The Future of Case Management in Georgia

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Georgia Department of Human Services

Vision, Mission and Core Values

Vision

Stronger Families for a Stronger Georgia.

Mission

Strengthen Georgia by providing Individuals and Families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

Core Values

- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect. Manage business operations effectively and efficiently by aligning resources across the agency.
- Promote accountability, transparency and quality in all services we deliver and programs we administer.
- Develop our employees at all levels of the agency.

Case Management Redesign

- Started June 2013
- Statewide team
- 3 meetings
- Established phases for implementation

Redesign Team Assumptions

- Case Management is implemented with wide variations across the state making data analysis, referrals, and documenting outcomes difficult.
- Case Management has a key role in fee-for-service market (and managed care) and needs to be enhanced to be competitive.
- Case Management is one of the most expensive services and requires high level of competency/training so should be used strategically within the Network.

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Redesign Team Assumptions

- There is a “continuum” of ADRC Counseling, Community Options Counseling, and Case Management that needs to be optimized.
- There is a need to clarify and prioritize the essential functions of Case Management – and ensure ongoing training & competency.
- In an ideal world, there are enough resources for objective, third-party assessments and reassessments for each client requesting or receiving services – we don’t have enough resources to do that.
- The system should ensure that assessments and determination of service types and service levels are as objective as possible.

Case Management Redesign

- Identify the models of case management – When? Who? Where? Goals?
- Clarify tiers/levels of case management – Risk Factors
- Develop ranges of case management interventions (based on Risk Factors)
- Identify measurable outcomes for case management
- Identify appropriate assessment tools
- Create an assessment protocol
- Develop Care Planning protocols

Access to Care Model

- Level I
  - DON-R + DD questions (BIP)
- Level II
  - NSI
  - Food Security
  - Risk Assessment Tool → Risk Levels

Gazing into the Future

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Target Consumers

- Complex Cases
- Immediate risk to health and safety
- Cannot be served through ADRC interventions
- Need face-to-face contact
- Education/planning
- Transitioning among levels of care

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Core Principles

- Capacity based
- Conflict free
- Culturally competent (cultural humility)
- Individualized
- Person-centered
- Professionally responsible

Core Competencies

- Interpersonal Team Skills
- Judgment and Analytical Ability
- Adaptability
- Assessment skills
- Service Planning and Service Access

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Core Functions

- Assessment
- Service Plan Development
- Service Plan Coordination
- Advocacy
- Reassessment
- Discharge

Outcomes

- Older persons and persons with disabilities will experience reduction in risk factors that contribute to out of home placement
  - Indicator #1: increased support as measured by Unmet Need score from DON-R
  - Indicator #2: reduction in intention to place as reported by caregivers, when present
  - Indicator #3: reduced number of risk factors indicated by periodic reassessments

Outcomes

- Older persons and persons with disabilities will have increased awareness and/or access to services.
  - Indicator #1: number of services offered/referred/or provided by case management
  - Indicator #2: number of education activities provided by case management
  - Indicator #3: reduction in barriers to accessing services indicated by Service Plan documents

Outcomes

- <u>Outcome #3:</u> Older persons and persons with disabilities will demonstrate increased management of chronic conditions.
  - Indicator #1: increased compliance with medications, treatment or doctor visits
  - Indicator #2: increased confidence in managing chronic conditions as reported by consumers
  - Indicator #3: reduction in number of hospitalizations/ emergency room visits
  - Indicator #4: increased knowledge of chronic conditions/ medications as reported by consumers

Tools & Resources

- Assessment tools
  - Comprehensive assessment
  - Specialized assessments
- Service Plan
- Technology to track outcomes
- Quarterly case management meetings

Upcoming Opportunities

Webex on Risk Assessment Tool (RAT)

Two sessions:

- June 25, 2015: 1:30 PM – 2:30 PM
- June 30, 2015: 9:00 AM – 10:00 AM

Questions

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Conversation

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