

# Indiana Family and Social Services Administration

## Long Term Care Transformation Case Management

December 4, 2017





# Agenda Overview

- Welcome and Meeting Purpose
- Introductions
- LTC Transformation Goals and Priorities
- Review of Case Management Service Definitions and Qualifications
- Wrap-Up and Next Steps



# Case Management Definition

Case management means a comprehensive service including, but not limited to, the following:

- **Ongoing engagement to** ~~Conducting~~ **conduct** an assessment with an individual to identify:
  - Strengths
  - Preferences
  - Goals and desired outcomes for the future
  - Functional needs
  - Clinical support needs
  - Need for in-home and community services
- Supporting participants in the development of a person-centered support plan, which provides guidance on supporting the person to achieve their goals and desired outcomes



## Case Management Definition (cont.)

Case management means a comprehensive service including, but not limited to, the following:

- Monitoring service delivery to participants to ensure services are helping the individual towards their identified goals and desired outcomes
- **Provide ongoing advocating advocacy and options counseling to integrate health and supportive services** for participants **through an ongoing relationship**
- **Monitor the service plan** to ~~Ensuring~~ **ensure** the quality of ~~home and community-based services (HCBS)~~ **long term services and supports (LTSS)** for participants
- Reassessing participant support plans at least every ninety (90) days or more often if needed to determine the continuing need and effectiveness of services
- Reporting **and following-up on** incidents affecting health and safety



# Service Requirements

1. Comprehensive assessment, such as a comprehensive caregiver assessment, falls risk assessment, etc.
2. Periodic reassessment
3. Ongoing development of a person centered support plan in consultation with the individual and whoever else the individual wishes to be involved, at a time and place convenient to the individual.
  - Involve informal caregivers if the person does not object to the involvement of such caregivers
  - The extent of the involvement of caregivers in the provision of assistance will be documented in the person-centered support plan
  - The case manager shall ensure that there is **develop** a back-up or emergency plan **with the individual** in place in the event that formal and informal caregivers are unable or unavailable to provide supports.
  - Identify services to be included in support plan, regardless of funding source
4. Referral and related activities to help the individual access needed services



## Service Requirements (cont.)

5. Provide linkage, support and advocacy
  - Assist with maintenance of eligibility for Medicaid and other supports
  - Advocate for individuals' unmet needs and empower them to access needed services and supports
  - Support caregivers through connection to resources and education
6. Facilitate community integration as desired
  - Support individuals in developing their network of support in their community
  - Support individuals in making valued contributions to their community
7. Coordinate services and supports during all transitions (hospital to home, institutions to community, etc.) whenever possible
8. **Coordinate and collaborate with health care coordinator in order to integrate with health care**
9. Monitoring and follow up activities
10. Incident reporting



# Case Management Performance and Outcome Measures

1. Timeframes for service provision, as outlined in IAC 455 2.1-8-1
2. Documentation standards, as outlined in DA HCBS Provider Reference Manual
3. Satisfaction and person-centeredness measures
  - Individuals express they have control of and/or input into their plan of care
  - Care plans goals reflect individual preferences for a variety of life domains
  - Increased community engagement
  - Increased quality of life
  - Decrease in caregiver burden
  - Individual preferences for care during advanced serious illness are supported

# Case Management Performance and Outcome Measures (cont.)



4. Healthcare utilization measures
  - Decreased use of emergency room
  - Decreased days in hospital
  - Decreased days in a skilled nursing facility
  - Decreased 30-day readmission rate
  - Increased identification of behavioral health needs
  - Decreased adverse events related to medication non-compliance/interactions
  - Decreased adverse events related to falls





# Provider Responsibilities

- Complete the State's required case manager orientation training before providing case management services.
- Complete training to meet case management core competencies:
  - Active listening and engagement
  - Facilitation of person centered assessment and planning processes
  - Knowledge of system processes and service options, **including integration with health care and social services**
  - Identification of service and support options to meet identified needs consistent with a person's desired outcomes
  - Culturally sensitive ~~and population-specific~~ knowledge
  - Population-specific knowledge, **including aging and disability competency training**
  - Facilitation of active engagement in community life, including making contributions and building relationships
  - Advocacy and protection of individual's rights
  - Conflict resolution and mediation
  - **De-escalation through evaluation of the individual and the environment**



## Provider Responsibilities (cont.)

- Complete training on:
  - Community resources and supports including both private and public pay options
  - Philosophy and importance of person-centeredness, self-determination and independent living
  - Developing person-centered support plans that incorporate all types of services and supports, regardless of funding source
  - Supporting families and caregivers



## Provider Responsibilities (cont.)

- Case managers must complete a minimum of twenty (20) hours of training per calendar year on topics related to case management services and supports. Hours will be pro-rated for the first year for newly-hired case managers.
- Case management providers have the flexibility to identify training topics relevant to the individuals supported by the case managers, **including safety training for case managers providing services in individual's homes.**
- Of the 20 hours required per calendar year, case managers must complete training on each of the following topics:
  - Level of care
  - Incident reporting
  - Case management service definition
  - Community resources and supports including both private and public pay options
  - Supporting families and caregivers



## Provider Responsibilities (cont.)

- Identify provider compliance issues (e.g. HCBS Setting Rule Compliance)
- Ensure that case managers, at a minimum:
  - Follow up on identified issues
  - Immediately address critical issues
  - Address any concerns with services or outcomes
  - File and follow up on incident reports
  - Coordinate services
  - Share information on the participant's well-being as required by the participant's person-centered support plan
  - Collaborate with the participant's other providers
  - Collaborate with other authorized entities



## Provider Requirements (cont.)

Ensure that assessments, person centered support plans, case notes, level of care reviews, and other actions are data entered in DA's case management system within seven (7) calendar days of the action.

- A case manager must document in the case management system:
  - Contacts regarding the participant and their services. These would include, but not be limited to, contacts with:
    - Participant or a legal representative
    - Participant's providers
    - Potential providers
    - Individuals the participant has identified as part of the person centered planning process
  - Any issues which must be reported, including, but not limited to:
    - unusual incidents affecting the participant's health and welfare
    - Resolutions of issues and incidents



## Provider Requirements (cont.)

- At a minimum of every ninety (90) days, the case manager, using the DA's monitoring tool, must review service deliverables as determined by the person-centered plan, to determine if participant's assessed needs are being addressed and assess whether the participant is satisfied that the services meet their needs and goals.
  - The case manager must conduct the first face-to-face assessment with the participant in the home
  - The case manager must conduct at least two of the four required 90-day assessments in the home



## Next Steps and Wrap-Up

- *Questions or Comments:*  
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*Happy Holidays!*