

CASE MANAGEMENT

Case Management

Case management is an activity that assists recipients in gaining access to necessary care and medical, behavioral, social, and other services appropriate to their needs. Case management should be individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include assessment, care planning, referral/linkage, and monitoring/follow up.

Assessment

Comprehensive and culturally appropriate assessment should determine a recipient's service needs, strengths, resources, preferences, and goals to develop a care plan. Assessment should address all aspects of the recipient, including medical, physical/functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, and vocational/educational areas. Assessment should include early identification of conditions and needs for prevention and amelioration. Assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, and educators to form a complete assessment. Assessment should include periodic reassessment to determine whether a recipient's needs or preferences have changed.

Care Planning

Care Planning is the development and periodic revision of a specific care plan based on the information collected through ongoing assessment and reassessment. The care plan should be comprehensive and address the recipient's identified needs, strengths, resources, and preferences. The care plan specifies the recipient's goals and the actions necessary to address the medical, behavioral, social, and other service needs of the recipient. Care planning should include the active participation of the recipient and the recipient's natural and paid supports. The care plan should optimize Medicaid funding and other resources. The goal of care planning is to develop an appropriate and fiscally responsible plan of care that enhances quality and access outcomes.

The care planning process should ensure the active participation of the recipient and promote self-direction and self-management. The care planning process involves information sharing with the recipient and his or her supports in order to help the recipient make informed decisions. A recipient's care plan should be revised as his or her needs, preferences, and goals change.

Referral/Linkage

Referral and related activities link a recipient with medical, behavioral, social and other programs, services, and supports to address identified needs and achieve goals specified in the care plan.

Referral and linkage activities include:

- Coordinating the delivery of services to reduce fragmentation of care and maximize mutually-agree upon outcomes.
- Facilitating access to and directing recipients to services and supports as identified in the care plan.
- Making referrals to providers for needed services and scheduling appointments for the recipient.

- Assisting the recipient as he or she transitions through levels of care.
- Facilitating communication and collaboration among all service providers and the recipient.

Monitoring/Follow-up

Monitoring and follow up includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the recipient. Monitoring activities may involve the recipient, his or her supports, providers, and others involved in care delivery. Monitoring activities should help determine whether:

- Services are being furnished in accordance with the recipient's care plan;
- Services in the care plan are appropriate and effective;
- There are changes in the needs or status of the recipient that should be addressed;
- The recipient is making progress toward his or her goals.

CARE MANAGEMENT

Care Management

Care management addresses the programmatic and preventive service needs of a population. Care management is outcome-focused and monitors the population and service delivery system using data. Care management programs apply systems, incentives, and information to improve care and assist recipients and their system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively. The functions of care management include:

- Systematic data analysis to target recipients and providers for outreach, education, and intervention
- Monitoring system access to care, services, and treatment including linkage to medical or clinical home
- Screening, triage, and referral
- Monitoring and building provider capacity
- Monitoring quality and effectiveness of interventions to the population
- Supporting the medical or clinical home through education and outreach to recipients & providers
- Facilitating Quality Improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/National Standards of Care
- Advocating for recipients to ensure that recipients receive appropriate, evidence based care
- Acting as a liaison to providers to ensure the use of Evidence Based Practices
- Educating recipients about disease states to include medication adherence, prevention and risk factor reduction
- Ensuring follow-up with hospital discharge instructions for high risk, high acuity, high cost recipients; ensure continuity of care
- Coordinating transitions from state and local facilities (adult justice system, psychiatric hospitals, developmental centers, hospitals, nursing facilities) across the system of care for high acuity, high cost recipients
- Assisting providers with coordination of services for high risk, high acuity, high cost recipients