
Policy Research Brief

RESEARCH AND
TRAINING CENTER
ON COMMUNITY LIVING
UNIVERSITY OF MINNESOTA

Innovative Models and Best Practices in Case Management and Support Coordination

This Policy Research Brief describes models, innovations, and best practices in case management and support coordination for persons with disabilities. The approaches presented here were identified during a study exploring the redesign of case management services for people with disabilities in Minnesota, and have broader applicability to other states as well. The study was conducted at the Research and Training Center on Community Living (RTC), University of Minnesota, and supported by Minnesota Department of Human Services Contract #A87436 to the RTC. This brief is authored by Angela Amado, Project Director and Research Associate with the RTC, and is based on the technical report Redesigning Case Management Services for People with Disabilities in Minnesota: A Report to the Legislature (available online at <http://rtc.umn.edu/docs/DHS-5062-ENG.pdf>). Development of this summary was supported by the National Institute on Disability and Rehabilitation Research through Cooperative Agreement #H133B031116 with the RTC. The author acknowledges the contributions of all the technical report authors to the research described in this brief. For further information, contact Angela Amado at 651/698-5565 or amado003@umn.edu

■ Introduction

In this time of decreasing human services resources, expanding demand for these resources, and the increasing expectations of self-determination on the part of individuals with disabilities and their families, many states are examining their case management and/or support coordination structures. There are strong federal pressures to limit or decrease case

management expenditures while improving quality and expanding consumer choice. Professionals as well as persons receiving services are asking questions such as: Is case management necessary? How should it be organized? What roles should it have in the overall support system? What are the most effective models of, and best practices in, case management or support coordination?

In 2005, the Minnesota state legislature required the Department of Human Services (DHS) to submit a report on redesigning case management services for people with disabilities. DHS contracted with the Research and Training Center on Community Living (RTC) at the University of Minnesota to describe best practices in case management for people with disabilities under age 65 and to recommend improvements based on the identification of innovative models and best practices in case management (Amado et al., 2007). This *Policy Research Brief* describes case management models, innovations, and best practices identified for this project.

A summary of research on policy issues affecting persons with developmental disabilities. Published by the Research and Training Center on Community Living, Institute on Community Integration (UCEDD), College of Education and Human Development, University of Minnesota.

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■ Purpose and Method of Study

The study investigated case management practices and models for supporting persons under age 65 with physical disabilities, cognitive disabilities, and/or complex medical needs. The targeted populations included:

- People with developmental and/or intellectual disabilities.
- People under the age of 65 who are using Personal Care Attendant (PCA) services.
- People under the age of 65 who have a disability and are using home care services.
- People with traumatic or acquired brain injury (TBI).
- People with physical disabilities or chronic medical condition(s) under the age of 65.
- People in nursing facilities (NF) who are under the age of 65.
- Other people receiving Home and Community Based Services (HCBS, “waiver”) not mentioned above but who would potentially be included in one of Minnesota’s four disability waiver programs:
 - *Community Alternative Care (CAC)*: Home and Community Based Services funding for children and adults with chronic illness who would otherwise require hospital level of care.
 - *Community Alternatives for Disabled Individuals (CADI)*: Funding for children and adults with disabilities who would otherwise require care in a nursing facility.
 - *Traumatic Brain Injury (TBI)*: Funding for individuals with acquired or traumatic brain injury.
 - *Mental Retardation and Related Conditions (MR/RC) Waiver*: Funding for children and adults with intellectual disabilities or related developmental disabilities.

Thus, this project addressed numerous population groups, some of whose case management needs were being met through both social services and public health programs.

Previous research had identified the following challenges regarding case management:

- Increased choices creating a demand on resources.
- Tensions created by limits on services.

- Duplication and redundancy.
- Overlapping eligibility for programs.
- Variation of rules, standards and reimbursement from program-to-program.
- Inequities from group to group.
- Multiple assessment processes.
- Variation in quality from county to county and case manager to case manager.

With these in mind, the RTC researchers conducted a literature review and in-depth reviews of case management models and best practices, using the following strategies:

- Examination of the professional literature as well as national and State reports describing case management models and practices, including support coordination and service brokerage.
- Gathering of information on different case management structures in 20 states by interviewing State representatives and reviewing reports and other materials available on State Web sites. The 20 states from which information was gathered via phone, Web sites, written reports, or a combination thereof, were: Arizona, Colorado, Connecticut, Delaware, Florida, Kansas, Maine, Maryland, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin, and Wyoming.
- Identification of innovative models, through asking national and international experts to nominate such models, then gathering written reports and interviewing people responsible for developing or implementing those innovative models.

■ Results and Discussion

Current trends, national implications, innovations, and best practices in case management were examined in three areas: (a) federal influences on case management, (b) differences between States in human services and case management structures, and (c) innovations which certain States and local areas are undertaking in case management. The findings from that examination are summarized below. Additional federal trends not discussed here are also influencing States to examine

and alter the ways in which they structure case management and their disability and aging services systems.

Federal Influences

The federal Centers for Medicare and Medicaid Services (CMS) defines case management as an activity that “assists individuals to gain access to needed care and services appropriate to the needs of an individual” (Cooper, 2006). Three recent federal initiatives affecting case management and support services for persons with disabilities include the Deficit Reduction Act of 2005, CMS Quality Framework for Medicaid Home and Community Based Services, and choice of case manager within Medicaid rules.

Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 has major provisions affecting numerous Medicaid and Medicare programs, and includes an overall reduction of \$39 billion in federal spending over the next five years for these programs. This act expanded statutory language concerning Targeted Case Management Services (TCM), especially concerning the allowable scope of TCM. This new language did not appreciably alter the scope of what could be covered. However, language was added to prevent States from claiming federal Medicaid dollars for activities that fall under Title IV-E (child welfare responsibilities). This change caused some States that had previously funded certain case management services through TCM to find another funding source for those services.

CMS Quality Framework

The Centers for Medicaid and Medicare Services developed a Quality Framework for Home and Community Based Services to improve the quality of services and supports for people with disabilities. The Framework focuses on the desired outcomes of HCBS, quality management, and improvement efforts. It includes the following seven design areas:

- *Participation Access*: Access to community supports, information and referral, timely intake and eligibility determination, as well as reasonable promptness.
 - *Person-Centered Service Planning and Delivery*: Individually-oriented needs assessment and service plans, implementation and monitoring, and services as planned, as well as responses to changing needs/choices and participant direction.
 - *Provider Capacity*: Organizational licensure and certification, sufficient providers (agencies and staff), adequate staff training, and provider monitoring.
 - *Participant Safeguards*: Incident reporting and response, risk assessment/balance with choice, monitoring of behavioral and pharmacological interventions, medication administration, emergency and disaster preparation/response, as well as health monitoring.
 - *Rights and Responsibilities*: Protection of rights and decision-making authority, as well as due process and grievance procedures.
 - *Outcomes and Satisfaction*: Surveys that show outcomes of and satisfaction with services provided, data used to identify and respond to dissatisfaction and poor performance, generally and for specific subgroups.
 - *System Performance*: Systematic gathering and analysis of performance data, community participation in designing and appraising system performance and improvement activities, financial accountability, a system that strives to improve quality.
- HCBS programs will be held accountable for monitoring specified “desired outcomes” in each of these areas. The Quality Framework not only requires quality assurance systems to gather quality-relevant data, but also that the data be used to improve the quality of services. This is to be accomplished through three specified quality management functions:
- *Discovery*: Knowing what outcomes are being accomplished, identifying problems, determining opportunities for improvement, and finding sources of effective practice.
 - *Remediation*: Responding to problems on an individual, agency and system-wide basis.
 - *Improvement*: Using information about HCBS programs and those persons enrolled in them, knowledge of effective practices, and information and knowledge dissemination to improve the quality of services and supports; elevation of the expectations of and demand for higher quality by service recipients and their advocates.

Although the CMS Quality Framework is not regulatory, it provides a framework for certain expectations of quality outcomes for HCBS. This includes the expectation that any State with these services is actively reviewing the quality of its community services system and planning for quality improvement. Case management systems are often a key element of how States and local entities implement quality assurance and enhancement activities under this framework.

Choice of Case Manager

The statutory authority for Medicaid Home and Community Based Services allows the Secretary of Health and Human Services to waive any of three specific provisions of Medicaid law. All other provisions of Medicaid law apply to HCBS programs. One of the most basic of these assurances to all Medicaid recipients is free choice in their selection of qualified service providers (including case management providers). Waiver plans and waiver applications in several states have been challenged in federal reviews if there is a sole source of case management such as Counties. This emphasis on choice of case manager will likely continue.

State Case Management Structures

The study found that the degrees and types of innovation in case management were affected by State governance and system structures. In this section, five ways in which States differ in service system structure and case management dimensions are described.

Governance Structure

One primary area where States differ is their governance structure for human services administration. Some States administer human services through a State-regulated, County-based system, including Wisconsin, Minnesota, and Michigan. Strengths of County-administered systems include local control and accountability, as well as use of local tax revenue. Other States regulate human services and provide case management through a single State-administered system, with regional offices for more local contact. A State-administered system often allows for more equitable administration of policies and procedures, as well as a centralized database. Such a structure also often allows these States to more easily do a complete overhaul when certain changes are implemented. A few States use other system structures, such as private case management agencies, contracted independent

non-profit entities that provide case management either regionally or statewide, mixed public and private systems, and case management through service provider agencies.

Definition of Case Management

Case management has two key features: (1) providing an interface or connection between individuals with disabilities and the system of publicly-funded and generic services and supports; and (2) assuring that these services meet reasonable standards of quality and lead to important life outcomes for individuals (Cooper, 2006). The professional literature about case management models (summarized in Amado, 2005) points to five possible roles or functions for case management:

- Administration
- Crisis management
- Consumer empowerment
- Individual advocacy
- Systems advocacy

These roles could be seen as additive, going from the most basic and required functions to roles that are desirable but beyond the required minimum. A fundamental question in the design of a case management model is who should fulfill the various roles.

As case management has evolved, different terms such as “service coordination,” “support coordination” and “resource management” have been used (Cooper, 2006). As self-directed services and consumer control have increased, the role of supports brokering – assisting individuals to self-direct their services – has also emerged. In some states the role of the case manager has shifted to that of “service broker,” especially for people receiving support due to physical disabilities or mental illnesses. Some programs for individuals with developmental disabilities also utilize this role. Service brokering involves directing people to needed services, coordinating payment for those services, and empowering the consumer to manage them.

Efforts Across Disability Groups

At least two States, Maryland and Washington, are working to systematically address equitable policies, procedures, and efforts across all disability groups, and are attempting to bring all services for people with disabilities under age 65 together in a unified system. The State of Washington is undertaking a significant systems coordination effort to improve coordination

across populations and services, and to improve its use of information technology to support this coordinated system. Washington State has implemented 15 major initiatives to better coordinate the system and break down the separate “silos” of services, across not only all their disability groups but also corrections, children’s mental health, and other groups. An information management system in which information flows from assessment, to planning, to monitoring, to incident reporting, to quality assurance, across all these groups, is also being developed and refined. One element of this coordinated system is a single entry point that provides easy access for any person with a disability.

Efforts to Deal with Limited or Decreasing Resources

Virtually every State is faced with increasing numbers of consumers and limited or diminishing resources for direct services and for case management. States are attempting to address this challenge in a variety of ways. For example, Delaware has made a commitment to develop reform proposals to identify more effective ways to design case management for its citizens with developmental disabilities. Its approach is to clarify the State’s vision for the whole services system, identify larger systems changes such as increasing self-determination, and then determine the role of case management or support coordination within that vision. Another example of dealing with this challenge is a new case management structure planned in New Jersey, described under “Innovative Models” (see page 9).

Case Management Outcomes and Performance Standards

Measuring the outcomes of case management, such as individual life outcomes that result from an individual having a case manager, is difficult. Previous research studies of case management outcomes, and of the effectiveness of different case management models, have yielded mixed results regarding costs, satisfaction, and life outcomes (e.g., Zimmer, Eggert, & Chiverton, 1990). Part of the challenge is due to the interwoven complexity of the services system. Case management does not operate in a vacuum separate from the quality of the services system or services funding.

Some States measure consumer satisfaction with and outcomes of case management with expanded quality assurance efforts that assess the overall quality of people’s lives. Examples include accreditation reviews (e.g., The Council on Quality and Leadership)

or the National Core Indicators, which measures a State’s overall performance on quality of service indicators, including case management (Taub, Bradley, & Smith, 2003).

In lieu of or in addition to determining quality service outcomes, States determine if, at a minimum, case management processes are being adequately implemented. Examples of process standards include amount of time to complete assessments, planning, and initiation of services, or that requirements for an annual plan are being met. Some States have improved the determination of whether case managers are meeting such process deadlines and standards (e.g., schedules for completed assessment, number of days for service initiation, etc.) through developing an effective date-based management information system.

Innovative Models

The study identified the following six types of innovation among the 20 states reviewed. After each type of innovation is described, one example is described more fully. More information about these and other examples of the types of innovations can be obtained from the Web sites that are listed in Table 1.

Increased Self-Determination

Part of the variance in the role of a case manager and definition of case management across states depends on how deeply the principles of self-determination and self-direction have been integrated into the service system structure. Oregon, New Jersey, Maryland, Vermont, and New Hampshire, and some Wisconsin counties, have strong programs for self-determination, consumer empowerment, and self-direction. The original Robert Wood Johnson Foundation self-determination pilots and the original Community Supported Living Amendment states have also provided models for establishing such programs, although some have not been sustained.

The typical design in these programs is that an individual receives an allocation and has control over how that allocation is used. The most innovative service models are those that incorporate the foundational principles of self-determination, including consumer control of their services budget and contribution to community life. A critical part of the case management/support coordination role is to assist individuals and their allies to determine the most creative and best use of their allocated resource dollars to design a personally-tailored support package. In these programs,

Table 1. Web Sites for More Information About Innovative Models

<u>Place</u>	<u>Initiative</u>	<u>Web Site</u>
Minnesota	Quality Assurance	www.qapanel.org
Minnesota	South Country Health Alliance	www.mnscha.org
Minnesota	Universal Assessment	www.hcbsstrategies.com/univassess.htm
New Jersey	Real Life Choices Program	www.fscnj.org/rlcprovover
Oregon	Information System	www.oregon.gov/DHS/healthplan
Pennsylvania	Information System	www.humanservices.state.pa.us/hcsis/
United States Centers for Medicaid/ Medicare Services	Quality Framework	www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf
Washington State	Information System	www.dshs.wa.gov/ddd/CMIS.shtml
Washington State	Quality Initiatives	www.leg.wa.gov/JLARC/Audit+and+Study+Reports/2006/06-7.htm
Wisconsin	Family Care Program	www.dhfs.state.wi.us/lcicare
Wisconsin	Managed Care	www.dhfs.state.wi.us/managedLTC
Wisconsin, Dane County	Choice of Support Broker/Case Manager	www.danecountyhumanservices.org/dd_adult.htm
Wyoming	DOORS	www.cms.hhs.gov/PromisingPractices/Downloads/wyib.pdf
England	In-Control Project	www.in-control.org.uk

the roles and functions of case management/support coordination emphasize assisting the person and his or her allies in designing an individualized, self-directed, community-supported life.

In the most progressive self-determination models, support packages are individualized; are not reliant on congregated/small group service models; and involve family, friends, and natural community supports. As described by O'Brien and O'Brien (2006):

Individualized support does not mean that people spend their time alone. Many individuals share their homes with chosen others and have good relationships with co-workers and fellow citizens. Service design for individualized support starts with a person rather than with any sized facility for labeled people and finishes with personally-tailored supports that strive to change as people's capacities and opportunities to participate in community life do (p. 10).

While some states have venues for providing direct funding to consumers, sometimes the roles and structures in such programs are not defined according

to or are not true to self-determination principles. For example, in Minnesota some service recipients have very well-developed, individualized and personalized community support systems, but many individuals and families purchase traditional congregated services with their "consumer-directed" support dollars.

Among the programs listed in Table 1, those in England, New Jersey, and some Wisconsin counties follow the self-determination model. Following is a profile of this model as it is applied in New Jersey.

One Model for Self-Determination: New Jersey's Real Life Choices

In New Jersey's Real Life Choices program, individuals may buy services from many sources but, significantly, *not* from traditional congregated services such as group homes or day programs. About 600 people receive services in this program, which started with persons on the community services waiting list but has since expanded to persons leaving institutions and students transitioning from high school to adult services.

Critical support roles include a monitor (the only traditional case management role), a support coordinator, a family/peer mentor, and specialized services such as a facilitator of a circle of friends which helps the person design their life and support system. The support coordinator facilitates the plan development, connects the individual and family to community resources, and assists the person to design and purchase individualized support. The person may also get additional assistance to develop a career and to identify and locate the place they would most like to live. The family and peer mentors are individuals (or their family members) who are already living on their own in the community and have community careers. The mentors help other individuals with disabilities and their families think through the person's plan and develop natural supports and connections to have a community life. This program has a high level of consumer satisfaction.

Determining Individual Allocations and Support for Creative Options

Every innovative model in the study that was based on self-determination incorporated a comprehensive assessment of a person's situation, including the person's support needs and adequacy of support network, and designating an individualized support allocation (prior to plan development). In these programs, an extensive system of support brokers and facilitators of circles of support assist the individual and/or their family to develop the plan for the best and most personally-tailored support situation possible with the individual allocation. Three such examples are (see Table 1) New Jersey's Real Life Choices program described above, England's In-Control Project, and Wyoming's DOORS program, which has a unique allocation methodology and is described below.

One Model for Individual Allocation Methodology: Wyoming DOORS

Wyoming has initiated an Individual Resource Allocation model called DOORS for its service recipients with developmental disabilities. This program has been recognized by CMS as a "promising practice." The DOORS program includes a well-researched, sophisticated formula for determining an individual's service allocation based on participant characteristics and service utilization patterns. The formula places a premium on fairness and equity, improves equity of resources within and between populations, and supports the free choice of provider. Also, because Wyoming

is a State-administered system, an individual's funding is portable and easily moves with them to different providers, service types, and parts of the state.

Consumer Choice of Case Manager

Consumer choice of provider, including case manager, is an important feature of Medicaid law and the CMS Quality Framework. One element for increasing consumer choice of case manager is expanding the number of agencies offering case management. However, simply expanding the number of case management agencies does not ensure real and meaningful choice. More must be done to ensure choice. Individuals do not necessarily experience real choice by simply being provided a list of potential case management agencies, or being provided the choice of county case management versus one private agency. Rather they need opportunities to meet potential case managers, to hear from other consumers about different case managers or case management agencies, and also be afforded other means to experience real market choice.

Many States operate entirely non-public case management systems and some provide for open enrollment of case management providers in their Medicaid programs, a policy that enhances consumer choice. With open enrollment, gate-keeping responsibilities for service eligibility are typically maintained by a public entity, while service coordination functions are provided through a variety of agencies. For example, in the Florida developmental disabilities system, *service coordination* functions are purchased exclusively from private agencies while the State retains *gatekeeping* responsibilities.

Following is a profile of the model in which consumers choose their case managers, as it is applied in Dane County, Wisconsin (also see Table 1).

One Model for Choice of Case Manager: Dane County, Wisconsin

One of the innovative models for choice of case manager is the developmental disabilities services system in Dane County, Wisconsin. All individuals with developmental disabilities in the county are funded on the basis of self-determination principles, and have control over their service dollars and how their services and support are designed and delivered. In addition to implementing and continually expanding its realization of the principles of self-determination, the County also instituted choice of case managers. Six private agencies provide case management, and there are three

case management provider fairs each year for individuals to meet case managers and make a choice. The County recommends that consumers and their families meet at least three different case managers before making a choice. Consumers indicate that having a choice of case manager is one of the most important features of their support structure, even more important than the size of the services allocation they receive.

In addition, as self-determination was being instituted, some individuals wanted to have a relative or friend serve as their case manager. To honor this choice, a seventh agency was established to provide the administrative support for individuals not licensed as case managers. This agency and the County play key roles in monitoring the support provided by relatives or friends functioning as case managers.

The County retains the functions of screening, eligibility determination, and allocation of service dollars, and county case managers have increased their role in quality assurance. In addition, a small number of complex cases are retained on county caseloads. Safeguards are in place if individuals seem to be abusing the system by changing case managers too often.

Coordinated Database Systems

A coordinated system requires a well-designed, consumer-friendly management information and support technology system that can simplify, streamline, and make as comprehensive as possible the process of collecting and using information concerning service recipients. A comprehensive information management system in which information flows from intake to assessment, to planning, to monitoring, to incident-reporting and quality assurance, which is also linked to service-billing systems, can greatly improve access and ongoing service coordination across all disability groups. When duplication is reduced, the amount of time that case managers and case aides devote to consumers can be increased. With such an information system, inequities between groups, individuals, and Counties can be reduced and monitoring of performance standards can be enhanced. Some States have already developed or are working to develop such a well-coordinated database system to manage the complex information-gathering processes involved in case management and service provision. Poorly-developed database systems can be very expensive. For example, one State designed an information system for people with developmental disabilities that was abandoned after only seven years.

Among the places listed in Table 1, Pennsylvania, Washington State, and Oregon utilize a model of coordinated statewide database systems. Following are profiles of this model as it is applied in these three States.

Model Database Systems: Pennsylvania, Washington State, and Oregon

Pennsylvania developed a database system called Home and Community Services Information System that cost about \$50 million. The state contracted with an outside technology company and this site has won information technology awards. The strength of this design is changing the business model from its former basis in County contracts to an organizational basis around the individuals who receive support. The larger-picture business model is a design centered on individual service recipients, their enrollment into the system, their service plan, and so forth. With the people who are enrolled in the service as the main focus, Counties are entities through which business is conducted. This system is also modularized, so other States can use different modules, which Massachusetts is doing.

Washington State also implemented a universal assessment process and implemented a Case Management Information System in January 2008. This system was developed in Oregon for \$20 million. Washington State paid the contractor \$2-3 million to adapt it to Washington. The system links financial information to clinical data, reduces errors, tracks minimum requirements being fulfilled, and assists in more uniform enforcement of policies. It has been called a “case manager’s dream.”

Oregon and Pennsylvania have invested \$20 million and \$50 million respectively to develop such coordinated databases. Rather than re-inventing the wheel, some or all of these systems have been purchased from and adapted by other States at significantly reduced cost.

Managing the Challenge of Limited Resource Growth

Virtually every state is faced with increasing numbers of consumers and limited or diminishing resources for case management and direct services. States are attempting to address this challenge in a variety of ways.

Following is a profile of how New Jersey is meeting the challenge of shrinking resources (also see Table 1).

One Model of Managing Decreasing Resources: New Jersey's Tiered Levels of Case Management

To address high caseloads and limited resources, New Jersey has implemented a formal tiered case management support system for persons with developmental disabilities. As a State-administered program, the State reviewed all people with developmental disabilities receiving services and identified many individuals who did not actually need intensive ongoing case management support. It was felt that these consumers primarily needed information, education, referral, and a source of connection to the system when there were problems. Many in this group are children living at home with minimum services such as in-home support or respite care. This group was placed into a new program called "Connections" with a minimum level of case management identified as "Resource Case Management." Phone contact is maintained at least once annually.

People receiving waiver-funded services have been divided into either Program Case Management or Primary Case Management. Program Case Management is provided to individuals who are enrolled in structured service programs in which there are other sources of regular oversight, such as group homes, supervised apartments, and day programs. Visits are required quarterly, but caseloads have been divided so that one case manager can visit several individuals at the same service site. Program case managers have approximately 90 people on their caseloads. Primary Case Management is reserved for those who are the most vulnerable, and caseloads are limited to 35 service recipients to allow for monthly contact.

Publicly-Administered Managed Care

Some States have developed managed care programs for services for people with disabilities and/or elderly persons. Some States use health care organizations to coordinate support for both acute health care and long-term support needs, while in others managed care is only used for acute health care services. In addition to being administered by private health care organizations, such programs can also be publicly administered.

Among the places listed in Table 1, Minnesota and Wisconsin have publicly-administered managed care programs. Following are profiles of this model as it is implemented in these two States.

Models of Publicly-Administered Managed Care: Minnesota and Wisconsin

Minnesota is a State that administers health and social services through county government. The South County Health Alliance is a County-administered managed care program in a more rural area of the state, in which 14 Counties have joined in a collaborative effort to address health care needs.

Wisconsin is currently piloting a more comprehensive program called the Family Care program, which combines all long-term care funding streams into one flexible, long-term care benefit. Counties administer these funds for all persons with disabilities. It has been piloted in five counties and provides services for people with developmental disabilities, traumatic brain injury, physical disabilities, and the elderly. All Medicaid long-term care waivers and State long-term care dollars are combined into one amount and a capitated dollar amount is provided to each County. This is an entitlement program without a wait list and it provides a flexible benefits package. The person decides what life outcomes they want and services are provided to meet those goals; people are not bound to a menu of pre-determined services. In the pilot phase, this approach has saved the State an average of \$400 per person per month, thanks mainly to savings in primary and acute care. There is less reliance on institutions such as nursing homes and people are healthier now. Case managers have a different role: managing quality, developing care networks, and engaging in more interdisciplinary efforts.

■ Conclusion

Case management is a critical component in the design of support services systems. Efforts to improve the design and provision of case management have the potential to greatly affect the quality of life of individuals with long-term care needs who rely on publicly funded services and supports. Based on this study, there are at least three factors to consider in the design of case management as states move to increase consumer control, improve quality, and manage resources for the best outcomes possible: providing adequate support structures for self-determination, promoting consumer choice of case manager, and streamlining processes.

Providing Adequate Support Structures for Self-Determination

Many initiatives are underway to increase self-determination and consumer control. However, simply allocating service dollars to consumers is insufficient without well-designed structures for creative planning in the use of those service dollars. States such as New Jersey, Delaware, and Maryland are addressing the challenge of tighter resources for services by increasing their efforts in self-determination and consumer control over their services allocation. Key elements of such a design include an assessment process that leads to a determination of an individual allocation and intensive support for individuals with disabilities to design the supports they will buy with their services dollars. Another element in such programs is maximizing the use of informal support mechanisms before or along with using paid services.

Promoting Consumer Choice of Case Manager

Design of a case management system and assuring consumer choice of case managers involves a number of elements:

- There should be clear delineation of responsibility for the gatekeeping (i.e., eligibility determination, assessment of need) and monitoring roles.
- There should be no conflict of interest. Case management should be impartial, provided by individuals who do not have a vested interest in any service decision.
- Case management should be provided locally, by individuals who know local community resources.
- Structures are needed to assure that case managers and the case management system are held accountable, including clear understanding of the right to choose and change case managers.
- Choices should be provided in ways meaningful to and easily negotiated by the consumer and his or her family.

Providing meaningful choice to consumers entails more than simply providing a list of potential agencies, offering the county versus one other agency, or offering two different agencies. Desirable structures include opportunities for individuals and families to meet potential case managers, and to have clear guidance for the decision-making process.

Streamlining Processes

Complex funding systems, overlapping eligibility determinations, and burdensome requirements for documentation all contribute to systems with redundancy, needless complexity, and inequity. Some states are addressing these issues with efforts to standardize processes between different disability groups, such as a universal assessment process and universal planning processes. States' efforts to streamline processes and increase equity include both standardizing individual allocation methodologies and developing well-coordinated, streamlined database management information systems. Such systems can also improve efficiency, increase time for individual attention to consumers, and enhance the determination that case management performance measures are being met. The technology is available to make these complex information and billing processes manageable for everyone involved.

Other efforts to improve case management include addressing the design and effectiveness of a state's quality assurance system, standardizing performance measures across funding streams and disability groups, standardizing caseload size, and coordinating efforts across all disability groups. Some states are also addressing their funding of case management by reevaluating their balances between administrative claiming, service claiming, and use of the targeted case-management funding stream. Finally, reform efforts should be balanced against the basic principles of improving access and service availability while assuring basic safeguards, improving accountability and performance, honoring individualization, and promoting consumer choice and self-determination.

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