



**Intellectual and Developmental Disabilities
TCM/Care Coordinator Summit
Education & Training**

Presented by: Aquila "Q" Jordan
Home and Community Based Services

Summit Overview

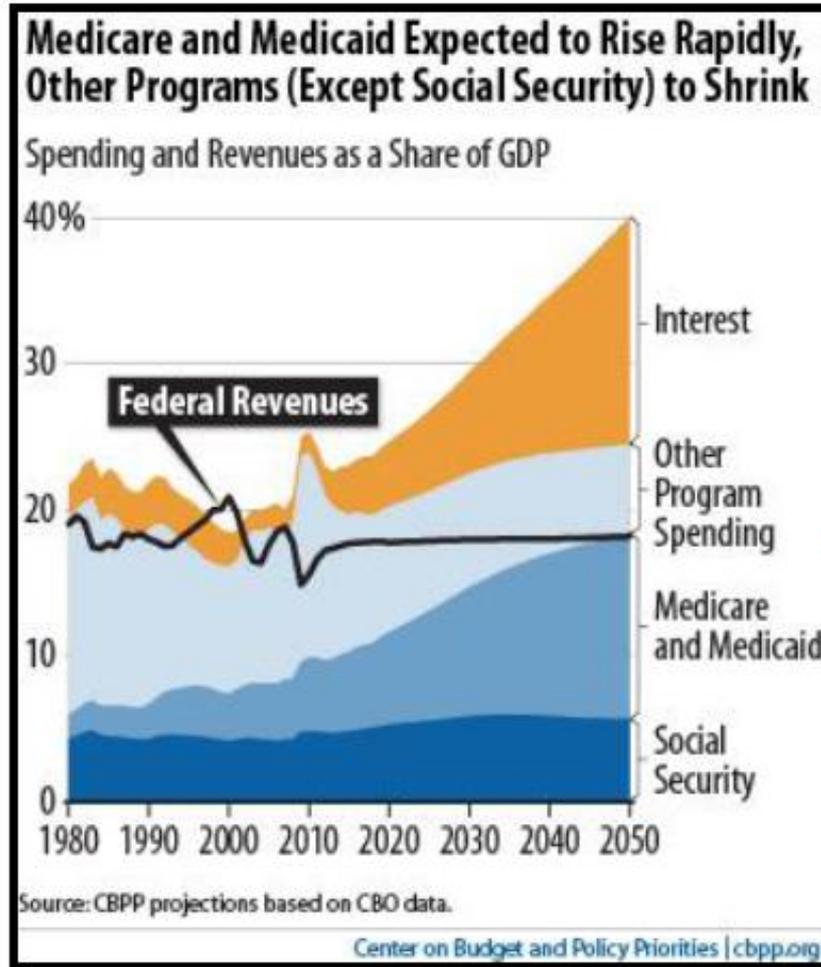
- ▶ The purpose of the TCM-Care Coordinator Summits is to provide a learning opportunity that fosters relationship building between care coordinators and targeted case managers
- ▶ The goal is to help TCMs and Care Coordinators think creatively about providing the services and supports that will help an individual be independent and part of their community
- ▶ Additional trainings and education opportunities for more specific topics will be available throughout the year.



Better Lives for Aging and Disabled Persons in Kansas >>

- Self-Determination
- Greater Independence
- Competitive Employment
- Better Overall Care
- Improved Access to Services

Medicare and Medicaid



Demand for Long Term Supports and Services is growing.

87% of the 12 million Americans who need LTC receive it from unpaid Family Caregivers.

Many individuals with IDD are being cared for by aging parents / family

NASDDDS

National Association of State Directors of Developmental Disabilities Services

CMS Expectations of Managed Care

1. Adequate Planning and Transition Strategies
2. Stakeholder Engagement
3. Enhanced provision of HCBS (ADA/Olmstead)
4. Alignment of Payment Structures with MLTSS Programmatic Goals
5. Support for Beneficiaries
6. Person-Centered Processes
7. Comprehensive and Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

Goals of KanCare

- ▶ Greater independence on the part of individuals and families in accessing and linking to appropriate services and supports.
- ▶ Better health and coordination of behavioral health, physical health, and long-term supports and services
- ▶ Identifying right services at the right time in the right place to meet needs
- ▶ Increasing provider capacity to meet an individual's needs, including those for challenging behaviors and complex medical needs

Most Integrated (IDEAL)

Everybody can live in the community.

- In family homes with support
- In their own homes
- In shared living
- Children and adults
- Employment and/or Activities
- Irrespective of medical or behavioral labels
 - * People with trachs, g-tubes, suctioning, ventilators, medical frailty
 - * People with behavioral reputations; frequent criminal offenders

Reduce use of nursing homes, ICFs, larger settings

Character of Home and Community Based Services

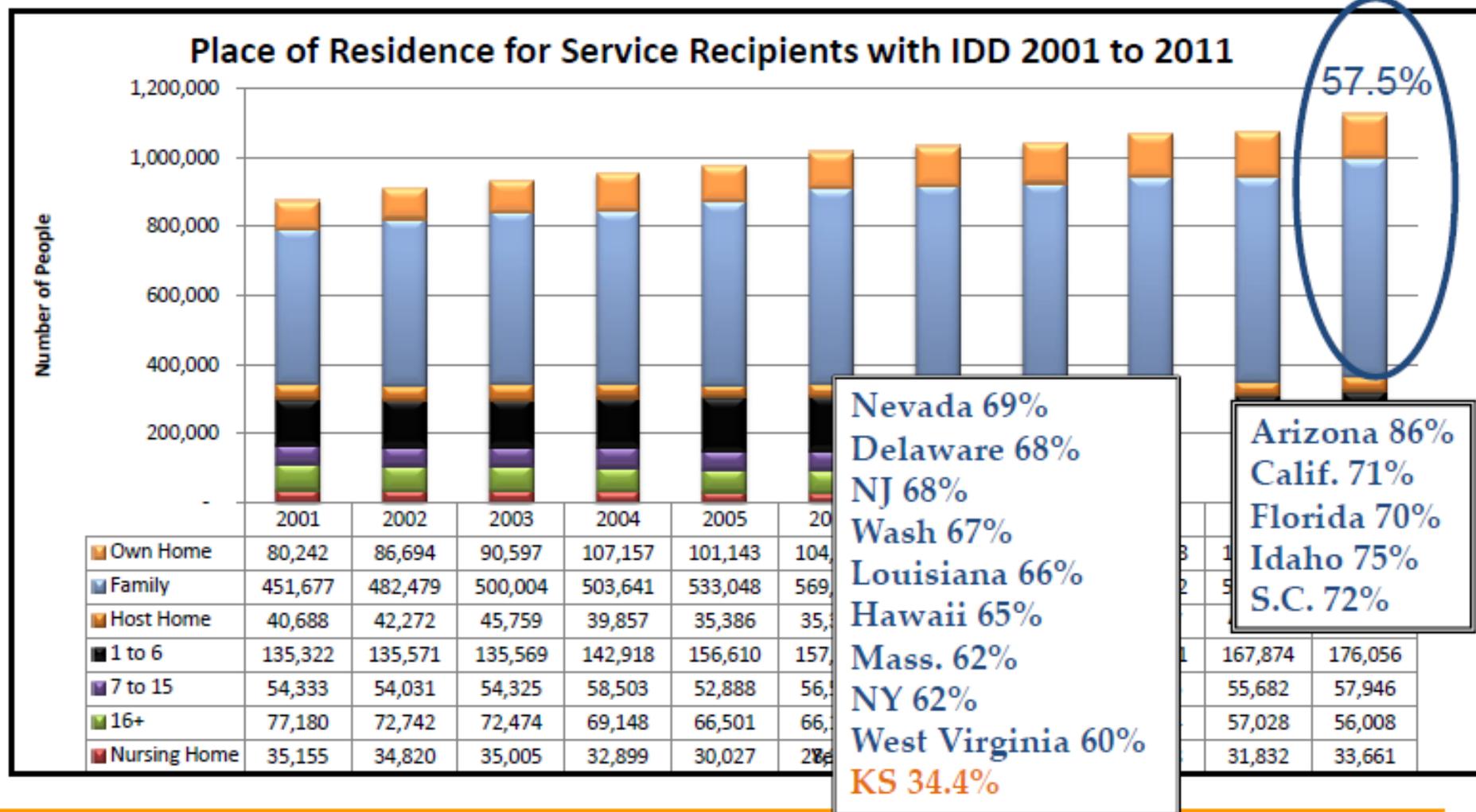
CMS acknowledged:

“Some individuals who receive Home and Community Based Services in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting.”

CMS stated:

Using such settings to provide —home and community based services are contrary to the purpose of the 1915(c) waiver program.

Most People with IDD in Service Live with Family



Families are Not Group Homes

Families include parents; siblings; grandparents; other relatives

- Help each other; they sacrifice for one other
- Hurt each other; they apologize and forgive
- Have fun and celebrate with each other
- Have secrets and things they don't talk about
- Have troubles, get tired and discouraged
- Spend time together in different settings
- Do the impossible with very little all the time
- Commit abuse and take advantage of each other
- Can't do everything by themselves, need help
- Have routines, customs and habits
 - they have their way of doing things



Families are complicated, BUT family is the context for everything

- Personal outcomes will be influenced by the family

What's Important to Families

- ❑ Having Access to Services As Needed Close to Home
- ❑ Eliminating Waiting Lists or Minimizing Length on It
- ❑ Assistance Transitioning from School-to-Adult Life
- ❑ Employment Options: Real job with Needed Support
- ❑ Support for families that is flexible, meets their needs and is consumer/family-directed
- ❑ Confidence that their sons and daughters having a good and happy life with friends, family, a valued role in the community
- ❑ Assurance about what happens to their daughters and sons when they die & who will be there for them

Measuring Progress

**MANAGED CARE IS
more than a financing mechanism.**

Defining quality outcomes for people with disabilities

- Seeking opportunities for integrating care with services
- Improving independence and self-determination
- Working and living in the community with strong relationships
- Focusing on the person: their dreams, hope and desires
- Collaborating together to find innovative solutions

PROGRESS

**supporting more people and their
families in the community**



Not Being Able
To Speak...
Is Not The
Same As Not
Having Anything
To Say.

Case Management and Care Coordination

January 21, 2014

Complementary Roles

- ▶ **Case/Care Management** consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. This includes primary care case management, which cannot be provided by a targeted case manager.
- ▶ **“Targeted” Case Management** services are those aimed specifically at special groups of enrollees such as those with *Intellectual/developmental disabilities* or chronic mental illness.

Comparison of Components

- ▶ Conduct & Participate in Assessments
 - ▶ Develop/update Person-Centered Support Plan and other support plans
 - ▶ Referral and Related Activities
 - ▶ Monitoring and Follow-Up Activities
- Conduct Needs & Health Risk Assessment
 - Develop Integrated Support Plan, including physical & behavioral
 - Coordinate and approve services and supports
 - Evaluate & Monitor the ISP & services

Targeted Case
Management

Care Coordination

Care Coordination

“Care coordination” is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care and service plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Comprehensive care management involves:

In Kansas, comprehensive care management is the responsibility of the MCO Care Coordinator

- ▶ Identifying individuals with high risk environmental factors and/or high-risk medical factors and those with complex health care needs, who may benefit from a Health Home.
- ▶ Conducting a comprehensive health-based needs assessment to determine the individual's physical health, mental health, chemical dependency, and social needs.
- ▶ Developing an Integrated Support Plan based on the comprehensive needs assessment, and with the input of the individual, family members or other persons who provide support, and guardians.
- ▶ Coordinating and collaborating with other service providers.

Care Coordination activities

Care coordination activities include, but are not limited to:

- ▶ Coordinating and collaborating with other providers to monitor individual's health status, medical conditions, medications, and side effects
- ▶ Assisting in scheduling referrals and creating/promoting linkages to other agencies, services, and supports, including to behavioral health services
- ▶ Sharing information with individuals, families, guardians, or other support persons regarding specific disorders, treatment and provider options, systems of support, services and assistance available.
- ▶ Monitoring ED and Inpatient admissions to ensure appropriate transitions in care are coordinated and timely
- ▶ Coordinate transition in conjunction with CDDOs, CSPs and TCMs
- ▶ Engaging patients in self-care regarding chronic conditions.
- ▶ Implementing ISP and managing through the use of quality metrics, assessment survey results and utilization reviews to monitor and evaluate impact of interventions.
- ▶ Locating resources beyond scope of services covered by Medicaid or through the HCBS services, which may be available from different sources
- ▶ Working with the TCM to update ISP based on PCSP, BSP and changing needs

As a TCM

The Targeted Case Manager (TCM) in Kansas plays a role in IDD System that directly affects the health and welfare of IDD participants and their ability to live in independently their homes/communities.

However, that role is limited by CMS guidelines.

TCM Limitations

- ▶ The maximum allowable TCM units per customer = 240 TCM Units per calendar year.
- ▶ TCM units will be added to the ISP and can be increased as needed per month, including birth month
- ▶ TCM's should use the same Prior Authorization for Additional Units request, which must be submitted prior to services being reimbursed.

TCM Components

▶ Assessment

- Taking a consumer history
- Identifying individual's needs
- Completing assessment and related documentation
- Gathering information, if necessary, from other sources

▶ Referral Activities

- Helping individual obtain needed services
- Activities that help link an individual with medical, social, or educational providers
- Reporting ANE or suspected ANE
- Encouraging informal supports and formal service providers to be more flexible or seeking new or non-traditional options

▶ Develop PCSP/POC

- Participating in BASIS process
- Updating PCSP as person's needs change and ISP is updated
- Ensuring PCSP specifies goals and actions to address the medical, social, education, and other needs
- Providing input into the development of the ISP

▶ Monitoring Activities

- Ensuring ISP is implemented and addresses individual's needs
- Ensuring services are furnished according to individual's ISP
- Monitoring that services in ISP are adequate
- Identifying changes in needs and status and notifying MCO

Coordination works with TCM

Development of an Integrated Service Plan

(based on information collected through the assessment process)

▶ **Person–Centered Support Planning (PCSP)**

- PCSP lists the goals and actions necessary to address the medical, social, educational and other services person needs
- The TCM provides the BSP, Emergency Back–Up Plan, and other support plans to be used in developing the ISP

▶ **Integrated Service Plan (ISP)**

- The ISP is comprehensive and includes the PCSP, Behavioral Health and Physical Health supports and services
- ISP should address same goals and objectives as the PCSP
- TCM should work closely with a Care Coordinator to create an Integrated Service Plan that meets an individual's needs

NOTE: The Individual (child or adult) should be an active participant
(remember they are more likely to engage if active participant)



There is a wide variation in mental abilities, behavior and physical development in individuals with Down syndrome [any IDD]. Each individual has his/her own unique personality, capabilities and talents. In other words, people with Down syndrome are not all the same; just like individuals in the typical population are NOT all the same
– Noah's Dad (blog)

Assessments

- BASIS Assessment by CDDO informs tiers
- CDDO offers choice of TCM & MCO
- Assessment process identifies needs
- Changing needs may require assessment
- MCO Needs/Health Risk Assessment
- Identify LTSS needs physical & behavioral health needs

- ▶ **Assessments (Consistent and Predictable)**
- ▶ **Participant Choice**
- ▶ **Participant Needs Are Met**
- ▶ Participation in Person-Centered Process
- ▶ Plan of Care Meets Needs & Preferences
- ▶ Plan of Care Service Initiation & Timelines
- ▶ Health and Safety Risks
- ▶ Participants Are Safe
- ▶ Protection of Participant in Emergency

Assessments

- ▶ **Comprehensive and identify an individual's needs**
 - Performed by qualified evaluator
 - Participant involved in assessments

- ▶ **BASIS Assessment**
 - Conducted by CDDO's qualified assessor
 - TCM and consumer's support team participates
 - Timing of Assessment
 - CC may participate if member wants or chooses
 - Assessment is scheduled around person, not TCMs/CCs request
 - Pre-planning to schedule (2 months) is a best practice

- ▶ **Health Risk/Needs Assessment**
 - Conducted by MCO Care Coordinator
 - Can be conducted at the same time as PCSP or other assessments
 - Identify needed supports, services, and risks for a person
 - Used to develop the comprehensive Integrated Service Plan

Want vs. Need

▶ Scenario:

- A customer's attendant that lives in the home is asking for an increase in time. There has been no change in condition of the customer.
 - Want or Need?
 - What actions would you take?

▶ Scenario 2:

- A consumer's parents have become very ill and the individual's family members are unable or unwilling to provide assistance for the next few weeks. It is Friday after at 4:50 pm and a new placement needs authorizations to provide temporary residential support

Nothing about me without me.



Cathy, 45, has a killer freestyle and is a jazz performer.

Person-Centered Process

- Person/Guardian should be active participants
- ISP informed by PCSP, BSP, etc.
- PCSP updated and includes preferences
- Initiate changes to meet needs
- Crisis/Emergency requires fast answers
- ISP is annual and due by end of birth month

- ▶ Assessments
- ▶ Participant Choice
- ▶ Participant Needs Are Met
- ▶ **Participation in Person-Centered Process**
- ▶ **Integrated Service Plan Meets Needs & Preferences**
- ▶ **Service Initiation & Timelines**
- ▶ Health and Safety Risks
- ▶ Participants Are Safe
- ▶ Protection of Participant in Emergency

Person-Centered is a Process

- ▶ It is a process for both planning and service delivery, not an instrument or tool
- ▶ **Person centered means conducting all activities from the Person's Point of View– what is important to them**
- ▶ Balancing what others believe is important for the person against their right to self-determination

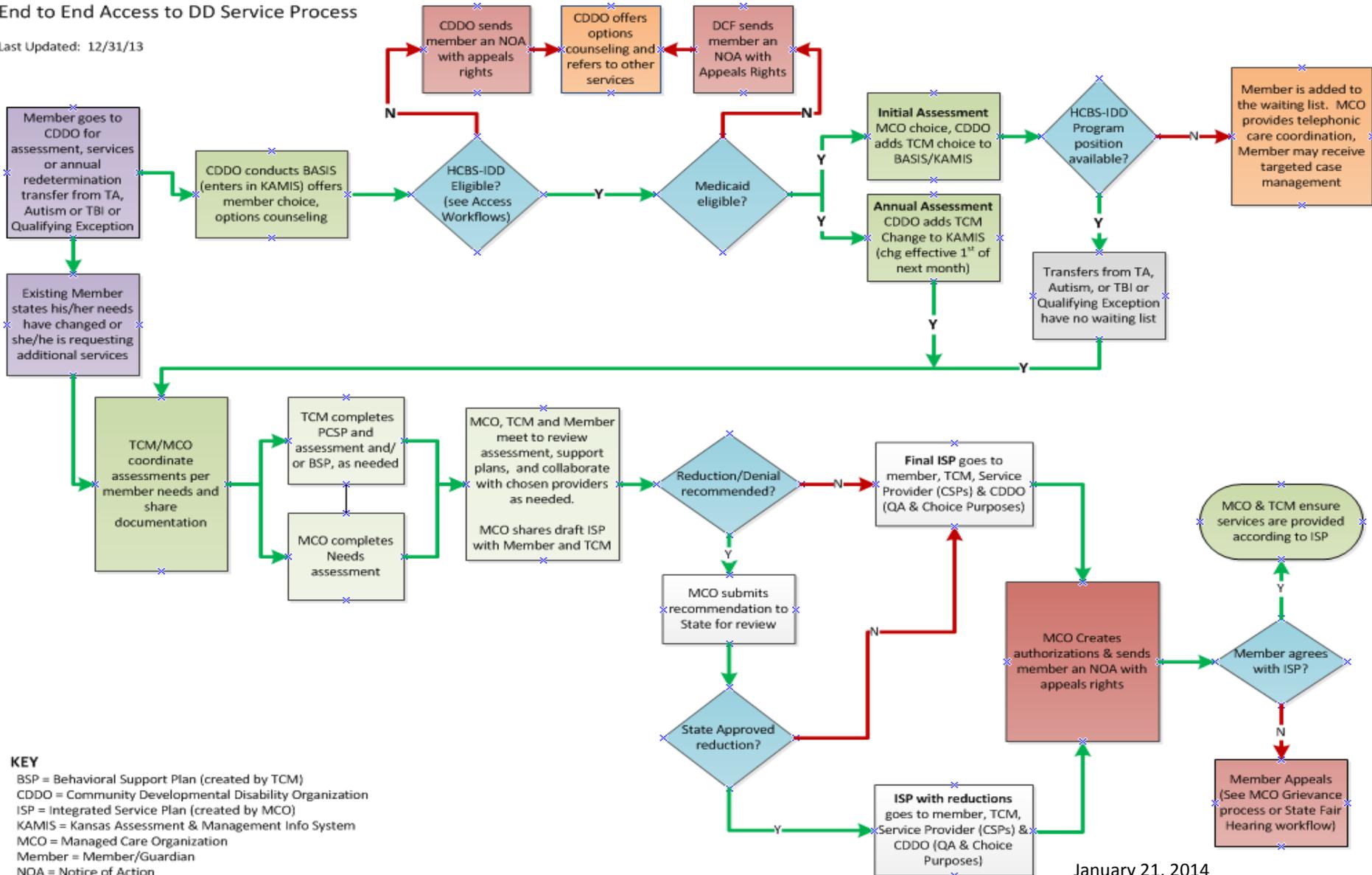
Focus on the Person

- Employment
- Choice
- Self-Determination
- Independence
- Relationships
- Community
- Self-Advocacy
- Skill Development
- Relationship-Based Living Arrangement
- Assistive Technology

Integrated Service Planning

End to End Access to DD Service Process

Last Updated: 12/31/13



KEY

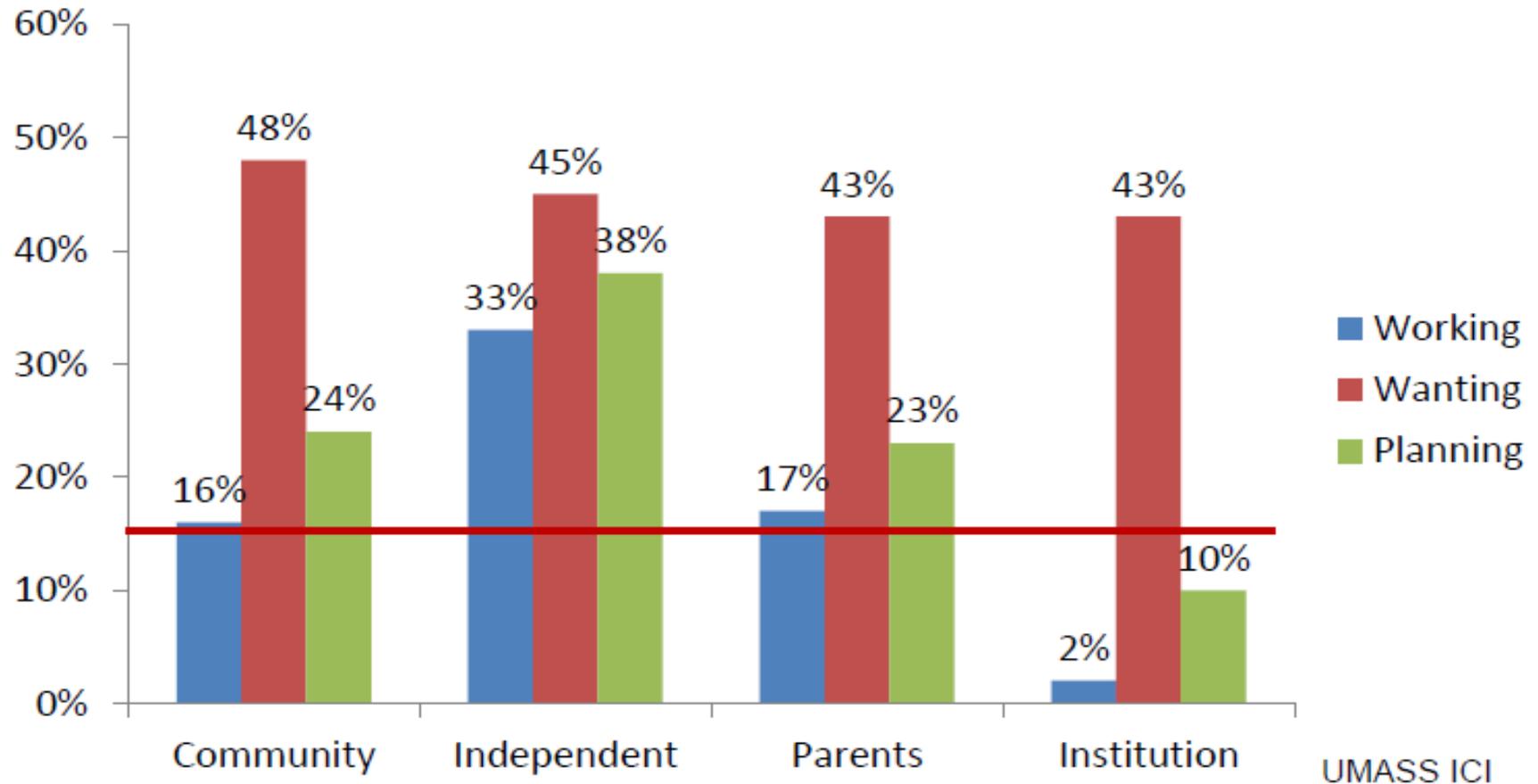
- BSP = Behavioral Support Plan (created by TCM)
- CDDO = Community Developmental Disability Organization
- ISP = Integrated Service Plan (created by MCO)
- KAMIS = Kansas Assessment & Management Info System
- MCO = Managed Care Organization
- Member = Member/Guardian
- NOA = Notice of Action
- PCSP = Person Centered Support Plan (created by TCM)

January 21, 2014

- ▶ Person–Centered Process starts with BASIS
 - Goals and preferences noted and included
 - Timely (prior to individual’s birth month)
- ▶ ISP is developed based on multiple sources
 - Record review, observation and interviews
 - Behavior Support Plan
 - Individualized Education Plan
 - Medication Utilization
 - Emergency Room and Hospitalization
 - Needs Assessments
 - The Person–Centered Support Plan is a key part of the Integrated Support Plan, but each person is an individual – unique – and the ISP should reflect an individual’s unique needs

Person–Centered Process

Plans Don't match people's desire to work



NASDDDS

National Association of State Directors of Developmental Disabilities Services

Person Centered Practices

Goal: John wants to be a fireman.

➤ Determine why.

- Status? Uniform? Excitement?
- Honor family history? Image of strength?
- They like the fire house?

➤ Physical Barriers: Type II Diabetes

- John needs to reduce weight but is not motivated
- John needs to visit the Dentist because of teeth issues
- John lives in a rural area with limited providers

➤ Behavioral Barriers

- John requires frequent supervision and redirection
- John often tries to leave day supports and gets angry if he doesn't get to buy candy in the middle of the day

Example (Cont.)

- ▶ **The person-centered plan developed explores:**
 - Opportunities to visit the fire house
 - Opportunities to volunteer
 - Opportunities that include wearing a uniform
 - Opportunities for enjoyable physical exercise
 - Joining a gym to increase physical strength
- **Integrated Service Plan explores**
 - Additional units for In Home Supports/Supportive Home Care for one-on-one visits to the firehouse
 - Value-Added benefits or In Lieu of Services for education about diet, nutritionist counseling or Weight Watchers
 - Create opportunities for enjoyable physical exercise (get a dog to walk; start a dog walking business; volunteer with the park service (uniform and name badge and exercise)

Instructions

1. Enter all required fields which are indicated by the yellow star icon * .
2. Click on the **Create** button.
3. The **Apply Changes** button is used if changes to the data in the Files Uploaded By Information or Customer Information regions change.
4. The **File Upload** region will display. Follow the upload instructions displayed within this region.
5. Once all documents are uploaded, click on one of the following buttons:
 - The **Exit** button - you will return to the website.
 - OR
 - The **Next Customer** button - to continue to add customers and to upload their documents into the Utility.
Clicking on this button will clear all the customer information fields however, your information will remain.

[Exit to Website](#)[Create](#)[Next Customer](#)

Files Uploaded By Information:

- * First Name: * Last Name:
- * Organization Name:
- * E-Mail: * Contact Phone Number:
(enter numbers only)

Customer Information:

- * Customer First Name * Customer Last Name :
- * Date of Birth: * Social Security Number:
(enter numbers only)
- * Medicaid ID Number: Kamis Person Number:



The goals of managed care are to provide better results through service and support coordination across multiple services and providers to meet individuals' needs.

Managed Care & IDD

Isaiah at our Family
Reunion – August 2013

Supports for Protection

- Emergency Back-up Plan updated
- Self-Direction
- Abuse, Neglect, Exploitation
- Critical Incidents
- Adverse Incident Reporting System
- Health & Safety Risks are identified
- Additional services and supports needed

- ▶ Assessments (Consistent and Predictable)
- ▶ Participant Choice
- ▶ Participant Needs Are Met
- ▶ Participation in Person-Centered Process
- ▶ Plan of Care Meets Needs & Preferences
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- ▶ **Health and Safety Risks**
- ▶ **Participants Are Safe**
- ▶ **Protection of Participant in Emergency**

Challenging Behaviors

- ❑ Undiagnosed or untreated mood disorder
 - Some disorders are misdiagnosed or misedicated
- ❑ Undiagnosed or untreated post traumatic stress
 - Sexual abuse >75%
 - Exclusion, rejection, bullying and humiliation 100%
 - Frustration from awareness of limitations
- ❑ Undiagnosed or untreated depression
 - Biological/Physiological
 - Environmental/social – loneliness
- ❑ Reasons
 - Result of assessments, support models and practices that are not person-centered
 - No awareness of treatment options
 - No knowledge of neurological/psychological challenges

IDD & BH is common

- ▶ ~ 32% of individuals with IDD have a mental illness
- ▶ ~53% take 1 of 4 medications for mood disorder, psychotic disorders, anxiety, behavior
- ▶ ~64% take at least 1 psychotropic medication
- ▶ Referral to a specialist
- ▶ Application of positive behavior supports
- ▶ Early identification of physical, medical, social or other factors
- ▶ Alternative activities an options available
- ▶ Identification of environmental stressors

By the Numbers

Person-Centered
Options

Betty, 29, lives with roommates

- ▶ Individual is self-abusing by hitting their head; is aggressive toward others; does not have speech.

Integrated Assessment:

Medical conditions that cause pain: sinus; migraine; broken bones; abdominal condition; medication side effects; dental pain;

Behavioral Health: sleep and mood charting; functional assessment;

Social: Abuse and/or neglect; loneliness; boredom

From the assessment, create an Integrated Service Plan

Participants are Safe

- ▶ All critical incidents are identified and addressed.
 - Are participants asked monthly about critical incidents?
 - Incident reporting and resolution completed in AIR within 24 hours of incident
- ▶ Effective and current emergency plans are in place.
 - Effective and current back-up staffing plans are in place.
 - Back-ups for self-directed are critical to provide services
 - Care Coordinator and TCM should have identified back-ups for holidays, sick days, etc.
 - Emergency & Back-up plans should be updated with PCSP as needed throughout the year
- ▶ Annual Person-Centered Planning process and ISP should include annual assessment of critical incidents, hospitalizations, and strategies to address prevention of future incidents

Critical Incidents

- ▶ What is a critical incident?
 - An adverse event or incident that potentially results in serious outcomes such as death, serious injury, ER visit, hospitalization, elopement, natural disaster, etc.
- ▶ When is it appropriate to report?
 - Consumer is participating in a KDADS funded program
 - Resident of any premises owned or operated by a provider or facility licensed by KDADS
- ▶ Where do I send the report to?
 - Adverse Incident Report (A.I.R) web based tool
 - User security clearance need, www.aging.ks.gov *(Please see instructions for access to AIR)*

Who Reports? The person or provider who becomes aware of an adverse incident

Critical Incidents

- ▶ Abuse or Exploitation
 - Physical
 - Sexual
 - Psychological
 - Financial
 - Emotional
- ▶ Neglect
 - Including self-neglect
- ▶ Inappropriate sexual contact
- ▶ Suicide / Attempted Suicide
- ▶ Unexpected Death
 - Includes unexplained death not related to medical condition
- ▶ Serious Injury
 - Loss of limb or function
- ▶ Natural Disaster
- ▶ Misuse of Medications
- ▶ Elopement

Mandatory Reporting to APS is still required

When in doubt ... Report.
www.kdads.ks.gov



Kansas
Department for Aging
and Disability Services



Keeping the Promise to the Person

Keeping the Promise

June 2009

In 2009, a group of self-advocates defined “home” and “community” and shared their vision for the future.

- ▶ “We believe that when our country recognizes —the right of individuals to live independently, enjoy self-determination, make choices, contribute to society, pursue meaningful careers and enjoy full inclusion and integration in the economic, political, social, cultural and educational mainstream of American society (as in the Rehabilitation Act of 1973 as amended, 29U.S.C.794), that we will indeed be in control of own lives.”

When taken together these promises made to citizens with developmental disabilities establish a clear national purpose:

- Increasing self-determination and personal control in decisions affecting people with developmental disabilities and their families
- Providing opportunities for people with developmental disabilities to live and participate in their own communities
- Improving quality of life for individuals and families as they define it for themselves
- Supporting families as the most important and permanent unit of development, protection, and lifelong assistance to persons with developmental disabilities
- Investing in each individual’s developmental potential and capacity to contribute in age-related roles as productive and respected community members
- Ensuring access to sufficient, high-quality health and social supports to protect each person’s health, safety, rights, and well-being
- Moving people with developmental disabilities out of poverty by significantly increasing opportunities for real work with real pay

Top Service Challenges for States

- ▶ **Highest Cost Individuals**
 - People with challenging behavior
 - Criminal offenses adjudicated and non-adjudicated
 - Sexual offenders
 - Mental health disorders
 - People with significant medical care needs
- ▶ **Waiting Lists**
 - Decreasing or minimizing use
 - Serving based on priority need or place in line
- ▶ **Managing Cost**
 - Equity & Fairness
 - Reasonableness
- ▶ **Implementing Promising Practices**
 - Person-Centered Practices;
 - Positive Behavioral Approaches;
 - Competitive Employment;



Think Outside the Box



- ▶ Stimulate and support innovative solutions
- ▶ Service designs & support strategies enable people to get what they need not just what is available
- ▶ Find Creative solutions to meet identified needs
- ▶ Improve access to services and providers
- ▶ Forge productive and creative partnerships
- ▶ Promote use of natural and community resources

Beware of “locking in”
to set models

Building community
infrastructure

Comparison of Components

DO's

- ▶ TCMs do work closely with CCs to assess and meet person's needs
- ▶ TCMs provide targeted services to person
- ▶ TCMs/CCs are courteous & respectful to each other
- ▶ TCMs are primary contact for IDD System
- ▶ CCs are primary contact for person/TCM with MCO
- ▶ TCMs/CCs focus on the person, not their positions

DON'TS

- CCs don't micromanage the TCMs
- TCMs don't provide direct services to person
- CCs don't replace TCMs; they support each other
- TCMs and CCs don't discuss personal opinions, matters with consumers
- TCMs and CCs don't duplicate work, they coordinate activities

Resolving Conflicts

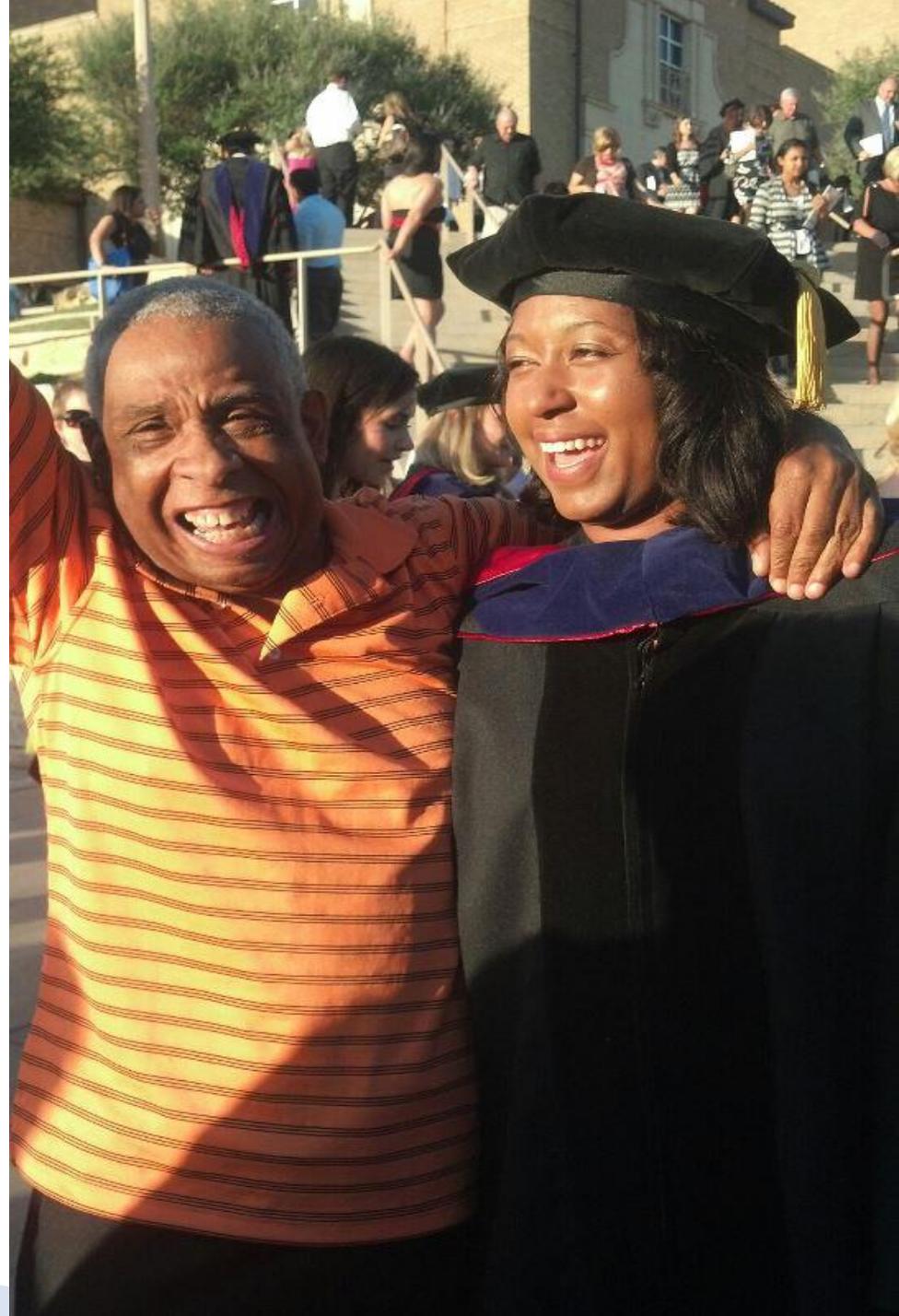


- ▶ Care Coordinator authorizes services on ISP
- ▶ TCM assesses and develops the support plans
- ▶ Questions:
 - What happens if they disagree about the amount, scope and duration of services?
 - What happens if the MCO recommends a reduction in services after the continuity of care period?
- ▶ Answer:
 - Work together as a team with the person's best interest at the center of the planning process
 - MCO will submit reductions, denials and terminations to the State for approval and final decision

Most People with Live with Family

**Sustainability
depends on how
well the system**

- supports
families and**
- supports people
with employment**



State's Role



- ▶ KDADS will:
 - Ensure that people with disabilities and families have access to information about the plans and a problem resolution process.
 - Ensure statutes, rules, and policies are followed
 - Report on performance of MCOs and licensed providers to CMS
 - Stay engaged with stakeholders and consumers
 - Conduct operational and financial reviews
 - Monitor feedback from consumers/providers through complaint systems, consumer surveys & outreach sessions with stakeholders

- ▶ KDADS QMS will:
 - Conduct oversight of TCM and MCO (QMS ride-a-longs)
 - Continue program oversight and quality assurance activities

- ▶ Review outcomes data:
 - increase in community living, decrease in institutional living
 - Increased care coordination to meet person's needs

Recent Changes for IDD

▶ Day Supports

- Effective January 1, 2014, Day Supports is billed as:
 - (1 unit=1 day) to (1 unit=15 minutes)
 - Billable procedure code= T2021
 - Up to 32 units in a day, Maximum of 100 units per week
 - Maximum of 460 units in a month

▶ Requests for Additional Services

- On February 1, 2014, those who are receiving some, but not all requested HCBS-IDD services will be sent a letter about how the State plans to address the “underserved” list.
- TCM agencies and Independent TCMs can receive the weekly IDD Provider Bulletins for up-to-date information

Accessing KDADS Provider Issue Log

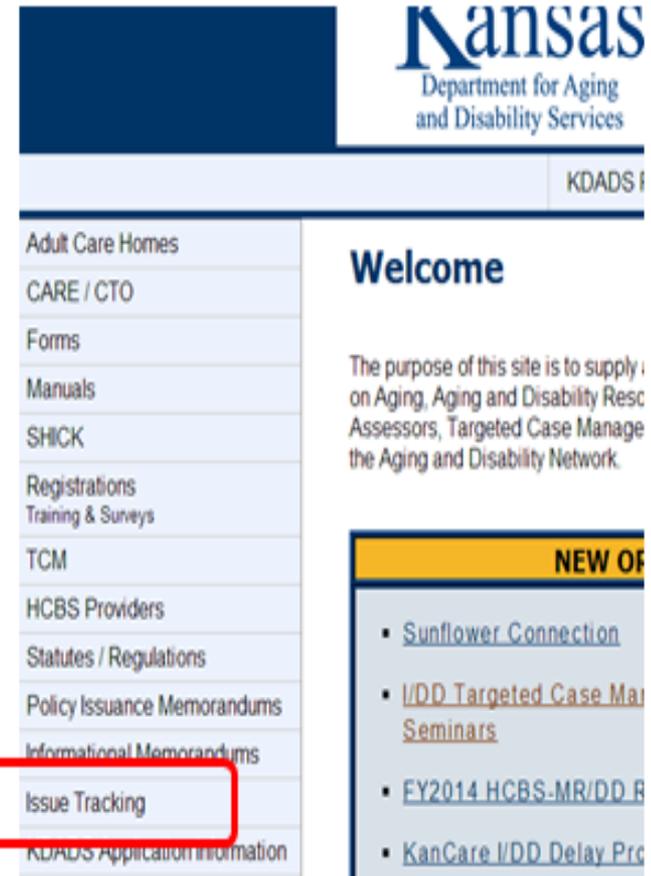
1. Go the KDADS website - www.kdads.ks.gov
2. On the top bar of the page:
 - Click "Provider Information"
3. On the left bar of the Provider page:
 - Click "Issue Tracking"

The Issue Tracking Log is a web application to allow providers to post issues, which will be reviewed by MCOs and/or KDADS.

This application is being beta tested and will be available for use soon. This is designed for providers to post issues, including billing/claims issues.

Member issues: KanCare Ombudsman
kancareombudsman@kdads.ks.gov.

Critical Incidents: Report within 24 hours in A.I.R.



The screenshot shows the KDADS website interface. At the top right is the logo for the Kansas Department for Aging and Disability Services. Below the logo is a navigation bar with the text "KDADS". On the left side, there is a vertical menu with the following items: Adult Care Homes, CARE / CTO, Forms, Manuals, SHICK, Registrations Training & Surveys, TCM, HCBS Providers, Statutes / Regulations, Policy Issuance Memorandums, Informational Memorandums, and Issue Tracking. The "Issue Tracking" link is highlighted with a red box, and a red arrow points from the text in the first section to this link. On the right side, there is a "Welcome" message and a "NEW OF" section with several links: Sunflower Connection, I/DD Targeted Case Management Seminars, FY2014 HCBS-MR/DD R, and KanCare I/DD Delay Proc.

KDADS Staff

Aquila “Q” Jordan, JD/MPA

Director, HCBS

aquila.jordan@kdads.ks.gov

Susan Fout, RN

TCM & Quality Assurance

Program Manager

susan.fout@kdads.ks.gov

Greg Wintle

HCBS-IDD Program Manager

greg.wintle@kdads.ks.gov



[**www.kdads.ks.gov**](http://www.kdads.ks.gov)

785-296-4986