Counties Unique Role in Case Management

A MACSSA Policy Statement

July 2015

Minnesota Association of County Social Service Administrators

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Introduction

In almost every discipline of social services, case management is at the center of the direct services offered to the consumer. Minnesota counties strongly believe that the viability and preservation of our core case management services is of utmost importance as we look to the future. Counties are uniquely positioned to provide effective, high quality case management due to our ability to integrate services at the local level. Above all, it is the investment in the relationship and building a personal connection between the county staff and the consumer that has the greatest impact and provides the most efficacies.

What is County Case Management?

At a basic level, case management services assist an individual in identifying the individual's goals, strengths and needs; involve planning with the individual what services and community resources might help the individual to accomplish the individual's goals; provide referrals (and often accompany) the individual to obtain services and resources; and monitor and coordinate with those services and resources to assure that the individual is getting the help needed to accomplish the individual's goal and to address the individual needs[1].

In concert with current Legislation and Rules, Minnesota counties invest significant amounts of local levy dollars into programmatic, fiscal, legal, and other administrative aspects of case management services. Given that context, counties consider case management to be at the center of our community-based service system. These services directly impact individuals who are critical to the identity of our communities. County boards have responsibility, under statute, for the development of an affordable system of care serving children, families, and adults that are uninsured or underinsured.

Counties in our combined roles as “payer/purchasers”, “developer of integrated services”, and “direct care providers”, are well positioned to partner with the State and local vendors to continue case management service delivery into the future. Our practice philosophies reflect a holistic framework to promote a consumer-driven, community-based, and recovery-focused system of care.

[1] Minnesota Department of Human Services. *Case Management Services*. Retrieved on May 7, 2015. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=132311.

These roles are further defined as follows:

Payer and Purchaser

Counties utilize local property tax revenues along with federal and state funding to purchase a broad range of human services for citizens. Counties have an existing infrastructure that ensures access to these needed services, provides contracting protocols, monitors quality, and authorizes payment for services. Even when larger counties have contracted for case management services, the counties have still retained a clear role with the vendor by providing performance oversight, monitoring client access, and streamlining client integration into the local system of care. Regardless of size and population, all counties provide services that are tailored to meet the unique geographical and demographic needs of their communities.

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Counties pay a local funding match for certain Medicaid-covered services including case management. Moreover, counties often pay for services at 100% county cost when services are deemed necessary, and no state, federal, or private funds exist (e.g. mental health hold orders, out of home placements for children, etc.). Counties have been willing to look at the local investment in case management services in terms of "getting the job done." The county case management relationship is based on a long-term commitment with no pre-determined starting or stopping point. The focus is to holistically improve the overall functioning of the client. If case management is ever restructured based only on billable time for defined tasks, the shift away from a long-term relationship model could create significant gaps in the service system for specific duties that no one may be required or resourced appropriately cover (e.g. housing supports, court involvement, transitional care out of residential/inpatient care, etc.).

Developer of Integrated Services

Adults and children in need of case management services typically have complex needs that may include food, clothing, shelter, and access to health care coverage. Counties are in a key position to address the holistic needs of consumers by integrating Social Services, Financial Assistance, and Public Health, with the consumer being the focal point. Consumers seeking case management often have multiple needs that are best served through a county-delivered system that can integrate all public services and internally coordinate the needs of each consumer. Effectiveness of county case management increases as access to all appropriate public services are streamlined.

Because of local contacts and familiarity, counties are well positioned to avoid duplication, navigate jurisdictional nuance, and address issues of diversity. Counties bring passion, commitment, and expertise to the development of an array of embedded services that specifically respond to community needs. Counties, especially in rural Minnesota, are often the sole provider of direct care services which usually require additional efforts (and additional levy resources) to ensure the basic needs of each community member are appropriately met.

Provider (Coordinating with the External Service Network)

Counties offer specialized expertise in serving public consumers. Because of long-standing local reference points, counties are best positioned to link individual citizens with unique local supports (both formal and informal). Counties claim expertise in intensive person-to-person and community-based service delivery. By understanding the integration of funding (Private, County, State, and Federal funding) *and* the available community resources (County, Non-Profit, Private), Counties are uniquely afforded the perspective to provide case management services in a manner that are customized to the individual. Addressing the needs of consumers in this dual manner mitigates the limitations of a model that is based more solely on "funding" as the primary driver of service delivery. Funding defined tasks naturally creates an incentive for "task completion" for all eligible clients, regardless for the individual's need for the specified services. Counties believe it is critical that individualized care plans are customized to match personal needs with community services. The funding needs to be packaged in a manner that supports customized care plans.

How Can County Case Management Improve into the Future?

Funding, care delivery, increased acuity, data privacy, and liability are all becoming more complex and difficult to manage. There is an ever-growing need for simplification and streamlining of case management services. The overarching goal of county case management is to meet clients at their starting place and then incrementally and purposefully help each individual improve to their highest level of functioning, according to their life goals.

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Focus Points for Improvements:

1. Streamline equitable funding formulas for county case management at sustainable levels to best address the statewide needs for this proven and cost-effective service. Complimentary to this funding reform, there is an imminent need to establish clear practice standards to include: formatted case notes, weighted or tiered caseload targets, standardized assessments, and standardized billing protocols/audits from outside payer sources (e.g. MCOs). There are many unnecessary complexities and incongruent processes when consumers and county case managers try to navigate changes as individuals choose different health care providers, move to a different county, or seek out new programs. This lack of standardization creates functional barriers and personal frustrations as people try to access services.

2. Train both new and experienced county case management staff/vendors under client-centered philosophies that respect individual differences and address issues of diversity (Olmstead).

3. Define meaningful performance measures for county case management that objectively reflect the collective thinking of consumers, county case managers, and others who directly help consumers achieve progress on their life goals. We need measurements to evolve beyond task-performance, and instead measure progress/stability on individualized goals.

Why do Counties want to Continue Providing Case Management Services into the Future?

County case management is a core function interwoven in the fabric of the local community service delivery system. Counties have extensive history and experience providing and contracting for these direct care services. Counties have also learned how to be responsive to the comingling of political, economic, and social forces that impact these subpopulations. This unique skill set and perspective enables county staff to triage real life circumstances with consumers very efficiently and effectively, drawing upon the full continuum of county services. This approach to community-based care would be very hard to replicate outside the public sector.

Foundational Elements for the Future of County Case Management

1. County case managers are directly integrated into the local network of care and are therefore able to offer smooth coordination and seamless handoffs with other community providers. This strength should be maximized into the future. Counties also offer the stability of a governmental infrastructure, which embeds checks and balances and minimizes internal and external gaps, silos, and barriers to consumers. We strive to limit disparities for the people we serve, and through standardization, improve the quality and consistency in how we serve others.

2. Counties should continue to maintain our primary position in providing (or purchasing and overseeing) case management services. Direct connection to the County Attorney, the Courts, and DHS afford counties important systemic advantages. Most critically, counties understand case management is built on establishing a mutual relationship between the case manager and the consumer. As opposed to a system built on funding "tasks", Counties understand we can measure vital rapport in tangible terms of client successes, health, and safety.

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3. Counties are able to manage overall revenues and expenses across disciplines to sustain core services through hard economic times. An integrated service model will reduce the impact of volatility in any particular service area, at any given point in time. Counties' role in the community-based network of care, our partnering with consumers to measure individual successes, and our long-standing fiscal commitment to preserving the core mission of county case management over the long term, should be respected and preserved into the future.

July 2015

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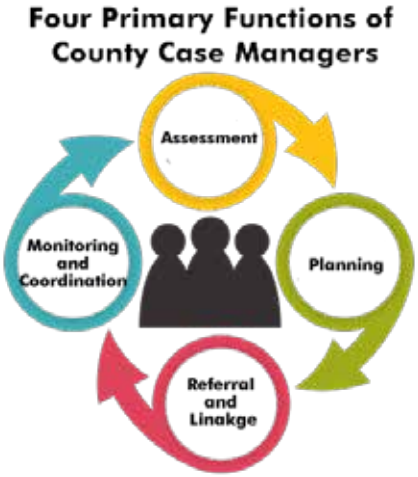
Adult Mental Health Case Management

What is Adult Mental Health Case Management?

Adult Mental Health Case Management is a service designed to support the needs of an adult with serious and persistent mental illness (SPMI) who has a significant impairment in functioning and may otherwise be at risk for extended and frequent hospitalizations, jail, homelessness, or involuntary treatment. Case management is provided by professionals who have experience and education in the mental health field and who are experienced with a recovery-oriented, person-centered approach to service delivery.



Unique Characteristics of Adult Mental Health Case Management

As the Local Mental Health Authority, the county plays a critical role in the delivery of case management services including:

- Assessing the need and advocating for new or expanded mental health services;
- Offering consultation and training to county and private agency case managers;
- Providing oversight of the data practices and appeals processes;
- Communicating with the health plans and the Department of Human Services (DHS);
- Facilitating community planning with the adult, their family and support system, community agencies, DHS, health plans, law enforcement, corrections, housing, vocational, financial assistance, medical, legal, and advocacy agencies;
- Developing contracts with and providing oversight to private agencies;
- Providing 24/7 mental health crisis services.

What Does Success Look Like?

The goal of case management is to help the adult access needed vocational, educational, social, medical, and mental health services. Outreach and advocacy are recognized as a part of case management. Case managers also teach adults how to access community services themselves, in an effort to promote self-sufficiency, community integration, and recovery.

Successful case management starts with a recovery, person centered approach that promotes hope, honors choice, and partners with the person to improve their health and wellness. County case managers have strong collaborative relationships with other county partners such as financial workers, home and community based services, child and family services, county attorneys, law enforcement and corrections. These relationships are the key to helping people along in their recovery. County agencies also have access to funding to fill in gaps that insurance and other services don't cover.

Outcomes that measure recovery indicators in areas such as housing, employment, physical health/wellness, and community connectedness are important to assess whether case management contributes to improving the lives of individuals with SPMI. Decreased utilization of resources such as hospitalizations, emergency room visits and jail are also indicators that are reflective of the effectiveness of case management.

Example from the Field…

Mako had been living in recovery from mental illness for several years quite successfully: living independently, working full time, and maintaining significant social connections. Her mental health began to decline and got to a point in which she quit her job. She reached out to the county and requested case management services. After further decline of her mental health, she became quite isolated and suffered from self-neglect to the degree of putting her physical health in danger. Because of the collaborative relationships already established, her county case manager was able to engage with law enforcement to do a welfare check and subsequent transport hold to get her to the emergency room for psychiatric care.

Through close communication/collaboration with the local hospital, Community Behavioral Health Hospital, county attorney, and other community providers, her case manager facilitated discharge planning and coordinated ongoing care through community services. She was eventually successfully discharged from the hospital, moved back to independent living, and obtained employment again. She continues to receive case management services. •

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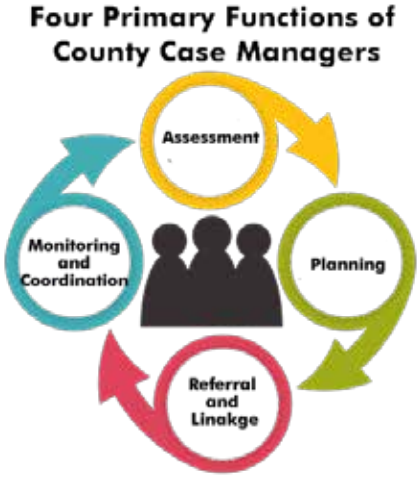
Chemical Dependency Case Management

What is Chemical Dependency Case Management?



Chemical Dependency (CD) Case Management services are provided to individuals diagnosed with chemical dependency or chemical abuse. Case management services provide ongoing assessment, referral, coordination and monitoring of treatment and recovery services for individuals in need. The goal is to work with the person to improve their safety, dignity and quality of life. Case managers assist individuals in maneuvering through multiple layers of services, requirements, rules and guidelines.

CD Case Management includes:

- Referrals for assessment, inpatient and outpatient treatment.
- Ongoing monitoring and support of treatment services, early recovery, and treatment transition.
- Coordination of chemical dependency and mental health care services.
- Assistance with obtaining primary medical and dental care along with health insurance.
- Support, coordination and referrals for transportation, housing, medication management and education, public assistance and job search activity.
- Supportive services for crisis intervention and relapse prevention.

Unique Characteristics of Chemical Dependency Case Management

Availability: Chemical Dependency services are accessible to all individuals who meet eligibility criteria regardless of level of need and ability to pay.

Acuity: An individual seeking case management usually presents with a high level of need due to impacts on many life domains that may require immediate attention. Case management can occur through voluntary or involuntary means, often depending on their level of risk or harm to themselves or others.

Multi-disciplinary: Individuals with chemical health needs may also have other co-occurring needs, such as mental health, physical health or cognitive disorders. The intertwining nature of the disorders usually require linkages with other county services, such as mental health, disability, child protection and financial services. At times, a person in need of chemical dependency case management may also be connected to county corrections or justice systems.

Example from the Field…

Sarah is a 25 year old, single mother with three children under the age of 6. Sarah was diagnosed with Depressive Disorder at the age of 15 while she was in foster care. Sarah began using alcohol and marijuana as a teenager and transitioned to heroin use at the age of 23. Sarah was arrested for possession and had her children placed in foster care. Through case management services Sarah was able to complete chemical dependency treatment, obtain housing, stabilize her mental health and regain custody of her children. •

What Does Success Look like?

Case managers focus intently on working with the individual to improve their ability to live within the community in a safe and stable environment, while obtaining treatment for their addiction. From a systems perspective, success is measured in decreased county cost for detoxification services, declining rates of hospitalizations, and reduced wait-times to access inpatient and outpatient treatment.

Success is measured individually, achieving and maintaining chemical health is a life-long endeavor. For one person, success may be measured in being one day sober; for another it may be about reaching life-long goals of education, career, family or health that can only be accomplished through long term chemical health stability.

January 2016

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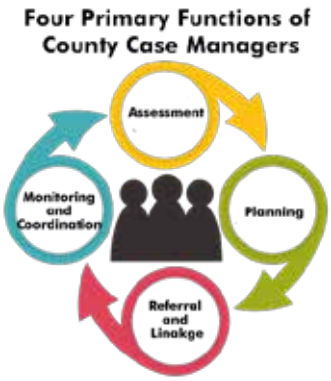
Child Welfare Case Management

What is Child Welfare Case Management?



Child Welfare Case Managers coordinate social and other services designed to help the children under age 21 and the child's family gain access to needed social services, mental health services, habilitative services, educational services, health services, vocational services, recreational services, and related services including, but not limited to, volunteer services, advocacy, transportation, and legal services.

The need for child welfare case management services can present in a number of ways. A child may need ongoing child protective services, or may have become involved with the juvenile justice system through issues surrounding truancy, running away from home, or being a sexually exploited youth. Case management services are also beneficial when the parent of a new child is also a minor, a parent has expressed the need for additional support and outreach, a child is moving through the adoption process, or for a child who has been put into an out-of-home placement. In some situations, case management can begin during a child protection assessment or investigation.

Unique Characteristics of Child Welfare Case Management

Child-Centered. Child welfare case management is child-centered. This does not imply that family needs are neglected or ignored, but it does place the needs of the child above all else. Maintaining the safety of the child is paramount.

Wide scope. Due to the varying possibilities that lead a child to need case management services, the scope for services is broad. The individual needs of the child make it so that each case plan is completely unique from another. This requires a tremendous amount of collaboration with system and community partners, the availability of a wide array of resources, and training on varied approaches.

Inherent tension. Child welfare case management may be delivered on a court-ordered, non-voluntary basis. Counties have a duty to provide core protective services. Case management in this, and other disciplines, is most effective when the person is engaged and willing to receive services. Because of the non-voluntary nature, the possibility for tension and conflict is high. This requires case managers and providers to be highly skilled in negotiation, engagement, and mediation skills.

Court Involvement. Many times, the court is involved due to civil or criminal proceedings on the part of the child or their parents. The child welfare system is closely integrated with the county attorney, law enforcement and court systems to assure that the legal timelines and parameters have been met by the case manager, to support the best possible outcome for the child.

What Does Success Look Like?

As in other forms of case management, individualized goals are set and worked on throughout the duration of services. In situation where the child has been removed from the home, reunification with their family is a significant indicator of success. In those where reunification is not possible, permanency for the child, including adoption, is the best form of success.

One of the best strategies to sustain positive change is to focus on educating the child and their families about the specific needs of the child. When families have improved understanding of the needs of their child and know how to access resources to support the child's well-being, it illustrates the intervention has produced positive outcomes. Ultimately, the goal is for the child's family to be able to provide a safe and supportive home that meets the child's needs, and no longer require the services provided by child welfare case management.

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Example from the Field…

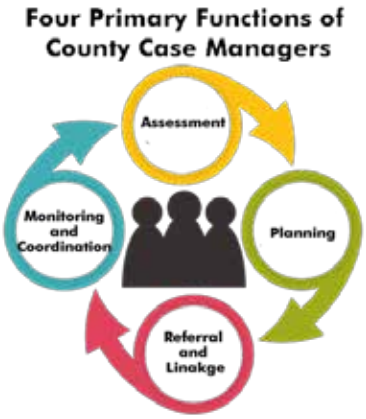
Jaimie entered the child welfare system due to conflict between her and her custodial parent. She had a history of being involved in the juvenile probation system. Jamie was placed in a family foster care home and child welfare case management services was provided to support Jaimie in addressing her educational needs, address parent-child conflict issues, and build increased family connections between Jaimie and her non-custodial parent as well as siblings.

Jaimie experienced challenges in her transition to family foster. Case management services included supporting Jaimie's foster parents, coordination with the school system to support Jaimie's academic needs, planning and coordination of visitation schedules between Jaimie and her siblings, referral and coordination of family group conferences focused in building a permanency plan for Jaimie, and addressing the parent-child conflict issues.

Based upon assessment of risks it was agreed upon that it was in Jaimie's best interest to remain in family foster care. Jaimie did well in her family foster care placement and graduated from high school with honors. Jaimie was offered and accepted Extended Foster Care benefits to support her as she attends college. Case management services continue to support Jaimie in her visitation with her birth family including siblings, development of independent living skills, and support of the foster care provider who continues to be a resource for Jaimie. •

Children's Mental Health Case Management

What is Children's Mental Health Case Management?



Children's Mental Health (CMH) Case Management is a service designed to support the needs of a child with a mental health illness, who has a significant impairment in functioning in multiples areas of their life, such as school, community and family. Mental illness crosses all socioeconomic levels. When the negative impacts of the child's mental health issues are beyond the family's ability to manage, the case manager can assist the with connecting to the needed resources and services. At times, the severity of the mental health symptoms result in the need for hospitalization or out-of-home placement. Case management is provided by professionals who have experience and education in the mental health field and who are experienced with a recovery-oriented, person-centered, and family-focused approach to service delivery.

Unique Characteristics of Children's Mental Health Case Management

Family-focused: Children's mental health case managers are trained to serve the child independently and also as part of the family. Educating the family on the mental health needs and the behavioral presentation of the child helps the family and others involved to better understand and identify the service needs of the child.

Local Supports: Children can experience a strong bond to their local community based on their involvement in the educational system. Therefore, significant emphasis is placed on obtaining local services and resources so that, when possible, they are able to develop the skills to manage their mental health needs within the context of the community in which they live.

Systems Integration: Often, integration with other county systems are required to formulate the best plan of care for the child. Child protection, health and social services, school districts, and the corrections systems are all required to work collectively for the needs of the child. Local administration of the Children's Mental Health Case Management System ensures an integrated approach.

Commitment to Cultural Needs: Counties are in a unique position to assess the current resources, compare them to the needs of the population, and determine what is needed to address any gaps that may exist as it relates to the availability of resources to address specific cultural needs.

Transition: Children do not remain children forever. A significant focus is put on transitional planning as a child ages, and matures into adulthood. Services for children can look and feel different than services for adults, therefore navigating this transition with the child and their families is an important endeavor to promote future success.

What Does Success Look Like?

Children served through children's mental health case management have chronic and severe needs. For some, they will never be symptom free. A child's functioning may be cyclical, so success is evident when the crises are fewer and the child and their family are able to respond to those stressors without escalating to the point of hospitalization, or law enforcement involvement.

Success happens when children and their families have an awareness of the child's mental health diagnosis, how it is manifested, and how to respond to symptoms in a manner that keeps the child and the family safe and functional.

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Example from the Field…

In 2013, Maria was 15 and living with her mom, step-father and younger siblings. She has a traumatic history including having been sexually abused by her biological father. Her mental health diagnoses include Post Traumatic Stress Disorder, anxiety disorder, depression, and most recently, borderline personality disorder. When she began receiving county case management services, Maria refused to follow rules at home. She could be belligerent, aggressive, engaged in self harm (cutting), and frequently made threats of suicide. She engaged in unsafe behaviors like running from home, meeting boys and adult men on the internet, and having sex with them. Maria's mother has her own history of physical and sexual trauma and abuse, and needed a great deal of support to begin to manage Maria's challenges.

Over a period of 5 years, the case manager facilitated various services for the family including several out of home placements in group homes and treatment centers, day treatment programs, in-home parenting and therapy services, outpatient services, school programming, psychiatry, and several types of trauma focused therapies. The case manager helped Maria consider options including Job Corps and independent living programs. Maria has had many struggles, but has just turned 18 and is living with her grandparents and finishing high school. She has elected to remain involved with her CMH case manager because she finds the services helpful and the relationship supportive. •

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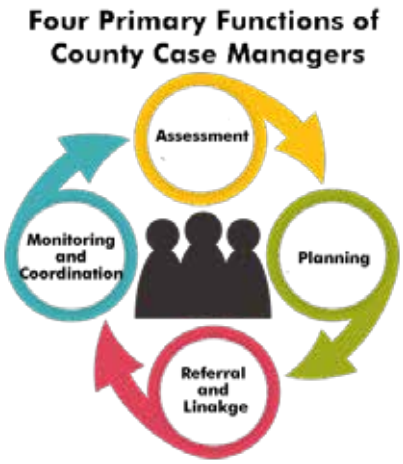
Developmental Disabilities Case Management

What is Developmental Disabilities Case Management?



Based on the Rule 185 definition of eligibility for case management, Developmental Disability Case Management is for persons with a developmental disability or related condition designed to assist them in gaining access for daily living to needed social, medical, educational vocational, and other supports and services. County levy dollars may fund portions of the person's plan of care, and this population frequently relies on certain Medicaid waivers to lend financial support to the client plan of care.

Supported by diagnostic conclusions and evaluations, a developmental disability is a diagnosis characterized by substantial functional limitations and significantly sub-average intellectual functioning that exist concurrently with demonstrated deficits in adaptive behavior with all conditions manifested before the person's 22nd birthday.

The county case manager works to minimize the impact of the disability on the person's life while assuring continuity of services and supports for the person. Persons with a developmental disability tend to have a lifelong engagement in case management.

Unique Characteristics of Developmental Disabilities Case Management

- **Experience:** Frequently paired with the provision of Medicaid Home and Community Based services, Counties have tenure in providing Developmental Disabilities Case Management in Minnesota. In recent years some counties have begun contracting out this service set, while still overseeing the quality of services provided. Case management professionals were key to facilitating the de-institutionalization of this group of citizens as Minnesota.

- **Collaboration:** People engaged in developmental disabilities case management rely on case management professionals to be advocates for community access, inclusion and person centered outcomes. Often, this type of case management is viewed as a lifelong service.

- **Strong Provider Partnerships:** Individuals receiving this service rely on the case manager's ability to forge strong provider partnerships on their behalf. Counties and case managers throughout the state have built strong partner networks to provide essential resources for each individual served.

What Does Success Look Like?

Effective case management is measured in part by the person's successes in obtaining and maintaining community-based living in a setting of their choice, pursuing vocational goals, effectively addressing health needs, and achieving community integration. There is a pronounced social reliance on the individual case manager's professional skills of brokering, advocacy, community organizing, empowering others, and their ability to develop an effective treatment team to deliver a comprehensive, person centered case plan. Minnesota relies on these case management professionals to understand and implement the recent court rulings pertaining to Olmstead and the Jensen settlement.

January 2016

Example from the Field…

Mani lived in one of Minnesota's state hospitals for the first 30 years of his life, then moved to a home in the community. Mani was young and wanted to work, therefore an employment day program was a primary need. Although he had numerous physical and emotional challenges, the case manager engaged a team of people to address these barriers. His new home was not served by special transportation, so the case manager was instrumental in establishing a transit option just for him. Additionally, vehicle adaptations and ongoing behavioral program training for persons working with Mani were secured through case management. Mani resided the last 20 years of his life in a community based group home, successfully going to work each day and enjoying earning a paycheck. •

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Long-Term Care Services and Supports-Waiver Case Management

What is Long-Term Care Services and Supports-Waiver Case Management?

Long-Term Care Services and Supports Waiver (LTSS) Case Management is a service designed to support the needs of children, adults and seniors with varying degrees of physical, cognitive, emotional/behavioral, mental/medical health abilities. County case managers assist people to access and navigate services and supports based on the person's values, strengths, goals and needs.

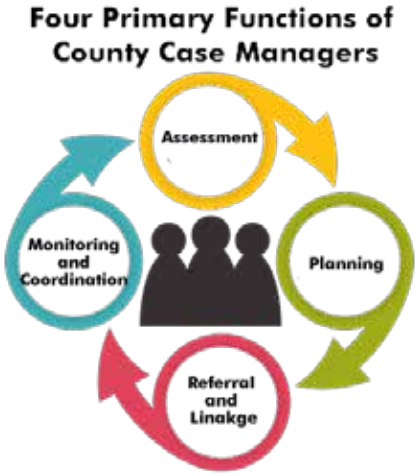
Case management is an essential component of Minnesota's Home and Community Based Service Programs (HCBS). These programs are available to individuals who choose to reside in the community and meet the eligibility criteria.

The six HCBS programs are unique, and are tailored to meet the needs of specific populations.

Minnesota's Home and Community Based Service Programs (HCBS)

- **Alternative Care (AC):** For people over age 65 years who are at risk of nursing home placement.
- **Brain Injury (BI):** For people with a traumatic, acquired or degenerative brain injury who require the level of care provided in a nursing facility that provides specialized services for person with BI, or who require the level of care provided in a neurobehavioral hospital
- **Community Alternative Care (CAC):** For people with chronic illness and who are medically fragile, under age 65, who require the level of care provided in a hospital.
- **Community Alternative for Disabled individuals (CADI):** For people with chronic illness and who are medically fragile, under age 65, who require the level of care provided in a nursing facility.
- **Developmental Disability Waivers (DD):** For persons with developmental disabilities or a related condition who require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD).
- **Elderly Waiver (EW):** For people over the age of 65 who require the level of care provided in a nursing facility and choose to reside in the community.

Why Counties are Uniquely Qualified to Provide LTSS Case Management:



- **Experience:** Counties have long standing experience and knowledge in the administration and management of HCBS programs in partnership with DHS.
- **Collaboration:** The strong connections county case managers maintain with other internal county services (such as Adult/Child Protection, Financial Assistance, Behavioral Health and Public Health) bring additional support and value to the individuals and families.
- **Strong Provider Partnerships:** For years, Counties have contracted directly with HCBS providers and maintain strong collaborative ties to the broader provider community. Counties are in the best position to assess the need for new or expanded services and supports, because of these relationships.
- **No Conflict of Interest:** With few exceptions, Counties are not providers of LTSS services other than case management. County case managers are best positioned to assist people in accessing services of their choice without the conflict of agency self-referral.

What Does Success Look Like?

County case management has proven positive and measureable outcomes in areas such as community living, employment, reducing environmental barriers, improving and stabilizing health needs, and enhancing independent living skills. Simply put, success with LTSS Case Management is achieved when a person is able to safely live in the community in an environment that promotes their individual needs and choices.

Example from the Field…

Elena is a 75 year old woman who is severely brain damaged and is unable to communicate except through some facial expressions. She requires 24/7 care and is completely dependent on others. Elena is on the CADI waiver and is enrolled in Managed Care. She receives PCA services to assist with positioning, bathing/dressing, incontinence care, wound/skin care and range of motion. Elena lives with her husband who also has multiple major health issues. Recently, their home became infested with bedbugs. All of the equipment in the home, including a hospital bed, suction machine, foam mattress, and medical supplies were considered infested and had to be treated. As a result of the infestation, the client and her spouse were being evicted. The County Case Manager, working with the Elena's spouse, medical doctor, hospital, transportation company, medical supply providers, DHS, county financial worker and managed care coordinator, ensured that Elena received the needed supplies, home care and services to safely transition to her new home environment. •

January 2016

MACSSA
Minnesota Association of County Social Service Administrators

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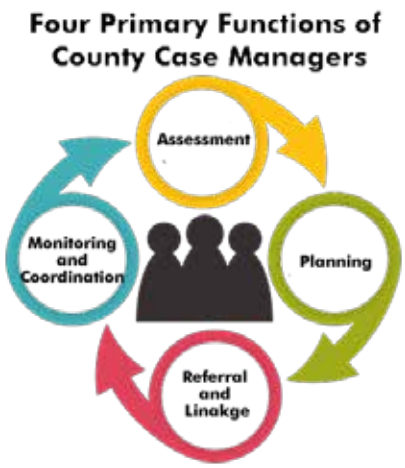
Supportive Housing - Homelessness Case Management

What is Supportive Housing-Homeless Case Management?

Homelessness is traumatic. People experiencing homelessness often live with a multitude of losses. People who are homeless have lost the protection of home and community, and are marginalized, isolated, and stigmatized within the larger society. The homeless are highly vulnerable to violence and victimization. Counties in Minnesota are in a unique position to bring these concepts together and integrate services through their case management work.



Meeting people where they are—geographically, philosophically, emotionally—is the essence of outreach and case management to people experiencing homelessness. Case managers take services to where people are, and are often the first and only point of contact for people who might otherwise be service-disconnected. While the definition of homeless in Minnesota is complicated, generally speaking, persons including individuals, unaccompanied youth, or families with children who lack a permanent place to live continuously for a year or more or at least four times in the past three years are eligible for this type of case management.

Unique Characteristics of Supportive Housing-Homeless Case Management

Housing First is an evidence-based practice that looks at housing as a tool, rather than a reward, for recovery. It is an approach to ending homelessness that centers on providing permanent housing first and then providing services as needed and requested.

Motivational Interviewing is a collaborative, person-centered approach to elicit and strengthen motivation to change behaviors. It offers providers a useful framework for being with and interacting with people who are experiencing homelessness or struggling with substance use, mental illness, and traumatic experiences. Assisting people to find the motivation to change behaviors can be a lengthy, yet effective process, especially when many learned behaviors have been essential to survival on the streets.

What Does Success Look Like?

It is increasingly clear that if a family does not have stable long-term housing the outcomes for the adults and children are awful. The same can be said for adults of all types. You can't address child welfare issues if families are homeless. You can't stabilize a person's mental illness if they are homeless. It is critical that the skills and knowledge county case managers have about homelessness come together through strong case management models that integrate services across the spectrum of services.

In virtually all communities housing is a major challenge because of cost, availability and access issues. County case managers build relationships with landlords and other community partners to bridge these issues.

Length of time in stable housing, reduced use of the Emergency Room, fewer detox visits, fewer arrests, employment, and access to health care are all examples of outcomes demonstrating success.

Example from the Field…

Mary was a street case manager who would spend her entire day building relationships with the homeless population. She once provided a tour to county staff of all the places homeless folks lived nearby in the community. They were invisible to staff until Mary's tour.

Chuck was a homeless man diagnosed with schizophrenia, who roamed the downtown area with a scowl on his face. He was very tall and with long hair that appeared to not have been washed in a long time. The county often received calls from citizens asking the agency to do something about him. Mary interacted with him, on his terms, for over 18 months. She would sit next to him. She would ask him if he needed anything.

Eventually, he felt comfortable with Mary.

Eventually, he listened to Mary.

Eventually, he got help because of Mary.

Through Mary's efforts, Chuck found an apartment and he chose to wash and cut his hair. He then chose to see a psychiatrist, and began taking medications for his mental illness. Chuck was no longer homeless. •

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