Service Coordination Core Training Module
Component 1

It is important to remember that the purpose of this training program is to provide general information about case management services for eligible Medicaid recipients. This information is not meant to replace the specific policies and guidelines of your employing agency. You will receive more detailed training from your employing agency.

Definition of Case Management/Service Coordination:

Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. A case manager is responsible for intake and referral, assessment, care plan development, outreach, and implementing and tracking services to an individual. [1]

A quality case management system eliminates fragmentation and duplication of consumer services, assures the continuity of necessary services, monitors all aspects of consumer care, observes changes in condition or unmet needs, assures the most appropriate and cost-effective consumer care, facilitates a close and positive relationship with the consumer and affords the consumer the security of knowing a person who is knowledgeable of their needs and will assist them as needed. [2]

Many agencies and organizations across Alabama provide case management services to assist individuals in gaining access to needed medical, dental, legal, social, education, and other services. Case Management also includes assessing and monitoring the outcome of services, which were arranged by the case manager. Agencies may use other terms to describe Case Management services, such as, but not limited to: Care Coordination, Service Coordination, Care Management, etc.

The case manager may provide these services in a face-to-face contact or by telephone contact with the recipient, depending on your agency. Case management services may also be provided with collateral on behalf of the service recipient. A collateral could include the recipient's immediate family and/or guardians, federal, state, or local service agencies (or agency representatives), and local businesses or others who work with the case manager to assist the recipient.

[1] Alabama Administrative Code Ch 36, HCBS for the E&D, Rule No 560-x-36.04 – Covered Services
[2] Alabama Medicaid Agency HCBS E & D Waiver Policy & Procedures Manual

Through the Medicaid State Plan, the Alabama Medicaid Agency provides reimbursement of "targeted" case management services for contract providers who have met the licensure and certification requirements of the State of Alabama, *the Code of Federal Regulations*, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual*. Case management services are "targeted" to serve Medicaid eligible recipients in one of eight target groups depending on the agency which has been authorized to provide services to that specific target group. Specific qualifications are defined in the documents listed above that an agency must meet in order to be approved for a Medicaid contract to proved case management services to a specific target group. After an agency has an approved contract, case management services may be "targeted" to the group of individuals the agency serves. There are eight target groups:

Adults with mental illness
Adults with mental retardation
Children with a handicap
Children with foster parents
Women who are pregnant

Individuals with AIDS/HIV-Positive
Individuals who receive adult protective services
Individuals who are medically at risk

In addition to targeted case management services, several of Alabama's Home and Community Based Services (HCBS) waiver programs offer case management as a service to waiver participants. HCBS waiver programs afford individuals who are in danger of nursing home placement the opportunity to remain in the community. As a waiver participant, recipients receive Medicaid State Plan benefits plus additional Medicaid waiver services. The menu of waiver services varies from one waiver program to another and is selected based on the common needs of the population the waiver is designed to serve. Case managers in these programs work with recipients to develop, implement and monitor an individualized Plan of Care that identifies how the services and supports a person needs will be delivered. The Plan of Care may include waiver services which are authorized by the case manager as well as non-waiver services provided by formal or informal caregivers.

Case management services may be provided to a recipient who resides in their own home or in a household of another. Some targeted case management services may be provided in a supervised residential setting. Individuals who are in a hospital, skilled nursing facility, intermediate care facility, prison, jail, or other total care environment, are not eligible for Medicaid reimbursement of any case management services provided during the time they are in the total care environment. Some employing agencies may provide case management services to consumers in these locations that are not reimbursable by Medicaid.

Roles of the Case Manager:

Effective case management is based on a mutual understanding that both the case manager and the individual/consumer are working collaboratively toward achieving the basic goal of protection and/or providing needed services to those seeking assistance. Clarity about the roles and responsibilities of a case manager is essential to assist individuals in gaining access to needed services. These roles of a case manager include:

- Coordinator
- Advocator
- Enabler
- Facilitator
- Negotiator
- Developer
- Assessor
- Evaluator

TASKS:

Since the 1970's case management has become pervasive in the human services. Many areas have developed case management services such as mental health, developmental disabilities, child welfare, long-term care and services for elderly people, persons with a disability and children with special health care needs. These case managers' tasks reflect the complex, comprehensive needs of the clients they serve. The following are the six core tasks involved in Case Management:

Needs assessment

A needs assessment is a written comprehensive assessment of the person's assets, deficits and needs. Fact gathering of the social, cultural, medical, educational and environment are a part of this process. Assessment is a simultaneous, ongoing process and depends on the interaction of the person, family and case manager as the needs and wants are identified.

During the intake process an individual may be required to complete an application for case management services. A relative or other responsible person may sign applications when the recipient is a minor or is incapacitated. The agency should also record any Third Party Health Insurance information as reported by the recipient; and, a Social Security number must be obtained when available in order to verify Medicaid eligibility.

- Identifying Information

This would include basic demographic information about the person served such as name, date of birth, social security number, address, etc. If the client is unable to provide this information, the information may be secured from a family member or guardian.

- Socialization and Recreational needs

This would include, but is not limited to, daily activities, social and community activities, visits with family and friends, support groups, supportive employment, faith- based or social club activities and other areas to promote communication such as telephone conversations, email and other internet communications.

- Training needs for community living

This would include, but is not limited to, daily activities, personal hygiene, housecleaning, money management, shopping, socially appropriate communication and behavior, use of community services, and use of public transportation. Functional assessment of the person in relationship to independence and need for support is helpful in order to accomplish any of the above areas.

- Vocational needs

This would include support of the educational needs of the person. Specifically, vocational training is assisting the person in the public or private classroom and or home teaching in an effort to use the resources available to support their educational goals. To encourage and/or support the opportunities of job readiness, job training and job placement. Vocational assessment is an option if the person has not demonstrated job skills or if there is a need for consideration of their mental, cognitive or physical disability. Consider the level of stress of the person and also be positive and supportive of their efforts.

- Physical needs

This includes, but is not limited to, housing, food, clothing, bathing, transportation, person/household income and a safe environment. Consider the house structure and plans for safety for the person and special adaptations for the person with a physical disability.

- Medical care concerns

This includes, but is not limited to, need for primary care, specialty care, dental evaluation and treatment, psychiatric and mental health counseling, and various therapies that support the health of the person. Consideration is given to the compliance of prescribed therapies, medications, medical interventions, and nutritional support. It is important to consider access to medical equipment, prosthetics, wheelchairs and special seating, specialized bed and other needed medical equipment.

- Social/emotional status

  This includes, but is not limited to, need for substance abuse or addiction services, unsafe/irresponsible sexual behavior, socially unacceptable behavior/violent, parenting skills, marital problems/family stability, and mental illness. Consider the stress of the person and also the caregiver. Respite services may be needed to support the health of the family and their relationship with other family members including siblings.

- Housing, physical environment

  This includes, but is not limited to, safe environment, appropriate facilities for health, and adaptations for mobility for the person within the structure and exit. Considerations are given to prior evictions, prior homelessness, multiple relocations for the person and family, and where the person is located in this physical environment/freedom to move within the home.

- Resource analysis and planning

  This includes, but is not limited to, local, state and federal resources for the person and family you are serving. It is important to know the local community, availability, access and eligibility requirements of programs and resources that might benefit the person you are providing case management services. As a case manager it is critical to build relationships with resource providers in order to more effectively advocate for services, and support the development of other needed services. Many communities have a local community resource directory. This can be utilized and updated as additional resources and services are developed.

A case manager uses many skills to develop a trusting working relationship with the recipient to ensure the desired outcomes. The process begins with intake/referral and continues throughout the agency's relationship with the person.

Needs assessment is an evolving and fluid process that requires the case manager to engage the recipient in a working relationship that is a reasonable collaborative process based on current circumstances. The case manger should look for strengths, needs and resources that the individual has that are going well. These self-help strengths may be used to engage and provide direction to the recipient in the working relationship with the case manager.

The overall goals of case management are gaining access to community support services and coordinating access to these services. Assessments can be done in a variety of settings, using different types of information-gathering forms and utilizing this information to a particular population. It is important to use your agency's forms that the Alabama Medicaid Agency has approved.

Guidelines for Assessments:

1) Initial contact - This process must begin within the time frames set by your employing agency that will be in accordance with required Medicaid guidelines.

2) Re-assessment - This process must be dynamic and on going. The person's progress is reassessed through interviews, observations and follow - up contacts at intervals set by your employing agency that will be in accordance with required Medicaid guidelines.

CASE PLANNING

Case planning or care planning is the development of a systematic, client-coordinated Plan of Care, which lists the actions required to meet the identified needs. The plan is developed through a collaborative and dynamic process involving the recipient, their family or other support system, and the case manager. The plan is developed from the assessment and is considered an on-going process as the needs of the person change. It must be completed in conjunction with the needs assessment within time frames set by your employing agency that will be in accordance with required Medicaid guidelines.

Case planning builds a partnership with the recipient to develop a workable plan that builds on identified strengths, needs and risk factors identified during the assessment. What does the recipient value? Identify the values and build on them. Does the recipient need in-home support and/or protection, what concrete services such as food, shelter, medical services, etc. are needed, and does the recipient need legal, protective, or emotional support or respite care? What is the severity of the situation?

Options and strategies should be discussed that will assist the individual in meeting their needs. A consensus should be reached to determine the goals and necessary steps for reaching the goals.

Case planning also includes the selection of service providers to meet the identified needs/goals and who will be responsible for

each step needed to reach the goal. A time frame should be established to meet and/or re-assess the goals.

Models of Case Planning

There are many different theories and ways to do case planning, each one with its advantages and disadvantages. Three different approaches to case planning will be discussed here in an effort to demonstrate the different types of case planning. These approaches include: 1) Person-Centered Planning, 2) Family Centered Care Planning and 3) Consumer-Directed Care. Again, these concepts are not the only way to do case planning with an individual. Further, it is important to learn and follow the approach that your employing agency uses to meet the goals of case planning.

Person-Centered Planning: An important part of person-centered planning is using the term consumer when referring to the client. Case plans must be developed with the consumer. Person-centered planning is a process of organizing the provision of services to focus on assisting consumers to choose and attain roles in the community that reflect her/his self-determined aspirations. It is intended to ensure maximum consumer participation and ownership of her/his plan. This would also include the participation of identified others such as family, partners or friends. It is very important that the consumer be involved in the creation and implementation of their service plan in order to ensure that goals are successfully attained. Key characteristics of person-centered planning include:

1) **Person Orientation:** A focus on the consumer primarily as a person with strengths, not as a "case" exhibiting symptoms of disease.
2) **Environmental Specificity:** A focus on the real world context of where a person currently or prefers to live, learn, work or socialize.
3) **Functioning:** A focus on performance of everyday activities associated with valued roles and tasks.
4) **Involvement:** A focus on consumers (client) participating in all aspects of their plan.
5) **Individualization:** A focus on the unique characteristics of each person, tailoring all aspects of their plan, including their needs and wants.
6) **Self-determination:** A focus on individuals making choices and decisions for themselves.
7) **Outcome-orientation:** A focus on evaluating a person's success in terms of the achievement of specific outcomes.
8) **Support:** A focus on providing assistance for as long as it is needed and wanted.
9) **Growth Potential:** A focus on the inherent capacity of any person to grow, to improve her or his abilities.[3]

[3] Person-Centered Discharge Planning Manual for Alabama DMH/MR, BCPR Consulting, 2000.

Family-Centered Care planning: Families are vital to the overall success of case management activities. The core goals are improving and sustaining quality of life for the family and child/youth. The following are key elements of *family-centered care.*

1) Incorporating into policy and practice the recognition that the family is the constant in the child's life which the service systems and support personnel within those systems fluctuate.

2) Facilitating family-professional collaboration at all levels of hospital, home, and community care:

- care of an individual child;
- program development, implementation, evaluation, and evolution; and,
- policy formation.

3) Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.

4) Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, economic, educational and geographic diversity.

5) Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports to meet the diverse needs of families.

6) Encouraging and facilitating family-to-family support and networking.

7) Ensuring that hospital, home, and community service and support systems for children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.

8) Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

Consumer-Directed Care: The National Institute on Consumer-Directed Care defines consumer direction as "a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. Consumer direction ranges from the individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services. Choices and control are both key elements of any consumer-directed system". Some consumer-directed care programs permit consumers with disabilities to perform tasks such as choosing, scheduling or training caregivers while others provide

cash allowances that enable people to purchase or manage their own supportive services. [4]

Service Arrangement – Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. The case manager will assist the recipient in locating needed services and then calls or visits those persons or agencies on the recipient's behalf to assure the receipt of services identified in the case plan. Contacts may be through visits; phone conversations or other contacts with the consumer and/or agency programs on the recipient's behalf.

Arranging of services could include conferring with an attorney on behalf of a recipient or arranging for a visit for the recipient with an attorney. It is the arrangement of the service, not the actual service itself that is considered a part of case management. For example, transporting a recipient is never allowed as a targeted case management service for Medicaid reimbursement, however, arranging for transportation is considered a case management service. If a recipient needs counseling, the case management service is to arrange for the counseling, not to provide the counseling.

Social Support – Through interviews with the recipient and significant others, the case manager determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case manager will assist the recipient in expanding or establishing a support network through linking the recipient with appropriate persons, support groups, or agencies.

Reassessment and follow-up – Through interviews and observations, the case manager evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals set by your employing agency that will be in accordance with required Medicaid guidelines. In addition, the case manager contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments, and then revises the case plan if necessary.

The case manager is responsible for assessment of the recipient and service providers to determine if the services received are adequate in meeting the identified needs. Revisions to the Case Plan occur as needed when: (1) new risks are identified; (2) there are changes in the family structure, living conditions, or other

[4] AARP Public Policy Institute, 1999.

events; (3) the plan needs to be updated based on progress or the steps of the current plan are complete; (4) the individual is not making progress, steps are not being completed and the plan needs to be revisited; (5) the service delivery is not effectively meeting the established goals of the individual; or (6) the individual is in crisis and the Case Plan must be reassessed to resolve the crisis.

Monitoring – The case manager determines what services have been delivered and whether they adequately meet the needs of the recipient. The Plan of Care may require adjustments as a result of monitoring progress toward established goals.

The case manager continually evaluates the Case Plan and the effectiveness of services being provided. Observations and reports regarding the progress, or lack thereof, must be documented.

Case Transitioning/Case Closure/Case Termination- Although there are a variety of reasons why a consumer's case may be closed with an agency, typically a consumer has met the goals of the case plan or has reached an age when they can no longer be served by a specific agency. Successful termination involves preparing the consumer for the separation from the services and case manager, and making sure that the consumer able to transition into being on their own or into new services. Important tasks associated with case termination include 1) determining when to implement termination, 2) mutually resolving emotional reactions experienced during the process of separation, 3) evaluating the service provided and the extent to which case plan goals were accomplished, 4) planning to for the consumer to maintain gains achieved and to achieve continued growth. A case manager should always consider case termination with a consumer and prepare for termination no matter no long they will be working with a consumer. [4]

Documentation Requirements:

Documentation in accordance with provision of case management services through The Alabama Medicaid Agency is considered a legal document. Therefore, the core elements of prescribed case management services are reflected in individual documentation. Within these individual documented reports of service, the following is necessary:

- Name of recipient;
- Date(s) of service;
- Name of provider agency and person providing services;

[4] Hepworth, D. & Larsen, J. (1993) Direct Social Work Practice: Theory and Skills, 4th Edition. Brooks/Cole Publishing, Pacific Grove, CA.

- Description of service, including the nature, extent, and units of service provided;
- Place of service;
- Time in five minute increments; and
- Signature of Case Manager.

In writing the description of service, the following items are recommended:

1) What services were provided,
2) When these services were provided,
3) Where they were provided,
4) By whom they were provided,
5) Why they were provided
6) How they were provided, and
7) Plan for continuation.

It is important to have documentation clear, concise and connected. The documentation serves as a means of communicating with others the reason for your services, service provided, goals, and follow-up plans.

Buzz words that describe a case management service includes, but is not limited to: assessed; advocated; arranged; coordinated; enabled; evaluated; facilitated; linked; monitored; negotiated; planned; and referred.

Documentation for “targeted” case management services that are reimbursed by the Medicaid Agency must be retained for three years plus the current year to substantiate that services billed to Medicaid were actually delivered to the Medicaid recipient. However, if audit, litigation, or other legal action by or on behalf of the state or federal government has begun, but is not completed at the end of the time frame defined by Medicaid and the employing agency requirements, the provider must retain the records until resolution.