



Case Management in North Carolina

MTA, Inc




Continuum of Care: Different Outcomes

- Treatment: relief of distress, reduction in symptoms
- Crisis: resolution of crisis
- Rehabilitation: acquisition of life roles
- Case Management: linkages to services and support




New York Outcomes

- One of 4 outcomes is focus:
 - Resolve problems which interfere with independence or self-sufficiency
 - Resolves problems which interfere with maintenance or attainment of self-support or economic independence
 - Maintain community stay
 - Prevent inappropriate hospitalization
- For those difficult to engage you are responsible for providing options that are more responsive to needs




PA CM Goals for CM:

- The two primary goals of case management are:
- (1) to increase client retention in and completion of treatment in order to move clients toward recovery and self-sufficiency; and,
- (2) to increase client access to core services such as primary health care, psychiatric care, stable and secure living environment, positive support networks, vocational training, and employment.




Targeted Case Management

- One of the only services that allows for discrimination
- Eligible population definitions included in your SPA (State Plan Amendment)
- Eligibility is not for a lifetime – must be reassessed regularly




Case Management and TCM

- Deficit Reduction Act Defined:
 - Assessment
 - Treatment planning
 - Referral and referral related activities
 - Evaluation and monitoring of plan
 - See handout from DRA




Case Management and TCM

- Deliberate narrowing of definition
 - Cost concerns
 - Ineligible client concerns
 - Ineligible services
 - Family members ineligible but getting treatment




Case Management and TCM

- New interim final rule issued that added restrictions
 - Moratorium
 - Still in disarray
- Advice we have now:
 - DRA
 - State Medicaid Director's letter




Case Management and TCM

- General agreement
 - Case management is not a direct service – it is not treatment
 - Case managers should not duplicate each others efforts
 - Medicaid should be the payer of last resort
 - Case managers are responsible for the coordination of care as well as for linkages to services/supports
 - Case managers are not a filter for additional services nor a conduit to the provider they work for




Case Management and TCM


- General agreement
 - Case managers for MR/DD and for mental health do not have to follow "any willing provider" rules and the states can pick and choose who will provide those services



The Federal View of Case Management




- Central player
- No conflict of interest
- Comprehensive assessment
- Time line and strategy developed
- Coordination all players
- Primary manager of all
- Plan is case plan not Tx plan




Case Management Defined

- "The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed needs."




Case Management Defined

- “In the context of this regulation, it is the individual’s access to care and services that is the subject of this management – not the individual.”




Case Management Defined

- Case management can refer individuals to services and supports regardless of who pays for those supports
 - Not limited to just Medicaid
 - Can self refer but only if client chooses freely
 - Clients can choose to not take your advice or agree to certain linkages or referrals




Case Management Defined

- Case managers can confer and discuss client needs with those who are not eligible for Medicaid or who are Medicaid eligible but not in the target population.
 - Yes but only on behalf of the covered individual – direct relationship to the eligible individual’s care is required.



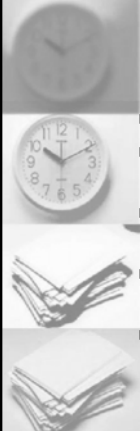
Case Management Defined

- Case managers can provide CM services both face to face and collateral according to federal rules:
 - Written is not currently included or emailing



Case Management Defined

- CM/TCM Providers cannot require a client to use their services.
 - yes – voluntary
- CM/TCM cannot be used as a gate keeping function
- CM/TCM cannot be used to limit client choice of providers - watch for self-referrals (if CM can provide more than one service) and limited agency choices







Case Management

- Services must be necessary
- Client must be unable to access the services and supports on their own
- The service consists of one of 4 buckets of activities
- Requires evaluation of impact of treatment plan on client's recovery
- Requires vigilance in determining if plan is being implemented – active treatment concept





Case Management

Development of Service Models


Case Management Team

- Model should be one that allows for independence not a recruiter for other services you provide
- Team of case managers that report to a separate supervisor prevents capacity from being stuck in places it cannot be used
 - Can therefore be centrally located


Case Management Team

- Case management is embedded in ACT, Community Support Teams, Intensive Home Based services
 - Cannot have TCM as well
 - Watch for duplication in other areas as well
 - If consumer meets criteria for more than one target population – get them to choose
 - Coordination with other managers to avoid duplication




Case Management Team

- Case managers should be able to deal with children, adults, and families
 - Especially in rural areas, geographic assignments make a big difference in access and capacity
 - With families each member must have own plan but want to prioritize linkages especially if benefit more than one person




Case Management

- Much work can be done by phone
 - If consumers have phones – regular contact, reminders, etc.
 - Coordination of care – huge issue – much more efficient by phone
- Emphasis on phone work
 - Allows for higher caseloads which will be important




Case Management Team

- Receives referrals
 - Need a diagnosis and determination that these services are necessary
 - Referring staff should have clear guidelines for eligibility requirements and level of need
 - Should not be referred solely for transportation
 - Other ad hoc interventions
 - There should be the capacity to deal with emergency issues without formal case plan




Case Management Team

- Internal referrals
 - Should be formal systems for each type of service
 - Consumer offered choice
 - Documentation of choices offered



Communication

- Danger is that silo'd care will result
 - Communication strategies need to be developed and staff held accountable
 - Case manager plays very central role in this
 - Can you use technology?
 - Email
 - Electronic medical record
 - Other forms




Helping Relationships

- Case management as a separate service – decoupled from community support
- Consumer will have to develop multiple helping relationships
 - More real world
 - Less dependency on one person or position
 - Will need help and support to do this




Case Management

What are Medicaid Case Management Services?



Case Management Defined


- 4 Buckets:
 - Assessment: comprehensive to allow for one CM – not confined to just talking to client – reassessment at least annually
 - Treatment planning: must include the individual
 - Referral Related activities: need to be careful
 - Evaluation and modification of the plan: includes coordinating activities and conferring with others, not just client if necessary – and as often as necessary



Before Services Can be Delivered Effectively


- Engagement of individual in the process
- Developing a trusting relationship
 - In the end it is all about the relationship
 - See handout
 - Engagement is a critical skill for case managers

Center for Psychiatric Rehabilitation, Boston University



Case Management Defined

- Case managers are responsible for an assessment
- What is a case management assessment?
- How can this be person-centered?




Covered Services

CM Assessment: determining client needs using multiple sources including client

The case management assessment

- Organized review of client needs
- How big a priority? What kind of impact?
- How have they been dealing with this? Anyone else helping them? Anyone else available?
- Do they need help? What kind?


- See example: Philadelphia



Covered Services

CM Assessment

- Some usual covered activities:
 - Meeting with client/family members
 - Completing assessment tool
 - Gathering authorizations to get information from other providers
 - Reviewing biopsychosocial with client and family to familiarize yourself and to ask questions
 - Review treatment priorities of client; where past treatment; what worked and what didn't
 - Determine commitment to development and implementation of plan
 - Determine how much support they are likely to need to implement plan
 - Client and family education about role of case manager
 - Others?



Case Management Defined

- Not a treatment plan, but a case management plan:
 - The planning process –not event
 - Who do you need to link to – in what order – what effort
 - What types and kinds of coordination?
 - When and how will you assess effectiveness



Covered Services

Treatment Planning:
Some usual covered activities:


- Developing the initial treatment plan includes covered activities such as:
 - coordinating treatment planning meetings,
 - making sure the individual understands the treatment planning process and is included in planning,
 - helping the individual prioritize their needs and identify strengths and the skills and supports they need as a result,
 - on-going evaluation with the individual and your supervisor together of the effectiveness of the plan,



Covered Services


Treatment Planning:
Some usual covered activities:

- discussions with other members of the treatment team about their roles in the plan, their perceptions about what would be most effective, and the level of participation they think will be required of the individual,
- Writing the treatment plan. This is a covered activity if with client – concurrent documentation




Case Planning

- Goal: Individual moves to apartment
 - Link to ADL skill building assistance in:
 - Medication compliance
 - Managing an apartment and Safety
 - Coping skills
 - Travel training, etc.
 - Link to local supports: police, pharmacy, grocery, church
 - Call bi-weekly to talk to CS worker
 - Review monthly with individual and plan for next month



Case Management Defined

- What are linkage and referral related activities?
 - “Case management referral activity is completed once the referral and linkage have been made.”
 - Referral: process of directing someone to a service or support
 - Linkage means something more: not defined federally
 - Not just the referral but the ability to use and manage the referral?



Covered Services


- Two parts:
 - Strategy: Planning for implementation of the various parts of the plan: timelines, appointments, priorities, etc.
 - Implementation of the plan: Assistance with accessing services and supports



Covered Services
 Planning Implementation:


Some usual activities:

- Meetings with the individual to map out a schedule and determine transportation needs.
- Discussions with the individual and their family about the reasons for various appointments.
- Gathering necessary data, filling out required forms, and developing lists of questions to ensure the individual gets the best results from the plan and the services and supports they are being linked with.
- Locating and obtaining commitments for services that are necessary and are needed by the individual where they are unable to locate these services on their own –phone work.
- Developing a timeline or strategy for when and how soon the different services listed on the treatment plan will need to be implemented with consumer




Covered Services
 Implementation:

- Some usual activities:
 - calling and setting up appointments,
 - assisting the individual to get to the appointment (remember transporting a individual is not a billable activity);
 - talking with services and supports to describe what the individual needs,
 - helping the individual to develop a list of the right questions to get the information and services they need,
 - discussing with the individual how they will be expected to participate,
 - discussing the rules they will be expected to follow,
 - reminding individuals about appointments,
 - accompanying the individual to some appointments to ensure proper and effective linkage and services.




Texas Definition of Advocacy

- Note advocacy is not used in federal definition but....
- Advocacy: asserting treatment needs; requesting special accommodations; evaluating provider effectiveness and compliance with agreed upon treatment plan; requesting improvements and modifications to ensure maximum benefit from the services and supports.




Coordination and Monitoring

- Ensuring active treatment
- Ensuring appropriate treatment
- Ensuring client agreement that overall plan is effective



Active Treatment


Active treatment, however, is not simply a collection of disparate services: it is a concept that embraces the whole range of services a patient needs. The total effect of active treatment is that the individual components are integrated and directed toward achieving the goals established in each individual's plan of care.



Covered Services

Monitoring Implementation

- *You are not monitoring the client*
- *You are monitoring the implementation of the plan*
 - Is the consumer getting the services in the plan
 - If not, why not?
 - If yes, are they satisfied with the provider(s)/services?
 - Are providers doing as expected?
 - Are they coordinating their respective roles
- *Active treatment*







Covered Services

Monitoring Implementation

Some usual activities:

- Getting commitments from multiple providers to not just provide needed services but to coordinate their efforts;
- Making sure that services are being provided according to the treatment plan;
- Making sure that necessary communication between providers and the individual is happening.
- Meeting or speaking over the phone with collateral contacts to see if the individual is participating in treatment, to evaluate the effectiveness of the interventions, to get status reports, and to map out strategy.
- Meetings with the client and their families to determine if they are getting all of the services on the plan as ordered; if not, why not?






Covered Services

Evaluating the Plan

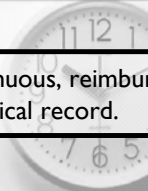
Some usual activities:

- Some of the same activities as treatment planning – evaluating what happened, what didn't happen, what worked, what didn't work, what are new priorities, who will participate in new plan?
- Contacting all members of team to get their input
- Meetings with client, family, treatment team members

Documenting Medically Necessary Services


Telling a coherent, continuous, reimbursable story in the medical record.






Medicaid and Documentation

- Golden Thread Discussion:
 - Assessment:
 - Biopsychosocial
 - Psychiatric
 - CM
 - Treatment plan and treatment plan reviews
 - Content: goals, objectives, interventions, etc.
 - Emphasis on this acting as a road map for the provider and consumer



Medicaid Documentation

- Golden Thread Discussion:
 - Progress Notes
 - Take your case plans with you so you remember what you are doing and mean to accomplish
 - Basic information: dates, signatures, name of service, name of client
 - List goal/objective: favors objectives
 - Presenting problem: statement of medical necessity
 - List the interventions
 - Describe client response
 - Plan for next visit or visits



Case Management Assessment

- See example
- Domain based
- Prioritized by scores
- Looks for alternative supports – Medicaid payer of last resort
- Clear focus on service needs, not providing services
- Can be used to look at outcomes by trending scores



Treatment Planning

- Treatment planning and the diagnosis
 - CM services are not usually diagnosis specific
 - Certain diagnoses needed for eligibility usually along with other indicators of need
 - Type of diagnosis may indicate level of need



The Client

- Client currently experiencing auditory hallucinations that he responds to frequently resulting in eviction from apartment. Current situation began 3 months ago when client stopped taking medications. Client moved in with brother, currently on meds but not stable and family (other treatment team members) are concerned about client's compliance as client admits to frequent lapses in past. Client unable to attend day programming and difficulty with social isolation as a result. Client seeing psychiatrist bi-weekly to stabilize medications.




Issues First:

- 1. Client not stabilized on meds so currently still symptomatic – *continued linkage to psychiatry; client teaching*
- 2. Client not consistently medication compliant – *research other resources; client teaching*
- 3. Client socially isolated – not good as it adds to his paranoia and bizarre behavior – *research local supports; family resources; other activities*
- 4. Unstable living situation jeopardizing community placement – *housing plan needed*




Referral to Mental Health Services for Tx Plan

- Objectives:
 - Client will stabilize on medications that will reduce symptoms so that he can attend day treatment. As measured by....
 - Client will work with Rx Team (ID them) to recognize and then minimize side effects from the medication that make compliance more difficult. As measured by....
 - Client will work with Rx Team to be able to connect the use of medications with reduction in symptoms that risk his community placement. As measured by...
 - Family members (ID) and client will be able to identify meds, their purpose and major side effects. As measured by....




Interventions:


- Client will continue to see MD bi-weekly
 - CM to meet with client bi-weekly for ½ hour prior to MD meeting to ID questions
 - CM will engage family to accompany client to medication appointments.
 - CM will ID any med changes and ensure scripts filled and family notified
- Client and family will meet with nurse weekly for one hour for medication education.
 - CM will coordinate appointments and arrange transportation if necessary
- Client will see current primary care doctor to make sure he/she knows about psych meds and to screen for any contraindicating co-morbidities.
 - CM will assist family/client to set up appointment.
 - CM will accompany client to appt in order to advocate for appropriate follow-up appointments and to assist client in explaining current medications.
 - CM will coordinate correspondence and communication between psychiatrist and primary care MD,




How Individualized?


- Some problems lend themselves to common solutions – this is likely in CM
 - Benefits
 - Linkages to treatment
- The longer someone is in treatment the more individualized




Progress Notes 


- Must indicate necessity for service so relate the service to the plan
 - Client's circumstances
 - Client's participation
 - Client's response
 - Next steps







Progress Notes 


- Often:
 - Do not describe an intervention
 - Do not describe services that easily relate to the goals and objectives even if they are listed



Progress Note 





“Met briefly with consumer. He reports that he is stable and taking his medications as prescribed. He agreed to a follow-up appointment. He reported no difficulties at this time.”




Progress Note 

- Goal: Stable Psychiatric Functioning;
Objectives: Consumer will determine housing choice. Consumer will develop a plan for obtaining permanent housing.

“Consumer in crisis bed and is homeless with no entitlements. Educated consumer about options for housing if SSI is denied. Explored consumer’s preferences. Consumer stated she would prefer SRO but is open to other options. Agreed we will follow-up by end of week.”




Progress Note 

- Met with client today. He appeared well-groomed and in a good mood. He stated he went to choir practice and sang last Sunday at both services. States he felt exhausted. Client did state that he enjoyed himself but that he needed encouragement from family to participate.




Case Management

CASE RATES



Case Rates

- Built on an assumption of cost, caseloads, and average services
- Often proof of service requires minimum interactions
- Note always that the minimum is the absolute floor
- Watch for overly prescriptive case rates – concern about medical necessity



Case Rates

- With case rates and fee for service both:
 - Required services must meet Medicaid requirements:
 - Each and every service documented
 - Services and service definition critical
 - Medical necessity critical




Case Rates

- Compliance risks:
 - Everyone gets the floor regardless of need
 - Clients kept in higher payment bracket by just providing additional services regardless if medically necessary
 - Front loaded or back loaded services
 - Cookie cutter treatment plans




TCM

Program Development



CM Program

- Assignment of staff – based on estimated caseloads (45)
- Reporting relationships – trying to maintain independence
- Strategic Plan for implementation



How do I move forward?

- Plan for development of program
 - Development of business plan
 - Average numbers of CM visits in current caseload
 - Average caseloads
 - 24 month pro forma
 - Job descriptions: SA; power, etc. – will determine training needs
 - Consumer and family training – start early
 - Standardized – this should not have to be individually negotiated between each case manager and family/consumer
 - CM training
 - Assignment of cases – geographic if possible
 - Development of case plans or redevelopment of integrated plans
 - Development of communication strategy



Training

- Re- teach the art of case management
 - Staff
 - Clients
 - Families
 - Referral sources
- Use the language of the regs in developing case management plans



Case Management

- Key competencies:
 - Understanding the community and available resources
 - Understanding the treatment resources available
 - Who pays for what?
 - What are conditions for payment?
 - Understanding how to access benefits, financial supports
 - Being resourceful in developing natural and community resources
 - Ability to coordinate service delivery systems
 - Knowing what case management can do and bill for!



Thanks!

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