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CORE ROLES OF CARE COORDINATION AND WAIVER CASE MANAGEMENT

AGENDA

- DHS Care Coordination and Waiver Case Management (definitions)
- Similarities between Care Coordination and Waiver Case Management
- Differences between Care Coordination and Waiver Case Management
- Overlap between Care Coordination and Waiver Case Management

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DHS CARE COORDINATION VS WAIVER CASE MANAGEMENT DEFINITIONS

CARE COORDINATION AND WAIVER CASE MANAGEMENT

According to the Minnesota Health Care Programs Manual(MHCP):

Care Coordination: “A service for people enrolled in Minnesota Senior Health Options (MSHO) and/or Minnesota Senior Care Plus (MSC+). It provides assessment and coordination of the delivery of all health and long-term care services among different health and social service professionals and across settings of care.”

Waiver, AC and ECS case management: A service that provides people and their families with access to assessment, person-centered planning, referral, linkage, support plan monitoring, coordination and advocacy related to waiver/AC/ECS services, resources and informal supports that are not necessarily funded through the waiver/AC/ECS.

ROLE OF CARE COORDINATOR VS WAIVER CASE MANAGER

ROLE OF CARE COORDINATOR AND WAIVER CASE MANAGER

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Care Coordinator:

- Eligibility: Must be enrolled in MSHO or MSC+ for members on Elderly Waiver, Community Well or in a Nursing Home.
- Primary Focus: Medical and Long-Term Care Integration
- Scope of services: Health and Social Services across all care settings
- Anchor Point: Health Plan enrollment
- Goal: Help members live independently by connecting them to supportive services and their health care plan, including preventive care and other health needs.

Waiver/AC/ECS Case Manager:

- Eligibility: Must qualify for waiver/AC/ECS programs
- Primary Focus: Person-centered planning
- Scope of services: Waiver-funded services and informal/community supports
- Anchor Point: Waiver/AC/ECS program eligibility
- Goal: Advocacy, linkage, and holistic support planning

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SIMILARITIES

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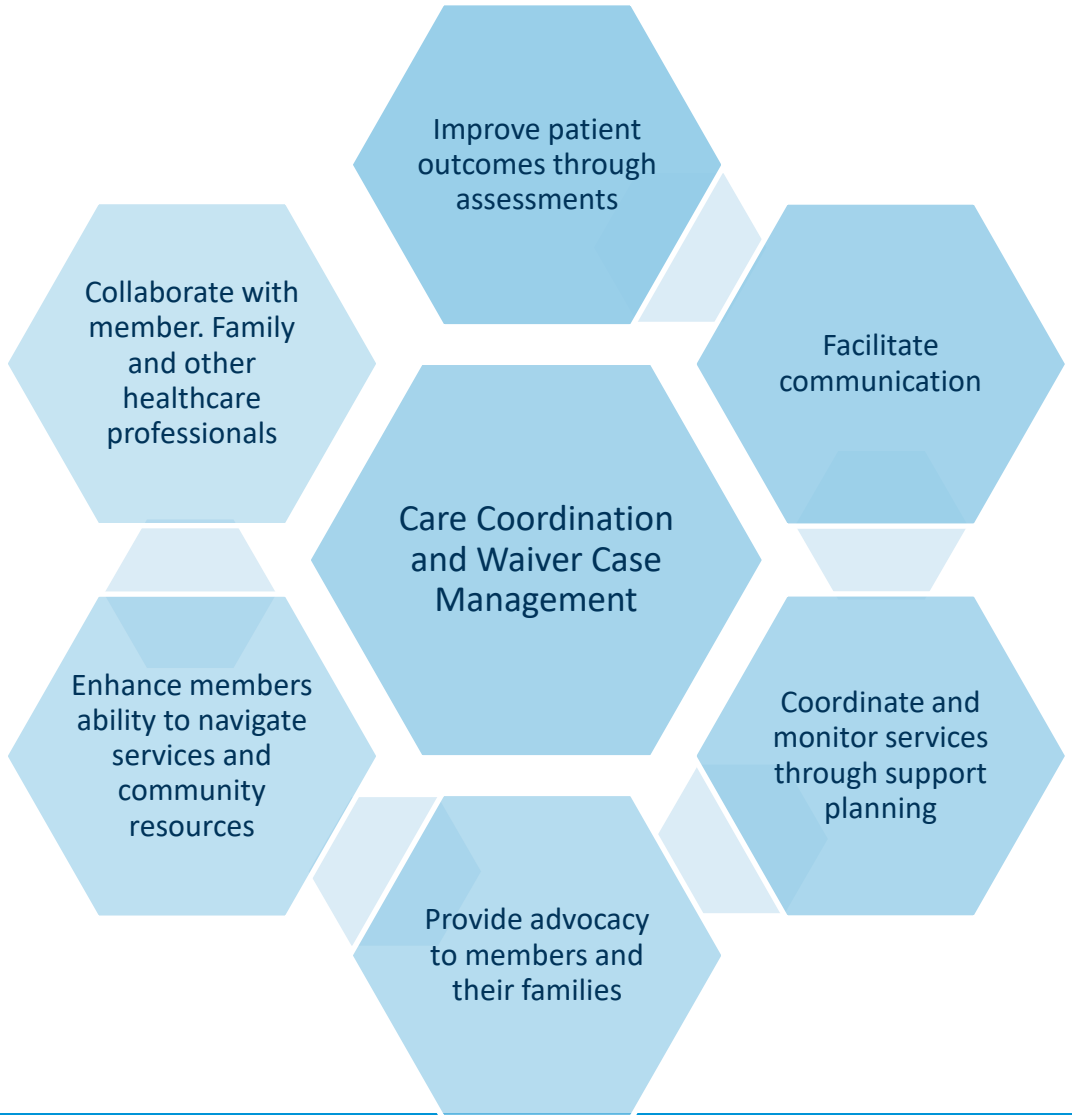

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DIFFERENCES

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Care Coordination: manages all health and long-term care services across different providers and services including social and community supports. The role of the Care Coordinator is to complete assessments, support plans, and coordination of all health and social services for the members. They are both the Care Coordinator and the Certified Assessor.

Waiver Case Management is: a specialized service that focuses on connecting individuals with specific waiver programs and services. The role of the Waiver Case Manager is also to complete assessments and support plans, but the main difference is referral and coordination for waiver-funded services only. They generally do not attend the assessment, since it is the certified assessor who completes the assessments.

DIFFERENCES BETWEEN CARE COORDINATION AND WAIVER CASE MANAGEMENT

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- Model of Care
- Advanced Directives
- Gaps in Care
- Ensure needed check-ups and screenings
- MSHO Supplemental Benefits
- Transitions of Care/follow up after hospitalization
- Safe disposal of medications
- Staying Healthy section of MnCHOICES
- Performance Improvement Projects (PIPs) for Diabetes, etc
- Collaboration with Interdisciplinary Team (ICT)
- Locating providers including PCPs

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OVERLAP BETWEEN CARE COORDINATION AND CASE MANAGEMENT

OVERLAP

- The emphasis on social determinants of health and social service referrals is an overlap between Care Coordination and Waiver Case Management.

- Both models require a person-centered and collaborative approach that respects the member's autonomy and dignity, and engages the member, family, and providers in a shared decision-making process.

- Care Coordinators and Waiver Case Managers both complete assessments, care planning, and set up services to address member needs. Combining these meetings reduce duplication and improve the member experience.

- Communicating with each other when sharing or transferring a case, ensures members receive the most comprehensive care possible.

- Waiver CM submit requests for State Plan Services to the Care Coordinator, who then reviews and may approve, suggest changes, or decline. Health Plan processes claims for State Plan Services.

BCBS CARE COORDINATOR DEFINITION AND TASKS

BCBS definition: The assignment of an individual who coordinates all Medicare and Medicaid health and long-term care services for MSHO and MSC+ Enrollees.

Tasks of Care Coordinators for BCBS include:

- Completion of timely assessments and Support Plans
- Education on MSHO and Supplemental benefits
- Follow up with member after hospitalization/Transitions of Care
- Assistance with obtaining a PCP as needed
- Collaboration with Interdisciplinary Care Team (ICT)
- Managing gaps in care
- Participation in Performance Improvement Programs (PIPs)
- Authorization of services in Bridgeview
- Coordination of services
- Completion of DTR's
- Discussion of Safe Disposal of Medications

THANK YOU!