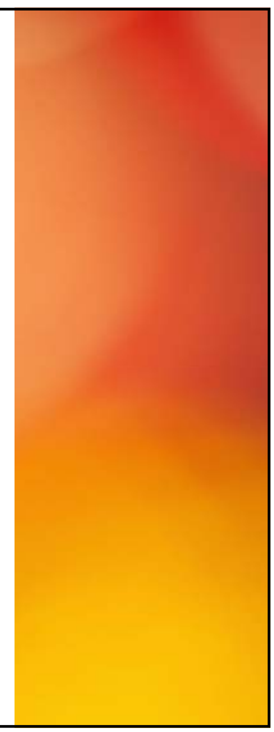
Collateral Information

- Mental Health Assessments and or Treatment from other providers
- Substance Use Assessments/Treatment
- Neuro-Psychological Assessment
- Psycho- Sexual Assessment
- Psycho-Educational Assessment
- Individual Educational Plan(IEP)



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Service Coordination

- Scheduling Initial and Annual Clinical Assessment
- Referral and Placement coordination to Higher Level of Care (TFC or TYH) and ensure Service Agreement is completed with CFS LG
- Respite coordination if youth is in a TFC or FST placement
- Coordinating and scheduling for Medication Management appointments
- Referral for other services: vision, dental, hearing, speech, neuro psychological, educational support

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Monitoring and Follow up

- Monthly Medicaid check
- Have a copy of the Youth Case Management Program checklist for each client to assure compliance.
- Medicaid check by the 5th working day of the month(have up to 6 months to bill 1 unit per month to assist family)
- Medication Management appointments
- Treatment Team meetings
- YDI services the youth is receiving (FSA, FST, Therapy, SU)
- Always work towards a successful discharge.

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Tools for effective Case Planning:

1. YCM Program Checklist (located in SharePoint under Library-Clinical Tools-Program Checklists)

2. Aura Training Manual (located in SharePoint under Library – Manuals-Clinical)

3. Active Treatment Planning Manual (located in SharePoint under Library-Manuals-Clinical)

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Putting it All Together

- Empowerment, Partnerships, and collaboration
- Open and respectful communication
- Individual and family strengths
- Individual responsibility and self-determination
- Team decision making and individualized care
- Transparency and Accountability
- Trauma sensitive culture
- Active care and treatment

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TARGETED CASE MANAGEMENT SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE, PROVIDER REQUIREMENTS

(1) The requirements in this subchapter are in addition to those contained in provisions generally applicable to Medicaid providers.
(2) Targeted case management services for youth with SED must be provided by a licensed mental health center as defined in ARM 37.87.102. A mental health center must:
(a) have a current license endorsement permitting the mental health center to provide targeted case management services; and
(b) be enrolled in the Montana Medicaid program as a targeted case management services provider.
(3) Targeted case management services for youth with SED must be supported by narrative documentation in accordance with ARM 37.85.414 record keeping requirements.
(4) Targeted case management services for youth with SED must be provided under a case management plan in accordance with ARM 37.86.3305.
(5) Case management plans for youth with SED must be completed within the first 21 days of admission to targeted case management services and updated at least every 90 days or whenever there is a significant change to the youth's condition. The case management plan must:
(a) use the standardized assessment tool approved by the department to determine the appropriate level of service intensity needed by the youth and the youth's family or caregivers;
(b) incorporate standardized assessment tool findings into the plan;
(c) support continued benefits from TCM reflected in youth service planning;
(d) reflect the least restrictive and appropriate level of care;
(e) identify the strengths of the youth and the youth's family or caregivers;
(f) include a crisis response plan;
(g) include a plan for each youth age 16 1/2 and older to transition to adult mental health services;
(h) include a discharge and transition plan from targeted case management services.
(6) Upon admission to TCM services and prior to all treatment team meetings of TCM services, the targeted case manager shall meet face-to-face with the youth's family or caregivers to complete a family treatment team meeting preparation checklist and questionnaire. If the meeting cannot be accomplished face-to-face, the targeted case manager shall document in the youth's file the reason for conducting the meeting through phone contact or telehealth. The checklist and questionnaire must contain and document the following components:
(a) explanation of the purpose of the treatment meeting and documentation of the youth's family or caregivers understanding;
(b) identification of natural supports in the youth's life;
(c) a notice to the family that the youth's treatment plan shall be delivered at times and in locations that are flexible, accessible, and convenient to the youth and the youth's family or caregivers, including evenings and weekends;
(d) evaluation with the youth and the youth's family or caregivers to identify and address risks and safety concerns at home and in the school and in the community; and
(e) evaluation with the youth and the youth's family or caregivers to identify strengths that can be used as the basis of the treatment plan in the areas of school, vocational, family, social, and community functioning as well as towards meeting developmental skills and abilities.
(7) Individual treatment plans and those participating in treatment team meetings must:
(a) use language that is understandable to the youth and the youth's family or caregivers and, where necessary, translate clinical terminology including but not limited to diagnoses and acronyms into language that is understandable; and
(b) actively seek to understand and demonstrate respect for the unique and diverse backgrounds of the youth and the youth's family or caregivers including but not limited to roles, values, beliefs, races, ethnicities, sexual orientations, gender expressions, gender identities, languages, traditions, communities, and cultures.
(8) In addition to the requirements outlined in (7), individual treatment plans must include:
(a) identification of natural supports or treatment goals intended to develop natural supports; and
(b) a crisis plan that identifies safety concerns, potential crises, triggers, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and identified supports of the youth and the youth's family or caregivers.
(9) Targeted case management providers shall share with the youth and the youth's family or caregivers baseline and updated outcome measurements including measurements of the youth's emotional and behavioral functioning, living situation, school outcomes, risk of harm to self or others, substance use, and progress toward individualized goals. Targeted case management providers shall meet with the youth and the youth's family or caregivers at least every 90 days for the purpose of sharing this information.
(10) In addition to the discharge requirements outlined in ARM 37.106.1917, a youth must be discharged from targeted case management services when treatment plan goals have been met, when the youth no longer desires targeted case management, or when the youth no longer meets the criteria for entry into targeted case management services.
(11) Mental health centers with a youth targeted case management endorsement must have policies and procedures in place to provide timely access to services for youth by:
(a) ensuring mental health centers have adequate resources to provide timely access to the standard assessment tool for intake of youth; and
(b) detailing a communication plan to the youth's family or caregivers if the youth is placed on a waitlist, including a process for referral to other services providers.

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Here is the BIG news!

Effective November 1st, 2023, there will be only ONE YCM per child. We are dissolving the need for Primary and Secondary YCM

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So what does this look like.....

- Prior to Nov. 1, the current primary will assure that all documentation is up to date and ready to transfer.
- On November 1, the secondary will need to change team assignments to reflect the discontinuation of the current primary and team members associated with the primary (AM, etc.)
- The current secondary, will assign themselves the primary.
- Additional team assignments will need to be made including the new Area Manager, Home Manager, Program Manager, etc.
- The current secondary will take over ALL YCM duties for their assigned youth on November 1, 2023.

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Next Steps

The new primary will need to do the following:

Step 1:

- Close the secondary YCM program.

Step 2:

- Open a new primary YCM program. **SEND A TASK TO MARGIE KRAITER.**
- You need to make sure that the address is correct for the Legal Guardian is correct. She will use that to determine the Frontier Differential status.
    - When sending the task, please include the staff name, client name, and what service you want authorized (ex. YCM-Billings)
- If you do not do this correctly, the revenue will go to the wrong place.

Step 3:

- You DO NOT need to complete an STDS for the closure of the secondary program level.

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