



North Carolina Department of Health and Human Services  
**Division of Medical Assistance**

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Beverly Eaves Perdue, Governor  
Lanier M. Cansler, Secretary

Craigian L. Gray, MD, MBA, JD, Director

**MEMORANDUM**

**TO:** CAP/C Supervisors and Case Managers  
**FROM:** Teresa Piezzo, RN, BC, BSN  
Home Care Initiatives Manager  
**DATE:** September 30, 2009  
**RE:** Training Sessions, Rate Changes, FL-2 Forms, Website Changes,  
Incident Reports, Assistive Technology Expo, Seasonal  
Vaccinations, Freeze, Incontinence/Ostomy/Urological Supplies,  
Determination of Hours, Initial Assessment – Short Version,  
Referrals from PDN, Family-Centered Planning  
# 2009-10

**New Case Manager Training**

**DMA will offer training for new CAP/C case managers on Thursday, November 12, 2009. It will be held at DMA, in room 297 of the Kirby Building, from 9:00 AM to 4:00 PM. A sign-up sheet is attached.**

This training is an optional extension of the self-study case manager training. Completion of the CAP/C self-study case manager training is **required** before attending this in-house training. The self-study is located at <http://www.ncdhhs.gov/dma/capctraining/capctraining.html>. Allow plenty of time to complete the training, and submit your final exam prior to attending in-house training. The in-house training is an informal, small-group, interactive session in which we reinforce some of the more difficult and/or important concepts and have plenty of opportunity for questions and answers.

If you are interested in attending this training, please submit the attached registration form. If you are interested but unable to attend, this training is offered approximately every other month; be on the look-out for the CAP/C memos for information and registration.

**Refresher Case Manager Training**

**DMA will offer training for all CAP/C case managers on Monday, October 12, 2009. It will be held at DMA, in room 297 of the Kirby Building, beginning at 10:00 AM. The meetings will last until 4:00 PM or until all questions are answered, whichever is earlier. A sign-up sheet is attached.**

This training session is open to everyone except for those case managers who are new and have not yet attended a new case manager training. This will be an informal question-and-answer type session with no set agenda. If possible, please indicate your questions on the registration form; this will help us gather appropriate resources for you prior to the training session.

**AS OF THIS TIME, ONLY TWO AGENCIES HAS REGISTERED FOR THIS TRAINING SESSION. THIS TRAINNG SESSION IS, THEREFORE, AT RISK FOR BEING CANCELLED. PLEASE REGISTER AS SOON AS POSSIBLE IF YOU ARE INTERESTED IN ATTENDING.**

### **Special Training for Contracted Nurses**

**DMA will offer training for nurses who are contracted by case management agencies to do assessments and consultations. It will be held at DMA, in room 297 of the Kirby Building, on December 9, 2009 beginning at 10:00 AM. A sign-up sheet is attached.**

This training is open to both the nurses and the case manager supervisors responsible for contracting them. It will provide an overview of the CAP/C program, specific information regarding the assessment, and discussion of the nurse's consultative role in plan of care development, incident report review, etc.

### **Rate Changes**

Please note that there are many rate reductions which become effective October 1, 2009. Of particular importance to you will be the following new rates: Case Management \$57.72 per hour, Nurse \$36.72 per hour, and Nurse Aide \$14.16 per hour. Please refer to the new CAP/C and other fee schedules at <http://www.dhhs.state.nc.us/dma/fee/index.htm>, and to the October Medicaid Bulletin. Please do not submit a plan of care revision to DMA if the only change you are making is the adjusted rates. Make a 'pen and ink' revision, and include the rate changes on the next plan of care that does need to be submitted to DMA.

### **FL-2 Forms**

EDS has asked that hard copies of FL-2 forms not be sent via certified mail. This actually delays the approval process.

If you are using electronic FL-2s, when you submit your initial or CNR to DMA, please include a copy of the approval notification as well as the form that you submitted.

CMS regulations require annual level of care determinations, and restrict funding for services provided during the period of time that level of care has lapsed. CAP/C uses the FL-2 form as level of care determination. It is therefore important that FL-2s get done according to these federal regulations. Please use the following procedure:

- The 'level of care evaluation date' is
  - a. If called in to EDS, the date of the EDS approval.
  - b. If not called in to EDS, the date the physician signed the form.(Note that nothing has changed regarding whether or not the FL-2 is submitted to EDS)
- The next FL-2 must be approved or signed no later than this date the next year. For example, if you are working on your CNR that is due October 5, and at last year's CNR the physician signed the FL-2 on September 8, you must get this year's FL-2 signed on or before September 8.
- The FL-2 still must be obtained no earlier than the month before the CNR month. For example, if your CNR is due on October 5, September is your CNR month (the month during which you are working on the assessment and plan of care), so your FL-2 may be obtained in August. In our specific example, this year's FL-2 would need to be approved or signed no earlier than August 1 and no later than September 8.
- If you can foresee your FL-2 being done late (for example, at the time of the CNR, the child is out of state in a treatment program or because of a custody arrangement), please get the FL-2 approved or signed prior to the child's departure. This way, there is no lapse in resuming services once the child returns home, and the child can continue to receive services such as diapers or supplies that they still need while gone. A copy of this FL-2 should be sent to your consultant along with an explanation of why it was obtained. Send it when you obtain it; do not wait for the next CNR.
- The same applies if the child is hospitalized. Get an FL-2 so that you don't have to wait for it in order for the child to go home and so that there are no issues with Medicaid paying for the hospitalization.
- If you cannot obtain the FL-2 on time because the doctor is taking a long time to get it back to you, thoroughly document your attempts to get it; i.e., your follow-up phone calls. Please submit a copy of this documentation to your consultant so that we have it in our files in the event of a CMS audit.

- Remember, there can never be more than one year in between FL-2s, and there must be an FL-2 done within the two months prior to the CNR due date. So there may be times in which you will need to get an 'extra' FL-2 in order to get things back on schedule.

### **Website Updates**

You may have already noticed some of the updates to CAP/C information on the web. These changes include:

- An updated Parent Handbook
- An updated CAP/C brochure
- An updated CAP/C overview training
- An updated case management agency contact list
- New forms for: referral, physician's request for nursing services, participation notice, discontinuation of participation notice, service authorization for regular hours, service authorization for respite hours, discontinuation of service authorization, and incident report
- FAQ section updated

Please begin using the new forms immediately. This would be a good time to check to see that you are using the most current version of all of the CAP/C forms. Please also notify your discharge planners, CDSA workers, and other referral sources of the new referral form.

Look for the statewide Quality Assurance data for July 1, 2008 through June 20, 2009 to be posted soon.

### **Incident Reports**

Just a reminder: you don't need to submit an incident report for a hospitalization until the child is discharged from the hospital. It is unlikely that you will have the information you need to complete the form prior to that time. Remember, incident reports are not about collecting data, they are about ensuring quality. We can find out that your patient was in the hospital by looking at the claims. What we need from the incident reports is your evaluation of and response to that hospitalization. Please see the previous (July 22) memo for more information.

### **Assistive Technology Expo**

The NC Assistive Technology Expo is an exciting two-day event designed to increase awareness and provide current information about assistive technology. It will be held December 3-4, 2009 at the North Raleigh Hilton. Participants will learn about the latest in assistive technology devices, services, strategies and community resources.

If you would like to learn more, visit <http://www.pat.org>, or contact:

Sonya Van Horn

Phone: 919-872-2298 (voice)

Email: [assist@pat.org](mailto:assist@pat.org)

To download the registration form in pdf format, click this link:

[http://www.pat.org/images/uploads/attachments/2009\\_AT\\_Expo\\_Registration\\_Brochure.pdf](http://www.pat.org/images/uploads/attachments/2009_AT_Expo_Registration_Brochure.pdf)

Note: You must have Adobe Reader 8.0 or later to open the pdf file. If you are a screen reader user or cannot open the pdf file, use the Word doc file below.

To download the registration form in Word doc format, Click this link:

[http://www.pat.org/images/uploads/attachments/2009\\_AT\\_Expo\\_Registration\\_Brochure\\_Word.doc](http://www.pat.org/images/uploads/attachments/2009_AT_Expo_Registration_Brochure_Word.doc)

### **Seasonal Vaccinations**

Flu and RSV season is approaching. Please refer to the October Medicaid Bulletin for information regarding flu vaccine and Synagis vaccine for children. Encourage families to have their children and themselves vaccinated.

### **Freeze**

Many of you are already aware that a freeze has been placed on CAP-DA. This freeze only applies to CAP/DA; it does NOT apply to CAP/C. There are already a lot of rumors and misinformation spreading. Please reassure your local referral sources that they may still make CAP/C referrals.

The CAP-DA freeze does not apply to recipients aging out of the CAP-C program. Those recipients will still be able to receive CAP-DA slots.

### **Incontinence, Urological, and Ostomy Supplies**

The DME policy will be revised soon (projected date November 1), making incontinence supplies, ostomy supplies, and urological supplies available through DME providers as well as home health providers.

What this means to you as a CAP/C Case Manager:

- Incontinence supplies (diapers) are only covered for children age 3 and older.
- There are quantity limitations to these supplies (for example, diapers are limited to 192 per month). If you need to exceed these quantity limitations, you must obtain the supplies through a home health provider.
- Any recipient who currently receives other home health services should continue to receive their incontinence, ostomy, and urological supplies through the home health provider.

More information, including the effective date will be available in an upcoming edition of the Medicaid Bulletin and in the DME Clinical Coverage Policy at

<http://www.dhhs.state.nc.us/dma/mp/dmepdf.pdf>.

### **Changes to Determination and Use of Nurse and Nurse Aide Scheduled and Respite Hours**

DMA has made some changes that we think will better meet our family's needs, simplify the plan of care process for case managers and for DMA, lessen the administrative burden to case managers of monitoring use of hours, and maintain cost effectiveness as we implement the recent changes to the way the budget is calculated.

#### **Scheduled Hours**

Hours will be approved in weekly, rather than daily, increments. The Case Manager shall assess the child's care needs and the caregiver(s)' availability and determine the number of hours a family is eligible to receive using the following formula:

Work Time	actual hours worked
	+ (½ - 1 hour lunch)
+	+ ½ - 2 hours commute
	<u>- hours other support available</u>
	50 hours max

*Employment schedule must be verified. Verification consists of a written statement on employer letterhead. The statement should verify that the caregiver is employed, and detail the hours/schedule of employment.*

Sleep Time	<u>8 hours/day, regardless of actual time slept</u>
(only for SC/N or HC levels of care)	
+	56 hours max

Personal Time	<u>time for caregiver ADLs/IADLs</u>
	20 hours max

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126 hours max

The Case Manager and family should then develop a daily 24 hour coverage schedule, as is done now. However, families will now have the flexibility to change that schedule within certain parameters and as long as they do not exceed their weekly allotment. The hours still need to be written into the Plan of Care and approved by DMA before services are started.

The approval of hours is still based on the care needs of the child. All of the hours authorized are contingent upon nurse or nurse aide interventions being provided for the child Q2-4 H during that time. For example, if a child needs ADL help and feeding assistance throughout the day, but sleeps through the night, then hours for sleep time will not be given. Hours are only authorized when nursing or nurse aide care is provided. It is the shared responsibility of the family, case manager, and provider agency to ensure that hours are used appropriately.

The approval of hours is still subject to the budget limit for the child's level of care.

Total formal support may not exceed 126 hours per week. This 126 hours per week includes those hours during which the child attends school or daycare (even if not paid by Medicaid) and those hours paid by private insurance. CAP/C still has a responsibility to supplement, not replace, existing resources.

The approval of hours is based on the needs of the child and the caregiver's availability to meet those needs, not on the maximum hours allowed. For example, a caregiver may not need a full 20 hours per week for Personal Time. A working parent, according to the above formula, may only need 40 hours per week for Work Time; in that case, they will not be authorized for 50 hours per week.

Complete the service authorization and task sheet with what the child's usual schedule will be. It is expected that the items on the task sheet will be completed as specified, regardless of the time the family chooses to use their hours.

The family may change their schedule without prior approval of the Case Manager within the following parameters. The Case Manager is responsible for ensuring that his/her CAP/C families understand these parameters.

- The family must stay within their weekly allotment of hours.
- Families/caregivers should understand that they are responsible for all hours of care not provided by CAP/C.
- Unused hours do not carry over into the next week.
- Once the hours have been used for the week, they are gone. No additional hours will be approved because a child is without hours at the end of the week due to poor planning on the part of the family. If a family does find themselves inadvertently in this situation, they have the option of using their respite hours, paying for the remainder of the week out-of-pocket (with the staffing agency's approval), or the staffing agency may provide the service at no cost.
- If a family uses their hours unwisely such that there is a threat to the child's health, safety, or well-being (i.e., there are no hours left at the end of the week, and no caregivers available for the child), the Case Manager has the discretion to place the family back on a daily schedule with the need for changes to be approved by the Case Manager. The Case Manager shall also evaluate whether the occurrence warrants a referral to Child Protective Services. Repeated occurrences place the family at risk for termination of CAP/C services; CAP/C must still assure our recipient's health, safety, and well-being, and we can not do that if there are consistently blocks of unstaffed time.
- The Nursing or Nurse Aide care tasks specified on the service authorization must be provided during the hours the parent chooses. If a child sleeps through the night with no care needs, the family may not use their weekly hours during sleep time. Hours are to be used only for nursing or nurse aide care, not for baby-sitting. If an infant with a tube feeding is approved, then the hours must be used during the times when a tube feeding is given. Otherwise, the aide is performing only age-appropriate ADL care or babysitting, not CAP/C care.

The Case Manager should be vigilant when reviewing claims and nurse/nurse aide notes in ensuring that hours are being used appropriately. Inappropriate use of hours should be brought to

the family's attention and corrected. If the inappropriate use of hours continues, the Case Manager should bring it to the attention of his/her DMA Nurse Consultant.

The change becomes effective immediately. Any change needed to the number of hours approved based on this new procedure should take place after that date and no later than the next CNR.

Below are some other guidelines to be used in determining caregiver availability (Work Time):

#### Working at home

Caregiver availability will be assessed on a case by case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or arrange work hours around care needs.

#### Overtime and on-call

CAP/C hours will not be authorized to cover overtime hours in excess of the maximum allowed per program and budget limitations.

CAP/C hours will not be authorized to cover on-call time. However, if the caregiver is actually called to work, the actual hours worked and commute time may be authorized in accordance with program and budget limitations.

#### Attending school/online courses

Registration and course schedule should be verified each semester by the case manager. CAP/C will cover time spent out of the home for classes, subject to program and budget limitations. It is the primary responsibility of the parent to schedule study time around the child's care needs, however if this is not possible in whole or in part, it will depend on the care that needs to be provided to the patient during the study time. Supervision will not be covered. Actual frequent nursing interventions that the parent can not reasonably be expected to interrupt study time for; i.e., suctioning a patient Q 15 mins will be covered at the rate of up to 2 hours study time for each hour spent in class subject to program and budget limitations. Courses should be toward the pursuit of a degree or with the goal of obtaining or bettering employment. Time for recreational classes would be considered respite.

#### Work and school

The number of hours approved is subject to program and budget limitations. Exceptions to the maximum hours allowed will not be made based on occurrence of work and school. If both are part time, and combine to form 50 or less hours per week, then the 50 hours per week will be allowed if otherwise eligible. If more than 50 hours per week are used, the parent will need to make other arrangements for the remaining time.

#### Home schooling children

When the patient is home-schooled: In a school setting, the teachers and staff are not well-trained in the care of the child, and have many children that need their attention simultaneously. At home, the parent knows the child's care, is able to provide the child close attention and is in fact already doing so because they are teaching, so the caregiver is considered available during this time – no additional hours would be provided for the home-schooled time.

When the siblings of a not-school- age child are home-schooled: This will be considered on a case-by-case basis. Since there is some flexibility to home-schooling, the primary responsibility falls to the parent to try to schedule the home-school session while the patient naps, is involved in therapy sessions, or while CAP/C is already in the home providing services, etc. If this is not possible, that would need to be demonstrated, and approval would depend on the care that needs to be provided to the patient during the school time. Supervision will not be covered. Actual frequent nursing interventions that

the parent can not reasonably be expected to interrupt school time for; i.e., suctioning a patient Q 15 mins will be covered.

When both are home-schooled: This also will be considered on a case by case basis, depending on the needs of the patient during school time. As above, frequent nursing interventions occurring during the school time that would adversely affect the sibling's education will be covered.

#### Inability to provide care for physical/mental health issues

In all cases, the nature of the disability or health issue will be considered in relation to the ability of that person to provide the care the recipient needs.

Permanent disability – Long-term exception to the maximum allowed hours will not be made. If with maximum CAP/C support, the child can not safely be cared for by the disabled person in the absence of CAP/C staff, other arrangements that will meet the needs of the child need to be considered.

Short-term-illness or recovery – with evidence from a treating physician of illness or injury affecting the person's ability to provide care the child needs, short-term-intensive hours will be granted for a limited time. The physician note should include the exact restriction and duration of the restriction. Short-term-intensive hours are subject to program and budgetary limitations. If the restriction lasts beyond 6 months it is no longer considered short term and the criteria for disability above then apply.

#### Presence of other sick/disabled persons in the home

two CAP/C recipients – the maximum number of hours is per household. Please discuss with your DMA Nurse Consultant how to assign hours when there is more than one CAP/C recipient in the home.

sick/disabled adult – additional assistance can not be provided by CAP/C because of the presence of a non care-giving sick or disabled adult in the home. If additional services are needed, they should be sought specifically for the adult that is in need of the services – for example obtain PCS, CAP-DA, or PDN services for the adult.

#### Unwillingness to learn or to provide care

If a caregiver is technically available to provide care but is afraid of providing that care or of being left alone with the patient, CAP/C will approve additional short-term-hours, subject to program and budget limitations, to allow for teaching and training of the caregiver. The case manager, home care agency, and family, should work collaboratively on this. Long-term exception to the maximum allowed hours will not be made. If, despite concerted efforts on the part of the above parties, the caregiver remains unable to care for the patient, alternative arrangements that will meet the needs of the child should be considered.

#### Multiple siblings

Additional assistance can not be provided by CAP/C because of the presence of siblings in the home. The hours approved must be based on the needs of the CAP/C recipient. If a parent feels that more hours are needed because of the demands of other siblings, then arrangements should be sought for the siblings; i.e. hire a babysitter/nanny, arrange after-school care, use respite time, etc.

#### Volunteer work

CAP/C understands the needs of some parents to “give back”; i.e. volunteer time at a church whose members funded the installation of a wheelchair ramp for their child.

Efforts should be made by the family to arrange this time around existing CAP/C hours and their child's care needs. If needed, requests for additional hours of CAP/C to accommodate volunteer work will be considered on a case by case basis. At a minimum, the case manager would need to verify the work and the work schedule and notify DMA of any changes.

**Respite Hours**

All CAP/C recipients, whether staffed by a Nurse or Nurse Aide, would be eligible for any combination of in-home or institutional respite according to the following formula:

SCHEDULED HOURS PER WEEK	RESPITE HOURS PER YEAR (July 1 – Jun 30)
30 or less	720
31-60	540
61-90	360
91-126	180

This also, is still subject to the budget limitation for the child's level of care.

As with regularly scheduled hours, respite hours are per household. Please discuss with your DMA Nurse Consultant how to assign hours when there is more than one recipient in the home.

This change becomes effective immediately. Any change needed to the number of hours approved based on this new procedure should take place after that date and no later than the next CNR.

**Initial Assessment – Short Version**

In order to serve recipients more quickly and promote continuity of care, CAP/C has developed the following procedure for initial assessments. *This procedure is only valid for 1) children who are in the hospital and otherwise would have to be discharged to PDN and transfer to CAP/C later, and 2) recipients currently out of state who have complex medical needs such as ventilators or trachs, and need services in place as soon as they arrive in state.*

In these two cases *only*:

1. The Case Manager will submit as much of the assessment as he/she is able, but including the following minimum requirements:
  - The CAP/C referral form
  - The telephone-approved FL-2
  - The anticipated discharge/start of service date
  - The family's demographic information (section 1 of the assessment)
  - The home environment assessment (section 8 of the assessment), which may be completed by interviewing the family using the questions in chapter 9 of the CAP/C manual
  - a list of services the child currently receives and those services he/she is currently being referred to
  - a preliminary cost summary
  - a preliminary 24 hour coverage schedule

All of the above documents may be submitted simultaneously by fax. It would be a good idea to call your Consultant to let them know to expect the information.
2. The Case Manager will verify the recipient's Medicaid eligibility.
3. The Consultant will prioritize these reviews. If approved, approval will be granted for a maximum of six weeks of service. There is no guarantee that services will continue beyond the six weeks.
4. The Case Manager may issue service authorizations and participation notices as needed for the six weeks.

5. The nurse case manager or social worker/nurse case management team should plan to be at the patient's home upon arrival to ensure that all equipment, caregivers, etc are in place and that caregivers are adequately trained regarding care and equipment, so that the child can be safely case for in the home. Any issues regarding health, safety, or well-being should be addressed.
  6. The case manager should follow up by phone or visit approximately one week after start of services. The purpose of this follow up is to asses the provision of services and address any needs or issues that have arisen related to caring for the patient at home.
  7. No later than 30 days after start of services, the entire assessment and plan of care, including review and changes to the previously submitted information, should be received at DMA.
  8. The consultant will prioritize these reviews. If approved, the approval will be for the remainder of the CNR year. If denied, services will end at the end of the six weeks.
- Please contact your consultant if you have any questions about this procedure.

**Referrals From PDN (Private Duty Nursing)**

CAP/C has been seeing an increase in referrals of children already receiving PDN services. PDN consultants at DMA have been working to more carefully review each case. In many cases, they are reducing the number of hours approved, and/or referring children to CAP/C for case management services and respite services. However, it has become the practice of some home care agencies to submit CAP/C referrals for every child they have that gets PDN. Sometimes these referrals are inappropriate; i.e., referring an 18 year old who in a few months would be back on PDN. Many times the family is not even aware that the referral is being made. These agencies are now being asked to go through the CAP/C Case Manager, so that you can ensure that the family is aware of the referral, understands the differences between the two programs, and would like to proceed with the referral. It is not CAP/C's intention to not take these referrals; we would like to move as many children over to CAP/C as we can. However, we want to make sure that our recipients' privacy and freedom of choice is respected.

Below is a comparison of the two programs to help you in helping families weigh their options.

	<b>Private Duty Nursing (PDN)</b>	<b>Community Alternatives Program for Children (CAP/C)</b>
Type of Program	Optional State Plan program	1915c Waiver
Financial Eligibility	Requires Medicaid (Blue Card)	Must be eligible for MAB, MAD, I-AS, H-SF; however parents' income is not considered
Client Type	All ages Require high-acuity RN/LPN care	Ages 0 through 18 Require RN/LPN care or NA care
Prior Approval	No FL2 requirement Referral form Letter of medical necessity from Physician Hourly Review Tool (test)  DMA Nurse Consultant reviews information and approves/denies as indicated	Must be a risk of institutionalization (FL-2 required) Must be medically fragile Requires Referral Form to be approved by DMA, then EDS-approved FL-2, local Case Mgr makes in-home initial assessment and develops plan of care approved by DMA  DMA Nurse Consultant reviews assessment and plan of care and approves/denies as indicated
Services Offered	Receives only regular Medicaid services	Receives regular Medicaid services in addition to the following Waiver Services <ul style="list-style-type: none"> <li>➤ Case Management (required)</li> <li>➤ CAP/C Nursing } (one of these is required)</li> <li>➤ CAP/C Aide }</li> <li>➤ In Home Respite Care (nurse or aide)</li> <li>➤ Institutional Respite Care</li> <li>➤ Waiver Supplies (reusable diapers and disposable liners)</li> <li>➤ Home Modifications (limited to specific items such as wheelchair ramps, widening doorways)</li> </ul>

Recertification	Every 60 days provider agency submits 485 and 486 to DMA; nurses notes reviewed upon request	Annual Continued Needs Review (CNR) including FL-2, assessment, plan of care, as well as 485, nurses notes, and MAR as applicable
Provider Type	Must use only one agency to provide the nursing staff	Nurse or CNA staff can be provided by multiple agencies if needed
Care coordination/case management	Provider nursing agency coordinates services	Case manager (which is required component of program) provides comprehensive coordination of care including assessment, planning, and coordinating services, and including linkage to non-Medicaid resources.
Cost	No cost neutrality requirement	Cost neutrality requirement to waiver; care needs must be met within child's monthly budget: Intermediate Level of Care \$2730 Skilled Level of Care \$3537 Hospital Level of Care \$28729

## **This Memo's Training Topic: Family-Centered Planning**

The CAP/C program, as well as all Medicaid programs, encourages the use of a family-centered model of care. Changes are being made to the CAP/C program (for example the use of weekly rather than daily hours), to make it more family-centered and less traditional/system-centered. You will be kept up to date as these changes occur. At some point in the future when economic barriers and travel restrictions are lifted, DMA (not specifically CAP/C) plans to provide local training sessions regarding family centered planning. In the meantime, here are some of the general concepts and characteristics.

Traditional models of planning for service provision have operated *around* the individual receiving the service, with professionals (such as doctors, nurses, support workers, case managers, and therapists) making decisions regarding the types of support received. Traditional models have also focused on the person's deficits and needs, labeling the person and creating a disempowering mindset from the start.

Family-Centered Planning offers an alternative to such models, striving to place the family at the center of decision-making, treating family members as partners. It recognizes that the family is the constant in the child's life, while the service system and support systems fluctuate. It recognizes that parents are the experts on their own child and family. The process focuses on discovering the person's gifts, skills and capacities, and on listening for what is really important to the person and family. It is based on the values of human rights, independence, choice and social inclusion, and is designed to enable families to direct their own services and supports, in a personalized way rather than attempting to fit within pre-existing service systems. It encourages the use of natural and community supports. It focuses on the identification of the individual'/family's needs and desired life outcomes-not just a request for a specific service.

### **From SYSTEM-CENTERED**

Plan a lifetime of programs

Offer a limited number of usually segregated program options

Base options on stereotypes about persons with disabilities

Focus on filling slots, beds, placements, closures

Overemphasize technologies and clinical strategies

Organize to please funders, regulators, policies, and rules

### **Toward FAMILY-CENTERED**

Craft a desirable lifestyle

Design an unlimited number of desirable experiences

Find new possibilities for each person

Focus on quality of life

Emphasize dreams, desires, and meaningful experience

Organize to respond to people

### **What Are The Key Characteristics of Family-Centered Planning?**

1. Incorporate into policy and practice the recognition that the family is the constant in a child's life, while the service system and support persons fluctuate.
2. Strive for family and professional collaboration in all settings (home, community, hospital, school), especially in the areas of care giving, program development, program implementation, program evaluation, program evolution, and policy formulation.

3. Exchange complete and unbiased information between families and professionals in supportive manner at all times.
4. Incorporate into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families: including, ethnic, racial, spiritual, social, economic, educational, and geographic diversity.
5. Recognize and respect different methods of coping.
6. Implement comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports which meet the diverse needs of families.
7. Encourage family-to-family support and networking.
8. Ensure that all service and support systems for children with disabilities and their families are flexible, accessible, and comprehensive in responding to diverse family identified needs.
9. Appreciate families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized services and supports.

### **THE KEY VALUES AND PRINCIPLES SERVING AS THE FOUNDATION OF PERSON-CENTERED PLANNING**

1. Person-centered planning builds on the individual's /family's strengths, gifts, skills and contributions.
2. Person-centered planning supports personal empowerment, and provides meaningful options for individuals/families to express preferences and to make informed choices in order to identify and achieve their hopes, goals and aspirations.
3. Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person-centered planning supports a fair and equitable distribution of system resources.
5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.
6. Person-centered planning sees individuals/families in the context of their culture, ethnicity, religion and gender. All of the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process.
7. Person-centered planning supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties involved.

#### **Key Values and Principles That Serve As the Foundation of A Person-Centered System for The Department of Health and Human Services**

[A person-centered system involves person-centered thinking, planning and organizations.]

*These guiding principles apply to the system serving all people who need long term services and supports, and*

*their families. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.*

To be person-centered means:

- Treating individuals and family members with dignity and respect
- Helping individuals and families become empowered to set and reach their personal goals
- Recognizing the right of individuals to make informed choices, and take responsibility for those choices and related risks
- Building on the strengths, gifts, talents, skills, and contributions of the individual and those who know and care about the individual
- Fostering community connections in which individuals can develop relationships, learn, work/produce income, actively participate in community life and achieve their full potential
- Promising to listen and to act on what the individual communicates
- Pledging to be honest when trying to balance what is important to and important for the person
- Seeking to understand individuals in the context of their age, gender, culture, ethnicity, belief system, social and income status, education, family, and any other factors that make them unique
- Acknowledging and valuing families and supporting their efforts to assist family members
- Recognizing and supporting mutually respectful partnerships among individuals, their families, communities, providers and professionals
- Advocating for laws, rules and procedures for providing services, treatment, and supports that meet an individual's needs and honor personal goals
- Endorsing responsible use of public resources to assure that qualified individuals are served fairly and according to need

*Adopted by the Long Term Services and Supports Cabinet  
January 10, 2008*

cc: Patti Forest  
Lawrence Nason

**CAP/C TRAINING REGISTRATION REQUEST FORM**

CAP/C CASE MANAGER TRAINING (NEW)

November 12, 2009

Name: \_\_\_\_\_  RN  SW

County: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Length of time you have been a CAP/C case manager: \_\_\_\_\_

If applicable, length of time you have been a CAP/DA case manager: \_\_\_\_\_

*(Note: There will be no CAP/DA information presented at this training)*

Specific questions or situations you would like to discuss during training

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For the new case manager training, please fax this form and your final exam no later than one week before the applicable training session to:

**Jennifer Brest, RN, Lead CAP/C Nurse Consultant**  
**Facility and Community Care Section**  
**Division of Medical Assistance**  
**FAX: (919) 715-9025**

**CAP/C TRAINING REGISTRATION REQUEST FORM**

CAP/C CASE MANAGER TRAINING (REFRESHER)

October 12, 2009

Name: \_\_\_\_\_  RN  SW

County: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Length of time you have been a CAP/C case manager: \_\_\_\_\_

If applicable, length of time you have been a CAP/DA case manager: \_\_\_\_\_

*(Note: There will be no CAP/DA information presented at this training)*

Specific questions or situations you would like to discuss during training

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**Facility and Community Care Section**  
**Division of Medical Assistance**  
**FAX: (919) 715-9025**

**CAP/C TRAINING REGISTRATION REQUEST FORM**

CONTRACT NURSE TRAINING

December 9, 2009

Name: \_\_\_\_\_  RN  CM Supervisor

County: \_\_\_\_\_

Case Management Agency: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Specific questions or situations you would like to discuss during training

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