



SHS Overview

- **History**
- **Organization**
- **Service Population** (Description of special health care needs population)
- **Purpose** (Mission, Vision, Values, Goals)
- **Strategic Plan** (Goals and Objectives)
- **Service Coordination** (Model)
- **Essential Elements** (Comprehensive Assessment, Service Plan, Transition Plan, Medical Home)
- **Programs** (CYSHCN, HCY, MFAW, ABI)
- **SHS Projects** (Family Partnership, Council, and Grants)
- **Resources**

SHS Historical Summary

- 1927 - The Missouri Crippled Children's Service (CCS) was established by State Statute and funded by the state. The Board of the Curators of the University of Missouri was designated to administer this program of services for "medically indigent" children with orthopedic handicaps. The University of Missouri Hospital was named as the treatment center.
- 1936 - Federal funds were granted to Missouri under the provision of Title V of the Social Security Act of 1935. Contracts were negotiated with other treatment centers throughout the state.
- 1943 - The maximum age for care was raised from fifteen to twenty-one years.
- 1957 - Children with congenital heart conditions amenable to surgery were accepted for diagnosis and treatment.
- 1959 - Other categories of crippling illnesses were added as funds were available without detracting from services currently provided.

SHS Historical Summary

- 1974 - Missouri Crippled Children's Service transferred from the University of Missouri to the Department of Social Services, Division of Health, Section of Medical Care.
- 1985 - The Division of Health became the Department of Health.
- 1986 - Surgeon General C. Everett Koop coined the phrase Children with Special Health Care Needs to replace the old Crippled Children's Services (CCS).
- 1989 - Missouri Omnibus Budget Reconciliation Act mandated expanded Medicaid services for children. BSHCN began providing Administrative Case Management for Medicaid recipients of the Healthy Children and Youth Program.
- 1993 - Head Injury Program was transferred to the Department of Health from the Office of Administration.

SHS Historical Summary

- 1999 - Bureau of Special Health Care Needs (BSHCN) began to assist in administering the Medically Fragile Adult Waiver (MFAW) Program (originally referred to as the Physical Disabilities Waiver (PDW) Program). Each year the maximum number of recipients has increased, allowing for more recipients to receive these services.
- 2000 - BSHCN transferred the management of the Genetics Services to the Bureau of Genetics and Disabilities Prevention.
- 2001 - Family Partnership Initiative began.
- 2002 - Service Coordination for Children with Special Health Care Needs was provided statewide by contracted agencies.
- 2012 Section for Special Health Services was created.

SHS Organization

- Missouri Department of Health and Senior Services
 - Division of Community and Public Health
 - Section for Special Health Services
 - Adult Head Injury Unit
 - Bureau of Special Health Care Needs
 - Children and Youth with Special Health Care Needs Program
 - Healthy Children and Youth Program
 - Medically Fragile Adult Waiver Program

SHS Organization - Offices

- **SHS Central Office (CO)**
 - Jefferson City
- **SHS Regional Offices are located in:**
 - Cape Girardeau
 - Independence
 - Springfield
 - St. Louis
- **SHS Satellite Offices are located in:**
 - Cameron
 - Columbia
 - Hillsboro
 - Jefferson City
 - Kennett
 - Poplar Bluff

Description of Individuals with Special Health Care Needs

Individuals with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by individuals generally.*

*Adapted from the Maternal and Child Health Bureau (MCHB) of the Department of Health and Human Services, Health Resources and Services Administration (HRSA).

SHS Mission and Vision

MISSION:

- To develop, promote, and support community-based systems that enable the best possible health and highest level of functioning for Missourians with special health care needs.

VISION:

- All Missourians with special health care needs will have equal access to comprehensive quality health services, enabling them to achieve their highest level of functioning.

SHS Values

- Service systems that are responsive, adaptable, accessible and equitable across diverse communities.
- Quality health care for all persons with special needs.
- Active participation by individuals and families.
- Rights of individuals and families to choose services that meet their needs.
- Partnerships with state, local, and community entities.
- Effective and efficient use of public and private resources.

SHS Performance Measures

- Families of individuals with special health care needs will partner in decision making at all levels and will be satisfied with the services they receive.
- All individuals with special health care needs will receive coordinated ongoing comprehensive care within a medical home.
- All families of individuals with special health care needs will have adequate private and/or public health insurance to pay for the services they need.
- All individuals will be screened early and continuously for special health care needs.
- Community-based service systems will be organized so families can use them easily.
- All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Service Coordination

- Service Coordination is the fundamental element of all SHS Programs.
- The Service Coordination process includes:
 - Outreach/Identification and Referral/Application
 - Eligibility Determination
 - Assessment of Needs
 - Service Plan Development/Implementation
 - Monitoring and Evaluation
 - Transition/Closure

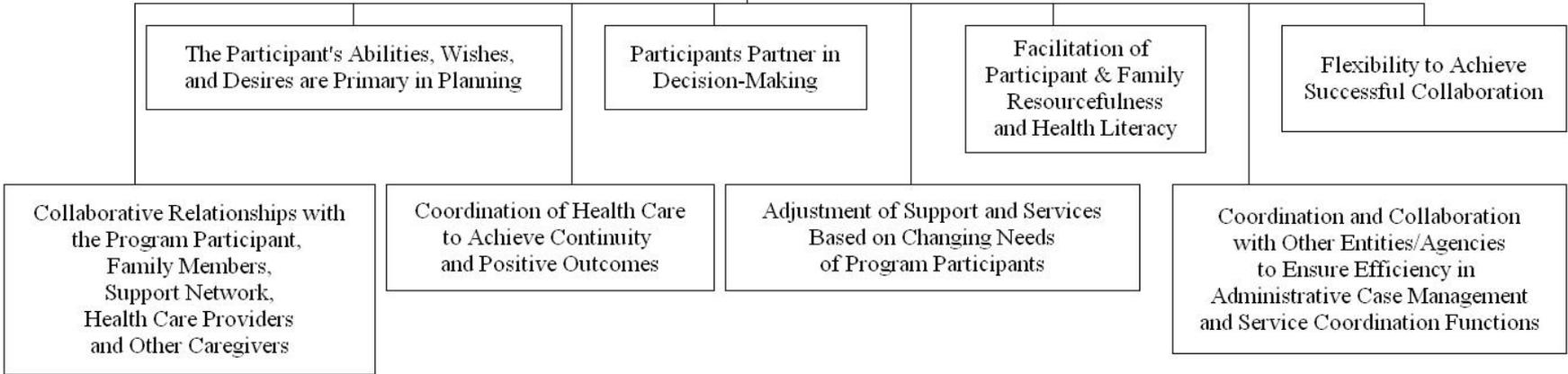
Strategic Plan

- **Special Health Services (SHS) participants/ families will receive services that enable the best possible health and greatest degree of independence.**
 - Objective 1 is to increase percentage of SHS participants/families who benefit from SHS Services. The strategies include increase percentage of:
 - Comprehensive Assessments completed within the required time frame.
 - SHS participants/families who report they partner with their Service Coordinator.
 - SHS participants/families who report that SHS services have improved the quality of their life.
 - SHS participants/families who report they are satisfied with SHS services.
 - SHS participants/families who report that systems are organized and easy to use.
 - SHS participants/families that report they have a Medical Home.
 - Objective 2 is to increase activities to provide information about SHS programs and services and collaborate with other agencies serving Missourians with special health care needs. The strategies include an increase percentage of:
 - SHS contact with Missourians to provide information about SHS services.
 - SHS participation as an exhibitor at educational events and conferences.

Section for Special Health Services
Service Coordination Model
 Definition, Principles and Key Components
 January 2012

Service Coordination is a culturally competent, collaborative, proactive and comprehensive health care process designed to help each person achieve the best possible health and the greatest degree of independence. The primary mechanisms of Service Coordination are individualized assessment, planning, plan implementation, monitoring and transitioning.

Principles of Service Coordination



Key Components of Service Coordination



Essential Elements

- Comprehensive Assessment
- Service Plan
- Transition Plans
- Medical Home

What is a Comprehensive Assessment?

- Service Coordinators utilize the Service Coordination Assessment (SCA) to assist in the identification of participant/family needs.
- The SCA is completed at least annually with participants/families.
- Needs that are identified by the participant/family and Service Coordinator are outlined in the development of the Service Plan.

What is a Service Plan?

- A Service Plan is developed from information obtained during the assessment process.
 - The plan is a ‘blue print’ for how services will be provided to meet the participant/family needs.
 - It is also a method of communication for payment of claims.
- A Service Plan is completed at least annually for each participant enrolled in a SHS Program (and receiving paid services from that program).
- A Service Plan is developed in cooperation with the participant/family and identifies:
 - Concerns, priorities, and resources of the participant/family
 - Outcomes or changes the participant/family wants to occur
 - Services needed to address the identified outcomes
 - Method, duration, and location of services
 - Service providers
 - Funding resources to cover the cost of the services
 - The effective date for the initiation of services

What are Transition Plans?

- Transition planning begins when the participant is enrolled in a SHS Program and continues periodically throughout enrollment.
- Team members collaboratively plan the needs of the participant at appropriate times such as:
 - Adolescents to Adulthood
 - Service Discontinuation
 - Change in a Service Coordinator or Agency
 - Major life event
- Transition Team Members may include:
 - Participant/Responsible Party
 - Family Members
 - Service Coordinator
 - Other key agencies

What is a Medical Home?

A *medical home* is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Individuals who have a *medical home* receive the care they need from a health care provider whom they know and trust. Individuals and their health care providers act as partners in a *medical home* to identify and access all the medical and non-medical services needed to achieve maximum potential. A medical home should be accessible, family-centered, continuous, coordinated, comprehensive, compassionate, and culturally competent.*

* Medical Home definition adapted from American Academy of Pediatrics.

Medical Home Components

- *Accessible*—care is personally, geographically, and financially accessible for families
- *Family-Centered*—families and providers share responsibility and information; they know and trust one another; families are involved in care coordination; and family expertise is acknowledged
- *Continuous*—providers are consistent; care is provided during wellness and illness; and providers assist with transitions
- *Coordinated*—coordination is established between families, providers, and agencies
- *Comprehensive*—all aspects of well-being are considered and addressed (medical, dental, developmental, educational, psychosocial, financial, and family support services)
- *Compassionate*—providers respect families, are supportive, recognize and assess the need for supportive services, and provide resource information
- *Culturally Competent*—family values and customs are considered and incorporated into care plans; translation or interpreter services are provided when needed; and written materials are provided in the family's primary language

Program Implementation

- Children and Youth with Special Health Care Needs (CYSHCN)
- Healthy Children and Youth (HCY)
- Medically Fragile Adult Waiver (MFAW)
- Adult Brain Injury (ABI)

Children and Youth with Special Health Care Needs

- **Service Coordination:**
 - Provides assistance with early identification of children with special needs
 - Assists children with special health care needs and their families in locating, coordinating, and accessing needed services
 - Provided statewide by contracted agencies
- **Limited Funding for Services:**
 - Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies.

Children and Youth with Special Health Care Needs

– Eligibility:

- Missouri resident
- Under the age of 21
- Medical and Financial eligibility for services

Children and Youth with Special Health Care Needs

- **Description of CYSHCN Program:**

- Provides assistance statewide for children birth to age 21 who meet medical and financial eligibility guidelines.
- Focuses on early identification and service coordination of children with special health care needs and their families
- Children with special health care needs are those children who have or are at increased risk for a disease, defect or medical condition that may hinder the achievement of normal physical growth and development and who require health and related services of a type or amount beyond that required by children generally.
- Participants obtain services from approved SHCN providers for medical care and ancillary services
- Children and Youth with Special Health Care Needs (CYSHCN) Program is payer of last resort
- Referred to in State Statute as Crippled Children's Service (CCS)

Children and Youth with Special Health Care Needs

Eligible Conditions – In General

- Arthritis
- Burns
- Cerebral Palsy
- Cleft Lip and Palate
- Cystic Fibrosis
- Digestive Disorders
- Hearing Disorders
- Heart Disorders
- Hemophilia
- Hydrocephalus
- Neuromuscular Disorders
- Orthopedic Disorders
- Paraplegia
- Quadriplegia
- Seizures
- Sickle Cell Disease
- Spina Bifida
- Spinal Cord Deformities
- Traumatic Brain Injury

Conditions Not Eligible for Children and Youth with Special Health Care Needs

- Abscesses
- Allergies
- Asthma
- Backache
- Behavioral Disorders
- Colds
- Constipation
- Cough
- Croup
- Diabetes
- Diaper Rash
- Diarrhea
- Earaches
- Failure to Thrive
- Fever, non-specific
- Headache
- Head Lice
- Hyperopia (Farsightedness)
- Insect Bites and Stings
- Malignant Neoplasms (Malignant Tumor)
- Mental Retardation
- Myopia (Nearsightedness)
- Non-specific Rash/Dry Skin
- Nose Bleeds
- Pink Eye
- Psychiatric Disorders
- Simple Fractures
- Sore Throat
- Sunburns
- Tonsillitis
- Upper Respiratory Illness

Healthy Children and Youth (HCY)

- **SHCN administers this program:**
 - Through a cooperative agreement with the Department of Social Services, MO HealthNet (Medicaid) Division
- **Services Authorized by SHCN Nurses:**
 - Private Duty Nursing
 - Advanced Personal Care Aide
 - Personal Care Aide
 - Skilled Nurse Visits
 - Registered Nurse Visits
 - Administrative Case Management
- **Service Coordination:**
 - Assists children and their families through assessment of medical necessity, education and authorization of in-home nursing services
 - Provided by SHCN Nurses
- Services provided by **MO HealthNet (Medicaid) providers**

Healthy Children and Youth (HCY)

– Eligibility:

- Missouri resident
- Under the age of 21
- Requires medically necessary in-home services
- Enrolled in MO HealthNet (Medicaid)
 - SHCN authorizes services for participants who are enrolled in fee for service Medicaid, not managed care.

Healthy Children and Youth (HCY)

- **SHCN Service Coordinators:**
 - Assess the needs of the child and family through home visits to determine the medical necessity of specific services
 - Provide education, service coordination, and authorization of services
 - Provide referrals to help maintain the HCY participant safely in their home
 - Make monthly contact with the participants, families, and/or providers
 - Complete an assessment of the needs of the participant and their families at least annually
 - Help establish a medical home
 - Refer for EPSDT Screening Exams
 - Assist in assuring that appropriate medical care is provided through MO HealthNet (Medicaid)

Medically Fragile Adult Waiver (MFAW)

- **SHCN administers this program:**
 - Through a cooperative agreement with the Department of Social Services, MO HealthNet (Medicaid) Division
- **Services Authorized by SHCN Nurses:**
 - Private Duty Nursing
 - Advanced Personal Care Aide
 - Personal Care Aide
 - Registered Nurse Visits
 - Specialized Medical Supplies
- **Service Coordination:**
 - Assists individuals and their families through assessment of medical necessity, education and authorization of in-home medical services
 - Provided by SHCN Nurses

Medically Fragile Adult Waiver (MFAW)

- **Eligibility:**
 - Missouri resident
 - Age of 21 and over
 - Enrolled in MO HealthNet (Medicaid)
 - Have a federally-matched MO HealthNet (Medicaid) eligibility code
 - Requires medical care equivalent to the level of care received in an intermediate care facility
 - Not be receiving services from another state waiver program
 - Have participated in or been eligible for Private Duty Nursing through the HCY program
 - SHCN authorizes services for participants who are enrolled in fee for service Medicaid, not managed care.

Medically Fragile Adult Waiver (MFAW)

- **Description of MFAW Program:**
 - Provides home and community-based services to a limited number of individuals with serious and complex medical needs
 - Provides a cost effective alternative to placement in an intermediate care facility (ICF-IID) and is designed to allow participants who turn 21 to stay in their home with ongoing support. The support is made possible through the provision of services not otherwise available through MO HealthNet (Medicaid) State Plan Services for adults, such as private duty nursing services and medical supplies.
 - Services provided by **MO HealthNet (Medicaid) providers**

Medically Fragile Adult Waiver (MFAW)

- **SHCN Service Coordinators:**
 - Provide:
 - Service identification
 - Service planning
 - Prior authorization of medically necessary services and medically necessary equipment
 - Service monitoring
 - Referral
 - Revision of the service plan as needed
 - Make monthly contact with the participants, families, and/or providers
 - Conduct quarterly home visits
 - Complete an assessment of the needs of the participant and their families at least every six (6) months
 - Help establish a medical home

Adult Brain Injury (ABI)

- **Service Coordination:**
 - Assists individuals and their families in locating, coordinating, and accessing services for people who have survived a traumatic brain injury
 - Provided statewide by contracted agencies
- **Rehabilitation Services include:**
 - Neuropsychological Evaluation and Consultation
 - Adjustment Counseling
 - Transitional Home and Community Support Training
 - Pre-vocational/Pre-employment Training
 - Supported Employment/Follow Along
 - Special Instruction

Adult Brain Injury (ABI)

- **Eligibility:**
 - Missouri resident
 - **Age 21 to 65**
 - Medical documentation of a Traumatic Brain Injury (TBI) as defined in RSMo 192.735 (Medically eligible)
 - Financially eligible for rehabilitation services

Adult Brain Injury (ABI)

– Description of ABI Program:

- Participants receive service coordination and those who are financially eligible, receive rehabilitation services from approved SHS providers.
- Adult Brain Injury Program is payer of last resort for rehabilitation services.

SHS Projects

- Family Partnership Initiative
- Traumatic Brain Injury (TBI) Implementation Grant
- Missouri Brain Injury Advisory Council
- Assistive Technology
- University of Missouri – Kansas City (UMKC):
 - Family-to-Family Health Information Center

Family Partnership

- Provides families of individuals with special needs the opportunity to:
 - Offer each other support and information
 - Provide input to SHS, regarding the needs of individuals with special needs
 - Increase public and community awareness of the issues facing families
 - Promote legislation for programs for individuals with special needs and their families
- Members include individuals with special health care needs, as well as parents, legal guardians, and siblings.
- Activities are implemented through a contract for statewide services
- Family Partners can be contacted at 800-779-8652.

Traumatic Brain Injury (TBI) Implementation Grant

- Funding provided through Health Resources and Services Administration (HRSA)
- Awarded annually since 1997
- Focused on improving service delivery systems
- Projects have included:
 - Development of a Training Academy for Case Managers
 - Early identification of TBI
 - Interagency collaboration
 - Training in person-centered planning
 - Development of a web page
 - Development of an early referral system from hospitals to state service coordinators
 - Development of a resource/information book – The Missouri Greenbook: Living with Brain Injury
 - Development of NFL guide

Missouri Brain Injury Advisory Council (MBIAC)

- Comprised of fifteen (15) Governor appointed members for a term of three (3) years.
- Members represent people with head injuries, relatives of persons with head injuries, proprietary schools as defined in section 173.600, RSMo, professional groups, health institutions, or private industry and state agencies which administer programs regarding mental health, education, public health, public safety, insurance, and Medicaid.
- Meets four (4) times a year to study and make recommendations for improvement around systems to meet the needs of those who have survived a traumatic head injury
- Serves in an advisory role to the Federal TBI Implementation Grant
- Facilitated by the Adult Head Injury Unit

Missouri Assistive Technology

- The mission of Missouri Assistive Technology is to increase access to assistive technology for Missourians with all types of disabilities, of all ages.
- Programs and initiatives of Missouri Assistive Technology are directed by the Missouri Assistive Technology Council, which was established by state statute in 1993.
- Programs:
 - Device Loan - ETC
 - Device Demonstration
 - Device Recycling & Exchange
 - Legislative/Policy & Funding
 - Financial Loans
 - Telecom Access Program
 - AT Reimbursement Program for Schools
 - Last Resort Funding for Children - Kids Assistive Technology (KAT)
 - AT Conference (Power Up) & Training
 - Information Resources & Publications
 - IT Access
 - Accessible Instructional Materials

University of Missouri – Kansas City (UMKC)

Family-to-Family Health Information Center

The overall goal of this project is to:

- Provide information, training, and personal support to families of children and youth with special health care needs (CYSHCN) and professionals through collaborative partnerships that create improved access to healthcare, positive health outcomes, successful transitions, and an improved quality of life that create or improve systems.

VALUABLE RESOURCES

- DHSS Website :

<http://www.health.mo.gov>

- SHS Toll Free Number for Participants and Families

800/451-0669

- Questions?
- Comments?

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