Case Management Redesign

Draft service design

October 2018

This document is a draft, prepared by the case management redesign initial design team and will be updated based on the feedback from stakeholder and community engagement events.
# CM DRAFT SERVICE DESIGN

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Introduction

The Minnesota Department of Human Services (DHS)\(^1\) is committed to ensuring that Case Management (CM) Redesign include the diverse perspectives of counties, Tribes, providers, managed care organizations, the people we serve and others who are impacted by or involved in case management services. The effort aligns with the DHS equity policy and uses the governor’s strategic plan for community and civic engagement as a platform to ensure meaningful engagement in the work.

The effort also aligns with the DHS strategic plan which was launched to help guide and prioritize the work done within the organization. It provides a framework for ensuring we are working together on efforts critical to achieving the initiatives of the strategic plan.

The strategic plan has four key initiatives:

- **People**: Advance equity and reduce disparities by establishing an environment in human services that engages all people.
- **Services**: Redesign, simplify, and integrate services to achieve positive and equitable outcomes.
- **Finance**: Implement and support effective and timely technologies through strong partnerships to improve outcomes for the people we serve.
- **Technology**: Prioritize financing reform and sustainability practices that ensure funds are used effectively and efficiently in order to support human services and improve outcomes for people.

CM Redesign is an effort to simplify and better integrate across services; to ensure services are more person, family and community centered; are multigenerational; and help people meet their basic needs.

The Services key initiative strives to redesign, simplify, and integrate services to achieve positive and equitable outcomes. CM Redesign includes numerous partner, stakeholder and community engagement strategies to ensure we are meeting this goal. One of these strategies included the development of the initial design team to convene and define the service of case management and create a foundational set of standards around the delivery of the service. The result is the following draft service design which will be reviewed throughout the state so that as many people as possible can provide feedback on how services can be redesigned to be simple so that people know what they can expect and rely on regardless of the kind of case management service they receive.

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\(^1\) Please see glossary definition of DHS in Appendix B.
Background

There are several types of case management services in Minnesota, each with its own provider requirements and funding arrangements. The Minnesota Legislature directed DHS to redesign case management funded by Medicaid - called Medical Assistance (MA) in Minnesota - to:

- Increase opportunities for choice of case management service provider
- Define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services
- Provide guidance on caseload size to reduce variation across the state
- Develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process
- Develop reporting measures to determine outcomes for case management services to increase continuous quality improvement
- Establish rates for the service of case management that are transparent and consistent for all Medical Assistance-paid case management
- Develop information for case management recipients to make an informed choice of case management service provider
- Provide waiver case management recipients with an itemized list of case management services provided on a monthly basis

Tribal and county partners, together with stakeholders have been working with DHS to address these issues. DHS partnered with multiple stakeholders beginning in 2012 in order to address the legislative mandate. As a result of that initial work, DHS submitted a legislative report in 2013 that described the effort to redesign all types of case management services within multiple divisions at DHS, and in 2014, a subsequent report outlined additional work that was required to consolidate the definitions, activities, standards and rates where appropriate for case management services. For more detail about previous work, please review the Case Management Redesign Background document and the Legislative Report on MN Case Management Reform, February 2014, revised June 2014.3

In 2015, DHS established a Leadership Alignment Team consisting of leadership from DHS, counties and Tribes and began an information gathering phase to assemble, synthesize and make recommendations regarding next steps in the CM Redesign initiative. The Leadership Alignment Team, in recognition of the vital importance of stakeholder and community support, dedicated significant resources to stakeholder and community engagement. The following themes emerged from community and stakeholder conversations over the past two years:

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2 Please see glossary definition of service in Appendix B.
• There must be meaningful engagement of stakeholders in development of case management redesign recommendations
• Case managers must have the skills and resources to develop trusting relationships, with people receiving case management services, that respect the person’s culture and values
• Successful case management means services that address the needs of the whole family (e.g. parent/child), and services that build a person’s resiliency⁴, engagement and ability to be independent
• Roles and responsibilities of case managers must be clear, especially if a person has more than one case manager
• Lack of information and resources (time, training, administrative support) pose significant challenges to case managers
• Reduce complexity, duplication and inefficiencies
• Create a core set of case management services that is flexible to serve the unique needs of each individual

Building upon lessons learned from past efforts and community and stakeholder input, the Leadership Alignment Team has focused on annual, achievable steps toward long-term goals that will build on points of agreement and address state and federal policy changes as they arise. To achieve this, DHS, county and Tribal partners are leading efforts to:

• Create a planning infrastructure to support a long-term, collective approach to case management redesign
• Document the current county and state fiscal infrastructure involved in delivering case management services
• Build upon past work to solidify a universal definition of case management and to develop a core set of activities that form the foundation of any case management benefit
• Ensure community and civic engagement in the development of policies

Additionally, the Leadership Alignment Team assembled an initial design team⁵ to create a draft service design to be reviewed by stakeholders and community members across the state in an effort to get a broad feedback. This document includes the draft case management service design, as designed by the initial design team.

Specific next steps are included in each section, with broad next steps summarized at the end of this document.

Initial design team scope and purpose

Purpose
The initial design team was established in February of 2018 to define the service of case management and create a set of case manager provider standards around the delivery of the service. Specifically, to ensure

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⁴ Please see glossary definition of resilience in Appendix B.
⁵ A full list of team members is included in Appendix A.
consistency in **what everyone can expect and what everyone can rely on** when receiving case management services.

The initial design team consisted of individuals representing counties, managed care organizations, case management providers, family members of people receiving case management services and staff from the Department of Human Services. In order to ensure that people receiving services were well represented in the design, DHS worked with community partners to host conversations with people across the state. These conversations informed the initial design, and DHS has planned a series of additional community engagement events in order to make sure people receiving services have the opportunity to review and provide feedback on the draft service design. For more information about the approach to community engagement, please see the Stakeholder and Community Engagement section of this document.

The initial design team met eight times between March and September 2018 for in-depth conversations facilitated by the Management Analysis Division of Minnesota Management and Budget (MMB).

**Scope**

In order to ensure that meetings were productive and moved towards a collective goal, the team identified what was within scope and out of scope for their work.

**In scope**

- Create an initial design for a uniform set of case management services that will include:
  - Goals and outcomes
  - Eligibility and continuation of services
  - A consistent set of activities for all case management services:
    - Assessment
    - Planning
    - Referral
    - Monitoring
  - Roles and responsibilities of case managers
  - Qualifications and training of case managers

- Identify where the foundational service of case management and professional and organizational standards would need to be expanded upon, based on the needs of a population or expertise needed to provide the service

**Out of scope**

The following issues are interrelated to the development of a foundational service design for case management and inevitably surfaced during the meetings and conversations. However, it was out of scope of the initial design team to solve these issues, which will be addressed within the broader case management redesign work:

- Development of statutory language
- Financial impact/costs
- Intersection with financial modeling
- Intersection with care coordination
- Role of lead agency/mental health authority and implications for choice
- Outcome measurement and development of quality assurance processes
- Technology architecture and IT development
Initial design team commitment
The initial design team committed to working together and developed a set of guiding principles.

The group determined they would:

- Put people receiving services at the center of all discussions and considerations
- Focus conversations on creating positive outcomes for people receiving services
- Welcome opposing and supporting perspectives
- Consider the impact of any recommendations on all types of MA-funded case management and non-MA funded case management provided as required by local mental health authorities or lead agencies regardless of funding
- Consider the needs and impact on case managers when creating an initial design
- Consider the secondary impact of recommendations on stakeholders and groups that are impacted by the delivery of case management services
- Acknowledge past challenges while focusing the conversation on solutions

Planning assumptions
To support a consistent approach to the CM redesign, the Leadership Alignment Team agreed to a set of planning assumptions. The initial design team used the following assumptions for designing the foundational service of case management. The assumptions do not represent final decisions, however, they provided a framework for the team discussions.

- All types of MA-funded case management are included in the scope of the redesign efforts. This includes case management services that have been authorized but not yet designed, including Home Care Case Management.
- DHS will create a foundational set of policies that will govern all case management services. This means that DHS would seek a single authority for all case management services. This planning assumption assumes that case management services are removed from the waivers to a different federal authority.
- The foundational service of case management will have the following in common:
  - Core activities
  - Roles and responsibilities of service delivery
  - Provider qualifications and training
  - Ways to identify and measure common outcomes and quality
- The foundational service of case management and professional and organizational standards will be expanded upon based on the needs of a population or expertise needed to provide the service
- The foundational service of case management will inform the broader case management redesign discussions regarding payment modeling and methodology
Foundations of the service design

The draft service design was created using a shared vision and goals for case management, and builds upon vision and goals from the past.

Vision
Prior to developing the draft service design, the initial design team agreed upon a shared vision for case management services. Services should be:

- Simple, flexible, person-centered, culturally responsive, and universally available to those who qualify for them
- Effective in assisting people and families to access formal and informal supports such as medical, behavioral health, educational, social and other needed services that are available in the community

The team further emphasized that caseloads need to be manageable so case managers can advocate for, and be a resource to, the people receiving services, as well as develop authentic working relationships to create and implement plans that are person-centered. Establishing recommended case load sizes will be a complex process and rely on (but not be limited to):

- Details gathered through the financial analysis (described in the Next Steps section of this document)
  - i.e. - data on current staff to person ratios vs. case management service type, area of service and payment methodologies
- Input from counties and providers throughout Minnesota (to determine average and preferred case load sizes around the state both for counties and providers)

Goals of case management

**Option 1**
The initial design team created a set of goals for case management that are applicable across the foundational service of case management. The goals of case management are the reason behind providing case management as a service. Goals are not about how something is done, but will ultimately tie into how outcomes are identified and measured.

- Assist people and families to access formal and informal services and supports that help people achieve their goals and meet their basic needs
- Promote health, safety, and stability across settings and situations
- Support individually meaningful connections to family, friends and communities
- Support the quality of life as defined by the person

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6 Please see glossary definition of person-centered in Appendix B.
7 Please see glossary definition of supports in Appendix B.
8 Please see glossary definition of advocate in Appendix B.
Option 2
The initial design team created a goal that is applicable across the foundational service of case management:

Assist people and families to access formal supports, including medical, behavioral health, educational, social, and other needed services, and informal supports such as family, friends, and communities, that help people achieve their goals, meet their basic needs, stay safe, and pursue a quality of life as they define it.

In developing goal(s) for the service of case management, the initial design team identified an overall challenge which is the availability of services or resources may not be within the control of the case manager. This is a natural tension between the federal purpose of case management (to assist individuals in gaining access to needed medical, social, educational, and other services) and holding the case manager accountable for accessing resources. However, the case management service must be designed to meet the federal law, and case managers play a pivotal role regardless of the availability of the service. For example, a case manager cannot create affordable housing but the case manager can support the person in applying for a housing subsidy.

Purpose of redesigning – what will be different?
The draft service design was created around a lens of improving services in two key ways:

1) Define and standardize
One primary purpose of the initial design team was to define and standardize the delivery of case management as a service so that people know what they can expect and rely on, regardless of why they are receiving the service or what type of service provider they have. This is accomplished in this service design draft by identifying core expectations and responsibilities of organizations and case managers in the delivery of the service. It identifies the required activities and standards within each service component and the competencies all case managers need in order to provide the service.

2) Simplify
In addition to the legislative mandate to define the foundational service of case management and create a set of case manager and provider standards around the delivery of the service, DHS has an overarching goal to simplify and integrate services to achieve positive results and equitable outcomes. In order to ultimately be successful for the people receiving case management, the service must be designed to support people in the context of their individual, family and community environments to navigate and make informed choices in order to lead the lives they want.

The initial design team noted the importance of having organizational structures that set case managers up for success. Various stakeholders, particularly people providing case management services, talked about barriers to providing quality case management services, including:

- Not having enough time to meet face-to-face with the people they are serving
- Being overwhelmed by paperwork and administrative burden
- Confusing and inconsistent systems
- Lack of information and resources, including opportunities for training, resources with information about community based providers

Please see glossary definition of integration in Appendix B.
In every community engagement discussion, people receiving case management services talked about the challenge of navigating various services, managing different requirements, deadlines and paperwork, and organizing and coordinating communication across all of the different providers involved in their lives.

In addition to reducing complexity through a common definition and provider expectations (included in the draft service design), the final design will include expectations around:

- Alignment of timelines and administrative requirements
- Streamlining and reducing paperwork, with the perspective of what is needed to best support the person receiving services and their families
- Commitment to supporting the core responsibility of case managers, which includes a recognition of the time and costs associated when case managers are asked to fulfill additional state or federal requirements as part of related services
- Roles and responsibilities when someone has more than one case manager
- Roles and responsibilities when a person is working with a care coordinator

Next steps in 2019

DHS will work with partners, stakeholders and communities to finalize and further embed requirements into the final design that will lead to simplified, aligned, less complex delivery of the service.

**Outcomes**

The Minnesota Legislature mandated DHS to develop reporting measures to determine outcomes for case management services to increase continuous quality improvement. Currently, there is no consistency in how outcomes and outcome measures are identified across the various case management services. In some cases, outcomes and measures are tied to federal requirements. For example, in Minnesota, many federal Home and Community Based Services (HCBS) waiver requirements for quality assurance are demonstrated through case management measures and reporting. In addition, case management outcomes are often tied more broadly to the delivery of a related service and are not identified uniquely related to the case management service itself.

A primary goal for the foundational case management service design is to identify areas for alignment and standardization across all 12 MA-funded case management services with the intention of creating consistency, accountability and efficiency.

A measurement strategy will be developed as a component of the redesign to allow DHS to evaluate whether the redesign is resulting in any meaningful changes and whether the goals of case management services are met. Demonstrating the outcomes of case management services is essential to demonstrate the value of the service itself.

Next steps in 2019

DHS will continue to map existing measures used in each case management service and will develop a draft measurement strategy which will be reviewed and influenced by internal and external stakeholders.
Service design components

Overview
Federal law identifies the service components of case management as assessment, development of a care plan, referral, and monitoring and follow-up activities and provides broad definitions of each of these activities. The initial design team built upon federal definitions for each service area and further identified the activities and expectations within each service component as specific to Minnesota.

Each section of the service design includes an overall purpose of the service component, expected activities of a case manager, standards for how the service should be delivered, and policies regarding implementation of the service component.

The service design is organized by the following components that will be required regardless of why the person is accessing case management services:

- Assess
- Plan
- Refer
- Monitor

The service design identifies the expectations of and standards for case managers. In order for case managers to meet these expectations and standards, they must have the support and infrastructure of the organization that employs them. This document refers to the employing organization as “provider”. Provider organizations will be required through statute to assure that the necessary infrastructure and administrative support is present to allow case managers to achieve the expectations and standards outlined in the service design.

The foundational expectations and standards outlined in the service design do not address what activities trigger payment. For example, the requirements for face-to-face contact included in this document are related to the initial assessment and development of a plan. Face-to-face contacts and other requirements for billing will be
developed after the service design is reviewed by stakeholder and communities and may vary based on the type of service a person is receiving.

The development of the foundational service design also included:

- Identifying roles and responsibilities
- Supporting
  - Advocacy
  - Relationships
  - Resiliency
- Assessing equity impact

**Dual case management**

Under case management redesign, the foundational expectations around the delivery of case management as a service will be similar regardless of the population served. However, based on a person's unique needs or professional expertise needed to deliver the service, a person may have more than one case manager as defined by state law. When this is the case, it will be necessary to have clearly identified roles and responsibilities for each case manager. All case managers working with a person need to ensure that the person understands what each case manager is responsible for and how to communicate with each case manager. In addition, each case manager must ensure that the other case manager working with the person has access to information that is relevant for coordinating services, as determined in partnership with the person.

Each service component contains expectations about roles and responsibilities when multiple case managers are involved. The service components also include the expectation that case managers work in collaboration with care coordinators supporting the person.

Assess
Eligibility Assessment and Needs Assessment

Assessment is a core service component of case management. It can be challenging to separate assessments done to determine eligibility for a particular type of case management service from the needs assessment done by a case manager as part of ongoing case management services. There is overlap between eligibility assessments and case management assessments because information gained about a person through an eligibility assessment should be used by a case manager in conducting the case management assessment. However, there are also important differences that must be recognized in order to move towards the goal of creating foundational case management service components that anybody receiving any type of case management service can expect and rely on.

Eligibility for case management services is often based on an assessment of how a person’s condition impacts their functioning. For example, in order to qualify for mental health targeted case management (MH-TCM), an adult must be determined to meet the diagnostic and functional criteria for serious and persistent mental illness. As a result, functional assessments are routinely a part of eligibility assessments for MH-TCM. Similarly, the MnCHOICES assessment is used to determine if a person meets the level of care requirement to qualify for HCBS waiver services. In both cases, the information gained through the eligibility assessments performed should be used to inform the case management assessment. The MnCHOICES assessment results in a Community Support Plan (CSP) that includes a list of recommended services and supports. However, all case managers are expected to use these recommendations for services and supports along with a person’s identified needs and goals to develop a plan for case management services.

Case management services, regardless of the population served and the unique service or support resources available, are expected to address a person’s basic behavioral and physical health needs, social service needs, educational or employment needs. The development of a set of standard elements that are required as part of the assessment service component reflects the commitment to create clear expectations of how any case management service supports a person in meeting their needs and reaching their identified goals.

Purpose

The purpose of assessment is to identify a person’s goals, preferences, and need for services and supports, including medical, behavioral health, educational, social and other services. This assessment is distinct from other processes used to determine initial eligibility for case management services or assessment used to identify level of functioning or risk.

Expectations

Assessment is an ongoing process. The frequency of assessments should be based on - and must address - any changes in a person’s goals, needs, or access to services and support. The initial and ongoing information gathered should inform all other case management activities.

A comprehensive assessment must include the following:

- Demographics including:
  - Race, ethnicity, Tribal enrollment, Tribal residence, veteran and military status
- A person’s strengths, desires, preferences, needs, and goals
- Identification of a person’s formal and informal services and supports including:
Financial and social service benefits, health care coverage, housing, health, behavioral health, and transportation
  • Identified support system

- Employment and education
- Cultural and spiritual beliefs and practices
- Barriers the person has or is currently experiencing

Standards
A case manager must:

- Use processes that put the person in the center of the discussion and decisions
- Meet face-to-face with the person and their identified supports, parent and/or guardian as applicable, in order to complete the initial assessment, which should inform the case management plan
- Review the eligibility assessment and related documents that may have been completed prior to the person receiving case management services.
- Focus the assessment on a person’s goals, preferences, and need for services and supports.
- Use practices that support the development of honest and respectful relationships with the person and their identified supports, parent and/or guardian by using active listening, providing clear and unambiguous information, and respecting privacy and confidentiality
- Use techniques such as motivational interviewing to assess a person’s readiness for change and his or her capacity to integrate care or community supports into his or her life
- Work with the person to identify if there is any other case manager or care coordinator already working with the person

Plan
Purpose
The purpose of an individual’s case management plan is to document the person’s needs and goals as identified through the assessment process and the actions necessary to address those needs and achieve the person’s goals.

Expectations
The case management plan must include the following:

- Name and contact information
- Name of person’s formal and informal supports (regardless of whether paid or unpaid)
- Person’s identified
  - Strengths
  - Goals
  - Needs
  - Preferences
- Actions needed to reach identified needs and goals
- Timelines for each action
- Person responsible for each action
- Resources or supports needed and available to the person
- Identification of any needed services that are not currently available and action to be taken to obtain alternative services that could meet that need
- Cultural considerations
- Identification of any other case managers working with the person
- If the person is working with more than one case manager or care coordinator, the plan must specify roles and expectations of each case management and which professional will support each activity
- Identification of other professionals involved in the person’s life, e.g. care coordinator or financial worker

Standards
A case manager must:

- Develop the plan face-to-face with the person and their identified supports, parent, and/or guardian as applicable. The plan may be completed outside of the face-to-face meeting, but initial development must be done face-to-face and could be done in conjunction with the initial assessment.
- Develop a plan, in partnership with the person and their identified supports, parent and/or guardian as applicable, that is:
  - Simple and carried out with mutual respect
  - Informed by the assessment and attempts to match the person’s preferences
  - Designed to build the person’s skills and their ability to navigate and advocate for themselves
  - Clearly identifies the case manager’s role and what the case manager is accountable for
Use processes that ensure:
- The person is at the center of discussion and decisions
- Focus is on the relationship/partnership between the case manager and the person, not on compliance or regulatory functions
- Service and support options are explained, including the risks and benefits of each option, so that person can make an informed choice
- When case management and other services are mandated\(^\text{10}\), the case manager works with the person to identify choices available within the mandated services or supports

Have a proactive conversation with the person and their identified supports, parent and/or guardian as applicable, about how to communicate and coordinate with the case manager if the person is discharged from a hospital, residential treatment or other institutional setting.

Provide the opportunity for the person, and their parent and/or guardian as applicable, to sign the plan. The purpose of the signature is to indicate that the plan was developed in partnership with the person. If the plan is not signed, the case note should indicate the reason.

Provide a copy of the plan to the person and their parent and/or guardian as applicable.

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\(^{10}\) Please see glossary definition of *mandated* in Appendix B.
Expectations
The case manager must carry out the following referral activities:

- Work with the person and their identified supports, parent and/or guardian as applicable to prioritize
  needs and preferences to be addressed first
- Make choices and options clear to the person and their identified supports, parent and/or guardian as
  applicable
- Be clear on who will make referrals and how referrals to specific services or supports can and will be
  made
- Identify barriers and solutions for accessing services and supports
- Follow through to confirm the person has access to the services or supports referred to
- Advocate and troubleshoot with and on behalf of the person when there are barriers to accessing
  services
- Match the referral to the person’s cultural preferences whenever possible

Standards
The case manager must:

- Be knowledgeable about agencies and resources, and aware of options by geographic area
- Understand eligibility requirements and/or processes for determining eligibility for services and
  supports referred to
- Develop and nurture relationships with other community and social service providers to aid in effective
  referrals and timely access to services
- Work in partnership with the person and their identified supports, parent and/or guardian as applicable
  to decide what information is shared with other service and support providers, and when
- Work with the person and their identified supports, parent and/or guardian as applicable to determine
  the level of assistance the person needs to contact referral sources and obtain services
- In partnership with the person and their identified supports, parent and/or guardian as applicable, develop
  a clear plan for communication about the process and status of referral, including preferences
  and expectations around method of communication and frequency
- When case management and other services are mandated, the case manager must work with the
  person to identify choices available within the mandated services or supports
Monitor

**Purpose**

The purpose of monitoring is to gather information on how well the services and supports the person receives meet the person’s needs and preferences, and to assist the person in meeting their goals.

**Expectations**

A case manager must carry out the following monitoring activities:

- Regularly review and adjust the plan, in partnership with the person and their identified supports, parent and/or guardian as applicable, to meet their needs or to address changes in their life.

- The review should include whether or not:
  - The person’s needs are being met
  - Services are timely and being delivered in the manner that align with what the person needs and wants
  - Services are culturally appropriate and match the person’s preferences
  - The plan is written in a way that advances the person’s goals

- If the plan is not meeting the person’s needs, identify steps to adjust the plan. This includes identifying and addressing barriers to accessing services and supports when possible.

**Standards**

The case manager must:

- Specify the frequency of monitoring activities in the person’s plan based on the level of need of the person and other factors which might affect the type, amount, or frequency of service.

- Establish a clear plan for communication so that the person and their identified supports, parent and/or guardian as applicable can effectively communicate any questions or concerns to the case manager.
• Monitor the goals identified by the person, the activities for accomplishing each goal, and progress towards achieving the outcomes
• Focus on developing a trusting relationship with the person and their identified supports, parent and/or guardian as applicable by supporting shared decision-making and following-through on commitments
• Connect with all other case managers or care coordinators that the person is working with to communicate any changes to the plan that involve or impact the other case manager or care coordinator

Case manager competencies

The initial design team determined that in order to deliver case management as a foundational set of services, a case manager must have the following competencies:

• Strong written and verbal communication skills, including
  o Active listening
  o Building rapport
  o Non-verbal cues to build relationships
  o Interviewing
  o Emotional intelligence which includes empathy, anger/crisis management, conflict resolution
  o Negotiation skills
  o Motivational interviewing
  o Collaboration
• An orientation toward being culturally responsive
• An understanding of systems theory or person-in-the-environment theory
• Knowledge of strategies to put the person at the center of the work
• Critical thinking skills
  o Flexibility in thinking
  o Proactive and ability to plan
  o Problem solving
  o Solution focused
  o Good judgement
• Organization skills
• An understanding of the case management scope of practice

Additional context regarding competencies

This list of competencies was created within the context that in many areas of the state, workforce challenges make it difficult to find and retain case managers. The team acknowledged that some of these competencies may be present upon hire, and some may need to be obtained on the job and through continuing training and education.
Next steps in 2019

DHS will work with partners, stakeholders, and communities to identify qualifications and trainings needed to support the competencies of all case managers to inform the final design.

Intersection with other reform initiatives

Case management redesign intersects with many other reform initiatives at DHS.

DHS has an overarching goal to simplify and integrate services to achieve positive results and equitable outcomes for the people, families and communities served. The draft service design for case management was created from a lens of program simplification and service integration.

Case management redesign is one of several large initiatives aimed at achieving these. Other initiatives with these goal includes Waiver Reimagine, Uniform Services and Standards (USS), and System Modernization.

Minnesota Waiver Reimagine

The Minnesota Waiver Reimagine project seeks to identify and recommend system-level improvements to Minnesota’s disability waiver programs. The Waiver Reimagine project will identify ways to improve system structures to give people more choice and control over the services they receive.

- The goals of the Waiver Reimagine project are:
  - Equal access and benefits across disability waiver programs. The programs will be responsive to a person’s needs, circumstances and preferences
  - Align benefits across waiver programs for people with disabilities, including consistent limits and allowable services
  - Flexible and predictable benefit changes that recognize life changes and an increased use of technology
  - Simplified administration that make waivers easier to understand for people receiving services, county and Tribal administrators and service providers

The Waiver Reimagine project is focused on studying:

- Potential options for reconfiguring the waivers for people with disabilities (report deadline Dec, 2018)
- Different models for budgeting (report deadline Jan, 2019)

Uniform Services and Standards

The legislature directed DHS to develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process. This reflects the underlying goal of establishing clear and consistent case management service requirements and intersects with another agency-wide initiative, the Uniform Services and Standards (USS) project. The USS project aims to comprehensively reform and simplify the service requirements for mental health services in MA by aligning common standards across different services and eliminate requirements that do not add value or treatment quality.
Under current law, there are multiple certification processes for mental health services. The USS project seeks to move the various mental health service certification processes under a single licensure framework to ensure consistency and to reduce administrative complexity and waste. The experience gained through the project will be leveraged to inform the decision about whether DHS will pursue a case management licensure process.

System modernization

DHS has complex technology solutions connecting services to more than one million people in the state. More than 30,000 county, Tribal nation and state staff and 200,000 providers use these systems to deliver services. These groups are working together to try to provide integrated service delivery. DHS has also started modernizing IT systems to support integrated, person-centered human services delivery. These improvements will offer better, more tailored experiences to people applying for or participating in services, and also better experiences for the staff serving them.

Early in the spring of 2017, DHS began a partnership with the Minnesota Association of County Social Service Administrators (MACSSA)\(^{11}\) and White Earth Tribal Nation to set the vision for integrated, person-centered human services delivery in Minnesota. The result of this group’s work is the Integrated Services Business Model (ISBM), which will help to guide system modernization and transform many aspects of how people experience the human services system. The group purposefully decided to create the model to be specific enough to guide technology development and service delivery changes, yet flexible enough to work in every locality.

The ISBM is the agreed-upon framework for the delivery of human services in Minnesota in the future. This model was created with an extensive amount of input from counties of varying sizes as well as representatives from some of Minnesota’s Tribal nations, the Minnesota Association of County Social Services Administrators (MACSSA), leadership from across DHS, DHS Agency Divisions, Information Technology (IT) governance teams, and community relations stakeholder groups. These groups are creating the vision for modernizing human services technology, in order to provide services in the best way possible.

Case management redesign intersects directly with the ISBM. Both initiatives are proposing changes which:

- Use a two-generational approach, to ensure that services and strategies across programs consider not just an individual, but a whole family
- Improve the plan making process, so that plans capture the person’s holistic set of needs and achievable actions for real outcomes across all potential program areas
- Help the person get the assistance they need, when they need it, in the way that fits their preferences
- Creates a system responsive to varying levels of need

With the ISBM, there is the potential to create more consistent and streamlined services, reduce administrative burden associated with duplication of work, and create one platform from which to gather information.

Related discussion

There are a number of policy issues that, while not directly included in the service design for case management, are related to the delivery of the service across the state and were discussed by the initial design team.

\(^{11}\) Please see glossary definition of MACSSA in Appendix B.
Initial service eligibility and continuing service eligibility

The initial design team spent time unravelling the overlapping concepts of eligibility and assessment. All case management services require that specific criteria be met in order for a person to begin receiving or to continue receiving case management services. Operationally, this means that there is an assessment required. Assessments used to determine a person’s initial or ongoing eligibility for case management services are different from the required assessment activities performed by a case manager to determine a person’s need for specific services and supports. However, information obtained in the assessment to determine service eligibility is used to inform the assessment performed by a case manager to determine appropriate services and supports. Further complicating eligibility and assessment is the fact that, for some case management services, there is no MA reimbursement available for determining initial or ongoing service eligibility.

The initial design team was charged with creating recommendations for the foundational service of case management. For this reason, the initial design team addressed just the assessment activities performed by a case manager for a person who has already been determined to be eligible for the service. Moving forward, DHS and its partners will need to consider changes to the eligibility criteria to be used to establish a person’s eligibility for different types of case management services. Federal case management authority gives states significant flexibility in terms of defining eligibility criteria for the “target” population. As described above, the planning assumption is that case management services will be removed from the waivers. By removing case management from federal waiver requirements, Minnesota gains flexibility in terms of determining the eligibility criteria used to determine eligibility for case management services for people with disabilities.

Intersection between case management redesign and local governance

Under current state law, Minnesota counties are responsible for providing mental health and developmental disability case management services to county residents regardless of the person’s ability to pay. This obligation on counties has been referred to as “local governance” requirements. Changes to local governance requirements are outside the scope of case management redesign. However, local governance requirements must be understood and accounted for in the development of MA-funded case management services because Minnesota counties do not operate a “MA-funded” case management service and a separate “other payer or uninsured” case management service for county residents. This means that any changes to MA-funded case management requirements will directly impact counties both in terms of financial obligations and staff resources.

Choice

The legislature directed DHS to increase opportunities for choice about case management services. This means that a person must have access to information to help them understand the differences between case management service providers available to them. While this is a straightforward goal, because of the evolution of case management services in Minnesota, increasing choice can be challenging. There are several factors that practically limit the choice of case management provider organizations. Minnesota relies on counties to administer and in many cases, deliver case management services. In some counties the only case management provider organization is the county itself. Due to the geographic distance and low population density in some counties, it is simply not economically feasible for other case management provider organizations to operate. Home and Community Based Services HCBS waiver case management relies on counties to serve as “lead agencies” and conduct eligibility assessments for a variety of services and supports, including HCBS. As a result of these complexities, the initial design team discussed options related to how to increase choice in situations
where there is only a single entity providing case management services within the county. One option discussed was to establish a person’s ability to impact their choice of their case manager. This could be operationalized by providing a formal opportunity, such as an appeal, where people receiving case management services can request a different case manager. The draft service design for case management does not directly address the issue of increasing opportunities for choice, however, the issue of how to increase choice will continue to be considered and worked on by DHS and its partners.

**Federal requirements related to choice of case management services**

Federal law governing targeted case management services requires that states ensure freedom of choice of provider. States are allowed to restrict who can provide mental health targeted case management if the state can demonstrate that the restriction is required to meet the needs of people with mental illness. Currently, under Minnesota’s state plan, providers of mental health case management services must be counties or providers under contract with counties. Federal law also requires that people receiving HCBS waiver services have free choice of case management providers. Under federal law, the provider of HCBS case management services is not allowed to provide other HCBS waiver services, except when the State demonstrates that the only willing and qualified provider of HCBS case management in the geographic area also provides other HCBS services. Currently, as a result of some of the operational issues described above, Minnesota restricts a person’s choice of HCBS case management services to the lead agency (or county) using federal authority under section 1915(b)(4) of the Social Security Act.

**Stakeholder and Community Engagement**

Stakeholder and community engagement has been, and will continue to be, at the center of case management redesign and builds upon Minnesota’s Governor’s Strategic Plan for Civic Engagement. Furthermore, Minnesota Laws 2013, Chapter 63, Section 19, “Recommendations for Further Case Management Redesign” directs the commissioner of DHS to consult with existing stakeholder groups which include representatives of counties, Tribes, disability and senior advocacy groups, mental health stakeholders, managed care organizations, and service providers.

**Stakeholder engagement**

For the purposes of case management redesign, stakeholders include:

- Advocacy groups
- Contracted case managers
- Contracted providers
- County and Tribal case managers
- County and Tribal directors and supervisors
- Managed Care
- Non-profit organizations
- Related providers impacted by case management services (e.g., clinical care coordinators, courts, housing)
- State Legislators
Emerging themes

The following themes have emerged from stakeholder conversations in the past year:

- Stakeholders want to continue to be engaged in case management redesign. These preferences include open communication and transparency, regular and consistent updates, and knowledge about how stakeholder feedback was used.
- Case managers must have the skills to balance empathetic work with people, learn a complex system of services, and manage their time to complete all necessary documentation. Case managers work with a person on a continuous cycle of assessing, planning, referring, and monitoring.
- Culture has a profound impact on how someone views case management. Case managers must work to build relationships with all individuals, in order to build trust with them and learn about how they view case management and the services they may utilize.
- Payments for case management need to be more transparent, consistent and true to the cost of providing the service. Subcontracting plays a huge role in payment and the different payment mechanisms must be understood, in order to redesign the system.
- Case managers should have a consistent role, job title and job functions, and it roles and responsibilities need to be clearer when someone has more than one case manager.
- Challenges identified by case managers in delivering the service:
  - Not enough time to meet face-to-face with the people they are serving
  - Overwhelmed by paperwork and administrative burden
  - Confusing and inconsistent systems
  - Lack of information and resources, including opportunities for training, resources with information about providers
- Case managers want more training, need more time, resources, a case load mix which doesn’t produce burnout, feedback about their work, flexibility on the job, and clear expectations.
- The case management redesign effort should collaborate with other related human service initiatives, in order to support alignment of goals and advancements.

Stakeholders provided solutions and requested particular approaches for redesigning case management.

- Create a system that allows case managers to serve the family, not just the child. Known as a “2-gen” approach
- Figure out how specialization can help case managers, but not perpetuate the many layers which currently exist in the system
- Evaluate procedural steps for efficiencies
- Don’t strategize based on lawsuits and complaints
- Consider the different authorities for each case management program
- Create a core set of case management services that is flexible to serve the unique needs of each individual
- Move away from service menus, as these cause gaps
• Have a more flexible funding/budget structure for people’s service mixes and to ensure basic needs
• The case manager should support a coordinated service plan between all of the person’s providers

Community Engagement
For the purpose of case management redesign, community refers to:

• People served by DHS programs and services, and their family members, caregivers, and their support systems
• People that do not currently receive case management services but may be eligible
• Members of the community receiving direct services, members of their family, caregivers, identified support, etc.
• Trusted community leaders

Approach to community engagement
DHS is using the following strategies for community engagement:

• Local community events throughout Minnesota - see map below for locations of events
  o For each event, DHS will partner with area community agencies to coordinate outreach and structure conversation in a way that meets the needs of the community
  o DHS will provide funding for refreshments and gift cards for people who attend the events, as an incentive for their participation
• Local collaboration - DHS will collaborate with local organizations to identify opportunities to hear from the people they serve in an effort to include as many perspectives as possible
• Meaningful and authentic engagement with Tribal Nations and organizations that support American Indians in the metro area and rural Minnesota done in coordination with DHS Office of Indian Policy and DHS Tribal liaisons
• Surveys- DHS will partner with organizations to survey the people they serve

Scheduled local community events as of October 8, 2018:
Emerging themes

To date, the following themes have come forward from the community conversations:

- People want to set their own goals when working with case managers
- People are generally happy with the case management they are receiving, and some are nervous about the system changing
- Complaints about case management and the services they are receiving varied depending on the type of services they receive
- People receiving services want their case manager to know them well and to support them as a whole person
- People want their case manager to be knowledgeable, resourceful, compassionate, prompt, flexible, clear in his/her communication with clients via email, phone, texting, willing to get the person’s needs met, nice, polite, friendly, gives good, honest feedback, someone they can trust and trusts them back
• People want more information about their service options and they want to feel more in control of the services they receive

Themes identified through stakeholder and community engagement informed the draft case management service design. DHS will continue conversations with stakeholders and communities in order to review the draft service design and to inform final decisions needed in 2019.

Next steps

The next phases of case management redesign will build upon the work of the initial design team.

DHS will share and gather feedback on the draft service design with stakeholders and community members beginning in October, 2018

At the same time Tribal leaders will convene parallel groups that will provide a set of recommendations that will be incorporated into a final proposal.

While this work is being finalized the draft service design will be used to inform components of the financial analysis work being conducted by Navigant Consulting.

As written in the 2014 legislative report: “It was determined that any changes to the case management reimbursement system would take a great deal of financial analysis and implementation planning. The impact of changing the funding system needs to be discussed and evaluated before a rate that is consistent and transparent for all case management can be determined.”

To begin the needed financial analysis, DHS has a contract in place with Navigant Consulting to do the following:

• Document and comprehensively describe the finances currently associated with administering and providing Medical Assistance-funded case management services. This will include a description of the funds counties use when services are provided by a contracted provider and funds used to provide similar case management services that are not reimbursed by Medical Assistance.
• Develop models for a potential universal base rate for the cost to provide the case management service and compare models to the current payment structures and rates to assess potential impact

DHS and partners will use the information developed by the initial design team and Navigant to inform decisions on next steps in the rate development work.

Timeline

The case management redesign initiative has the following timeline:

• Oct, 2018-April, 2019: Meet with stakeholders and community members to review and gather feedback on the draft service design
• May, 2019: Finalize service design and rate methodology
• Sept, 2019: Legislative language ready for 2020 session
• July, 2020: Statutory language will need to pass in order to implement changes in 2021
• July, 2021: Begin to implement service design and rate structure changes
Final report
A final report will be developed based on the final service design and financial analysis conducted by Navigant Consulting. The report will be used to draft a legislative proposal with the engagement of partners and stakeholders prior to the 2020 legislative session.
## Appendix A: Initial design team members

### Initial Design Team Members

Purpose: Create an initial design for a uniform core set of case management services which will be vetted with stakeholders throughout the process.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Johnson</td>
<td>DHS/Community Supports/ Disability Services</td>
</tr>
<tr>
<td>Cheryl Lundsgaard</td>
<td>St. David's Center for Child and Family Development</td>
</tr>
<tr>
<td>Dagny Norenberg</td>
<td>DHS/Community Supports/Disability Services</td>
</tr>
<tr>
<td>Darrin Helt</td>
<td>DHS/ Community Supports/Mental Health</td>
</tr>
<tr>
<td>Deborah Ho-Beckstrom</td>
<td>Family member of person receiving case management services</td>
</tr>
<tr>
<td>Diane Marshall</td>
<td>DHS/ Community Supports/Adult and Children’s Mental Health</td>
</tr>
<tr>
<td>Elaine Carlquist</td>
<td>County Based Purchasing/ PrimeWest Health</td>
</tr>
<tr>
<td>Emily Schug</td>
<td>Dakota County</td>
</tr>
<tr>
<td>Gretchen Ulbee</td>
<td>DHS/Health Care/Purchasing and Service Delivery/Special Needs Purchasing</td>
</tr>
<tr>
<td>Janet Nilsen</td>
<td>Saint Louis County</td>
</tr>
<tr>
<td>Jennifer Thomas</td>
<td>Parent of person receiving case management services</td>
</tr>
<tr>
<td>John Sellen</td>
<td>Hennepin County</td>
</tr>
<tr>
<td>Kayla Nance</td>
<td>The Arc of Minnesota, Greater Twin Cities Region</td>
</tr>
<tr>
<td>Khu Thao</td>
<td>Touchstone Mental Health</td>
</tr>
<tr>
<td>Mary McGurran</td>
<td>DHS/Continuing Care/ Continuing Care/Adult Protection</td>
</tr>
<tr>
<td>Mike Herzing</td>
<td>Hennepin County</td>
</tr>
<tr>
<td>Penny Pesta</td>
<td>Morrison County</td>
</tr>
<tr>
<td>Rachel Shands</td>
<td>DHS/Continuing Care/ Aging and Adult Services/HCBS</td>
</tr>
<tr>
<td>Renee Donald</td>
<td>Restart, Inc.</td>
</tr>
<tr>
<td>Sheri Olson</td>
<td>Volunteers of America MN</td>
</tr>
<tr>
<td>Stacey Steinbach</td>
<td>Yellow Medicine County</td>
</tr>
<tr>
<td>Stacy Hennen</td>
<td>Grant County</td>
</tr>
<tr>
<td>Susan Kurysh</td>
<td>DHS/Health Care/Purchasing Service and Delivery/Benefits Policy</td>
</tr>
<tr>
<td>Susan McGeehan</td>
<td>HealthPartners/MN Council of Health Plans</td>
</tr>
<tr>
<td>Tracy Telander</td>
<td>HealthEast</td>
</tr>
<tr>
<td>Veronica Medina-Gillies</td>
<td>MN Brain Injury Alliance</td>
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</tbody>
</table>
Appendix B: Definitions

Minnesota’s complex network of case management services has resulted in using many words for similar meanings. These words, plus the words needed to describe case management service design are listed below. These definitions were created utilizing feedback from the initial design team and Minnesota Statute and Rule.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Process of supporting and empowering people to understand their rights and responsibilities, choices and options. Advocacy includes supporting a person through the process of resolving conflict, obtaining services or service providers that meet the person’s needs and preferences.</td>
</tr>
<tr>
<td>DHS (The Minnesota Department of Human Services)</td>
<td>The Minnesota Department of Human Services (DHS) helps to provide essential services to Minnesota’s most vulnerable residents. Working with many others, including counties, tribal nations, and nonprofits, DHS helps ensure that Minnesota seniors, people with disabilities, children and others meet their basic needs and have the opportunity to reach their full potential. While the vast majority of human services in Minnesota are provided by partners, DHS (at the direction of the governor and Legislature) sets policies and directs the payments for many of the services delivered. As the largest Minnesota state agency, DHS administers about one-third of the state budget. The largest financial responsibility of DHS is to provide health care coverage for low-income Minnesotans. DHS is also responsible for securing economic assistance for struggling families, providing food support, overseeing child protection and child welfare services, enforcing child support, and providing services for people with mental illness, chemical dependency, or physical or developmental disabilities. Through licensing services, DHS ensures that certain minimum standards of care are met in private and public settings for children and vulnerable adults. DHS also provides direct service through regional offices for people who are deaf or hard of hearing; through DHS Direct Care and Treatment, which provides direct care to people with disabilities; and through the Minnesota Sex Offender Program.</td>
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<tr>
<td>Identified support</td>
<td>Refers to whomever the person identifies as their support.</td>
</tr>
<tr>
<td>Informal support</td>
<td>Refers to a person who provides support to someone who receives the case management service without being reimbursed. All informal supports should be documented in the person’s case management plan.</td>
</tr>
<tr>
<td>Integrated, or integration</td>
<td>Services are coordinated and work together efficiently and effectively to help reach agreed-upon goals. From a technology standpoint, systems are able to successfully communicate and share information seamlessly. The Center for Medicaid Services refers to integration as harmonization of plans, processes, information, resource decisions, actions, results, and analyses to support key organization-wide goals. Effective integration goes beyond alignment and is achieved when the individual components of a performance management system operate as a fully interconnected unit.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Involuntary, or mandatory</td>
<td>This term covers anyone required by a court order to participate in the human services system. Examples include individuals subject to civil commitment, child in need of protective services (CHIPS), etc.</td>
</tr>
<tr>
<td>MACSSA (Minnesota Association of County Social Service Administrators)</td>
<td>The Minnesota Association of County Social Service Administrators (MACSSA) is a statewide association made up of county public social service directors or other administrative designees. The Association has been in existence since 1946 and is representative of all 87 Minnesota counties. Their mission is “building a unified network of partnerships to advocate for meaningful system improvement, influence policy and legislation and promote quality human services that positively impact our citizens, communities and counties throughout Minnesota.” MACSSA is a co-sponsor of the case management redesign and MACSSA leadership are members of the case management redesign initial design team.</td>
</tr>
</tbody>
</table>
| Person-centered                                                     | Person-centeredness is an important concept to modern health and human services approaches. It involves listening to people about what is important to them in order to help them live, learn, work, and fully participate in their communities on their terms. The goal is for people to lead lives that are meaningful to them. There are a number of closely related concepts around person-centeredness that play into this; the Center for Medicaid Services outlines the following, among others:  
  • Person-centered practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals  
  • Person-centered thinking helps to establish the means for a person to live a life that they and the people that care about them have good reasons to value  
  • Person-centered planning is a way to assist people who need services and supports to construct and describe what they want to bring purpose and meaning to their life. |
| Person-in-the-environment theory (also known as Systems Theory)     | A practice framework based on the notion that an individual and his or her behavior cannot be understood adequately without consideration of the various aspects of that individual’s environment (social, political, familial, temporal, spiritual, economic, and physical).                                                                                                                                                                                                                                                                     |
| Resilience                                                          | Resilience refers to an individual’s ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life’s challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery. Visit SAMHSA’s Partners for Recovery Initiative’s Resilience Annotated Bibliography – 2013 (PDF | 531 KB). |
| Service                                                              | In terms of case management, a service is the overall provision of case management to a person. The service of case management includes service components, which include, assessing the person, creating a plan with the person, referring the person to other programs and services outside of case management, and monitoring the service to ensure it is meeting the person’s needs.                                                                                                                                   |