DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	1-5-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001290	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner, Deps, CMS file	[X] Prepare reply for appropriate signature DATE DUE 3-28-11 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 30, 2010

Emma Forkner, Director
Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear Ms. Forkner:

Enclosed is the draft report of the Centers for Medicare & Medicaid Services' (CMS) quality review of South Carolina's Medically Complex Children's waiver program with control number 0675. This waiver serves children under the age of 18 who meet the Nursing Facility (NF) or Intermediate Care Facility/Mentally Retarded (ICF/MR) level of care.

We would like to extend our sincere appreciation to all who assisted in the review process. We found the State to be in compliance with all six of the review components. However, we included necessary recommendations for program improvements for all six assurance areas. We suggest you address these prior to renewal of the waiver in order to meet the assurances and maximize the quality of the waiver program. Please include a detailed plan, with target dates, to show improvements in required waiver performance issues identified in the report.

Please review the draft report and submit your comments within 90 days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by the 90th day, April 1, 2011, this draft report becomes a final document. We are available to discuss the report and to provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

We would again like to extend our sincere appreciate to the South Carolina Department of Health and Human Services, who provided information for this review. If you have any questions, please contact Connie Martin at 404-562-7412.

Sincerely,

Irina Roberts for

Jackie L. Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Mark Reed, Central Office

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

DRAFT Report

Home and Community-Based Services Waiver Review
South Carolina Medically Complex Children's Waiver
Control #0675
December 30, 2010

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services (DHHS) is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Medically Complex Children's Program serving children under the age of 18 who meet the Nursing Facility (NF) level of care (LOC) or Intermediate Care Facility/Mentally Retarded (ICF/MR) LOC. These children have a chronic physical/health condition that is expected to last longer than 12 months and meet medical criteria defined by the state documenting the dependency upon comprehensive medical, nursing, and health supervision or intervention. The services offered in this waiver include Care Coordination, Incontinence Supplies, Pediatric Medical Child Care and Respite Care. The average number of individuals served as of June 1, 2010 was 140 individuals. The approximate average cost per month YTD per person is $9,840.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per 42 CFR 441. In its submission of October 29, 2010, the State provided an overview of processes, instrument(s), systems and summary reports for each Federal assurance.

Summary of Findings

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends developing specific performance measures to assess accuracy of LOC decisions.

CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

2. Service Plans are Responsive to Waiver Participant Needs – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

3. Qualified Providers Serve Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

In addition to results submitted on audits of casement management providers, please provide results of monitoring of other provider types other than case management, e.g., In-home Skilled Respite and Pediatric Medical Day Care. Please explain the outcome of policies, procedures, and forms that were developed for implementation on July 1, 2010, and whether they meet the performance measure.

4. Health and Welfare of Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.

6. State Provides Financial Accountability for the Waiver – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed.

It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. The assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name:	Home and Community-Based Waiver for Medically Complex Children (MCC)
Operating Agency:	South Carolina Department of Health and Human Services
State Waiver Contact:	Maria J. Platanis
Target Population:	Children from birth to 18 years of age with a chronic physical and/or health condition expected to last longer than 12 months
Level of Care:	Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Number of Waiver Participants:	140 (as of June 2010)
Average Annual per capita costs:	$ 9,840
Effective Dates of the Waiver:	January 1, 2009 – December 31, 2011
Approved Waiver Services:	Children's medical day care, respite, care coordination and incontinence supplies.
CMS Contact:	Connie Martin

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care (LOC) need consistent with care provided in hospital, nursing facility or ICF/MR.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State utilizes a comprehensive assessment tool for both levels of care to determine the participant's medical, psychosocial, and functional abilities. Evidence submitted to support a LOC assessment and determination are as follows:

- ICF/MR LOC Staffing Report with DHHS Waiver Administrator/RN and Physician Consultant verifying criteria met as part of a 100% review;
- ICF/MR LOC Protocol;
- ICF/MR LOC DDSN Consumer Assessment Team (CAT) Monthly Log;
- DHHS Master spreadsheet of applicant NF LOC completion dates;
- Completed NF LOC Form, Completed ICF/MR Form, Corresponding MMIS screen reflecting MCC waiver enrollment date, Corresponding MMIS screen reflecting MCC waiver enrollment date;
- DHHS MCC Waiver Technical Assistance Review (TAR) Report of findings related to initial LOC determinations; and
- DHHS MCC Waiver Quality Assurance Review (QAR) Report of findings related to LOC determinations.

The State has demonstrated enrolled participants are re-evaluated at least annually or more frequently if warranted. The same assessment team that conducts the initial LOC determinations also conducts the re-evaluations of LOC. The Care Coordination staff conducts the re-evaluation using the same 1718 tool as the initial LOC. The state operates an electronic system (Phoenix System) that maintains NF LOC which includes LOC determination dates.

The Phoenix System identifies upcoming LOC re-evaluations due dates based on the date of the prior year's LOC. Enrolled participants are re-evaluated at least annually or more frequently if warranted. Evidence to support a re-evaluation of LOC is provided to all applicants at least annually and all participants' LOC was completed prior to the 365th date of the previous LOC are as follows:

- DDSN CAT Team ICF/MR Log representing the ICF/MR LOC re-evaluation dates;
- DHHS Master List of NF and ICF/MR LOC re-evaluations which occurred prior to the 365th day;
- Completed re-evaluations of LOCs determinations and the corresponding initial LOC reflecting timeliness;
- TAR Report of MCC waiver with findings related to annual LOC re-evaluation determinations; and

- QAR Report with findings as related to annual LOC re-evaluation determinations.

Nursing Facility LOC determinations are conducted by trained licensed RN staff utilizing the standardized comprehensive assessment tool (1718 Form). The tool identifies skilled needs and functional deficits.

ICF/MR determinations are conducted by a medical director, licensed nurse, and the Consumer Assessment Team (CAT), consisting of qualified psychologists. A standardized instrument is used to gather assessment information necessary for ICF/MR LOC determinations, as well as re-determinations, capturing three main components: diagnosis of mental retardation or a related disability, behaviors requiring supervision, and services needed for acquisitions of behaviors necessary to function with as much self-determination and independence as possible and /or to prevent deceleration or regression of optimal functional status. The State has submitted the following evidence to substantiate these instruments are appropriately applied:

- Completed NF and ICF/MR LOC instruments, which are maintained in the MCC waiver participant's case record; and the corresponding Medicaid Management Information System (MMIS) data identifying the waiver enrollment date;
- TAR Report of MCC waiver with findings related to NF and ICF/MR LOC determination using the correct instrument; and
- QAR Report with findings as related to LOC determinations using the correct instrument.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 89 percent of waiver enrollment was within 30 days of the initial NF & ICF/MR LOC. The LOC re-evaluation was dated and signed within 365 of the prior evaluation. The State has also conducted remediation by updating the policy and training to ensure waiver applicants are enrolled into the waiver prior to LOC expiration.

One hundred percent of sampled cases used appropriate instruments. However, there are no indications from State monitoring if the instruments were applied appropriately.

Suggested Recommendations

CMS recommends developing specific performance measures to assess accuracy of LOC decisions.

CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that is has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7Section 1915(c) Waiver Format, Item Number13

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The plan of care (POC) is the fundamental tool the State uses to ensure the health and welfare of the children in the Medically Complex Children's Waiver. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The Care Coordination Service Organization (CSO) staff is responsible for developing care coordination plans based on the comprehensive assessment of the participant's medical needs, problems and strengths. Problems are identified, interventions are outlined and initiated, and goals are set. The care coordination plan includes a statement of the participant's needs, related to a goal, with a specific service to meet the need including the amount, frequency and duration of the service. The completed care coordination plan is submitted to the Nurse Administrator, who is also the Waiver Administrator, for review and approval. The State submitted the following evidence that individual care coordination plans are reviewed to assure that all participants' needs and goals are addressed:

- Completed care coordination plan which is maintained in the MCC waiver participant's case record, and reviewed and approved by the Waiver Administrator.

The University of South Carolina conducts a survey by telephone interview of the waiver participant/responsible party, inquiring about the assistance of the care coordinator and services coordinated by the waiver.

The State conducts annual on-site reviews and reports initial findings back to the Nurse Administrator. If the report shows deficiencies, those providers are to respond with a written plan of correction. Service plans are updated and/or revised at least annually or when warranted by changes in the waiver participant's needs. The State submitted the following annual assessments conducted in the States computerized Phoenix system where each participant's electronic record is maintained:

- An example of a completed annual 1718 assessment;
- DHHS Master List of participants who received an annual re-assessment in accordance with State policy;
- TAR Report – Technical Assistance Review Report providing results of State audit; and
- QAR Report – Quality Assurance Review Report.

The CSO is responsible for creating a new service plan within 365 days of the initial care coordination plan. The State utilized the same methods for monitoring the care coordination plan updates/revisions as used for monitoring of the care coordination plan development. Changes to the care coordination plan are made as needed by the care coordinator with the results of monitoring or when information is obtained from the participant, his/her guardian, and/or service providers indicate the need for a change to the care coordination plan. The State utilized the same methods for monitoring the care coordination plan updates/revisions as used for monitoring of the care coordination plan development.

A monthly contact by telephone or an in-person visit must be made by the Care Coordinator to assess and re-evaluate the on-going needs of the child. Monthly contacts and quarterly visits must be documented using the Care Call System. Eighty-seven percent (360 of 415) contacts were completed. When no monthly contact was conducted, it was due to no response from the recipient. Policy was created to address non-compliance by a participant.

The initial care coordination plan is required to be approved by the Waiver Administrator. The service plan included in the electronic case record in Phoenix is also required to be signed and dated indicating approval by the nurse administrator. The following documents were provided as evidence that the State monitors the development of care coordination plans in accordance with waiver policy and procedures:

- Completed Phoenix Service Plan; and
- QAR Report

The State requires care coordinators have a waiver participant's parent or legal guardian complete a Freedom of Choice Form indicating their choice between waiver services and institutional care. Parents or legal guardians are informed in writing prior to waiver enrollment of waiver services and provided with a list of qualified waiver and non-waiver Medicaid service providers in their area.

The University of South Carolina is responsible for conducting a survey by telephone interview of the waiver participant/responsible party, inquiring about the access of appropriate services and supports in the community.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 74 percent of initial service plans were signed and dated by the waiver administrator. The State's remediation was to update policy to ensure the approval of services plans are approved prior to waiver enrollment.

The State's metrics also indicated 100 percent of re-evaluations were signed and dated by the waiver administrator. No remediation was needed.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
Authority: 42 CFR 441.302; SMM 4442.4

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State verifies providers initially and continually met required licensure and/or certification standards prior to their furnishing waiver services. Care Coordinators employed by the CSO must be licensed Registered Nurses with a minimum of three years experience with medically complex children.

The State reports that it monitors non-licensed/non-certified providers to assure adherence to waiver requirements. However, the Quality Management Chart states all providers are licensed or certified. They verify potential providers meet all standards and qualifications. Once the State confirms the provider meets all Medicaid standards and qualifications, the approved provider may enroll with DHHS to provide waiver services. The State is responsible for conducting annual provider reviews to ensure providers continue to meet criteria to render waiver services.

The State conducts reviews and provides technical assistance to the CSO, the Care Coordination waiver service provider. DHHS completes quality assurance reviews of providers and submits the findings to the CSO and the waiver administrator provides technical assistance and follows up as necessary. The following evidence provides documentation of the State's monitoring, training and actions taken when the CSO has not met requirements.

- TAR Report provides results of monitoring of performance measures related to provider qualifications;
- QAR Report provides results of monitoring of performance measures related to provider monitoring;
- Training activity agendas; and
- Training Session to review/update MCC policy.

The State reviewed the licenses of the eight nurses comprising nursing staff and Nurse Administrator. Metrics show 100 percent (8 out of 8) were licensed Registered Nurses.

Suggested Recommendations

In addition to results submitted on audits for case management providers, please provide results of monitoring of other provider types, e.g., In-home Skilled Respite and Pediatric Medical Day Care. Please explain the outcome of policies, procedures, and forms that were developed for implementation on July 1, 2010, and whether they meet the performance measure.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation. DHHS QA staff monitors health and welfare concerns through the quality assurance process which includes case record reviews of critical incidences, abuse, and neglect reports.

DHHS Program Integrity Division also investigates reports of abuse, neglect, exploitation, and fraud via a toll free hotline.

Based on the South Carolina Code of Laws, the SC Department of Social Services (DSS) is the investigative agency for children under 18 years of age. Upon enrollment into the waiver, all participants are given the DSS Abuse hotline information on how to report abuse. When the DHHS or the CSO receives reports of alleged abuse, the initial response is to ensure the child is protected. The DHHS/CSO does not allow the alleged perpetrator to provide any services until the investigation has been completed. A report is completed by the Care Coordination staff and reviewed by the Waiver Administrator. DSS is alerted and the service provider is requested to remove the alleged perpetrator from the child's environment. Upon completion of the investigation, the next action taken is dependent upon the results.

The following evidence supports the conclusion that the State seeks to address and prevent occurrences of abuse, neglect, and exploitation on an ongoing basis:

- QAR Report;
- MCC Abuse Report Form;
- Abuse Hotline handout to participants; and
- South Carolina Solutions Admission Agreement Form.

Of 140 participants the State reviewed 57 case records. There were no critical incidents reported (including mortality and injuries) for the sample of records chosen.

Suggested Recommendations

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the wavier program is consistent with its approved waiver application.
Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The waiver is both administered and operated by the Medical Assistance Unit as a component of the State Medicaid Agency. The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by local/regional non-State agencies and contracted entities.

The State engages in routine oversight of the MCC waiver program by enforcing the terms and conditions of the waiver service contracts. Meetings are held with waiver service providers to discuss specific waiver issues identified through State oversight. In addition, DHHS conducts monthly staff meetings with the CSO and the Care Coordination staff.

The State also engages in routine oversight of the MCC waiver program by conducting technical and/or quality assurance reviews annually. Aggregated discovery and remediation reports relating to each of the performance measures are reviewed and addressed.

DHHS has submitted the following evidence to support their ongoing administrative authority and to establish it is consistent with the approved waiver application:

- Service contract between DHHS and the CSO for Care Coordination Services;
- ICF/MR LOC Quality Management Process;
- Quality Assurance Review Report;
- Technical Assistance Review Report; and
- Copy of DHHS and the CSO Care Coordination staff meeting agenda which occur on a monthly basis or more often as needed to discuss various policy updates and training for the contractor.

Suggested Recommendations

CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the wavier program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State assures claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. DHHS Fiscal staff, Audit staff, and Program Integrity staff conduct ongoing monitoring of finances on a monthly basis.

As part of the ongoing monitoring process, State Quality Assurance (QA) staff compares services billed and paid to the POC to ensure services rendered were specified in the POC. The QA process is also used to monitor paid claims data and participant utilization reports. Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the State, sub-state entities, and providers. All findings are used to determine needed improvements as well as corrective actions.

Once a service is authorized in the Phoenix system the authorization is sent to the Care Call system to be utilized by service providers. Care Call tracks all services with codes and sends them to MMIS for payment. Claims must meet all applicable criteria to be submitted to MMIS for payment at which time the billing code determines the rate of reimbursement. Cost reports are developed to ensure that funds are being applied and used properly.

The following documents provide evidence that the State monitors claims to assure they are coded and paid accurately:

- MCC Waiver Cost report;
- Phoenix Service Provision (service authorization);
- Care Call Service Monitoring Reports;
- Care Call Time and Attendance Report;
- Care Call Resolution report;
- MMIS claims data; and
- Participant case record audit.

The State pulled paid claims data for the month of August 2010. All claims were reviewed and there were no claims returned as denied.

Suggested Recommendations

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed.

It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Waldrop	1-5-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER J01290	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Ms. Forkner, Deps, CMS file	[X] Prepare reply for appropriate signature DATE DUE 3-28-11 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.	2/16/11	—	Had Alma review for Deputy Level 2/17
2. Sam Waldrop			
3. George Mak	3/18/11 2/16/11		
4 Maria Platanes	3/10/11 2/16/11		

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

DRAFT Report

Home and Community-Based Services Waiver Review
South Carolina Medically Complex Children's Waiver
Control #0675
December 30, 2010

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services (DHHS) is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Medically Complex Children's Program serving children under the age of 18 who meet the Nursing Facility (NF) level of care (LOC) or Intermediate Care Facility/Mentally Retarded (ICF/MR) LOC. These children have a chronic physical/health condition that is expected to last longer than 12 months and meet medical criteria defined by the state documenting the dependency upon comprehensive medical, nursing, and health supervision or intervention. The services offered in this waiver include Care Coordination, Incontinence Supplies, Pediatric Medical Child Care and Respite Care. The average number of individuals served as of June 1, 2010 was 140 individuals. The approximate average cost per month YTD per person is $9,840.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per 42 CFR 441. In its submission of October 29, 2010, the State provided an overview of processes, instrument(s), systems and summary reports for each Federal assurance.

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Suggested Recommendations

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CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

2. Service Plans are Responsive to Waiver Participant Needs – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

3. Qualified Providers Serve Waiver Participants – The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. The assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name:	Home and Community-Based Waiver for Medically Complex Children (MCC)
Operating Agency:	South Carolina Department of Health and Human Services
State Waiver Contact:	Maria J. Platanis
Target Population:	Children from birth to 18 years of age with a chronic physical and/or health condition expected to last longer than 12 months
Level of Care:	Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Number of Waiver Participants:	140 (as of June 2010)
Average Annual per capita costs:	$ 9,840
Effective Dates of the Waiver:	January 1, 2009 – December 31, 2011
Approved Waiver Services:	Children's medical day care, respite, care coordination and incontinence supplies.
CMS Contact:	Connie Martin

- QAR Report with findings as related to annual LOC re-evaluation determinations.

Nursing Facility LOC determinations are conducted by trained licensed RN staff utilizing the standardized comprehensive assessment tool (1718 Form). The tool identifies skilled needs and functional deficits.

ICF/MR determinations are conducted by a medical director, licensed nurse, and the Consumer Assessment Team (CAT), consisting of qualified psychologists. A standardized instrument is used to gather assessment information necessary for ICF/MR LOC determinations, as well as re-determinations, capturing three main components: diagnosis of mental retardation or a related disability, behaviors requiring supervision, and services needed for acquisitions of behaviors necessary to function with as much self-determination and independence as possible and /or to prevent deceleration or regression of optimal functional status. The State has submitted the following evidence to substantiate these instruments are appropriately applied:

- Completed NF and ICF/MR LOC instruments, which are maintained in the MCC waiver participant's case record; and the corresponding Medicaid Management Information System (MMIS) data identifying the waiver enrollment date;
- TAR Report of MCC waiver with findings related to NF and ICF/MR LOC determination using the correct instrument; and
- QAR Report with findings as related to LOC determinations using the correct instrument.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 89 percent of waiver enrollment was within 30 days of the initial NF & ICF/MR LOC. The LOC re-evaluation was dated and signed within 365 of the prior evaluation. The State has also conducted remediation by updating the policy and training to ensure waiver applicants are enrolled into the waiver prior to LOC expiration.

One hundred percent of sampled cases used appropriate instruments. However, there are no indications from State monitoring if the instruments were applied appropriately.

Suggested Recommendations

CMS recommends developing specific performance measures to assess accuracy of LOC decisions.

CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that is has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7Section 1915(c) Waiver Format, Item Number13

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

The initial care coordination plan is required to be approved by the Waiver Administrator. The service plan included in the electronic case record in Phoenix is also required to be signed and dated indicating approval by the nurse administrator. The following documents were provided as evidence that the State monitors the development of care coordination plans in accordance with waiver policy and procedures:

- Completed Phoenix Service Plan; and
- QAR Report

The State requires care coordinators have a waiver participant's parent or legal guardian complete a Freedom of Choice Form indicating their choice between waiver services and institutional care. Parents or legal guardians are informed in writing prior to waiver enrollment of waiver services and provided with a list of qualified waiver and non-waiver Medicaid service providers in their area.

The University of South Carolina is responsible for conducting a survey by telephone interview of the waiver participant/responsible party, inquiring about the access of appropriate services and supports in the community.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 74 percent of initial service plans were signed and dated by the waiver administrator. The State's remediation was to update policy to ensure the approval of services plans are approved prior to waiver enrollment.

The State's metrics also indicated 100 percent of re-evaluations were signed and dated by the waiver administrator. No remediation was needed.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
Authority: 42 CFR 441.302; SMM 4442.4

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation. DHHS QA staff monitors health and welfare concerns through the quality assurance process which includes case record reviews of critical incidences, abuse, and neglect reports.

DHHS Program Integrity Division also investigates reports of abuse, neglect, exploitation, and fraud via a toll free hotline.

Based on the South Carolina Code of Laws, the SC Department of Social Services (DSS) is the investigative agency for children under 18 years of age. Upon enrollment into the waiver, all participants are given the DSS Abuse hotline information on how to report abuse. When the DHHS or the CSO receives reports of alleged abuse, the initial response is to ensure the child is protected. The DHHS/CSO does not allow the alleged perpetrator to provide any services until the investigation has been completed. A report is completed by the Care Coordination staff and reviewed by the Waiver Administrator. DSS is alerted and the service provider is requested to remove the alleged perpetrator from the child's environment. Upon completion of the investigation, the next action taken is dependent upon the results.

The following evidence supports the conclusion that the State seeks to address and prevent occurrences of abuse, neglect, and exploitation on an ongoing basis:

- QAR Report;
- MCC Abuse Report Form;
- Abuse Hotline handout to participants; and
- South Carolina Solutions Admission Agreement Form.

Of 140 participants the State reviewed 57 case records. There were no critical incidents reported (including mortality and injuries) for the sample of records chosen.

Suggested Recommendations

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the wavier program is consistent with its approved waiver application.
Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State demonstrates the assurance but CMS recommends improvements or requests additional information.
(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

As part of the ongoing monitoring process, State Quality Assurance (QA) staff compares services billed and paid to the POC to ensure services rendered were specified in the POC. The QA process is also used to monitor paid claims data and participant utilization reports. Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the State, sub-state entities, and providers. All findings are used to determine needed improvements as well as corrective actions.

Once a service is authorized in the Phoenix system the authorization is sent to the Care Call system to be utilized by service providers. Care Call tracks all services with codes and sends them to MMIS for payment. Claims must meet all applicable criteria to be submitted to MMIS for payment at which time the billing code determines the rate of reimbursement. Cost reports are developed to ensure that funds are being applied and used properly.

The following documents provide evidence that the State monitors claims to assure they are coded and paid accurately:

- MCC Waiver Cost report;
- Phoenix Service Provision (service authorization);
- Care Call Service Monitoring Reports;
- Care Call Time and Attendance Report;
- Care Call Resolution report;
- MMIS claims data; and
- Participant case record audit.

The State pulled paid claims data for the month of August 2010. All claims were reviewed and there were no claims returned as denied.

Suggested Recommendations

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed.

It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

South Carolina Department of
Health & Human Services

Nikki R Haley • Governor
Anthony E Keck • Director

March 21, 2011

Jackie L. Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, S.W. Ste 4T20
Atlanta, GA 30303-8909

Attn: Connie Martin

Dear Ms. Glaze:

Enclosed is the State's response with attachments, to the draft report of the Centers for Medicare and Medicaid Services (CMS) quality review of South Carolina's Medically Complex Children's (MCC) waiver program with control number 0675. The responses are embedded, in bold, within your draft report.

We are pleased the State was found to be in compliance with all six of the review components. As requested, we have addressed the suggested recommendations in order to maximize the quality of the waiver program. Included is our plan that shows improvements in waiver performance issues already initiated and implemented for the recommendations identified in the report. These improvements will also be incorporated in the MCC waiver renewal document.

We appreciate CMS' guidance for improving the MCC waiver program and its ability to serve the children of our state. If you have any questions, please contact Maria Platanis at 803-898-2644.

Sincerely,

Sam Waldrep
Deputy Director

Enclosures

cc: Mark Reed
Kenni Howard

Long Term Care and Behavioral Health
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2577 • Fax (803) 255-8204

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region IV

DRAFT Report

Home and Community-Based Services Waiver Review
South Carolina Medically Complex Children's Waiver
Control #0675
December 30, 2010

Home and Community-Based Services
Waiver Review Report

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 41'20
Atlanta, Georgia 30303-8909

CENTERS for MEDICARE & MEDICAID SERVICES
December 30, 2010

Emma Forkner, Director
Department of Health and Human Services

P.O. Box 8206
Columbia, SC 29202-8206

Dear Ms. Forkner:

Enclosed is the draft report of the Centers for Medicare & Medicaid Services' (CMS) quality review of South Carolina's Medically Complex Children's waiver program with control number 0675. This waiver serves children under the age of 18 who meet the Nursing Facility (NF) or Intermediate Care Facility/Mentally Retarded (ICF/MR) level of care.

We would like to extend our sincere appreciation to all who assisted in the review process. We found the State to be in compliance with all six of the review components. However, we included necessary recommendations for program improvements for all six assurance areas. We suggest you address these prior to renewal of the waiver in order to meet the assurances and maximize the quality of the waiver program. Please include a detailed plan, with target dates, to show improvements in required waiver performance issues identified in the report.
Please review the draft report and submit your comments within 90 days of receiving this letter. Your response will be incorporated into the final report, which will then become a public document. Should we receive no response from you by the 90th day, April 1, 2011, this draft report becomes a final document. We are available to discuss the report and to provide technical assistance. Please do not hesitate to let us know how we may be of assistance.

We would again like to extend our sincere appreciate to the South Carolina Department of Health and Human Services, who provided information for this review. If you have any questions, please contact Connie Martin at 404-562-7412.

Sincerely,

JtwvR~(I-v

Jackie L. Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Enclosure
cc: Mark Reed, Central Office

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region IV
DRAFT Report

Home and Community-Based Services Waiver Review
South Carolina Medically Complex Children's Waiver
Control #0675
December 30, 2010

Home and Community-Based Services
Waiver Review Report

Executive Summary

The South Carolina Department of Health and Human Services (DHHS) is authorized under §1915(c) of the Social Security Act to provide home and community based services under the Medically Complex Children's Program serving children under the age of 18 who meet the Nursing Facility (NF) level of care (LOC) or Intermediate Care Facility/Mentally Retarded (ICF/MR) LOC. These children have a chronic physical/health condition that is expected to last longer than 12 months and meet medical criteria defined by the state documenting the dependency upon comprehensive medical, nursing, and health supervision or intervention. The services offered in this waiver include Care Coordination, Incontinence Supplies, Pediatric Medical Child Care and Respite Care. The average number of individuals served as of June 1, 2010 was 140 individuals. The approximate average cost per month YTD per person is $9,840.

As requested per the CMS Interim Procedural Guidance, South Carolina submitted evidence to document adherence with program assurances as required per 42 CFR 441. In its submission of October 29, 2010, the State provided an overview of processes, instrument(s), systems and summary reports for each Federal assurance.

Summary of Findings

1. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization -The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends developing specific performance measures to assess accuracy of LOC decisions.

CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

2. Service Plans are Responsive to Waiver Participant Needs -The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator. Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

3. Qualified Providers Serve Waiver Participants -The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

In addition to results submitted on audits of case management providers, please provide results of monitoring of other provider types other than case management, e.g., In-home Skilled Respite and Pediatric Medical Day Care. Please explain the outcome of policies, procedures, and forms that were developed for implementation on July 1,2010, and whether they meet the performance measure.

4. Health and Welfare of Waiver Participants -The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

5. State Medicaid Agency Retains Administrative Authority Over the Waiver Program
The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.

6. State Provides Financial Accountability for the Waiver -The State demonstrates the assurance but CMS recommends improvements or requests additional information.

Suggested Recommendations

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed. It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. The assessment also serves to inform CMS in its review of the State's request to renew the waiver.

State's Waiver Name: Home and Community-Based Waiver for Medically Complex Children (MCC)
Operating Agency: South Carolina Department of Health and Human Services
State Waiver Contact: Maria J. Platanis
Target Population: Children from birth to 18 years of age with a chronic physical and/or health condition expected to last longer than 12 months
Level of Care: Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR)
Number of Waiver Participants: 140 (as of June 2010)
Average Annual per capita costs: $ 9,840
Effective Dates of the Waiver: January 1, 2009 -December 31, 2011
Approved Waiver Services: Children's medical day care, respite, care coordination and incontinence supplies.
CMS Contact: Connie Martin

I. State Conducts Level of Care Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care (LOC) need consistent with care provided in hospital, nursing facility or ICF/MR.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMt.M 4442.5

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State utilizes a comprehensive assessment tool for both levels of care to determine the participant's medical, psychosocial, and functional abilities. Evidence submitted to support a LOC assessment and determination are as follows:

- ICF/MR LOC Staffing Report with DHHS Waiver Administrator/RN and Physician Consultant verifying criteria met as part of a 100% review;
- ICF/MR LOC Protocol;
- ICFIMR LOC DDSN Consumer Assessment Team (CAT) Monthly Log;
- DHHS Master spreadsheet of applicant NF LOC completion dates;
- Completed NF LOC Form, Completed ICF/MR Form, Corresponding MMIS screen reflecting MCC waiver enrollment date, Corresponding MMIS screen reflecting MCC waiver enrollment date;
- DHHS MCC Waiver Technical Assistance Review (TAR) Report of findings related to initial LOC determinations; and
- DHHS MCC Waiver Quality Assurance Review (QAR) Report of findings related to LOC determinations.

The State has demonstrated enrolled participants are re-evaluated at least annually or more frequently if warranted. The same assessment team that conducts the initial LOC determinations also conducts the re-evaluations of LOC. The Care Coordination staff conducts the re-evaluation using the same 1718 tool as the initial LOC. The state operates an electronic system (Phoenix System) that maintains NF LOC which includes LOC determination dates.

The Phoenix System identifies upcoming LOC re-evaluations due dates based on the date of the prior year's LOC. Enrolled participants are re-evaluated at least annually or more frequently if warranted. Evidence to support a re-evaluation of LOC is provided to all applicants at least annually and all participants' LOC was completed prior to the 365th date of the previous LOC are as follows:

• DDSN CAT Team ICFIMR Log representing the ICF/MR LOC re-evaluation dates;
• DHHS Master List of NF and ICFIMR LOC re-evaluations which occurred prior to the 365th day;
• Completed re-evaluations of LOCs determinations and the corresponding initial LOC reflecting timeliness;
• TAR Report office waiver with findings related to annual LOC re-evaluation determinations; and
• QAR Report with findings as related to annual LOC re-evaluation determinations.
Nursing Facility LOC determinations are conducted by trained licensed RN staff utilizing the standardized comprehensive assessment tool (1718 Form). The tool identifies skilled needs and functional deficits.

ICF/MR determinations are conducted by a medical director, licensed nurse, and the Consumer Assessment Team (CAT), consisting of qualified psychologists. A standardized instrument is used to gather assessment information necessary for ICF/MR LOC determinations, as well as redeterminations, capturing three main components: diagnosis of mental retardation or a related disability, behaviors requiring supervision, and services needed for acquisitions of behaviors necessary to function with as much self-determination and independence as possible and lor to prevent deceleration or regression of optimal functional status. The State has submitted the following evidence to substantiate these instruments are appropriately applied:

• Completed NF and ICF/MR LOC instruments, which are maintained in the MCC waiver participant's case record; and the corresponding Medicaid Management Information System (MMIS) data identifying the waiver enrollment date;
• TAR Report of MCC waiver with findings related to NF and ICF/MR LOC determination using the correct instrument; and
• QAR Report with findings as related to LOC determinations using the correct instrument.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 89 percent of waiver enrollment was within 30 days of the initial NF & ICF/MR LOC. The LOC re-evaluation was dated and signed within 365 of the prior evaluation. The State has also conducted remediation by updating the policy and training to ensure waiver applicants are enrolled into the waiver prior to LOC expiration.

One hundred percent of sampled cases used appropriate instruments. However, there are no indications from State monitoring if the instruments were applied appropriately.

Suggested Recommendations

CMS recommends developing specific performance measures to assess accuracy of LOC decisions.

CMS also recommends the State describe the methodology for determining sample sizes used for its monitoring processes to ensure the outcomes are statistically valid.

The State has incorporated the usage of the Phoenix Data Entry System (Phoenix) for the operation of the MCC waiver, including Level of Care determinations. Phoenix requires specific Level of Care criteria be met prior to determination. Phoenix only allows entry into the waiver with a LOC determination completed within 30 days. The State conducts a 100% review for designated review periods to assure Phoenix performed as programmed. Any errors found in the review report would be addressed immediately by determining if the participant is waiver appropriate. Using Phoenix for Level of Care determinations was implemented in May 2010.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that is has designed and implemented an adequate system for reviewing the adequacy of service plans for waiver participants.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7Section 1915(c) Waiver Format, Item Number13

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The plan of care (POC) is the fundamental tool the State uses to ensure the health and welfare of the children in the Medically Complex Children's Waiver. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

The Care Coordination Service Organization (CSO) staff is responsible for developing care coordination plans based on the comprehensive assessment of the participant's medical needs, problems and strengths. Problems are identified, interventions are outlined and initiated, and goals are set. The care coordination plan includes a statement of the participant's needs, related to a goal, with a specific service to meet the need including the amount, frequency and duration of the service. The completed care coordination plan is submitted to the Nurse Administrator, who is also the Waiver Administrator, for review and approval. The State submitted the following evidence that individual care coordination plans are reviewed to assure that all participants' needs and goals are addressed:

• Completed care coordination plan which is maintained in the MCC waiver participant's case record, and reviewed and approved by the Waiver Administrator.

The University of South Carolina conducts a survey by telephone interview of the waiver participant/responsible party, inquiring about the assistance of the care coordinator and services coordinated by the waiver.

The State conducts annual on-site reviews and reports initial findings back to the Nurse Administrator. If the report shows deficiencies, those providers are to respond with a written plan of correction. Service plans are updated and/or revised at least annually or when warranted by changes in the waiver participant's needs. The State submitted the following annual assessments conducted in the States computerized Phoenix system where each participant's electronic record is maintained:

- An example of a completed annual 1718 assessment;
- DHHS Master List of participants who received an annual re-assessment in accordance with State policy;
- TAR Report -Technical Assistance Review Report providing results of State audit; and
- QAR Report -Quality Assurance Review Report.

The CSO is responsible for creating a new service plan within 365 days of the initial care coordination plan. The State utilized the same methods for monitoring the care coordination plan updates/revisions as used for monitoring of the care coordination plan development. Changes to the care coordination plan are made as needed by the care coordinator with the results of monitoring or when information is obtained from the participant, his/her guardian, and/or service providers indicate the need for a change to the care coordination plan. The State utilized the same methods for monitoring the care coordination plan updates/revisions as used for monitoring of the care coordination plan development.

A monthly contact by telephone or an in-person visit must be made by the Care Coordinator to assess and re-evaluate the on-going needs of the child. Monthly contacts and quarterly visits must be documented using the Care Call System. Eighty-seven percent (360 of 415) contacts were completed. When no monthly contact was conducted, it was due to no response from the recipient. Policy was created to address non-compliance by a participant.

The initial care coordination plan is required to be approved by the Waiver Administrator. The service plan included in the electronic case record in Phoenix is also required to be signed and dated indicating approval by the nurse administrator. The following documents were provided as evidence that the State monitors the development of care coordination plans in accordance with waiver policy and procedures:

- Completed Phoenix Service Plan; and
- QAR Report

The State requires care coordinators have a waiver participant's parent or legal guardian complete a Freedom of Choice Form indicating their choice between waiver services and institutional care. Parents or legal guardians are informed in writing prior to waiver enrollment of

waiver services and provided with a list of qualified waiver and non-waiver Medicaid service providers in their area.

The University of South Carolina is responsible for conducting a survey by telephone interview of the waiver participant/responsible party, inquiring about the access of appropriate services and supports in the community.

Of 140 participants, 57 files were selected for the performance measure sample for this assurance. The State's metrics demonstrated 74 percent of initial service plans were signed and dated by the waiver administrator. The State's remediation was to update policy to ensure the approval of services plans are approved prior to waiver enrollment.

The State's metrics also indicated 100 percent of re-evaluations were signed and dated by the waiver administrator. No remediation was needed.

Suggested Recommendations

In response to this draft report, please explain other than changing policy what systemic change was implemented to prevent the recurrence of failing to have 100% of initial plans signed and dated by the waiver administrator.

Although performance measures included the proportion of participants whose plans were updated as needs changed, the Quality Management Review chart does not reflect results of the State's monitoring of this measure. Please provide metrics for this performance measure.

In addition to updating and revising policy the State implemented and now requires that all service plans be completed using Phoenix which monitors to ensure all service plans are signed by the SCDHHS waiver administrator. With this implementation the service plan is not complete without the signature of the waiver administrator and will prevent an applicant's entry into the waiver. The State conducts a 100% review on a continuous and ongoing basis using Phoenix. Requiring the Service Plan to be completed using Phoenix was implemented in October 2010.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Authority: 42 CFR 44].302; SMJ.\14442.4

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process. evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State verifies providers initially and continually met required licensure and/or certification standards prior to their furnishing waiver services. Care Coordinators employed by the CSO must be licensed Registered Nurses with a minimum of three years experience with medically complex children.

The State reports that it monitors non-licensed/non-certified providers to assure adherence to waiver requirements. However, the Quality Management Chart states all providers are licensed or certified. They verify potential providers meet all standards and qualifications. Once the State confirms the provider meets all Medicaid standards and qualifications, the approved provider may enroll with DHHS to provide waiver services. The State is responsible for conducting annual provider reviews to ensure providers continue to meet criteria to render waiver services.

The State conducts reviews and provides technical assistance to the CSO, the Care Coordination waiver service provider. DHHS completes quality assurance reviews of providers and submits the findings to the CSO and the waiver administrator provides technical assistance and follows up as necessary. The following evidence provides documentation of the State's monitoring, training and actions taken when the CSO has not met requirements.

- TAR Report provides results of monitoring of performance measures related to provider qualifications;
- QAR Report provides results of monitoring of performance measures related to provider monitoring;
- Training activity agendas; and
- Training Session to review/update MCC policy.

The State reviewed the licenses of the eight nurses comprising nursing staff and Nurse Administrator. Metrics show 100 percent (8 out of 8) were licensed Registered Nurses.

Suggested Recommendations

In addition to results submitted on audits for case management providers, please provide results of monitoring of other provider types, e.g., In-home Skilled Respite and Pediatric Medical Day Care. Please explain the outcome of policies, procedures, and forms that were developed for implementation on July 1, 2010, and whether they meet the performance measure.

Pediatric Medical Day Care (PMDC) was implemented on the July 1, 2010 start date using the Phoenix and Care Call systems. Related operational policies were in place. After completion of the service plan and waiver entry, the care coordinator is able to authorize the PMDC service for the participant for a specific number of hours per week using Phoenix. The authorization is then accepted by the provider. After the service is provided billing and tracking of the service occurs through the Care Call System. Reports are run to verify services were provided as authorized.

Prior to the implementation of the PMDC, providers were required to show proof of State Child Care Licensure which included requirements for fire and building codes, and staffing standards. In addition for compliance with the SCDHHS Contract Scope of Service, the State has attached the following sample of evidence for a PMDC Provider which documents that the provider meets the performance measure monitoring provider qualifications.

1. **Copy of SC DSS Day Care License**
2. **Copy of SC Nursing License verification**
3. **Evidence of background checks for direct care staff**
4. **Copy of CPR/BLS certification for staff**
5. **Evidence of PPD Tuberculin testing of direct care staff**
6. **Evidence of nursing staff member's minimum experience in pediatric nursing care**
7. **Evidence of training completed by the provider as it directly concerns the Pediatric Medical Day Care service**
8. **Staffing schedule as it pertains to nurse/patient ratio (e.g. one month's staffing schedule)**
9. **Copy of specific medical treatment plan for a participant attending the PMDC**

The implementation of the In-home Respite service was delayed due to the need for a waiver amendment related to unit of service/rate change. SCDHHS Contracts are currently in process for recruited providers. Tentative implementation date is March 2011.

Prior to implementation of the in-home respite, contracting providers will be required to show proof of SC nursing licenses for respite care givers, as well as background checks and proof of PPD testing. Policy development is in process and will be completed prior to implementation. This service will also be authorized and monitored in Phoenix and Care Call.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The State identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation. DHHS QA staff monitors health and welfare concerns through the quality assurance process which includes case record reviews of critical incidences, abuse, and neglect reports.

DHHS Program Integrity Division also investigates reports of abuse, neglect, exploitation, and fraud via a toll free hotline.

Based on the South Carolina Code of Laws, the SC Department of Social Services (DSS) is the investigative agency for children under 18 years of age. Upon enrollment into the waiver, all participants are given the DSS Abuse hotline information on how to report abuse. When the DHHS or the CSO receives reports of alleged abuse; the initial response is to ensure the child is protected. The DHHS/CSO does not allow the alleged perpetrator to provide any services until the investigation has been completed. A report is completed by the Care Coordination staff and reviewed by the Waiver Administrator. DSS is alerted and the service provider is requested to remove the alleged perpetrator from the child's environment. Upon completion of the investigation, the next action taken is dependent upon the results.

The following evidence supports the conclusion that the State seeks to address and prevent occurrences of abuse, neglect, and exploitation on an ongoing basis:

- QAR Report;
- MCC Abuse Report Form;
- Abuse Hotline handout to participants; and
- South Carolina Solutions Admission Agreement Form.

Of 140 participants the State reviewed 57 case records. There were no critical incidents reported (including mortality and injuries) for the sample of records chosen.

Suggested Recommendations

DHHS reported no instances identified through the State audit. In addition to official reports of abuse, neglect and exploitation, the State may want to consider developing performance measures to identify and track complaints and grievances as they are first reported through resolution.

Participants are notified of their right to complain through a participant's rights and responsibilities statement reviewed and signed at the initial visit by the Care Coordinator and responsible party. Complaints and grievances are received by the Care Coordination Staff directly from the responsible party or parents of waiver participants. Complaints and grievances are logged into Phoenix via the electronic complaint form by Care Coordinators. Phoenix initiates action to address the complaint or grievance. The complaint/grievance is sent electronically through to the waiver administrator to be addressed with Care Coordination Staff. If warranted the complaint/grievance is sent to quality assurance and provider compliance. The Phoenix Complaint Log tracks and

documents the actions taken towards reaching a resolution of the complaint/grievance. Phoenix Complaint Log implementation was initiated on August 2010. As a result of this process, the State will implement the following performance measure: The State will track 100% of all complaints and grievances reported through resolution.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains ultimate administrative authority over the waiver program and that its administration of the wavier program is consistent with its approved waiver application.

Authority: 42 CFR 441.303; 42 CFR 431: SMA14442.6; SA£i\14442. 7

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition of information or program improvements.)

Evidence Supporting This Conclusion:

The waiver is both administered and operated by the Medical Assistance Unit as a component of the State Medicaid Agency. The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by local/regional non-State agencies and contracted entities.

The State engages in routine oversight of the MCC waiver program by enforcing the terms and conditions of the waiver service contracts. Meetings are held with waiver service providers to discuss specific waiver issues identified through State oversight. In addition, DHHS conducts monthly staff meetings with the CSO and the Care Coordination staff.

The State also engages in routine oversight of the MCC waiver program by conducting technical and/or quality assurance reviews annually. Aggregated discovery and remediation reports relating to each of the performance measures are reviewed and addressed.

DHHS has submitted the following evidence to support their ongoing administrative authority and to establish it is consistent with the approved waiver application:

- Service contract between DHHS and the CSO for Care Coordination Services;
- ICF/MR LOC Quality Management Process;
- Quality Assurance Review Report;
- Technical Assistance Review Report; and
- Copy of DHHS and the CSO Care Coordination staff meeting agenda which occur on a monthly basis or more often as needed to discuss various policy updates and training for the contractor.

Suggested Recommendations

CMS recommends taking and maintaining minutes of the meetings held with waiver service providers for monitoring purposes.

The State will develop a policy and procedure to take and maintain minutes of meetings held with waiver service providers for monitoring purposes. Implementation will be immediate following the updating of policy in March 2011.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the wavier program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMA14442.10

The State demonstrates the assurance but CMS recommends improvements or requests additional information.

(CMS recommendations enable the State to improve upon the process, evidence or reporting. The submitted State evidence can be enhanced considerably with the addition information or program improvements.)

Evidence Supporting This Conclusion:

The State assures claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. DHHS Fiscal staff, Audit staff, and Program Integrity staff conducts ongoing monitoring of finances on a monthly basis.

As part of the ongoing monitoring process, State Quality Assurance (QA) staff compares services billed and paid to the POC to ensure services rendered were specified in the POC. The QA process is also used to monitor paid claims data and participant utilization reports. Cost reports are developed to ensure that funds are being applied and used properly by analyzing financial records maintained by the State, sub-state entities, and providers. All findings are used to determine needed improvements as well as corrective actions.

Once a service is authorized in the Phoenix system the authorization is sent to the Care Call system to be utilized by service providers. Care Call tracks all services with codes and sends them to MMIS for payment. Claims must meet all applicable criteria to be submitted to MMIS for payment at which time the billing code determines the rate of reimbursement. Cost reports are developed to ensure that funds are being applied and used properly.

The following documents provide evidence that the State monitors claims to assure they are coded and paid accurately:

- MCC Waiver Cost report;
- Phoenix Service Provision (service authorization);
- Care Call Service Monitoring Reports;
- Care Call Time and Attendance Report;
- Care Call Resolution report;
- MMIS claims data; and
- Participant case record audit.

The State pulled paid claims data for the month of August 2010. All claims were reviewed and there were no claims returned as denied.

Suggested Recommendations

CMS recommends the State develop and implement additional performance measures to capture data related to monitoring outside of the MMIS/financial system. For example, measures may include the number and percentage of claims with scope, frequency and amounts specified in the POC.

The State may also wish to include performance measures related to documentation maintained by providers to support amounts billed.
It is also recommended the State pull a statistically valid sample of paid claims data to review at least annually.

The State Medicaid Agency serves as both the Administrative and Operating Authority for the MCC waiver program. The agency has direct responsibility for ensuring financial accountability. This is done in a number of ways.

South Carolina's Care Call system is used for almost all waiver service claims. This is a system in which providers of in-home services make a call to a toll-free number to document service delivery. When payment is based upon the length of stay (care coordination monthly calls and quarterly visits, PMDC attendance, in-home respite care), two calls are made to document the start and end time of the service. When payment is not based on length of time in the home, (care coordination monthly contact), a single call from the home documents service delivery.

Care Call generates claims based upon documented visits. The claim will be based upon authorized services and will be the lesser of the delivered and authorized time (e.g., two hours authorized and 1.5 hours delivered = a claim for 1.5 hours; two hours authorized and three hours delivered = a claims for two hours). This ensures that provider billings do not exceed authorized amounts. It also provides a check to see if the phone call was made from the authorized location.

At this time, Care Coordination, PMDC, (and subsequently, in-home respite) are billed through the Care Call system. Currently, for services not part of the Care Call system, incontinence supplies, South Carolina has developed a system which checks to ensure that the participant is enrolled in the waiver and is Medicaid eligible at the time of the service. Care Coordinators review service delivery with participants on a monthly basis to ensure that claims are appropriate and that authorized services are being delivered.

In addition to the financial accountability offered by the Care Call system, the State also employs a quality assurance reviewer who conducts reviews of waiver service providers. The reviews consist of three components: staffing qualification reviews, administrative reviews and participant record reviews.

The SCDHHS Division of Program Integrity works closely with the Medicaid Fraud Control Unit for South Carolina's Attorney General's Office. Any suspected fraud is referred to this Unit.

The following performance measures are currently being implemented and will be incorporated in the upcoming MCC Waiver Renewal document.

1. **The State will ensure that 100% of services including scope, frequency, and amounts specified will be identified in the POC prior to billing through MMIS.**

2. **The State will ensure 100% of services will be properly documented by providers in order to support the amounts billed.**

3. **The State will use a statistically valid sample size for review.**

South Carolina
Department of Social Services

Columbia, South Carolina

A REGULAR LICENSE IS HEREBY GRANTED TO

THE WONDER CENTER
Kristi Coker, Director

To conduct a Child Care Center **under the provisions of 63-13-10 et seq., Code of Laws of South Carolina located at** 29 North Academy Street, Greenville **in** Greenville **County of the State of South Carolina.**

This regular license is for a maximum of 40 **children,**
limited to 28 children under 30 months of age.

This regular license is issued on June 29 **, 20** 10
and will expire by operation of law on June 29 **, 20** 12 **.**

This license is subject to revocation by the South Carolina Department of Social Services for the violation of any provision of the statute under which it is issued, or any of the regulations which are enforced by the South Carolina Department of Social Services. A change in location, ownership or sponsorship of the facility shall automatically void the license unless prior written authorization is received from the Department.

This license is the property of the Department of Social Services and shall be surrendered to the Department upon written notification.

Amended from provisional to regular license. Amended to indicate new director.

By Leigh W Bolick
Director, Child Care Services

Cynthia S Para
Director, Child Care Licensing

License No. 22490

DSS Form 2918 PC (Nov 08) RL

1. Copy of SC DSS Day Care License

JUDITH ANN HUDAK
GREENVILLE, SC 29607

License number: 90692
License type: RN
Original Issue Date: 01/13/2003
Expiration: 04/30/2012
Status: Active

Privilege To Practice: Multi-State

Individual listed above is in good standing with the SC Board of Nursing

DSS
Serving Children and Families

KATHLEEN M. HAYES, PH.D.
STATE DIRECTOR

MARK SANFORD
GOVERNOR

April 23, 2010

CONFIDENTIAL

Ms. Laura Meister, Director
The Wonder Center
29 North Academy Street
Greenville, SC 29601

Re: Tammy Pinion
SSN: XXX-XX-5730

Dear Ms. Meister:

We have reviewed the SLED/FBI civil applicant responses and determined the above referenced individual has no convictions pursuant to South Carolina Code of Laws Ann., Section 63-13-40 (as amended).

You are provided this information for licensing purposes only. This information should not be disseminated to any other person/child care facility.

Sincerely,

(Mrs.) Eva C. Gourdine
Special Agent in Charge
Investigations and Criminal Records
Division of Investigation

ECG/at

cc. Child Day Care Licensing & Regulatory Services, Region I

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
DIVISION OF INVESTIGATION
3150 HARDEN STREET, COLUMBIA, SC 29203
TELEPHONE: (803) 898-8005, FAX (803) 898-[illegible]
WEB SITE: www.state.sc.us/dss

3. Evidence of background checks for direct

Greenville Hospital System
Course Completion Report

Date Range: 2/7/2009 Through 2/8/2011

Delivered 2/8/2011

Data as of 2/7/2011 12:00 AM

Report Order: Department, Student, Learning

Learning Included: All Learning

Department Code/Title	Student	Learning Name	User ID	Completion Date	Completed At
08 7424-WONDER CENTER	HUDAK, JUDITH A	Basic Life Support (CPR) Competency	18862	10/11/2010	Greenville Hospital System
08 7424-WONDER CENTER	MILLER, REBECCA M	Basic Life Support (CPR) Competency	14811	9/24/2009	Greenville Hospital System
08 7424-WONDER CENTER	PINION, TAMMY S	Basic Life Support (CPR) Competency	19864	10/1/2009	Greenville Hospital System
08 7424-WONDER CENTER	SHEALY, SUSAN S	Basic Life Support (CPR) Competency	28545	12/15/2010	Greenville Hospital System
08 7424-WONDER CENTER	STRONG, KANDACE W	Basic Life Support (CPR) Competency	18505	9/24/2009	Greenville Hospital System

4. Copy of CPR/BLS certification for staff

South Carolina Department of Social Services
Child Care Regulatory Services

Staff Health Assessment

NAME: Rebecca Erline Miller DOB: 08-28-1955

Type of Activity in Child Care *(Check all applicable)*
☑ Caring for children ☐ Desk Work
☐ Adult Member of Household ☐ Food Preparation ☐ Driver of Vehicle ☐ Facility Maintenance

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH ASSESSMENT

PART I – MEDICAL HISTORY – Does this person have any of the following medical problems?

	Yes	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		✓
History of epilepsy?		✓
Diabetes?		✓
Current drug or alcohol dependency?		✓
Disabling emotional disorder?		✓
Does this person have any special medical or mental problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children. If yes, explain on reverse of form.		✓
Speech disorder?		✓
Significant physical findings/chronic medical condition or physical impairment?		✓
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		✓

PART II – AS SHOWN BY PHYSICAL EXAMINATION, DOES THE INDIVIDUAL HAVE:

	Yes	No
At least 20/20 combined vision, corrected by glasses if needed?	✓	
Normal hearing?	✓	
Normal blood pressure? 108/70	✓	

PART III – COMMUNICABLE DISEASES – Does this person have a communicable disease which would prohibit him/her from working in a child care facility?

☐ Yes ☑ No If yes, please comment: _____

Tuberculosis Certification *(if medically recommended or required by the Local Health Officer)*		
TYPE OF TEST:	**READING:**	**DATE:**
Mantoux PPD	0	9-2-09

Immunization Status

Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV. Immunization status reviewed: ☑ Yes ☐ No

Comments: Tdap given 4-13-10

Employee Health & Wellness Services
Greenville Hospital System
701 Grove Road/ESC
Greenville, S.C. 29605-5601 864-455-8994

Print Name & Address of Health Care Provider Telephone Number

Margaret C Bda RN 4-13-10

Signature of Health Care Provider Date of Examination

HEALTH ASSESSMENTS MUST BE OBTAINED AT LEAST EVERY FOUR (4) YEARS AFTER INITIAL ASSESSMENT AND SUBSEQUENTLY ACCORDING TO THE STATUTE.

DSS FORM 2926 (SEPT 06). Edition of NOV 99 is obsolete.

5. Evidence of PPD Tuberculin testing of direct care staff

Attn: Susie Peden
Resume
6/4/03

JUDITH A. HUDAK
ADDRESS: 107 Sandpiper Lane
Greenville, SC 29607
PHONE: 864-288-6119

PROFESSIONAL EXPERIENCE:

1997-2002- Clinical Staff Nurse, Neonatal Intensive Care unit, Holy Cross Hospital. Silver Spring, Md

Job Description: flex position. Worked 8-16 hours per week. Provided direct patient care in a level 2/3 NICU. Provided care for 2-4 infants. Assisted with discharge planning.

1994-1996- Volunteer: First Steps- A neonatal home visit program for first time mothers. Ramstein, Germany.

Job Description: made prenatal and post natal visits to home and hospital; performed assessments on mothers and babies and provided teaching on post partum care, infant care, and anticipatory guidance throughout the babies first year, at four months and at one year. Attended weekly multidisciplinary conferences to discuss high risk patients and plan of care.

1991-1994- Agency Nurse- SRT Medstaff, Springfield,Va 22151

Job Description: worked primarily in the neonatal and pediatric intensive care units at Walter Reed Army Medical Center

1990-1991- Assistant Nurse Manager, Neonatal Unit, 121st evacuation Hospital, Seoul, Korea: Captain, **US Army Nurse Corp.**

Job Description: Supervised 6 RNs and 7 LPNs on a 22 bed level I-III neonatal unit; responsible for monitoring and evaluating job performances of staff on a quarterly basis;

6. Evidence of nursing staff member's minimum experience in pediatric nursing care

functioned as unit quality assurance facilitator- devised several standards of care and an extensive knowledge and skills evaluation checklist; and, transported neonates as early as 24 weeks to tertiary care centers by air.

1987-1990- Clinical Staff Nurse, Neonatal intensive care unit, Walter Reed Army Medical Center, Washington, DC; **US Army Nurse Corps**

Job Description: Functioned as charge RN on a 40 bed neonatal unit, responsible for 5-6 RNs and 3-4 LPNs ; provided nursing care to both well and critically ill infants; coordinated patient care conferences for chronically ill neonates; compiled and computed data for workload management on unit; taught infant care classes to moms and precepted ICU students and new staff.

1985-1987- Clinical Staff Nurse, Walter Reed Army Medical Center, US Army Nurse Corps

Job Description: functioned as team leader/charge RN on a 30 bed General Medicine Unit; provided direct patient care while supervising 1-2 RNs and 3-4 LPNs.

Sept 1986- January 1987- Completed the Intensive Care Nursing Course at Walter Reed Army Medical Center

EDUCATION

BS in Nursing, Salve Regina University, Newport ,RI 1985

PROFESSIONAL ORGANIZATIONS:

NANN

CERTIFICATIONS:

CPR, NALS

Children's Hospital
The Wonder Center

29 N. Academy Street Greenville, SC 29601 (864) 331-1380 Fax (864) 331-1418

Department Specific Competency

Competency Eyewash Facility Date: 3-31-09

Employee Name: Kendace Strong Position: RN Staff

Performance Criteria	Self Assessment		Action Plan			Evaluation Summary	
Equipment & Skills (As outlined in GHS policy & procedure)	Have you ever performed this skill or used this equipment?		* Yes requires validation *No requires learn, practice, validate			Evaluation Method = Simulation or Actual Setting	
	*YES	*NO	Learn	Practice	Validate	Method	Date/Initial
1. Eyewash facility is in good working order.	✓				Ktz	Actual	3/31/09
2 Area is assessible with appropriate signage.	✓				Ktz	↓	
3.Eyewash facility operates with one movement	✓				Ktz		
4. Eyewash facility remains on after activation.	✓				Ktz		
5. Use both hands to open eyes in the eyewash	✓				Ktz		
6. Hold eyes open in running water.	✓				Ktz	↓	
7. Roll the eyeballs around so that water will flow on all surfaces of the eye & eyelid.		✓				Sim	
8. Seek medical attention.		✓				Sim	
9. Contact the building manager or a Haz Met officer. Follow the spill protocol as listed in the MSDS.		✓				Sim	
10. Clean the eyewash area with a hospital approved disinfectant.	✓				Ktz	Actual	
11.Complete the appropriate SREO form.		✓				Sim	
12							
13							
14							
15							
16							

Signature Kendace Strong RNC Initials KS

Signature Tammy Pinion RN Initials TP

7. Evidence of training completed by the provider as it directly concerns the Pediatric Medical Day Care services

Children's Hospital
The Wonder Center

29 N. Academy Street Greenville, SC 29601 (864) 331-1380 Fax (864) 331-1418

Department Specific Competency

Competency Vascular Access Device Factor Administration **Date:** 3-17-09

Employee Name: RonDace Strong **Position:** staff nurse RN

Performance Criteria	Self Assessment		Action Plan			Evaluation Summary	
Equipment & Skills (As outlined in GHS policy & procedure)	Have you ever performed this skill or used this equipment?		* Yes requires validation *No requires learn, practice, validate			Evaluation Method = Simulation or Actual Setting	
	*YES	*NO	Learn	Practice	Validate	Method	Date/Initial
1 Wash hands	✓				BLH	Actual setting	2-6-09 BLH
2 Apply numbing cream to port site							
3 Cover with clear dressing, wait 30 - 60 min							
4 Gather supplies per policy and procedure							
5 Set up sterile field							
6 Prepare, educate and position patient							
7 Wash hands							
8 Palpate port perimeter and locate center							
9 Determine device depth for needle size							
10 Wash hands							
11 Apply facial mask and don sterile gloves							
12 Clean in circular motion : center outward							
13 Use Chlorhexidine prep for min of 30 sec							
14 Follow with alcohol prep x 3							
15 Don second pair of sterile gloves							
16 Place needleless access to huber needle							
17 Attach and flush with 10 cc syringe of NS							
18 Palpate center of port and place needle							
19 Aspirate for positive blood return							
20 Administer medication using SASH							
21 Deaccess and apply bandaid or dressing							
22 Dispose of needle in sharps container	✓				✓	✓	

Signature/Initials
RonDace Strong RNC

Signature/Initials
Bonnie C. Hagner, RN BLH

Children's Hospital
The Wonder Center
29 North Academy Street
Greenville, SC 29601
(864) 331-1380 fax (864) 331-1418

The Wonder Center

Daily Staff Assignments

General Unit Tasks:	RN	General Unit Tasks:	CNA	Date: 5-7-10 Fri
Assignment / Pt Attendance / Cavicide Desk Area	Suzy	Lunch Prep + after lunch kitchen clean-up	Tami	Staff Call-ins:
Resp. Cart, AED + Refrigerator Logs	Judy	Cavicide toys & put away		Pt. Call-ins/ Pt. Information:
File pt. materials into longterm charts		Stock Linens /Supplies PRN		
Copy flowsheets & restock forms cart PRN		Linen change cribs & beds: Thursdays		Special Staff Assignments:

All Staff: Pt. items in dishwasher & straighten front room PRN

Staff: RN/ CNA	Suzy	Judy	Tami			
Patient Name:	[redacted]					
Patient Name:						
Patient Name:						
Patient Name:	assess: Trenton Karol	assess: Zachary MED@1303	Vitals			
Patient Name:						
Patient Name:						

8. Staffing schedule as it pertains to nurse/patient ratio (e.g. one month's

The Wonder Center
Individual Treatment Plan

Patient:	Christopher 'Mikey' Hannigan
Date of Birth:	11.18.07
Date of Admission:	8.25.09

Date of Plan:	12.22.10
Date of Next Review:	6.22.11

Therapies:

Physical Therapy - Kidnetics -Mary Jones
Occupational Therapy - Kidnetics - Erin Peterson
Speech Therapy- Kidnetics- Megan Theiling
MCC Waiver Coordination- SC Solutions- Alysen McCaughey
Service Coordination- Brightstart-Crystal Clark

Strengths & Skills:

Christopher 'Mikey' is a three year old boy who attends The Wonder Center part time. He has made some great gross motor progress during this review period; he began consistently and independently walking. Mikey enjoys movement in the swing or the jump-a-roo. He likes to look at himself in the mirror. Mikey has recently begun to show some interest in specific toys.

Long Term Goal:

Mikey will reach medically stable status and will transition into another school, community, or home-care setting.

Presenting Problems:

Complex Partial Seizures, Developmental Regression, Feeding Difficulties, Attached Frenulum

Primary Care Physician: Dr. Keith Stafford - Cornerstone Family Medicine

Multidisciplinary Team Members:

Name (please Print)	Title/Agency	Signature	Date
Tiffany Huergerford	child development Specialist/TWC		12.28.10
Tammy Pinion RN	RN / TWC	Tammy Pinion RN	12-28-10
Brittany Hannigan	Mother		12-28-10

9. Copy of specific medical treatment plan for a participant attending the PMDC

The Wonder Center
Individual Treatment Plan

Patient: Christopher 'Mikey' Hannigan
Date of Birth: 11.18.07
Date of Plan: 12.22.10
Date of Next Review: 6.22.11

Short Term Objective	Intervention Methods	Criteria for Achievement	Target Date
Mikey will maintain adequate nutritional intake for appropriate development and weight.	1. Communicate closely with physicians & family regarding status/care.	1. Mikey will plot within normal limits for his age on appropriate growth chart.	6.22.11
	2. Monitor and record weights on a monthly basis - report concerns prn.		
	3. Monitor and document all intake and output at the Wonder Center - report concerns prn.	2. Mikey will not exhibit chronic signs/symptoms of feeding intolerance during time spent at the Wonder Center.	
Mikey will benefit from the monitoring of seizure activity while at The Wonder Center.	1. Communicate closely with physicians & family regarding seizure activity.	1. Mikey will receive appropriate monitoring, treatment, and follow up care in the event of a seizure while at The Wonder Center.	6.22.11
	2. Observe and document any seizure activity at The Wonder Center.		
	3. Administer medications as ordered by physician.		
	4. Provide O2 administration and suction as needed during seizure activity.		
Mikey will exhibit improved communication skills through the use of sign and increased vocalizations to communicate his wants and needs.	1. Communicate closely with family and therapists regarding goals and progress.	1. Mikey will use simple sign to communicate without cuing 50% of the time when presented with the opportunity to indicate he would like 'more' of something.	6.22.11
	2. Provide activities for Mikey to communicate his wants and needs using sign.		
	3. Praise Mikey when he uses sounds or sign to initiate activities or to request items or assistance.		
	4. Communicate with therapists regarding activities ideas to help further Mikey's speech and language development.		

The Wonder Center
Individual Treatment Plan

Patient: Christopher 'Mikey' Hannigan **Date of Plan:** 12.22.10

Date of Birth: 11.18.07 **Date of Next Review:** 6.22.11

Short Term Objective	Intervention Methods	Criteria for Achievement	Target Date
Mikey will demonstrate increased oral motor coordination	1. Communicate closely with therapists regarding a plan for oral motor activities and progress.	1. Mikey will maintain tolerance for oral motor stimulation.	6.22.11
	2. Implement and maintain a plan for oral motor input and activities at TWC.		
	3. Incorporate oral motor stimulation into daily activities with Mikey at TWC.	2. Mikey will demonstrate increased oral motor coordination as evidenced the ability to chew and swallow age appropriate foods.	

The Wonder Center
A Program of the Children's Hospital
Located at:
29 North Academy Street
Greenville, SC 29601
(864) 331-1380
fax: (864) 331-1418

Dear Primary Care Physician,

As you know, Medicaid funds the care of patients at the Wonder Center. Medicaid requires care plans (or Individual Treatment Plans) be approved by a patient's Primary Care Physician. The Wonder Center is asking Primary Care Physicians for the following:

1. Please review the attached Wonder Center Care Plan.
2. Complete this form and sign/date at the bottom indicating approval of the plan. Please include any recommendations you may have.
3. Return this form to The Wonder Center
   a. Fax: (864) 331-1418 Attn: Tiffany Hungerford
   b. Mail: The Wonder Center
      Attn: Tiffany Hungerford
      29 N. Academy Street
      Greenville, SC 29601

As usual, we appreciate your support. Please do not hesitate to let us know if you have any questions, or if there is anything that we can do to assist you in the care that you provide.

Facility: The Wonder Center

Patient: Christopher Hannigan **DOB:** 11-18-07

Date of Plan: 12-2-10 Please check one:

- ☑ Individual Treatment Plan
- ☐ Treatment Plan Review
- ☐ Other: _____

Physician (please print): Dr Stafford

Name of Practice: Cornerstone Family Medicine

By signing below I acknowledge that I have received and reviewed the above-mentioned plan of care and approve of the goals and objectives outlined in the plan. I also authorize the implementation of this plan at the facility listed above.

Physician Signature: K. Stafford MD **Date:** 2/1/11