

## Appendix I

### Tasks Involved in Care Management and Their Desired Outcomes

The component tasks and desired outcomes for each of the four care management functions are described in outline form below. These were identified and used as the basis for developing the recommended care management standards.

#### **Intake and Screening**

##### **A. Component Tasks:**

1. Receive the referral.
2. Gather basic identifying information.
3. Identify the person's need.
4. Tell the person there's a wait list, if applicable.
5. Assign the case.
6. Contacts applicant and, preferably, do a home visit.
7. Conduct a "mini-screen" to determine county residency, medical and financial eligibility.
8. Determine whether the applicant should go on to an assessment or be referred elsewhere.

##### **B. Desired Outcomes from Quality Service:**

1. Effective outreach prior to screening, so that people who need services can be served.
2. Contact person in a timely manner.
3. Determine whether to do an assessment, what the person's immediate needs are, and what other needs the person may have for referral purposes.
4. Participant is treated with consideration and feels respected.
5. Worker takes enough time to get to know the person, establish rapport, and really figure out what the person needs.
6. Participant actively participates and has "choice" in identifying needs.

7. Identify informal and family supports.
8. Provide accurate information and appropriate referrals to resources that may be of help now, including SSI-E, MA personal care, public health nurse, meals on wheels, VA, Rural Housing, Inc., and volunteers.
9. Maintain contact with people on the waiting list and provide “crisis management”, if necessary.

### **Assessment**

#### **A. Component Tasks:**

1. Review intake/screening information to identify what other professionals should be included on the assessment team or as collateral resources.
  2. Worker reintroduces him/herself and the program to the participant.
  3. Coordinate with participant’s significant others.
  4. Home visit:
    - a. Provide information to the participant to help in determining what he/she wants.
    - b. Gather information about the person: likes/dislikes, needs, abilities, and existing supports.
    - c. Use assessment tool.
    - d. Use other assessment tools as appropriate for participant.
    - e. Involve the consumer and his/her family’s preferences.
    - f. Identify participant’s preferences and his/her family’s preferences.
    - g. Complete the COP functional screen.
  5. Read and review client’s rights with the participant and/or guardian.
  6. Complete eligibility determination and notice.
  7. Conduct team staffing and meet or consult with collateral contacts or get additional input, if needed.
  8. Complete forms that need to be filled out – social service agreements, etc.
  9. Complete signed offer of assessment or waiver of assessment.
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10. Document the person's abilities, needs, preferences, and informal supports and the services for which he/she is eligible.

**B. Desired Outcomes from a Quality Assessment:**

1. Care manager gets to know the participant and his/her history and its significance.
2. Participant feels respected; is related to as a person, not a disability; feels that his/her preferences have been valued; and feels empowered (i.e., given information and hope).
3. Participant has a good understanding of:
  - a. The program and what can be provided.
  - b. What is expected of him/her.
4. Care manager has accurate and complete information that will provide a basis for developing the care plan. This is an initial data base, not an end product.
5. Care manager determines the person's eligibility for a variety of programs and the referral sources needed. These would include programs and resources in addition to COP.

**Care Planning and Service Arranging**

**A. Component Tasks:**

1. Analyze information collected in the assessment.
2. Meet with professionals who participated in the assessment and consult with others as needed.
3. Establish service needs and components, based on what the participant and the professionals identify.
4. Identify service responses with the participant.
5. Identify the source(s) of funding, scope out what can realistically be provided, and establish the cost of the care plan. This involves an element of negotiation and recognition that the resources available to pay for services are finite.
6. Identify service providers.
7. Invite consumer participation and choice.
8. Write up the care plan and obtain signatures of all parties as required.
9. Contact providers and arrange for services.

10. Document worker qualifications by signing off on training form as required (COP Waiver only).

**B. Desired Outcomes from Quality Care Planning:**

1. Plan identifies services that meet the participant's needs.
  - a. Services promote optimal functioning.
  - b. Participant's safety and welfare are assured.
  - c. Plan builds on the person's strengths.
  - d. Plan identifies, includes, and encourages continued involvement of family and other informal supports.
  - e. Participant is comfortable with the plan.
2. Consumer participates in development of his/her care plan.
  - a. Participant understands the options available.
  - b. Participant exercises choice in selecting services.
  - c. Participant exercises choice in selecting providers.
3. The plan is one that works.
  - a. Is within limits of available financing.
  - b. Makes use of existing services.
4. Plan can be changed as needs change.
  - a. Participant knows how plan can be changed.
  - b. Includes a contingency plan for when things go wrong.
5. Plan contains a written summary of involvement of and agreement(s) between the participant, supports, and providers.

**Ongoing Monitoring**

**A. Component Tasks:**

1. Make periodic contact with the participant.
2. Make periodic collateral (i.e., agency to agency) contacts.

3. Determine whether services are being provided as in the care plan.
4. Determine whether care plan and services provided continue to be appropriate to meet the participant's needs.
5. Watch for abuse situations, especially where a relative provides care.

**B. Desired Outcomes from Ongoing Monitoring:**

1. Frequency of contact reflects the intensity of the participant's need. Participants in crisis should be monitored more frequently.
2. Services provided are appropriate and consistent with the care plan (or updated care plan if needs change).
3. Services change in response to changes in the participant's needs.
4. Participant is satisfied with services received.
5. County is protected from audit exceptions.