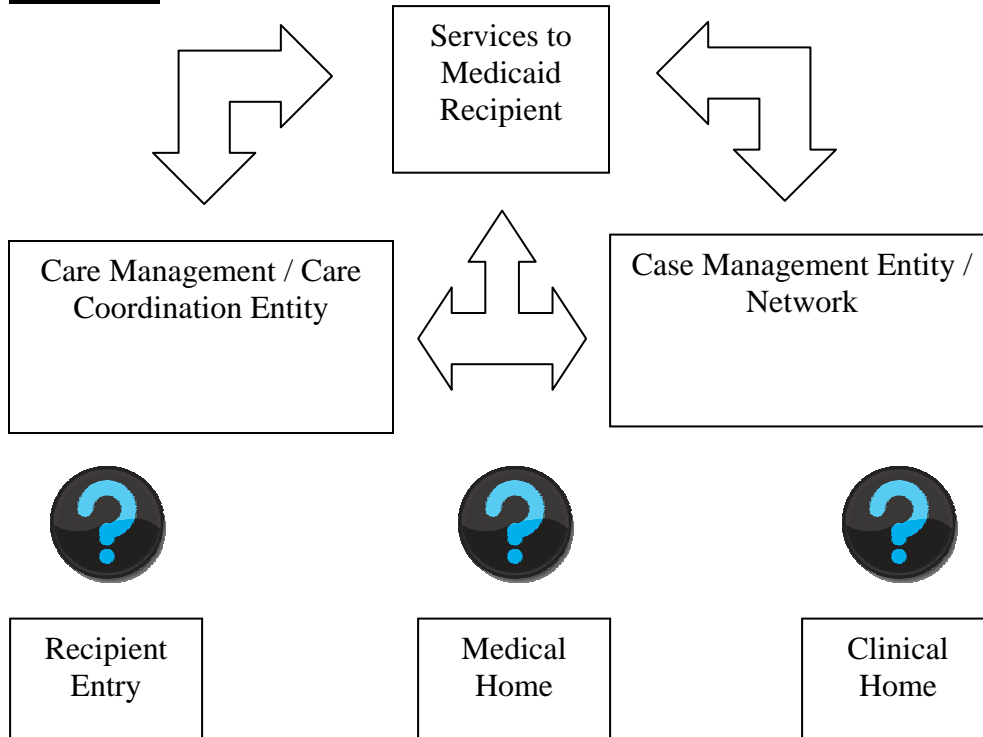


## Case Management Basic Concept Models:

### Model A:

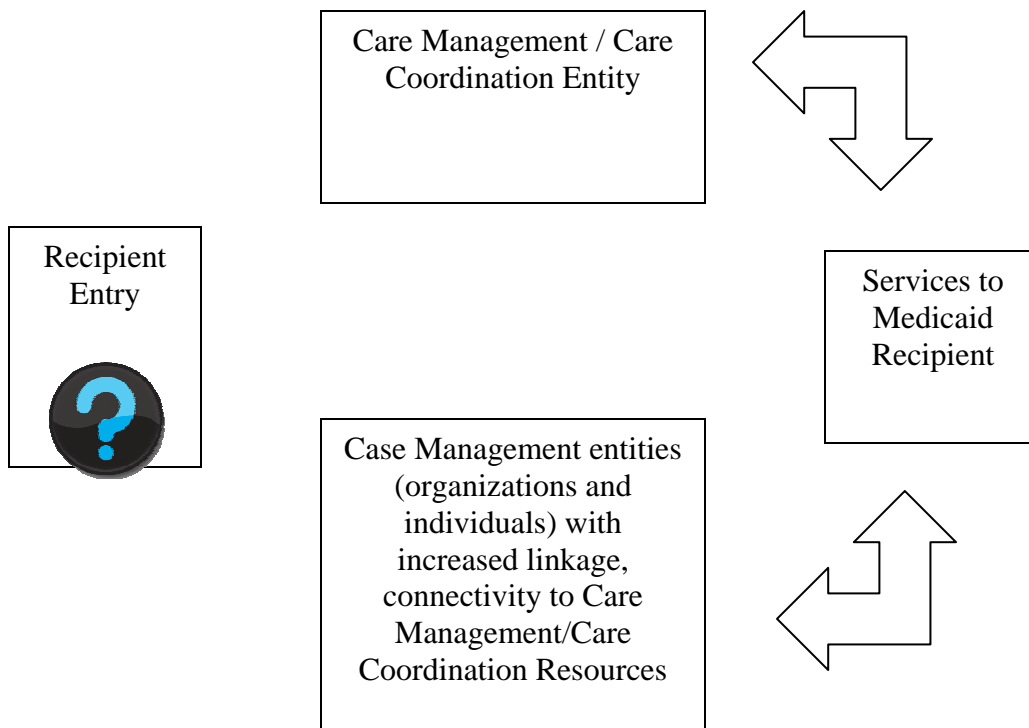


Some possibilities:

- Create case management networks that align with the Managed Care Networks
- Care Management Entity could provide utilization reviews, disease management, patient education, risk management, assign or serve as medical home
- Case management networks could pool resources for administrative functions
- A standardized assessment and care plan process that is automated and web-based and has authorized access by physicians, care coordinators, case managers, etc. could be created
- DHHS developed/approved training curriculum could be provided to each case management network with the network responsible for the training of its members

- An Entry Criteria for Case Management could be developed that assesses if a recipient needs case management, at what level and duration is it needed, when and if duplication may be acceptable, a determination for lead in case management if multiple services are involved, etc.
- Training that increases the knowledge base of case managers across service and program settings with the intent of allowing case managers to provide services in more than one setting

**Model B:**



Within this model there are common consultations, supports, resources, trainings, assessments, POCs, other forms, and standardized training across all services and programs.

Model C:

**ONE Entity that performs all functions of Care Management,  
Care Coordination, and Case Management**