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Targeted Case Management/Care Coordination 2014

TARGETED CASE MANAGEMENT	CARE COORDINATION
Consists of services are those aimed specifically at special groups of enrollees such as those with ***Intellectual/ developmental disabilities*** or chronic mental illness. The definition includes four components as identified by CMS. *The following list is not exhaustive, but provides typical examples of targeted case management activities:*	Consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. This includes primary care case management, which cannot be provided by a targeted case manager.
Assessment: - Participates in the BASIS assessment. - Completes Statewide Needs Assessment - Gathers information from other sources as necessary to complete the assessment. - Taking a consumer history - Identifying the individual's needs and completing the assessment instrument and related documentation; and	**Completes a comprehensive health –based needs assessment.** Care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care and service plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Development of Service Plan:
- Develops/updates Person Centered Support Plan.
  ○ Working with individual and others to develop goals and
  ○ Identify course of action to respond to the assessed needs
- Develops/Updates Behavior Support Plan
- Participates in development of Individual Education Plan (not just attendance at meetings)
- Discusses service options, needs and preferences
- Provides input into the Integrated Service Plan
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker)
	Develops Integrated Service Plan
	- Develop Integrated Support Plan, including physical & behavioral, based on the needs assessment and with input of the individual, family members, guardians or other persons providing support
	- Coordinate and approve services and supports to meet an individual's needs for physical health, behavioral health, social, educational, medical and long-term supports and services needs
	- Implementing ISP and authorizing services
	- Managing through the use of quality metrics, assessment and survey results, and utilization reviews to monitor and evaluate impact of interventions.
	- Update ISP with TCM based on PCSP, BSP and changing needs

Referral & Related-Activities: - Activities that help link the individual with medical, social, or educational providers - Referral to resources and other programs to assist with direct services and applications - Referral to link an individual to services including medical, social, or educational providers. - Seeking informal supports to provide services and supports to an individual - Report ANE or suspected ANE & make referrals as necessary	**Additional Activities:** - Assisting in scheduling referrals and creating/promoting linkages to other agencies, services, and supports, including to behavioral health services - Locating resources beyond scope of services covered by Medicaid or through the HCBS services, which may be available from different sources - Engaging patients in self-care regarding chronic conditions - Provide information and resources with the TCM
Monitoring & Follow-up: - Monitoring includes identifying changes in the needs and status of the individual, - Activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities - Identify changes in needs and status. Notify and provide information to the MCO Care Coordinator	**Primary Care Case Management:** - Coordinating and collaborating with other providers to monitor individual's health status, medical conditions, medications and side effects - Monitoring emergency and inpatient admissions to ensure appropriate transitions in care are coordinated and timely - Monitor individual's health status, medical conditions, medications and side effects if necessary - Identifies individuals that are high risk for environmental factors or medical and those with complex health care or behavioral health needs

The role of **Targeted Case Management** and **Care Coordination** are complementary and should work as a unit to focus on opportunities for integrating care and services, improving independence and self-determination, ensuring an individual can work and live in their community with strong relationships, and collaborating together to find innovative solutions. CMS recognizes care coordination as comprehensive care management and acknowledges the creation of targeted case management to assist a specific limited population. The examples above are not comprehensive or exhaustive of all duties and activities each may have, but they demonstrate a comparison for public consideration.