Optum

Optum Idaho

Targeted Care Coordination Toolkit

optumidaho.com

Optum Idaho Provider Services: **1-855-202-0983**

Adapted from the YES Practice Manual Feb. 2019; ID-101-2022, Rev. 3

What You'll Find Inside the Toolkit

This Toolkit is intended to provide a framework and foundation for Targeted Care Coordination (TCC) within the Youth Empowerment Services (YES) system of care in Idaho. This Toolkit introduces the YES system of care including the YES Principles of Care, YES Practice Model, and Child and Adolescent Needs and Strengths (CANS) tool. It outlines the components of Targeted Care Coordination, including phases and tasks, responsibilities within the role, facilitation of the Child and Family Team (CFT), qualifications, and guidance on billing. And lastly, the Toolkit provides tips and instructions for the development and submission of the person-centered service plan (PCSP).

Table of Contents

YES System of Care

Youth Empowerment Services (YES) is the mental health system of care in Idaho for youth with a serious emotional disturbance (SED)—a term used to identify youth under the age of 18 who have both a mental health diagnosis and a functional impairment. YES uses a youth and family-centered, team-based, strengths- and needs-focused approach for early identification, treatment planning and implementation of care. Child and Family Teams create coordinated care plans with measurable goals that respect the youth's strengths, needs, community and culture. Providers and agencies work together with the youth, family and other supportive individuals in the youth's life to monitor and adjust the treatment plan as goals are met and needs change.

YES Principles of Care

- **Family-centered** – Emphasizes each family's strengths and resources.
- **Family and youth voice and choice** – Prioritizes the preferences of youth and families in all stages of care.
- **Strengths-based** – Identifies and builds on strengths to improve functioning.
- **Individualized care** – Customizes care specifically for each youth and family.
- **Team-based** – Brings youth, families and informal supports together with professionals to identify the youth and family's strengths and needs, and to create, implement and revise a coordinated care plan.
- **Community-based service array** – Provides local services in a location chosen by the youth and family.
- **Collaboration** – Brings together families, informal supports, providers and agencies to meet identified goals.
- **Unconditional** – Commits to achieving the goals of the coordinated care plan.
- **Culturally competent** – Considers the family's unique needs and preferences.
- **Early identification and intervention** – Assesses mental health early and provides access to services and supports when the need is first identified.
- **Outcome-based** – Contains measurable goals to assess change.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

YES Practice Model

Engagement

- Communicating in a respectful and honest manner in order to build trusting relationships.
- Learning about the strengths and needs of the youth and their family with the intent of helping them reach their goals.
- Recognizing and valuing cultural identities and language.

Assessment

- Listening and ensuring families are heard and valued as experts.
- Identifying individual and family strengths and considering them a vital part of understanding the youth and their needs.
- Utilizing the CANS tool for initial assessment and updates.
- Making appropriate referrals based on the assessment.

Care Planning and Implementation

- Prioritizing youth and family preference when determining which strategies will be implemented to meet their goals.
- Identifying appropriate services and supports.
- Developing and implementing a coordinated care plan.
- Identifying methods to measure outcomes of goals.

Teaming

- Ensuring families have input regarding who is on their Child and Family Team.
- Engaging families as full and active partners in the process.
- Creating a decision-making method that is a joint activity with the youth and family.

Monitoring and Adapting

- Identifying services based on individualized need.
- Continuously evaluating the coordinated care plan and modifying it to ensure services are effective and appropriate.
- Understanding that setbacks don't reflect resistance.

Transition

- Recognizing that the youth and family are key in identifying resources and supports.
- Viewing the community as the preferred resource.
- Developing a transition plan and adapting level of care.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Accessing Targeted Care Coordination

Access Through Independent Assessment/ YES 1915i Waiver*

1 Independent Assessment (CDA and CANS)

2 Complete Medicaid Eligibility

3 Youth/Family provided list of TCCs

4 Family chooses TCC; calls to make appointment

Targeted Care Coordinator

Access Through Provider/ Traditional Medicaid

1 Youth/Family request a TCC from Provider

2 Provider refers family to a list of TCCs

3 Family chooses TCC; calls to make appointment

Targeted Care Coordinator

**YES 1915(i) waiver members are required to have TCC and to have a PCSP that is submitted to Optum.*

CLICK HERE TO RETURN TO TABLE OF CONTENTS

CANS Orientation for Child and Family Team

The CANS Tool

The Child and Adolescent Needs and Strengths is a tool that uses the information gathered during an assessment to create a record of the youth and family's strengths and needs. Strengths are areas of the youth's and family's life where they are doing well or have an interest or ability. Needs are areas where the youth and family needs support.

In addition to identifying strengths and needs, the CANS is used to:

- Capture information about the youth's ability to function within their family and community.
- Determine if the youth has a functional impairment.
- Create meaningful care plans.
- Monitor the outcome of services.
- Provide a common language for providers, youth and families to use when discussing strengths and needs.

Completing a CANS

The CANS is organized into individual and family life domains (areas). Each domain contains items that specifically relate to that area. The provider, youth and family use the information gathered during the assessment to work through each item in the CANS. They discuss items and collaboratively decide how to rate the items on a 4-part scale. Through this work the provider, youth and family are able to identify the strengths and needs of both the youth and family.

The ratings as determined by the provider, youth and family are then used to help determine the amount of support the youth and family need. After the CANS is complete, the provider talks to the youth and family about the results to make sure they are accurate and reflect their story. The family should receive a copy of their CANS, so they can review and refer to it during care planning.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Some of the domains identified in the CANS are not considered in other types of functional assessments and are part of what makes the CANS unique. The core CANS domains and some examples of the items under the domain are listed below:

Exposure to Potentially Traumatic/Adverse Childhood Experiences Domain

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect

Strengths Domain

- Family
- Interpersonal skills
- Talents/interests

Life-Functioning Domain

- Living situation
- Social functioning
- Resourcefulness
- Sleep

Cultural Domain

- Language
- Identity

Behavioral-/Emotional-Needs Domain

- Emotional and/or physical regulation
- Attention/concentration
- Depression
- Anxiety

Risk Behaviors Domain

- Suicide
- Self-harm
- Danger to others

Caregiver Resources and Needs Domain

- Physical health
- Mental health
- Substance use
- Involvement with care

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Using the CANS

The CANS is used in different ways to help improve the lives of youth and families. It can be used in care planning, for measuring outcomes and as a communication tool.

Care planning

One of the most significant ways the CANS is used is in care planning. When the Child and Family Team meet to plan the youth's treatment, they discuss the CANS ratings to make sure that the youth and family's strengths and needs are included in the plan. Sometimes a plan may focus on a subset of the youth and family's strengths and needs.

Need items identified within the CANS with a 2 or 3 rating should be considered when determining the youth's goals for improvement.

Strength items identified within the CANS with a 0 or 1 indicate a strength that can be used throughout treatment.

Measuring outcomes

Youth and families' needs and strengths may change over time due to mental health support, and the CANS should be updated to reflect these changes. One of the ways to determine if supports are helping is to revisit the CANS and track changes. This may be done upon request or when there is a substantial change that indicates the need for re-assessment outside of the standard 90-day update schedule. The youth's plan can then be updated to more accurately reflect their current strengths and needs.

Communication tool

The CANS provides a common language for providers, youth, families and their formal and informal supports to use when discussing the youth's mental health. It can also provide a picture of the progress that's been made and can help with recommendations for future care.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Targeted Care Coordination

Phases and Description of Targeted Care Coordinator Tasks

Tasks	Resources
Phase 1: Engagement	
1. Targeted Care Coordinator makes initial contact(s) with youth and family (telephonic or in-person) prior to first CFT meeting. 2. Gather necessary documents (for example: Comprehensive Diagnostic Assessment (CDA), CANS, psychological testing, current treatment plans, Individualized Education Program (IEP), etc.) 3. Complete intake and needed Release of Information (ROIs). 4. Complete Informed Consent/Confidentiality. 5. Build rapport and listen to family's description of life experiences. 6. Address immediate needs and/or potential risk of crisis. 7. Link to primary master's level clinician if not already established (family is given options and choice of agency and provider). 8. Orient the family (and identified CFT members) to TCC, CFT process, and CANS (initial in-person or phone contact.) 9. Identify CFT members and informal supports 10. Review and/or update CANS and ensure the primary treating master's level clinician agrees to Targeted Care Coordinator completing/updating the CANS. The initial or annual updated CANS can be completed in conjunction with an initial or updated Comprehensive Diagnostic Assessment, by the Independent Assessor or the treating clinician. 11. Identify actionable CANS items. (Actionable items are strengths scored 0 or 1 and needs scored 2 or 3.) 12. Develop a strategy with the family to share CANS items and family goals with the rest of the team during the first CFT meeting. (Could include all scores or just actionable items.) 13. Identify agenda for first CFT meeting taking into account any sensitive information and areas of difficulty. 14. Schedule first meeting.	***Documents to Complete/ Update/Acquire:*** *Documents included in this TCC Toolkit are marked with an asterisk (*) and a link is provided.* ▪ Intake » PCSP OSSM Consent Form » Agency intake paperwork » ROIs » Informed Consent » Etc. ▪ CANS ***Resources for Family/Team:*** ▪ ***CANS Orientation**** ▪ ***YES*** and ***Praed*** websites ▪ ***YES System of Care**** ***Resources for Targeted Care Coordinator:*** ▪ ***YES System of Care**** ▪ ***Accessing TCC Flowchart**** ▪ Phases of CFT and Description of TCC Tasks (pages 9-12)* ▪ ***CFT Facilitation Skills tip sheet****

(Phases and Description table continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Tasks	Resources
Phase 2: Planning and Assessment	
1. Targeted Care Coordinator facilitates CFT meetings geared towards developing the Person-Centered Service Plan from the CANS in collaboration with the youth/family, the master's level clinician, and any other CFT members. 2. Meetings include: ▪ Introduction/Agenda ▪ Informed consent/confidentiality ▪ Development of the PCSP: » Ground rules » Review family's vision/goals for the future and identify goals of the whole team » Identify plan to address conflict within the team » Review the updated CANS and choose/review priority actionable items » Develop goals or outcome statements » Identify strengths that can be used by the team to address goals/ actionable items. » Identify crisis plan ▪ Assign action items to team members 3. Facilitate consensus from all CFT members and assist in resolving disputes. Follow up with youth/family and team members between meetings (at least every 30 days) to check on assigned action items and monitor the youth's status. 4. Link youth/family to identified and agreed upon services: ▪ *Note: The youth and family should be offered more than one option of providers for each service needed. There may not always be multiple options for certain services and in those cases, please note on the PCSP.* 5. Distribute copy of PCSP via the PCSP portal to family and anyone else the family is allowing access (using the PCSP OSSM Consent form).	***Documents to Complete/ Update/Acquire:*** *Documents included in this TCC Toolkit are marked with an asterisk (*) and a link is provided.* ▪ Person-Centered Service Plan ▪ CANS ▪ PCSP OSSM Consent form ***Resources for Targeted Care Coordinator:*** ▪ Person-Centered Service Plan form and instructions ▪ ***YES System of Care**** ▪ Phases of CFT and Description of TCC Tasks (pages 9-12)* ▪ ***CFT Facilitation Skills tip sheet****

(Phases and Description table continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Tasks	Resources
Phase 3: Monitoring and Adapting	
1. Implement the person-centered service plan. 2. Follow-up CFT meetings based on need of the member/family. Meetings are prompted when: ▪ A parent or youth requests a meeting. ▪ The identified strengths and needs change. ▪ The existing services and supports are not working as expected. ▪ New resources are available. ▪ The progress towards a goal is slower than expected. ▪ The goals are met, and new goals need to be identified. ▪ There is a decrease in safety or a risk of crisis. 3. CANS updated as needed and at least every 90 days. 4. Share changes to CANS score with the team. 5. Address CANS areas that the team chooses not to prioritize. 6. Update plan as needed and at least annually, including changing strategies that have not been effective and adjusting services based on progress. 7. Celebrate successes. 8. Ongoing coordination and monitoring of services identified on the PCSP. 9. Ensure the medically necessary services are accessed, coordinated, and delivered in line with the YES Principles and Practice Model. 10. Continue to meet with the family and/or coordinate services and complete daily and weekly tasks outside of the CFT meeting. 11. Ensure that the plan is aligned and coordinated across the youth-serving systems and youth is being served in their community in the least restrictive setting. 12. Ensure all documentation is up to date (treatment plan changes, IEP, etc.). 13. Coordinate the collection of team minutes and conduct regular progress reports/notes.	***Documents to Complete/ Update/Acquire:*** *Documents included in this TCC Toolkit are marked with an asterisk (*) and a link is provided.* Person-Centered Service Plan ▪ CANS ▪ Progress notes from meetings ***Resources for Targeted Care Coordinator:*** ▪ Person-Centered Service Plan form and instructions ▪ ***YES System of Care**** ▪ Phases of CFT and Description of TCC Tasks (pages 9-12)* ▪ ***CFT Facilitation Skills tip sheet****

(Phases and Description table continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Tasks	Resources
Phase 4: Transition	
1. Improved CANS scores inform the team and plan of nearing transition (for example when action items (needs 2-3) become non-action (needs 0-1.) 2. Transition out of formal services occurs after discussion and consensus among team members. 3. Develop plan of transition with the CFT in a meeting that describes: ▪ How ongoing services will be accessed. ▪ Crisis plans that include a communication plan in case of emergency. ▪ Follow-up phone numbers for all team members that may be contacted. ▪ Effective use of natural supports and community resources. ▪ Indicators that a youth may need to return to the CFT/Targeted Care Coordinator. ▪ Formal discharge plan that describes strengths of the family, successful interventions, and ineffective interventions. ▪ The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met. ▪ The discharge/aftercare/safety plan describes specific follow up activities. 4. Ensure youth/family have a way to access services in the future. 5. Targeted Care Coordinator is also responsible for linking the youth to higher and lower levels of care throughout the duration of treatment. 6. If the youth transitions, for example, to a higher level of care during or after a crisis, the Targeted Care Coordinator coordinates between systems as the youth transitions. This includes updated CANS/PCSP as needed.	***Documents to Complete/ Update/Acquire:*** ▪ Person-Centered Service Plan » Transition Plan reviewed and agreed upon ▪ CANS ▪ Discharge Summary

Tips for Facilitating a Child and Family Team Meeting

Family and CFT Orientation (Prior to first official CFT meeting)

- Be diligent in reaching out to youth and families in ways that are welcoming and comfortable for them.
- Take time to listen to the family's story and perspective.
- Use language and body language that demonstrates a non-judgmental approach to understanding the family's situation.
- Be open and honest about mandated reporting requirements, the role of systems, mental health, regulations, and choices about sharing of information among team members.
- Encourage and support the participation of youth and families in identifying their individual treatment and services. Ensure that they understand what is and is not in their control.
- Take the time to explain the CFT process, CANS assessment, and answer questions. (Provide handouts and resources if family and team members want to learn more, for example; ***yes.idaho.gov***, ***praedfoundation.org***).

Introduction and Review Agenda

- Targeted Care Coordinators should have a discussion with youth and family before the meeting about what to expect, who will be there, and potential topics being addressed.
- Be attentive to who sits where. Some facilitators find it helpful to use name markers, assign seats, and have the youth and family arrive prior to the rest of the team.
- Asking the youth and family to introduce themselves first is one way to put family-centered and youth voice and choice principle into practice.
- Have each team member introduce themselves and identify their role/responsibility.
- Provide a copy of the CFT meeting agenda.
- Remember to refer team members to where on the agenda their concerns will be addressed, if it is not the right time in the meeting.
- Use "ice breakers," or creative ways to help the team members get to know each other.

Ground Rules

- Come to the meeting with a framework of ground rules in mind.
- The term "ground rules" may need to be explained.
- Encourage "balanced" participation from all members. Encourage quiet members to speak/contribute so the process is collaborative and team-based.
- It may be helpful to ask the team how some of the rules tie to the YES Principles of Care.
- Help "shape" the rules to be applicable to the entire team rather than singling anyone out.
- Positively framed rules are preferable to negatively framed rules.
- Review ground rules in every meeting and adapt as needed.
- Use a whiteboard or bring a big poster notepad to record ground rules and use for brainstorming throughout the meeting.

Reviewing Strengths and Needs CANS

- Identify and discuss strengths first, before identifying needs.
- Reference and share the useful strengths identified in the CANS.
- Gently re-frame deficit-based language and inappropriate language.
- If the team struggles to identify strengths, point out strengths you have seen while working with the family.
- Discuss needs identified on the CANS with the youth and family prior to the first meeting and have agreement with them on which needs represent their current challenges. This will help you come to the first meeting with a prepared list of needs to begin forming goals and brainstorming strategies.

Defining and Prioritizing Needs/Goals

- Use SMART goals (Specific, Measurable, Achievable, Realistic, and Time-Limited).
- Positively framed goals are preferable to negatively framed goals.
- Goals must be individualized and fit within the family's culture.
- Choose just a few goals to start. Plans with too many goals can lead to complicated plans that are hard to follow. You can move on to new goals/needs later in the process, after some have been addressed. Link at least one goal to anestablished behavioral health service.

Resolving Conflict

- Identify a process to resolve conflicts at the initial meeting and make sure it is documented on the person-centered service plan.
- Clarify areas of agreement and disagreement and focus on areas of agreement.
- Help team members look at all the options and see their choices.
- Find and remind the team members of the common goals.
- Allow breaks for de-escalation, if needed.

Brainstorming Strategies

- Lead the team in brainstorming multiple strategies for one outcome/goal at a time.
- Record all strategies identified; even if far-fetched (try not to let the team judge the ideas).
- Strategies should help achieve goals and meet needs.
- Allow the youth and family to select the strategies that work best for them and fit with the family culture.
- Include strategies that draw from the strengths of the youth and family.
- Make sure each strategy includes a specific action step that is assigned to a specific team member(s).
- Have the team pick the top 1-3 strategies for each need/goal.

Action Steps

- Assign action items to specific team members based on strengths identified.
- Follow up with assigned tasks in between CFT meetings.

Person-Centered Service Plan Development

- Make sure the person-centered service plan honors the 11 YES Principles of Care.
- It may be helpful to review the PCSP process document before completing the member's PCSP, as the process document contains ground rules for the CFT meeting and resolution strategies for conflicts within the CFT, both of which are essential for effective facilitation. It may be helpful to discuss these components toward the beginning of the meeting vs the end.
- If youth and family responses are limited, try using open ended questions when possible.
- Please ask the family all required questions on the form. "None identified" or "Family declined to answer" are acceptable responses if the question doesn't apply to that particular family's situation.
- Be conscious of applying a trauma informed lens to CFT meetings and PCSP development.

  For example, if there is a history of trauma and/or Oppositional Defiant Disorder (ODD) diagnosis, develop goal tied to emotions and core needs, rather than "the child will follow directions" or "the child will do what they are told" which addresses only background needs.
- Ensure that the youth and family are offered their choice of providers for each service identified within the PCSP.

  If only one option is available in that member's region, please note that on the plan.
- Select at least one established behavioral health service to support at least one of the goals listed in the plan.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- To ensure consistency and consensus, it would be helpful to summarize the PCSP (strengths, needs, actionable items, goals, owners of tasks, and ultimate vision for the family's future) at the end of the CFT meeting.
- If you are making a change to an existing PCSP, it must be signed and dated by the participants who are responsible for implementing the change as well as the Targeted Care Coordinator. Signature date(s) must be aligned to the most recent CFT meeting date to reflect agreement with changes made.
- If the family needs the PCSP translated to another language in order to understand it, please make those arrangements prior to submitting the PCSP to Optum for Code of Federal Regulations (CFR) review. The PCSP submitted to Optum for review must be in English.
- Optum only needs to review the PCSPs for YES members, and not traditional Medicaid members. This can be checked the same way you check a member's eligibility on Provider Express. Please refer to: ***Identifying Member YES Eligibility*** in this document.

Schedule Next Team Meeting

- Schedule the next meeting at the beginning of the meeting to ensure all members are present.
- When considering time, dates, and locations for meetings, ensure family-centered, youth voice and choice, and cultural/linguistic needs are put into practice.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

TCC Qualifications and Responsibilities

Service Description

Targeted Care Coordination is the process that assists youth and their family to locate, coordinate, facilitate, provide linkage, advocate for, and monitor the mental and physical health, social, educational, and other services as identified through a child and family teaming process that includes assessment and reassessment of needs and strengths. Targeted Care Coordination occurs through face-to-face or telephonic contact and is not intended to be duplicative of any other service. Targeted Care Coordination services vary in intensity, frequency, and duration in order to support the member's ability to access, coordinate, and utilize services and social resources that support the member to reach the goals on their coordinated care plan. Targeted Care Coordination can be delivered as a community-based service or in the outpatient clinic setting. Additionally, Targeted Care Coordination can be provided to members transitioning out of an inpatient or residential treatment. Targeted Care Coordination can be provided up to 180 days prior to the member's discharge from the inpatient or residential facility. All treatment, care, and support services must be provided in a context that is child-centered, family-focused, strengths-based, culturally competent and responsive to each child's psychosocial, developmental and treatment needs.

Targeted Care Coordination must be consistent with the Principles of Care and the Practice Model of the Idaho Youth Empowerment Services system of care.

Provider Qualifications

A provider who holds at least a bachelor's degree in a human services field and has completed the required Optum Idaho Targeted Care Coordination training and is practicing under Optum supervisory protocol.

OR

A provider who holds at least a bachelor's degree and has become a Certified Case Manager (CCM) through the Commission for Case Manager Certification (***ccmcertification.org***) and has completed the required Optum Idaho Targeted Care Coordination training.

For information on the required Targeted Care Coordination trainings, please go to ***optumidaho.com*** > For Network Providers > Provider Trainings.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Responsibilities

Targeted Care Coordination is provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment needs.

A Targeted Care Coordinator:

- Provides support and validation through engagement to gain trust to develop and maintain a constructive and collaborative relationship among the youth, family, and involved network providers, community stakeholders, child-serving systems and other formal and informal supports.
- Coordinates and facilitates the Child and Family Team Interdisciplinary Team Meetings face-to-face with the family and member present.
- Works with the CFT to develop an outcomes-focused, strengths-based person-centered service plan that includes both formal and informal services and supports.
- Coordinates and facilitates the CFT face-to-face with the member and family present to assess and/or reassess the strengths and needs to determine if changes are needed to update or modify the person-centered service plan. This can be done through Telehealth for a master's independently licensed clinician.
- Serves as a care navigator for the family and is responsible for promoting integrated services, with links between child-serving providers, systems and programs.
- Ensures that services are accessed, coordinated, and delivered in a strengths-based, individualized and relevant manner and that services and supports are guided by family voice and choice.
- Manages documentation of a CFT meeting including a description of the CFT interdisciplinary collaboration that occurred (date, duration), names of the attending participants, and the recommendations agreed upon in the meeting.
- Documents updates of the person-centered service plan and distributes to CFT team participants.
- Works with the member's clinician to update the CANS at least every 90 days or more frequently as needed. If the Targeted Care Coordinator is certified in CANS and has access to the ICANS platform, they may complete the CANS initial/annual and updates.
- Monitors to ensure that outcomes of services and activities are progressing appropriately by evaluating the goals and interventions documented on the PCSP.
- Is responsible for linking, monitoring, and follow up activities, to ensure that the youth and family's needs are met.
- Is responsible for engaging the CFT to develop a crisis/safety and transition plan, which is documented as a part of the PCSP.
- Facilitates the development of a conflict resolution process to resolve disagreements within the Child and Family Team, which is a part of the PCSP.
- Makes contact with the member and the member's family or guardian at least every 30 days. If the Targeted Care Coordinator cannot reach the member or member's family or guardian, they should document attempts made and a plan to re-establish contact.

Additional Information

Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.

Targeted Care Coordination services may be provided using Telehealth. See the Telehealth Services section of this manual for additional information.

Care Coordination Activities: The Targeted Care Coordinator will be reimbursed for care coordination activities under the following conditions (42 CFR 440.169):

- Collecting and compiling information to support assessment activities.
- Referral and coordination to arrange for services and related activities.
- Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.

Supervisors delivering direct services to a member may also supervise that member's Targeted Care Coordinator if there are no other options available to the member. As a reminder, it is best practice to separate direct supervision of another professional who is also providing services to the same member as the supervising clinician.

- Members who are engaged in Targeted Care Coordination should not be receiving Behavioral Health Case Management as this is duplication of services.
- Targeted Care Coordination services cannot be duplicative of any services or activities that the member is already getting from any hospital or residential discharge coordinators. Targeted Care Coordinators should work collaboratively with the hospital or residential discharge coordinators to ensure that treatment goals are not duplicative.
- Targeted Care Coordinators are not to provide other direct services to the member.
- Members engaged in Targeted Care Coordination must have a Child and Family Team (CFT) and a person-centered service plan (PCSP). If a member is a participant in the YES Program, their PCSP must be reviewed by Optum to ensure that the plan meets CFR requirements. Information on how to submit a PCSP to Optum for CFR review through the Optum Support and Service Manager (OSSM) tool is included in this Toolkit.
- Families who are working with a case manager at the IDHW Developmental Disabilities Program or Children's Mental Health (CMH) for Idaho WInS (Wraparound Intensive Services) plans or 20-511A do not need a Targeted Care Coordinator or PCSP. Those members will continue to work with their current case manager and develop a PCSP with them. To avoid duplication of services, each member should only have one PCSP that includes services accessed through all programs. If a family is unsure if they are working with an IDHW case manager, you can contact Medicaid for more information at **1-866-681-7062**.
- Liberty Healthcare conducts the independent eligibility assessments for both the YES Program and DD 1915(i) support services. There are some similarities between the two processes; however, separate assessments are required for each program and families will apply for each separately. This is because DD and YES are separate populations requiring different assessments and the Liberty contracts for each population have different requirements. Members who do not go through the independent assessment process do not need a Targeted Care Coordinator, though they are welcome to have one if they want Targeted Care Coordination.
- Members who moved from traditional Medicaid to the YES Program for Respite services may move back to traditional Medicaid if Respite is no longer needed or wanted. In this situation, the member does not need to obtain Targeted Care Coordinator or a PCSP. These members will receive notification from Self Reliance when it's time for renewal. They should follow their instructions to complete a redetermination at that time.
- The CFT meetings are conducted by the Targeted Care Coordinator and member/member's family face-to-face and an independently licensed clinician (or master's-level clinician working under supervisory protocol) must participate face-to-face or telephonically.
- Care Coordination Activities: The Targeted Care Coordinator will be reimbursed the following for care coordination activities:
  - Collecting and compiling information to support assessment activities.
  - Coordinating the Child and Family Team (CFT) meetings to ensure scheduling works for all attendees.
  - Compiling information to ensure all information is ready for the Child and Family Team.
  - Collecting and distributing documentation for CFT meetings.
  - Compiling the finished PCSP, submitting for CFR review, and distributing to the CFT.
  - Arranging referral and coordination for services and related activities included in the PCSP.
  - Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.
  - Targeted Care Coordination via Telehealth: Independently licensed master's level clinicians can provide TCC via telehealth.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

TCC Billing

Effective as of January 1, 2020

Authorization/Limits: ***No prior authorization is required.***

Fee Schedule Update: ***Effective as of January 1, 2020***

As of January 1, 2020, the reimbursement rate for TCC activities is the same reimbursement rate as face-to-face and telephonic services. Optum requires the use of modifiers to distinguish the type of TCC services provided as well as by what level of professional and whether service is rendered via telehealth. Please note that multiple modifiers may be applicable to one date of service.

Billing Targeted Care Coordination

TCC is billed with code T1017. Applicable modifiers are listed below:

Modifier	Description
U3	Targeted Care Coordination*
U2	Service rendered by a Certified Case Manager.
UA	Care Coordination Activities (See "Care Coordination Activities" below.)
HO	Master's level provider operating under supervisory protocol (i.e. LMSW)
HN	Bachelor's level provider operating under supervisory protocol. (In the case of the CANS, those with a CCM Certification would bill using the U2 modifier rather than HN.)
GT	Service rendered via telehealth. (See the Telehealth policy in the Optum Idaho Provider Manual.)

**T1017 without a modifier is identified as Case Management. The addition of the U3 modifier allows a higher reimbursement level for Targeted Care Coordination and identifies TCC as the service rendered.*

Please note that multiple modifiers may be applicable, depending on the context. For example, if a master's level provider operating under supervisory protocol is delivering Care Coordination Activities, they would bill T1017 HO UA.

T1017 – Targeted Care Coordination Service

Targeted Care Coordinators bill this code with the applicable modifier(s) for facilitating a Child and Family Team and completing check-ins with the member. Targeted Care Coordinators also bill this code when conducting meetings or calls between the member, the Targeted Care Coordinator and the provider outside of a CFT, etc. This code can be used face-to-face or
telephonically (see the table above for applicable modifiers).

Care Coordination Activities: The Targeted Care Coordinator will be reimbursed for care coordination activities under the following conditions (42 CFR 440.169):

1. Collecting and compiling information to support assessment activities.
2. Coordinating the Child and Family Team meetings to ensure scheduling works for all attendees.
3. Compiling information to ensure all information is ready for the Child and Family Team.
4. Collecting and distributing documentation for CFT meetings.

5. Compiling the finished PCSP, submitting for CFR review, and distributing to the CFT.
6. Referral and coordination to arrange for services and related activities included in the PCSP.
7. Follow up to coordinating care to ensure services are provided and member's needs are adequately addressed.

Billing Codes and Modifiers for TCC-related services are found on the table below. For detailed information on how to bill this service, including applicable modifiers, please consult your fee schedule.

CPT Code	Description	Unit
CANS		
H0031	CANS Assessment/Update for youth under 19 years of age.	15 minutes
Mileage Reimbursement		
T2002	Transportation and mileage reimbursement only available in conjunction with the following services: 90791, 90792, 90846, 90847, 90832, 90833, 90834, 90836, 90837, 90838, H0031, H1011 and T1017.	Per mile
CFT (For Providers other than the TCC in attendance)		
G9007	Child and Family Team (CFT) Interdisciplinary Team Meeting	15 minutes

H0031 – CANS

Optum network providers who are independently licensed clinicians (or master's level clinicians working under supervisory protocol) and bachelor's level paraprofessionals involved in the member's care who are certified in the CANS can bill for the initial/annual CANS (if one has not yet been completed) and CANS updates.

If a Targeted Care Coordinator administers the CANS, they bill the CANS code (H0031) with the applicable modifier(s) when completing and/or updating the CANS. CANS certified master's level clinicians can complete the CANS assessments utilizing telehealth services (see the Telehealth policy in the Provider Manual). Per the Provider Manual, the CANS assessments cannot be completed telephonically.

A CANS-certified bachelor's level paraprofessional in a human services field can complete CANS assessments. Per the Praed Foundation, CANS certified bachelor's degree individuals can complete the CANS, however, may need to refer some more difficult applications to a CANS certified master's level clinician. The CANS should not be conducted in a standalone appointment. Best practice when completing the CANS initial, annual and 90-day updates is to align with other behavioral health appointments to better assist members, especially if a member is receiving multiple behavioral health services. It is best practice to coordinate with the member's other behavioral health providers in order to not duplicate CANS assessments for the member.

The CANS must be administered face-to-face with the member and member's family present, or via telehealth when appropriate and if done by an independently licensed masters level clinician (See "Telehealth" in the Provider Manual).

To bill and be reimbursed for the CANS, providers must use the ICANS platform. The CANS must be entered into the ICANS system by any individual that has access to the ICANS system. The CANS assessment must be signed and finalized by the provider who administered the CANS.

To register for the ICANS platform, providers are required to sign and submit an Agency Agreement, Authorized User Agreement for each staff, and attend ICANS System training. For more information about this requirement, please navigate to ***https://icans.dhw.idaho.gov.*** For more information regarding provider qualifications and responsibilities related to CANS, please see the Provider Manual.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

T2002 – Mileage Reimbursement

Targeted Care Coordinators bill mileage reimbursement in conjunction with TCC (T1017) and/or CANS (H0031) for the time spent driving to meet a member for Targeted Care Coordination and/or a CANS assessment.

CANS certified master's level clinicians and CANS certified bachelor's level paraprofessionals can be reimbursed for mileage when completing the CANS assessment whether initial, update, or annual in the member's home. If providing multiple CANS assessments to different household members during the trip, best practice are to claim the mileage code one time.

G9007 – Child and Family Team Inter-Disciplinary Team Meeting

This code is billed by providers other than the Targeted Care Coordinator in attendance at the CFT. (Applicable modifiers:
U1 – prescriber; **HO** – Masters; **HN** – Bachelors; **HM** – Less than Bachelor's level)

Note: Targeted Care Coordinators bill the TCC code (T1017) with the applicable modifier(s) while facilitating CFT meetings. The other providers at the CFT may bill the CFT code (G9007) using the applicable modifier(s).

Other Notes and Updates

Case Management Billing Code

Please note that T1017 without the addition of a modifier is identified as Case Management. When applicable modifiers are added to T1017, various job functions of a Targeted Care Coordinator are identified (e.g. U3 for TCC, UA for TCC Care Coordination Activities). Please consult the table above for a listing and description of modifiers applicable to TCC.

Master's Level Reimbursement Rate for Targeted Care Coordinator

Master's level professionals who provide TCC services are reimbursed at a higher rate.

Certified Case Manager Reimbursement Rate for TCC

CCM certified professionals who provide TCC services are reimbursed at a higher rate.

Targeted Care Coordination via Telehealth

Independently licensed master's level clinicians can provide TCC via telehealth from one originating location to one distance site. Please refer to Optum's Telehealth guidelines in Optum Idaho's Provider Manual (Page 18). The Provider Manual is located on our website: ***optumidaho.com*** > For Network Providers > Guidelines & Policies > Provider Manual.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Person-Centered Service Plan

PCSP Form Instructions & Key Fields

Important Things to Note Before You Begin

- ***Form content must be keyed into the fillable PDF; handwritten forms will not be reviewed.***
- ***Fields which help the PCSP meet the Code of Federal Regulations (CFR) are indicated below as "(CFR)".***

Key Fields	Tips to Completing the Form
My Contact Information	Ensure the member's Medicaid ID, first name, last name, and DOB are completely correct as well as the TCC's contact information. **(CFR)** ▪ When documenting, ensure the plan does not incorrectly list another child's or sibling's name.
Getting to Know Me	**These questions help meet CFR**: ▪ What do I like to do and what is really important me? ▪ What are my talents and strengths? ▪ What type of things do I enjoy doing with family/ friends, and what are my relationships like with family members/ friends? ▪ Is there anything about my ethnicity, faith, language, or culture that we should keep in mind?

(PCSP Form Instructions table continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Key Fields	Tips to Completing the Form
My Risk Factors, Back-up Plans & Crisis Plan	▪ Developing a clear, robust, and realistic crisis plan is an essential tool for families and members. A crisis plan allows the family to maintain some degree of control over a situation that might otherwise feel out of control. It can give families a sense of power and offer options for times when decision making is difficult. Documenting clear strategies in advance can assist families in feeling prepared and supported when it is most imperative to the well-being of the member. ▪ If a risk to the member is identified elsewhere within the PCSP, ensure that it is addressed within the Crisis Plan. **(CFR)** ▪ In order to enhance the crisis plan, it would be helpful to include an emergency contact of a support outside of the household. ▪ Consider also adding the Optum Member and Crisis Line (**1-855-202-0973**) as an emergency contact option.
Assessments and Diagnosis	▪ Functional Assessments: Needs to be completed; include CANS date. **(CFR)** » If the CANS was updated since the original PCSP was created, include the most recent CANS date and information. ▪ "What does my CANS and other assessments say about me?" » Include at least one strength and one need from the CANS. **(CFR)** » Include the overall CANS score. **(CFR)**
My Goals and Recommended Services and Supports to Reach Each Goal	▪ Use the "Select a Service" field which corresponds with each identified goal to choose an established behavioral health service which will help the member achieve the goal. ▪ Use the "Other" option to write in informal services, e.g. karate class, church group, etc. ▪ All services identified within the OSSM platform should be linked to a goal within the PCSP. ▪ Do not include services and a provider if that provider is not aware of the member's need for them. » If the CFT decides that a service may be appropriate, the referral to a provider for assessment may be documented within the PCSP, but the service would not be included in this section, nor does that provider have to sign the PCSP before it can move forward for CFR review. Rather revisit that service at the next CFT meeting.
Transition Plan	▪ A transition plan can assist families in strategizing for changes in levels of care—whether planned or unplanned. ▪ Transition plans can aid members transitioning from one phase of life to another (e.g. from childhood to adulthood). ▪ They can help families anticipate upcoming changes. ▪ Proactively planning for transitions in advance can benefit families by creating predictability, stabilization and safety during times of change.

(PCSP Form Instructions table continued on following page.)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Key Fields	Tips to Completing the Form
Member and Family Signatures	▪ The following three yes/no questions in this section need to be answered. If the answer to any of these questions is "no," the plan will not meet. **(CFR)** » Was the child/youth and family given the opportunity to choose who participated in his/her/their person-centered service plan development? » Was the child/youth/family given the opportunity to choose the time and location of the person-centered service planning meetings? » I agree that the plan is written in language I can understand. ▪ All signatures of Targeted Care Coordinator, member, parent/guardian need to be documented. **(CFR)** ▪ Service Providers: Assure that all mental health and substance use providers within the Optum Network that are treating the member (as listed on the PCSP) have signed the PCSP or provided their agreement via email. If a member is receiving direct services from any of these providers, they must be listed on the PCSP and agree/sign. » If a provider attended by phone or missed the CFT meeting, they should email or provide in writing (email acceptable) their agreement with the PCSP to the TCC. The Targeted Care Coordinator's signature represents their agreement they have all applicable CFT team members' approvals on file. » For providers not within the Optum Network, an exemption can be made that they do not have to sign the PCSP, however all efforts should be made to obtain agreement and signature and these attempts should be documented.
Person-Centered Service Planning Process *Note: This is an additional PCSP document at the end of the PCSP File.*	▪ Resolution strategies: Resolution Strategies for the CFT meeting itself, including any conflicts of interest must be documented here. **(CFR)** ▪ Service and provider options that were offered to the member: The member should be offered more than one option of provider for each established service recommended within the plan. We understand that in some areas, there may not be multiple provider options for certain services. In those cases, please note accordingly in this section. » Should the member already have an established provider, the provider may be included in the options offered. » Please ensure that the services selected match those marked as recommended within the OSSM platform and the goal section(s) of the PCSP. ▪ Facilitator's signature: Just like the PCSP, this document should be updated each time there is a PCSP developed and signed/dated accordingly.

Optum Supports and Services Manager and Person-Centered Service Plan Portal

Link to OSSM & Additional Information

https://www.optumidaho.com/content/ops-optidaho/idaho/en/providers/targeted-care-coordination.html

Key Fields	Tips to Completing the Form
Sending the PCSP to Optum	▪ Optum and Targeted Care Coordinators will interact using a tool called Optum Supports and Services Manager. ▪ For members with traditional Medicaid that do not have respite, DO NOT use Optum Supports and Services Manager and instead store the PCSP in the member's chart at the agency for auditing purposes. ▪ The OSSM Instruction Manual is available at ***optumIdaho.com*** > For Network Providers > Targeted Care Coordination. ▪ There is also an OSSM Tutorial available on Relias.
Members, Treating Providers, and Other CFT Members Accessing PCSPs	▪ Once the youth/family provide permission (see PCSP Consent form under "Forms" on ***optumidaho.com*** > For Network Providers > Targeted Care Coordination), the Targeted Care Coordinator goes into OSSM to grant other CFT members access to the PCSP document via the PCSP Portal. » Only PCSPs that have been reviewed and that have met CFR are available for view by CFT members in the PCSP Portal. ▪ All other CFT members (except the Targeted Care Coordinator) including informal supports in the youth/family's CFT will be able to access the PCSP through the secure, "read only," side of OSSM called "Person-Centered Service Plan Portal." ▪ To ensure protection of all members' records, all CFT members accessing the portal will need an One Healthcare ID. These can be created on the PCSP Portal. Please see separate instructions on creating an ***One Healthcare ID*** for more details.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

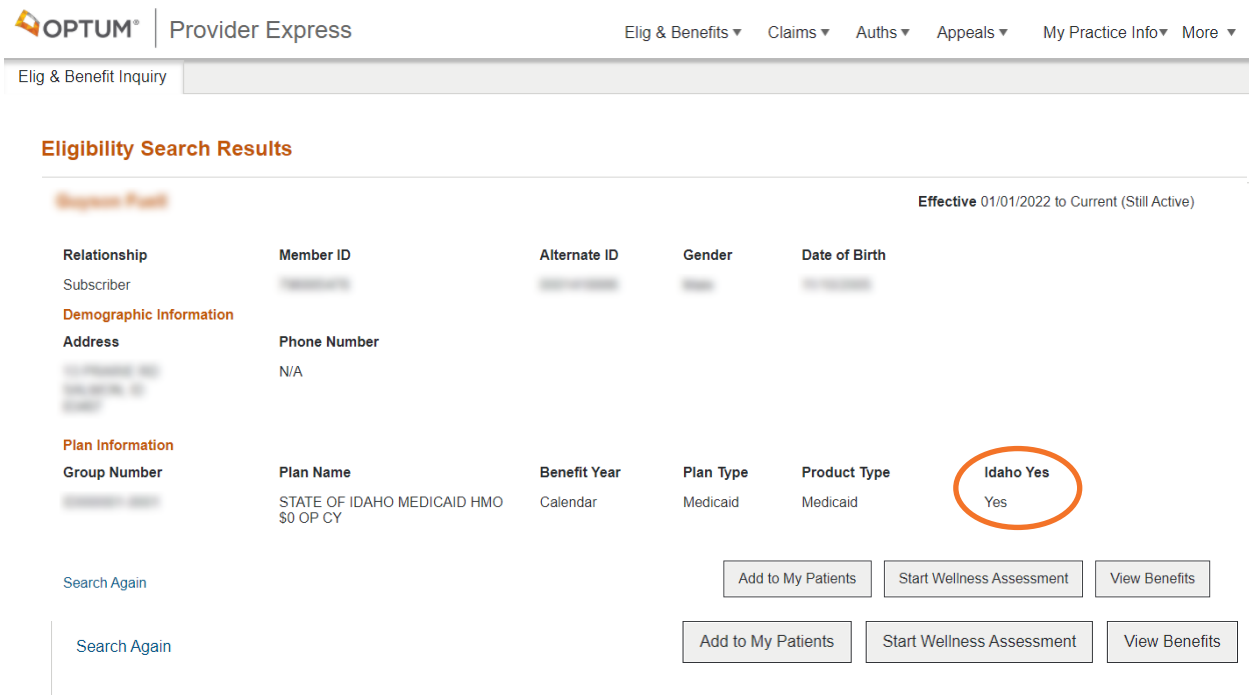
Identifying Member YES Eligibility

Optum only needs to review the PCSPs for YES members, who will have one of these client codes, as well as "YES" in their Group Name:

Client Code	Cosmos Group	Cosmos Contract/Group Name
Total Y.E.S. Non Duals		
N44	21910	Enhanced Child YES 0-18 Non Dual
YN36	21930	YES-Foster Care Title IV-E -ND
YN52	21972	YES-Aid to the Blind w/o Cash -ND
YN54	21995	YES-Perm/Term Disabl w/o Cash -ND
YN55	21996	YES-Homecare Disabl Child 133PL -ND
YN56	21998	YES-Refugee Medical Non Dual
YN61	22000	YES-Foster Care Non IV-E -ND
YN66	22002	YES-Presumpt Elig Pregnant Women Non Dual
YN67	22007	YES-Pregnant Women Non Dual
YN85	22084	YES-Enhanc/Transition MCD -ND
YN88	22091	YES-Basic Children 1 Non Dual
YN89	22092	YES-Enhanced Children 1 Non Dual
Total Y.E.S. CHIP		
YC60	22093	YES-Basic Children A 6-19 CHIP
YC63	22098	YES-Enhanced Children A 6-19 CHIP

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Below is how that looks in Provider Express when you check their eligibility:



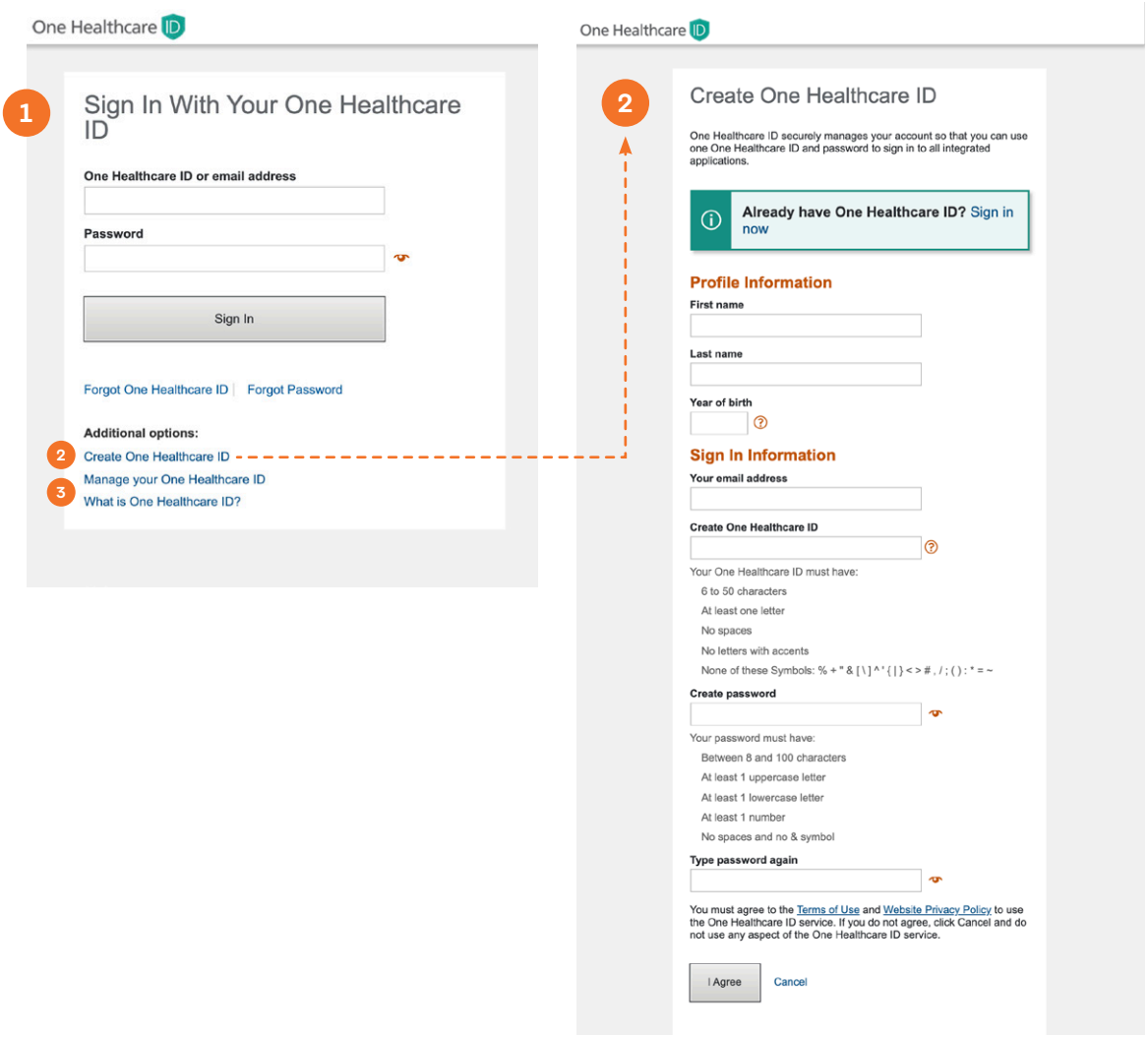
CLICK HERE TO RETURN TO TABLE OF CONTENTS

Creating a One Healthcare ID

Go to website: ***identity.onehealthcareid.com***

1. ***If you already have a One Healthcare ID***, login to One Healthcare ID.
   To reset your password, see the One Healthcare ID ***homepage***.
   To get your One Healthcare ID, also see the ***homepage***.
2. ***If you need to create a new One Healthcare ID***, see 'Additional options' and select 'Create One Healthcare ID'.
3. To manage your One Healthcare ID or learn more about it, also see 'Additional options'.
   Follow the steps needed for your scenario.

What you'll see when you visit the One Healthcare ID website:



CLICK HERE TO RETURN TO TABLE OF CONTENTS