
SECTION 12

CASE MANAGEMENT

Learning Objectives

1. Define case management and its components.
2. State the purpose of case management.
3. State the goals of case management.
4. Describe the standards of care for case management.
5. Identify how the components of case management and the standards of care apply specifically to CAP/C.

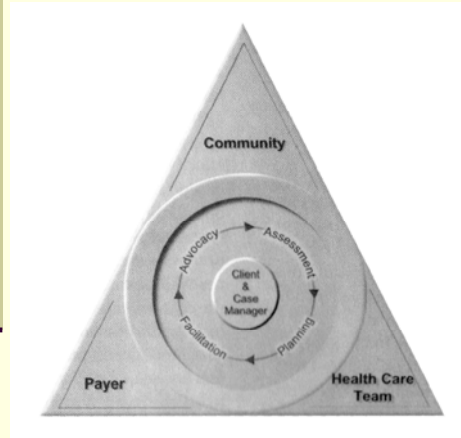
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CASE MANAGEMENT

This section of the training is based on
“Standards of Practice for Case Management”,
revised 2002, published by the Case Management
Society of America.

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DEFINITION OF CASE MANAGEMENT



Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

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DEFINITION OF CASE MANAGEMENT - ASSESSMENT



The case manager conducts a comprehensive assessment of the client's health needs in order to develop a plan of care.

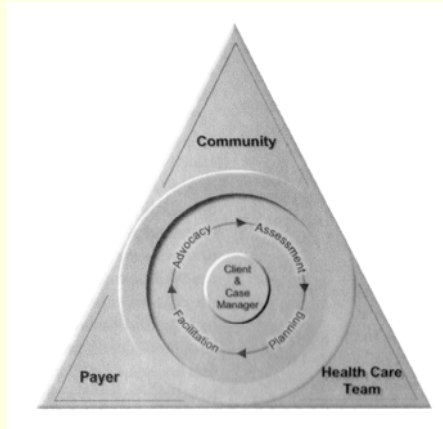
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The case manager should recognize the importance of the client's involvement in a successful assessment process and should provide and encourage opportunities for the client to communicate and collaborate with the case manager and the healthcare team.

The CAP/C Case Manager uses the FL-2 form, the CAP/C assessment form, and other resources such as nurses notes, agencies' careplans, and physician's statements to complete and document a comprehensive assessment of the child's and family's needs.

The family is expected to be actively involved in this assessment. The assessment should be focused on the child and on family needs that may affect the child or the family's ability to care for the child.

DEFINITION OF CASE MANAGEMENT - PLANNING



The case manager plans with the client, the primary care physician/provider, other healthcare providers, the payer, and the community to maximize healthcare response and quality, cost-effective outcomes.

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It is important for the case manager to engage the client/family in the planning process as the primary decision maker and goal setter.

The case manager should seek to ensure the development of appropriate contingency plans for each step of the healthcare process in the event of health or services complications.

The case manager should recognize that the plan of care is dynamic and may require on-going assessment and re-evaluation of health and progress.

The CAP/C Case Manager documents this plan mainly on the Plan of Care Form, but some components of the plan are documented on the assessment form. The Case Manager submits revisions when changes to the plan are needed. The plan should address every issue identified in the assessment and should include community resources and supports other than Medicaid. The family should direct the plan of care with input from the CAP/C Case Manager, the physician, and other supports as applicable including Early Intervention Services, the school system, etc.

Definition of Case Management - Facilitation



The case manager facilitates communication and coordination between members of the healthcare team, involving the client and family in the decision-making process in order to minimize fragmentation of the health care delivery system.

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The CAP/C Case Manager coordinates all the services and supports needed by the child/family to ensure that

1. the child and family receive all the necessary supports.
2. the services do not duplicate each other
3. the services are effective
4. the services are as cost-effective as possible.

DEFINITION OF CASE MANAGEMENT - FACILITATION, CONT'D.

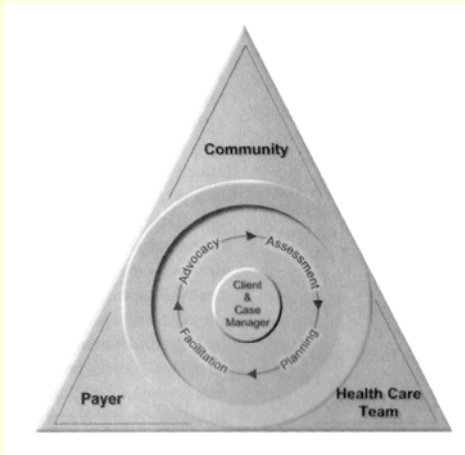


The case manager educates the client and member of the healthcare delivery team about case management, healthcare and treatment options, community resources, insurance benefits, psychosocial concerns, etc., so that informed decisions can be made.

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The CAP/C Case Manager also acts as a liason between the family and DMA, helping the family to understand CAP/C rules and decisions, and helping DMA to understand the family's needs.

DEFINITION OF CASE MANAGEMENT - FACILITATION, CONT'D.



The case manager problem-solves, exploring options to care when available and alternative plans when necessary to achieve desired outcomes.

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The CAP/C Case Manager explores all potential resource, not just CAP/C and Medicaid. The CAP/C Case manger also helps develop a back-up plan for events such as unstaffed shifts, power outages, etc.

DEFINITION OF CASE MANAGEMENT - FACILITATION, CONT'D.



The case manager encourages appropriate use of healthcare services and strives to improve quality of care and maintain cost-effectiveness on a case-by-case basis.

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The CAP/C Case Manager monitors and coordinates the overall healthcare of the child, not just the CAP/C care. For instance, the Case Manager ensures that the child is receiving appropriate primary care, such as immunizations and health screenings. The case manager monitors emergency room visits and hospitalizations and intervenes when able; i.e., educates the family regarding home care measures to be done at home to avoid an emergency room visit, or arranges to have the house cleaned of mold that is contributing to frequent hospitalizations for asthma exacerbations.

DEFINITION OF CASE MANAGEMENT - FACILITATION, CONT'D.



The case manager
strives to achieve client
empowerment.

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The CAP/C Case Manager encourages and facilitates the family to take an active role in the child's care and to advocate for the needs of their child and family.

DEFINITION OF CASE MANAGEMENT - ADVOCACY



The case manager is an advocate for both the client and the payer to facilitate positive outcomes for the client, the healthcare team, and the payer.

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It is important for the case manager to advocate understanding and respect for the beliefs, value system, and decisions of the client. The case manager should recognize the client's right to self-determination as it relates to the ethical principle of autonomy, including the client/family's right to make informed choices that may not promote the best outcomes, as determined by the healthcare team.

The case manager should support and educate the client to achieve self-advocacy whenever possible.

The CAP/C Case Manager balances the needs of the family, and CAP/C as well as other resources, to ensure that the child receives quality, cost-effective care within the limitations of the CAP/C program.

PURPOSE OF CASE MANAGEMENT

- To promote quality, safe, and cost-effective care.
- To promote utilization of available resources to achieve clinical and financial outcomes.
- To ensure appropriate access to care.
- To work collaboratively with the client/family, the physician, providers of healthcare, the payer, and others to develop and implement a plan that meets the individual's needs and goals
- To interject objectivity, healthcare choices, and promotion of self-care where it is lacking.

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GOALS OF CASE MANAGEMENT

- To enhance an individual's safety, productivity, satisfaction and quality of life.
- To assure that appropriate services are generated in a timely and cost-effective manner
- To assist clients to achieve an enhanced level of health and to maintain wellness and function by facilitating timely and appropriate health services

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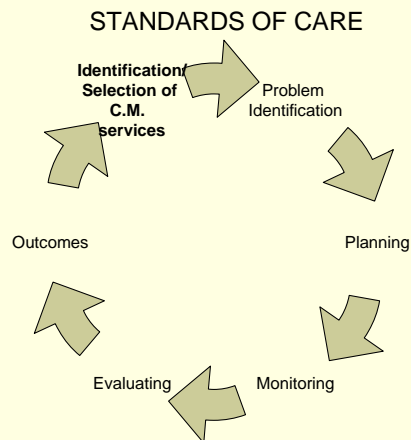
GOALS OF CASE MANAGEMENT, CONT'D.

- To assist clients to appropriately self-direct care, self-advocate, and make informed healthcare decisions to the degree possible
- To maintain cost-effectiveness in the provision of health services
- To facilitate appropriate and timely benefit and treatment decisions
- To maintain ongoing documentation and reporting of goal achievement

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STANDARDS OF CARE FOR CASE MANAGEMENT – IDENTIFICATION/SELECTION

Identify potential clients suitable for effective case management intervention.

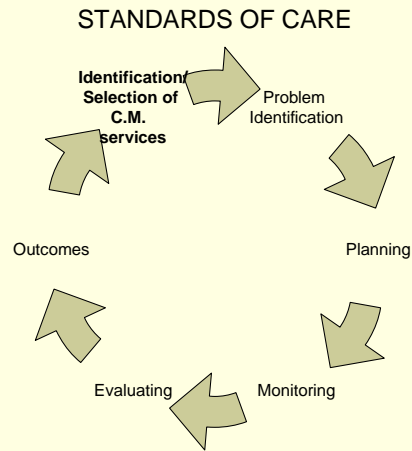


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The CAP/C Case Manager develops and maintains relationships with local physician's offices, hospitals and discharge planners, provider agencies, parent groups, and other program resources. By maintaining those relationships, case managers ensure access to CAP/C for those who need it, and better coordination of care for clients or potential clients.

STANDARDS OF CARE FOR CASE MANAGEMENT – IDENTIFICATION/SELECTION, CONT'D.

Conduct a thorough and systematic evaluation of the client's current status using standardized tools when appropriate, including the following components: physical/functional, psychosocial, behavioral, environmental/residential, family dynamics and support, spiritual, cultural, financial, vocational/educational, recreational/leisure pursuits, caregiver(s) capability and availability, learning capabilities/self-care, health status expectation and goals, transitional or discharge plan, and legal components.



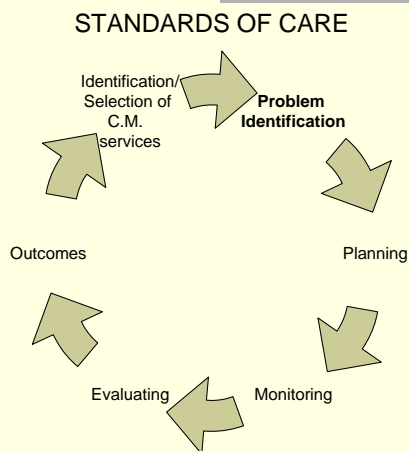
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When a parent, discharge planner, or other person calls a case manager to inquire about CAP/C services, the case manager has a discussion with the inquirer about the needs of their child, their expectation, and about CAP/C. The case manager completes the referral form and submits it to DMA.

STANDARDS OF CARE FOR CASE MANAGEMENT – PROBLEM IDENTIFICATION

The case manager will seek to identify opportunities for intervention, i.e., when there is:

- Compromised patient safety
- Over-utilization or under-utilization of services, or use of inappropriate services
- Ineffective treatment plan
- Permanent or temporary alterations in functioning
- Non-adherence to treatment or medications
- Medical/psychological/functional complications
- Lack of education of disease course/process
- Lack of family/social support
- Lack of financial resources to meet health needs



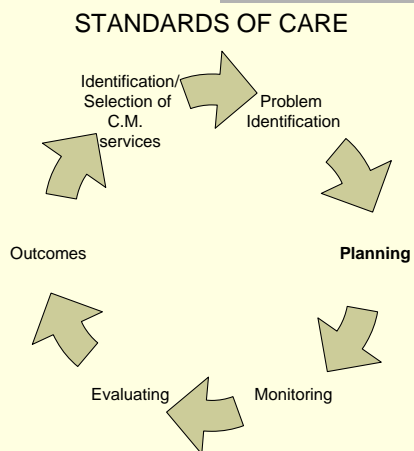
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When the referral is approved by DMA, the case manager performs a complete assessment, encompassing all of the above components, and utilizing all available resources and knowledge. The findings are documented on the CAP/C Assessment form. This assessment is the basis for determining the plan of care.

STANDARDS OF CARE FOR CASE MANAGEMENT – PLANNING

The case manager will:

- Interview, research, and otherwise gather relevant, comprehensive information and data to establish the factual and clinical basis upon which to develop an appropriate plan of care
- Understand the client's diagnosis, prognosis, care needs, and outcome goals of the plan of care
- Implement cost-savings strategies when possible, while considering the policy/benefits available to the client

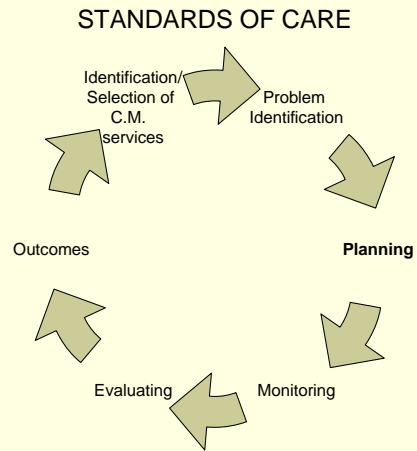


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The CAP/C Case Manager is familiar with community resources considers all of the options available to the client, including but not limited to CAP/C.

STANDARDS OF CARE FOR CASE MANAGEMENT – PLANNING, CONT'D.

- Proactively identify situations that are, or may become, barriers to goal attainment
- Work toward resolution of conflicts and problem solving
- Involve the client/family and the healthcare team in the ongoing plan of care
- Identify goals and related indicators for successful planning and implementation, such as clinical stability or client adherence to treatments and medications



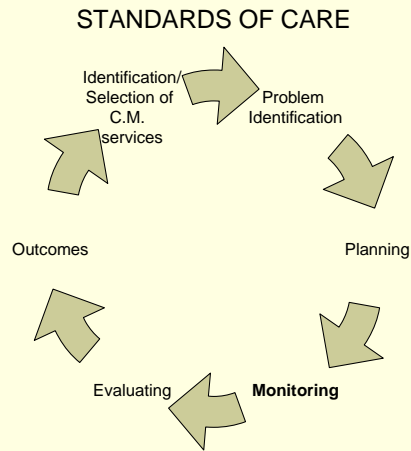
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The Case Manager involves the family in planning care. The case manager has a plan to resolve each and every need and issue identified in the assessment. These plans and actions are described on the Plan of Care form and in the case management notes.

STANDARDS OF CARE FOR CASE MANAGEMENT – MONITORING

The case manager will seek to:

- Maintain professional collaboration and communication with the client and family to the extent possible, so that important information regarding the client's health status and the impact on the goals and outcome off the plan of care can be disclosed



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The CAP/C Case Manager must:

1. have at least monthly contact with the client/responsible party
2. have a home visit with the client at least every 90 days

These contacts should include the following components.:

Medicaid card verified private insurance info checked/updated
update in child's health or care needs

hospitalizations, ER visits, doctors' appointments
acute illnesses: reason and results
changes in medications/diet/other new orders
has condition improved/maintained/declined?
therapies: changes, progress made
upcoming studies/appointments
new diagnoses, new treatments

update in caregiver availability or informal support system

changes to caregiver work or school schedule
changes to child's school schedule
addition or subtraction of members of household
changes in informal support system
changes in legal guardian, caregivers, custody arrangements
changes in family's health or needs
do family/caregivers have need for training?

equipment/supplies/orthotics

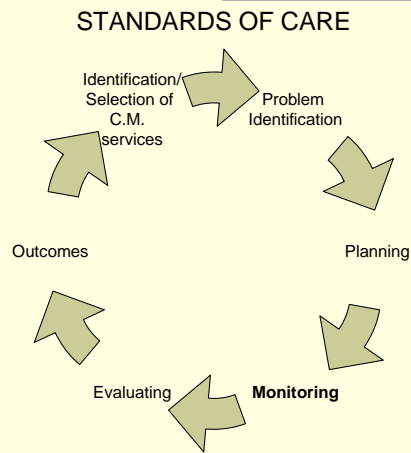
Has anything new been obtained?
Are quantities of current supplies sufficient?
Is anything new needed?
Any problems with supply companies?

staffing issues

concerns with any staff? with agency?
attendance issues?
unstaffed hours?
upcoming change in need for staff?

STANDARDS OF CARE FOR CASE MANAGEMENT – MONITORING, CONT'D.

- Maintain professional collaboration and communication with the members of the healthcare team so that the plan of care can be discussed objectively, problems can be identified, and adjustments can be made to the plan as needed



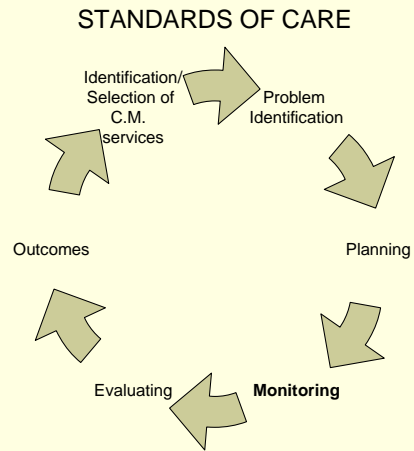
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The CAP/C Case Manager must

1. Have monthly contact with the recipient and family
2. Have monthly contact with the service providers regarding the provision of waiver services
3. have monthly contact with the home health nurse, if applicable, to review findings and coordinate care
4. Have quarterly contact with providers of non-waiver services
5. Have a quarterly home visit with the recipient/family while the nurse/nurse aide is present.
6. review a sample of supporting documentation every 90 days for nursing services/nurse aide services and respite
7. review claims from providers to be sure that the billed services were provided as approved on the plan of care and authorized.

STANDARDS OF CARE FOR CASE MANAGEMENT – MONITORING, CONT'D.

Maintain regular communication with pertinent healthcare providers regarding client transition across settings, barriers to care/services, and strategies or plan revisions that are needed. Ascertain that the goals of the care plan are appropriate, understood, documented, and are being met. Also advise the providers of adjustments or revisions to be made in the care plan.



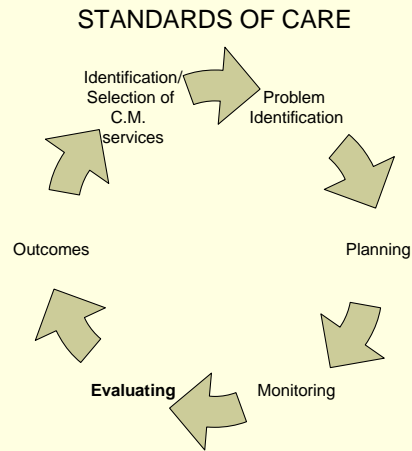
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See next slide.

STANDARDS OF CARE FOR CASE MANAGEMENT – EVALUATING

The case manger will seek to:

- Identify when a client's condition has reached a static or regressive situation and proactively facilitate adjustments in the care plan, providers, and /or services, when possible, to promote enhanced outcomes.
- Focus efforts on maintaining the stability of the client's family's home environment.



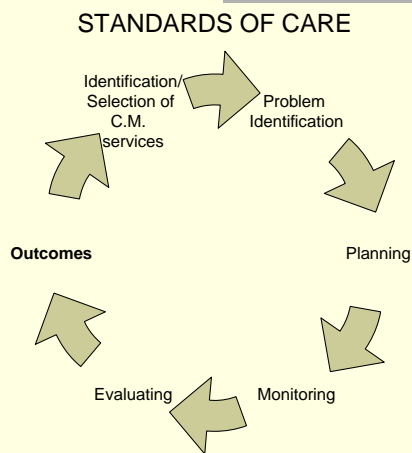
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The CAP/C Case Manager continually evaluates the plan of care through his/her monitoring activities, and submits revisions to the plan of care to DMA as needed.

STANDARDS OF CARE FOR CASE MANAGEMENT – OUTCOMES

The case manager will seek to:

- Focus on accountability for quality care and/or quality of life improvements as measured against the case management goals
- Recommend referral sources based on evaluation of the provider's quality of care and ability to meet the client's needs.
- Maximize client outcomes through incorporating community-based and non-benefit related services whenever possible.



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The CAP/C Case Manager:

- 1) Utilizes all resources to meet a client's need
- 2) Completes and submits the CAP/C Critical Incident Report as applicable
- 3) Participates in CAP/C Quality Assurance activities both within their own agency and with DMA (including surveys, desk reviews, and site reviews).

SUMMARY

- The Case Manager performs outreach activities to identify appropriate candidates for the CAP/C program, and submits referrals for those appropriate candidates.
- The Case Manager performs a thorough assessment and plan of care based on that assessment.
- The Case Manager maintains contact with the client at least monthly by telephone and at least every 90 days by home visit.
- The Case Manager maintains monthly contact with waiver service providers, and reviews their claims.

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SUMMARY, CONT'D.

- The Case Manager reviews a sample of nursing documentation on a quarterly basis.
- The Case Manager maintains quarterly contact with providers of non-waiver services.
- The Case Manager reevaluates the plan of care and submits revisions as appropriate as well as the annual Continued Needs Review (CNR).
- The Case Manager completes the Service Authorization and the Participation Notice.
- The Case Manager participates in CAP/C Quality Assurance activities.

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REVIEW QUESTIONS

Please make sure you can answer the following questions before proceeding to the next section.

1. You must make a home visit with your client at least every _____ days.
2. You must make contact with your client/responsible party at least _____.
3. You must make contact with your client's waiver service providers at least_____, and non-waiver service providers at least _____.
4. You must review supporting documentation such as nurses' notes at least _____.
5. If you are reviewing claims, and the agency provided services that were not on the service authorization, you may deny that claim.
6. True or False: A provider agency can not change the frequency of the supplies listed on the participation notice without your approval.

REVIEW ANSWERS

1. 90

2. monthly

3. monthly

4. 90 days

5. True. The service authorization is binding, and the agency may not provide any services not listed on it.

6. False. The participation notice is not an authorization. Although the agency should notify you of deviations from the participation notice, they are not required to get you approval first. That is why good communication with the family and supply providers is essential.