Case Management Roles and Responsibilities: Monitoring and Follow-Up

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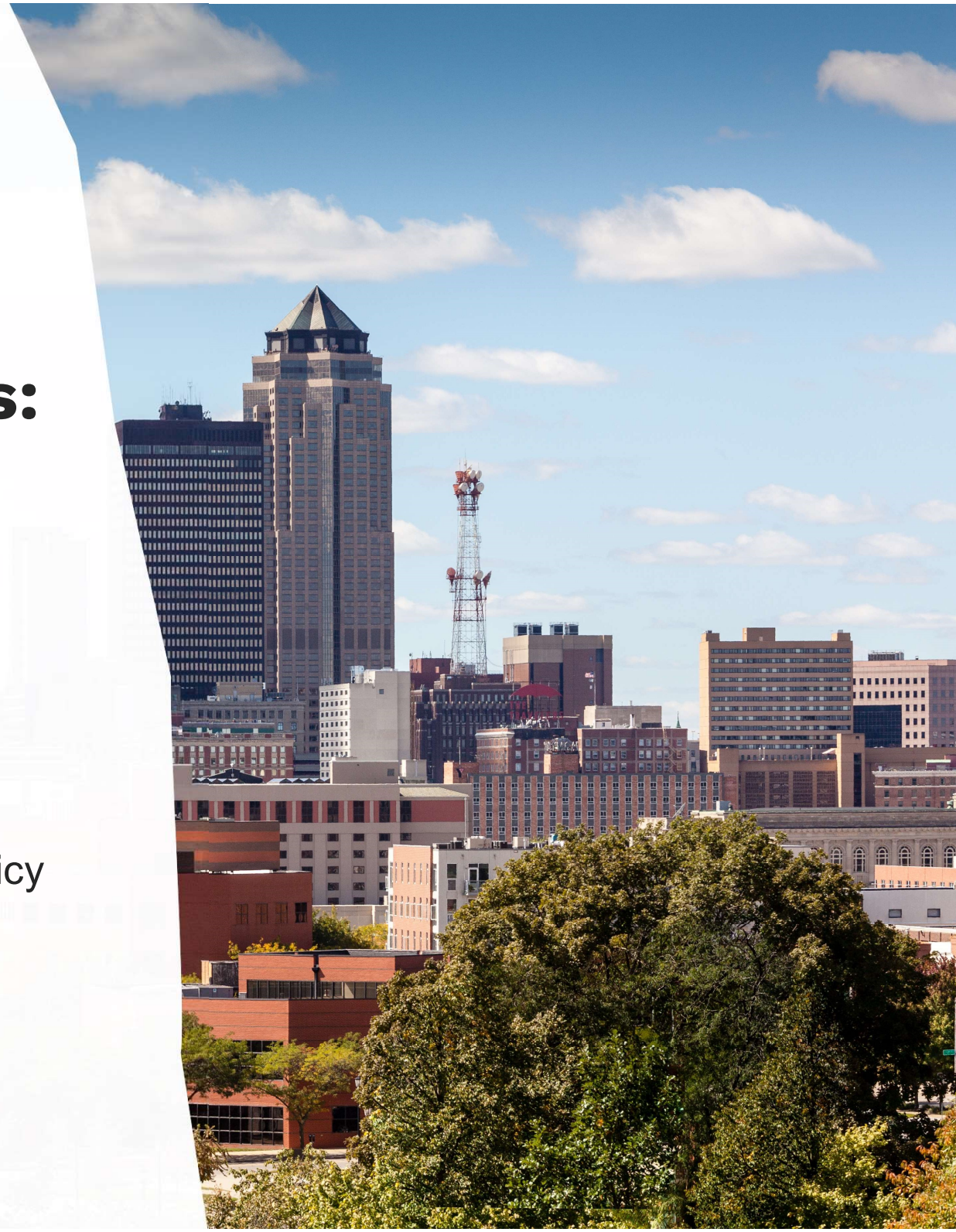


Agenda

- Introduction
- Review Case Management Authority
- Review of Case Management Roles and Responsibilities

Introductions

IOWA Health and Human Services

Case Management Authority

- Case Management is defined in Iowa Administrative Code 441-90
- Rule encompasses all categories of Case Management provided to individuals enrolled in a 1915(c) waiver and 1915(i) State Plan Habilitation Services.
- Example roles subject to Case Management authority:
  - Case Management
  - Targeted Case Management
  - Administrative Case Management
  - Community Based Case Management
  - Care Coordination

Targeted Case Management vs Case Management

- Targeted Case Management is provided to a specified group within the state plan.
  - Adults with Chronic Mental Illness
  - Children with Serious Emotional Disturbance
  - Individuals with Intellectual and Developmental Disabilities
- Case Management, unlike Targeted Case Management, is subject to rules related to statewide provision and comparability.
- Targeted Case Management is unavailable when a member is enrolled in
  - an Integrated Health Home, or
  - Iowa Health Link and assigned a Managed Care Organization (MCO).

Case Management Responsibilities

- Assessment
- Person-Centered Service Planning
- Referral and Related Activities
- Monitoring and Follow-Up

Path to Monitoring and Follow-Up

HCBS Core Standardized Assessment

Assesses an individual's need for HCBS services

Interdisciplinary Team Meeting

Develops the Person-Centered Service Plan

Person-Centered Service Plan

Defines the paid and unpaid services and supports the member will receive

Monitoring and Follow-Up

Activities to ensure member's health and safety needs are met

Definition of Monitoring and Follow-Up

- Purposeful activities and contacts necessary to ensure a member's person-centered service plan is effectively implemented and adequately addresses the eligible individual's needs.
- Monitoring and follow-up are essential to determine if the following conditions are met:
  - Services are being furnished according to the member's person-centered service plan.
    - Example: Is the member working on the goals and using the amount of units authorized for services?
  - Services adequately meet the health and safety needs of the member.
    - Example: Is the member getting to all their medical appointments?
  - Determine and address any member status changes that warrant adjusting their person-centered service plan.
    - Example: Does the member have a newly identified risk that needs to be addressed in the plan?

Person-Centered Planning and Practices

- Person-Centered Planning
  - Facilitated, individual-directed, positive approach to the planning and coordination of a person's services and supports based on the individual's aspirations, needs, preferences, and values.
- HCBS Settings Final Rule
  - Published in 2014 by CMS.
  - Requires individualized person-centered plans and person-centered processes.
  - Applicable to all receiving Medicaid funded HCBS
- Person-centered practices (PCP) must be used in monitoring and follow-up activities.

Person-Centered Monitoring and Follow-Up

- Case Managers often act as the facilitator for PCP.
  - Supporting members to lead the PCP process to the fullest extent.
    - Educating member to support their ability to lead their meetings.
  - Advocating for the members and the lives they want to live.
    - The member may want something that is in opposition of what the team believes is best for the member.

Person-Centered Monitoring and Follow-Up

- Case Managers are responsible for monitoring.
  - Ensuring the member's person-centered service plan is implemented appropriately
    - Example: Member states they want to get in shape. The case manager is responsible to monitor whether or not the member and team are implementing the steps to successfully achieve the goal.
  - Clear expectations and continuous collaboration with the whole IDT

Person-Centered Monitoring and Follow-Up

- Case Managers are responsible for follow-up.
  - CIR Remediation
  - Referral to both paid and unpaid services and support
  - Facilitation of IDT meetings
  - Amendments to the Person-Center Plan

Exercise

1.) Share examples of how you monitor goals you set for yourself.

2.) How do you ensure you are making progress?

Monitoring Activities

- Contacts with the members and legal representatives
- Contacts with providers and other interdisciplinary team (IDT) members
- Facilitation of IDT meetings
- Review of provider documentation of goal progress and the medication administration record (MAR)

Follow-Up Activities

- Activities to follow up to address gaps in care
- Submission and/or review of critical incident reporting
- Remediation of Critical Incidents
- Coordination of various paid and unpaid services and supports

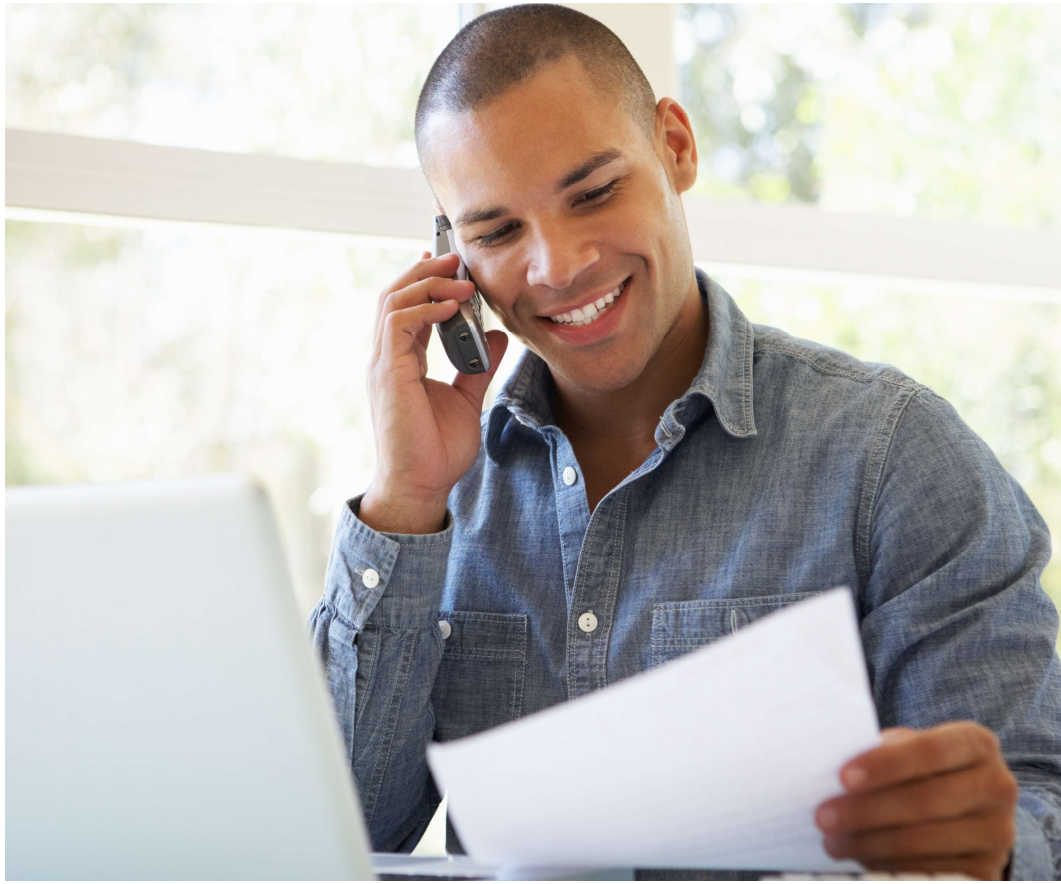
Contacts with Members

- At least one monthly contact is required
- At least one in-person visit at the member's home quarterly is required
- These contacts can be more frequent depending on the member's circumstance
  - Example(s):
    - Member transitions from institutional setting
    - Member presents an increase in medical or behavioral health concerns

Contacts with Legal Representative, Providers and Other IDT Members

- At least one contact per quarter

- These contacts can be more frequent if needed



Facilitation of IDT Meetings

- At least one annual IDT meeting is required to review and revise the person-centered service plan
- The meeting must be at the time, date, and location of the member's choice
- These meetings should be held as often as the member needs them

Review of Provider Documentation

- At least quarterly review of provider documentation including but not limited to:
  - Provider's service plan (*distinct from Case Management plan)
  - Goal progress notes
  - Member's MAR
  - Claims data

- More frequent monitoring of documentation may be required.

Exercise

Provide an example of when contacts and documentation review would be monitored more often?

Details of Monitoring

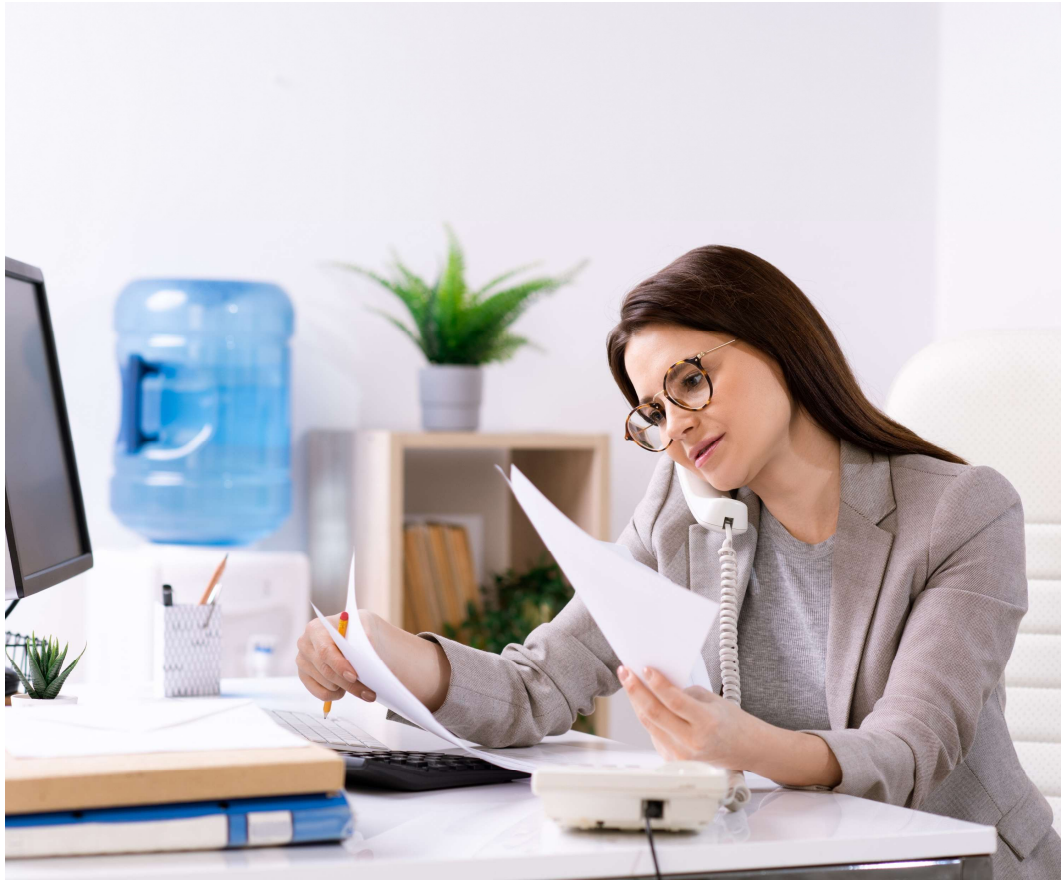
- Is the member receiving the services as outlined in their plan?
- Do the provider's goals align with the goals outlined in the Person-Centered Plan?
- How is the provider supporting the member in reaching their goal(s)?
- Does the member have unmet needs requiring an IDT meeting?

Details of Monitoring, continued

- Does the member's plan need to be revised to address gaps?
- Is the member under or over-utilizing services?
- Are the members satisfied with the services and support they're receiving?
- Have there been any incidents requiring a mandatory report and/or critical incident report?
- Has there been progress toward lifting or reducing any rights restrictions?

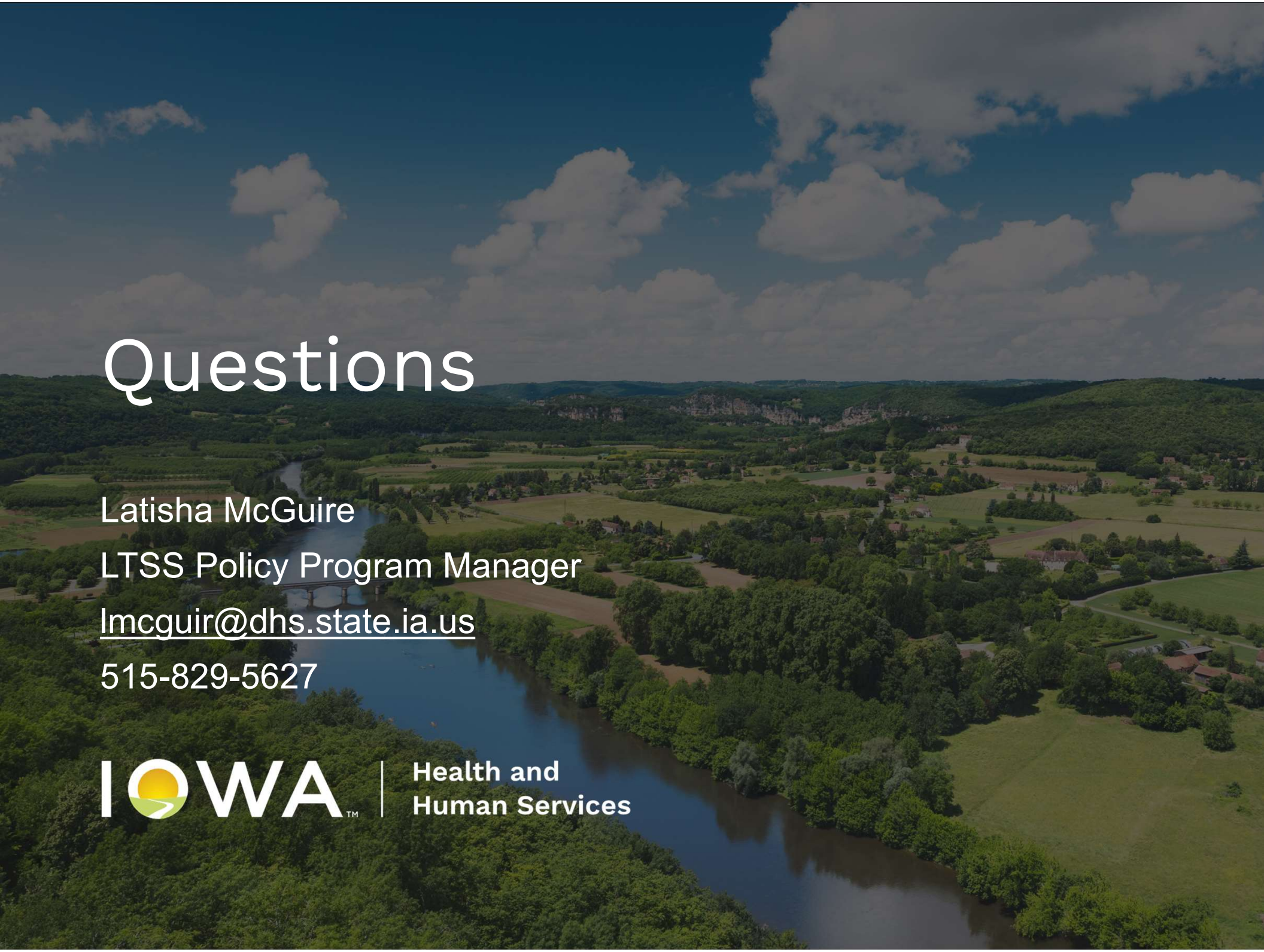
Details of Follow-Up

- Planning and facilitation of an IDT meeting
- Review and revision of member's plan
- Linkage and referral to community-based resources
- Introduction and application to providers



Exercise

When thinking about monitoring and follow-up, what do you think is the single most important strategy?



Questions

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