DEPARTMENT OF HUMAN SERVICES

Case Management Redesign

Draft service design

January 2019

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

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Executive Summary

Minnesota Department of Human Services (DHS) is seeking input on the draft service design for case management. This draft service design acts as a proposed set of standards for all types of case management funded by Minnesota's Medicaid program, called Medical Assistance (MA) in Minnesota. The case management redesign initiative is working to define and standardize, simplify and integrate services, and address disparities in the development of policies and delivery of case management services.

As a foundational step toward these goals, DHS, in partnership with stakeholders, agreed on foundational components which anyone who receives case management can expect and rely on when receiving case management. Rather than adding more regulation to case management, these standards are meant to clarify and simplify how case management should be provided to people in Minnesota. There are many types of case management and each type may have standards which go above and beyond what is listed in this document. Those additional standards will be mapped out after broad stakeholder review of the foundational standards detailed in this document.

The proposed foundational standards start on page 13 in the "service design components" section. The sections before the service design components give some context about why the case management redesign initiative is happening and the structure and approach used to create the service design. The remaining sections include an explanation of important topics related to the redesign which will need further development, other statewide initiatives, stakeholder and community input that informed the draft service design and the next steps for the redesign initiative including how the service design will be used to make new policy going forward.

The components of the draft service design were created collaboratively with the initial design team over eight months in 2018. The initial design team consisted of individuals representing counties, managed care organizations, case management service providers, family members of people receiving case management services and DHS staff. 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. DHS has planned a series of additional stakeholder and community engagement events to make sure people receiving services have the opportunity to review and provide feedback on the draft service design.

The feedback will be used to inform a final service design proposal for the Minnesota Legislature.

Introduction

The Minnesota Department of Human Services (DHS)[1] is committed to ensuring that the case management redesign initiative includes 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 initiative aligns with the DHS equity policy and uses the governor's plan for community and civic engagement as a platform to ensure meaningful engagement in the work.

The initiative 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.

Technology: Implement and support effective and timely technologies through strong partnerships to improve outcomes for the people we serve.

Finance: 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.

The *People* initiative aims to advance equity and reduce disparities by establishing an environment in human services that engages all people. To reduce inequities, it is necessary to address the broad social, economic and political factors that cause systemic disadvantages and that impact the needs, assets and challenges of communities experiencing inequities. In January 2017, DHS adopted a policy on equity directing staff to incorporate equity analysis into the development of all policies and to authentically engage persons from cultural and ethnic communities before policy decisions are made. An equity analysis is a review of the impact of proposals, policies and programs on various populations, with a particular focus on impact on communities experiencing inequities.

In commitment to this equity policy, community engagement will be a core focus of the case management redesign initiative throughout the planning and implementation process. The experiences and perspectives of people, families and communities will inform decision-making, program and policy development, implementation and evaluation.

The *Services* initiative strives to redesign, simplify and integrate services to achieve positive and equitable outcomes. DHS and its partners recognize that case management business processes and program policy must be streamlined, simplified and aligned to achieve this. Case management redesign includes numerous partner,

[1] Please see glossary definition of *DHS* in Appendix B.

stakeholder and community engagement strategies to ensure we are working together in these efforts. One of these strategies includes the development of the initial design team to convene and draft a definition for the service of case management and create a foundational set of standards around the delivery of the service so that **people know what they can expect and rely on** regardless of the kind of case management service they receive.

The result is the following draft service design that will serve as a foundation for case management. DHS will share this draft design with stakeholders and communities statewide to gather feedback, which will inform a final service design proposal for the Minnesota Legislature.

Background

There are several types of case management services[2] in Minnesota, each with its own provider requirements and funding arrangements. The Minnesota Legislature directed DHS, in consultation with external stakeholder groups, to develop specific recommendations and language for proposed legislation 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 to address the legislative mandate. As a result of that initial work, DHS submitted a legislative report in 2013 describing the effort to redesign all types of case management services within multiple divisions at DHS. In 2014, a subsequent report outlined additional work 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]

[2] Please see glossary definition of *service* in Appendix B.

[3] Both the Case Management Redesign Background document and the Legislative Report on MN Case Management Reform, February 2014, revised June 2014 can be found on the Case management redesign webpage at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/case-management-redesign/.

MA pays for case management under a variety of services and programs in Minnesota. The scope of the case management redesign initiative crosses many administrations within DHS and includes:

- Waivered case management, including:
  - Community Alternative Care (CAC)
  - Community Access for Disability Inclusion (CADI)
  - Developmental Disabilities Waiver (DD)
  - Elderly Waiver (EW)
  - Brain Injury (BI)
- Rule 185
- Adult mental health targeted case management (TCM)
- Children's mental health TCM
- Vulnerable adults TCM
- Developmental disability TCM
- Child welfare TCM
- Relocation services coordination TCM
- Alternative care

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 case management redesign initiative.

The Leadership Alignment team, recognizing the vital importance of stakeholder and community support, dedicated significant resources to stakeholder and community engagement. In each phase of the process, the approach to community engagement in the case management redesign initiative has been shaped by this statement from the governor's plan for civic and community engagement: "Communities of color, American Indian communities, LGBTQ communities and disability communities have previously been underrepresented in policy making. The failure to include these communities in the development of policy is detrimental to the long-term interests of the State of Minnesota. Effective meaningful engagement with all citizens in our state is essential to the functioning of Minnesota government. For engagement to happen, there has to be an intentional period of building trust with these communities. Trust must first be established with underrepresented communities before meaningful engagement can occur."

These themes emerged from stakeholder and community conversations over the past two years:

- There must be meaningful engagement of stakeholders and communities in the development of case management redesign recommendations.
- Case managers must have the skills and resources to develop trusting relationships with people receiving case management services and respect the person's culture and values.
- Successful case management means services that address the needs of the whole family, and services that build a person's resiliency[4], 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.

[4] Please see glossary definition of *resilience* in Appendix B.

- 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 on lessons learned from past efforts and stakeholder and community input, the Leadership Alignment Team focused on achievable steps toward these long-term goals:

- 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 on 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 team[5] to create a draft service design that will be reviewed by stakeholders and community members across the state. This document includes the draft case management service design, as developed by the initial design team.

Initial design team scope and purpose

Purpose

As a key step in the overall case management redesign initiative, the initial design team was established in February 2018 to draft a definition of the service of case management and create a set of standards around the delivery of the service — specifically, to ensure consistency in **what everyone can expect and what everyone can rely on** when receiving case management services. The primary focus of this team was to draft foundational policies and expectations that would be required of all case management services. As a next step, the foundational policies and expectations will be expanded upon to reflect additional expectations based on the needs of a specific population, expertise needed to provide the service to a specific population or to meet federal requirements for specific service areas.

The initial design team consisted of individuals representing counties, managed care organizations, case management service providers, family members of people receiving case management services and DHS staff. 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. 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.

[5] A full list of team members is included in Appendix A.

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

Planning assumptions

To support a consistent approach to the case management redesign initiative, the Leadership Alignment team agreed to a set of planning assumptions. The initial design team used these assumptions as a framework for designing the foundational service of case management. The assumptions do not represent final decisions. DHS will conduct analysis to determine feasibility and implications of these planning assumptions.

- All types of MA-funded case management are included in the scope of the redesign initiative. 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 to govern all case management services. This means DHS would seek a single federal authority for all case management services. This assumption is dependent on case management services being removed from the Home and Community Based Services (HCBS) waivers and included as a targeted case management option. This requires an extensive analysis of the requirements under each type of federal authority and the potential impact of making this change.
- 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 specific population or expertise needed to provide the service to a specific population.
- The foundational service of case management will inform the broader case management redesign discussions regarding payment modeling and methodology.

Scope

To ensure meetings were productive and moved towards a collective goal, the team reviewed and provided feedback on 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 specific population or expertise needed to provide the service to a specific population

Out of scope

Certain issues are interrelated to the development of a foundational service design for case management but are out of scope for the initial design team to solve. These issues inevitably surfaced during conversations, and they will be addressed within the broader case management redesign work:

- Development of statutory language
- Financial impact and cost
- Intersection with financial modeling
- Intersection with care coordination
- Role of lead agency and 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. Collectively, the group determined to

- 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- and non-MA funded case management provided, as required by local mental health authorities or lead agencies, regardless of funding,
- consider the needs of and impact on case managers when creating an initial design,
- consider the secondary impact of recommendations on stakeholders and groups impacted by the delivery of case management services and
- acknowledge past challenges while focusing the conversation on solutions.

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 of case management

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

Services are simple, flexible, person-centered, culturally responsive and universally available to those who qualify for them, and are effective in assisting people and families to access formal and informal supports[6].

The team further emphasized that caseload sizes need to be manageable so case managers can advocate[7] 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 caseload 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), such as data on current staff-to-person ratios vs. case management service type, area of service and payment methodologies and
- input from counties, tribes, and managed care organizations and providers throughout Minnesota to determine average and preferred caseload sizes.

Goals of case management

The initial design team created a set of goals for case management that are applicable across the foundational service of case management. The goals are the reason for providing case management as a service. Goals are not about *how* something is done, but how outcomes are ultimately identified and measured. Case management aims to:

- 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 quality of life as defined by the person.

In developing goals for the foundational service of case management, the initial design team identified an overall challenge: the case manager often has little or no control over the availability of services or resources. There is a 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 when they may not be available. 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 they can support the person in applying for a housing subsidy.

Purpose of redesigning – What will be different?

The draft service design was created with a lens of improving services in three key ways:

1) Define and standardize

One primary purpose of the initial design team was to develop recommendations on how to define and standardize the delivery of case management as a service so that people would 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 the draft service design by identifying core expectations and responsibilities of service providers and case managers in the delivery of the service. It identifies the required activities and standards within each

[6] Please see glossary definition of *informal support* in Appendix B.
[7] Please see glossary definition of *advocate* in Appendix B.

service component and the competencies all case managers need in order to provide the service, regardless of the population served. Clearly defining the service is a step towards creating a system of accountability for quality service delivery.

The work of identifying and defining additional service components to meet the unique needs of particular populations served was outside the scope of the initial design team. This work will be a component of the next phase of developing a final legislative proposal.

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 for the delivery of the service, DHS has an overarching goal to simplify and integrate[8] services to achieve positive results and equitable outcomes. In order to ultimately be successful for 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 to lead the lives they want.

The initial design team noted the importance of 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:

- Lack of time to meet face-to-face with the people they are serving
- Using case management to satisfy regulatory and compliance needs, limiting case managers' capacity to focus on core case management responsibilities
- Confusing and inconsistent bureaucratic and information technology systems
- Lack of information and resources, including training opportunities

In every community engagement discussion, people receiving case management services talked about the challenge of navigating various services and systems, managing different requirements, deadlines and paperwork, and organizing and coordinating communication across the range of 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 address expectations for:

- Alignment of timelines and service requirements
- Simplification of service requirements from the perspective of the person receiving services
- Commitment to supporting the core responsibility of case managers, including recognizing time and cost involved when case managers fulfill additional state or federal requirements as part of related services
- Roles and responsibilities when a person has more than one case manager
- Roles and responsibilities when a person is working with a care coordinator

3. Address disparities

DHS is committed to ensuring considerations of equity — in other words, fairness and justice — are embedded in decisions at all levels. The goal of the DHS equity policy is to institutionalize an approach to decision-making, program and policy development, implementation and evaluation which improves outcomes and reduces health and human services disparities and inequities for the people we serve. Disparities in health outcomes and

[8] Please see glossary definition of *integration* in Appendix B.

disparities in opportunities to participate in services are two areas which can be addressed through the redesign initiative.

Disparity in health outcomes

"Minnesota ranks, on average, among the healthiest states in the nation. But the averages alone tell an incomplete story. A closer look at the data reveals that communities of color, American Indians, lesbian, gay, bisexual, transgender and queer (LGBTQ) communities, the disability community, rural communities and low-income communities experience the highest inequities in the state." (Center for Health Equity, Minnesota Department of Health)

Participation in services

People from communities that have historically experienced inequities are often over-represented in protective services and under-represented in other services. For example, "when compared to White children, children of color and tribally affiliated children, with the exception of Asian/Pacific Islander children, are over-represented and experience a higher rate of involvement in child protective services, out-of-home placement and adoption. All children of color and tribally affiliated children were more likely than White children to receive a determination of child maltreatment, have an opening for case management services, or undergo a slower rate of adoption." (Minnesota Child Welfare Disparities report 2010, Minnesota Department of Human Services)

To begin to address these disparities, the case management redesign initiative includes stakeholder and community engagement throughout the stages of planning and policy development.

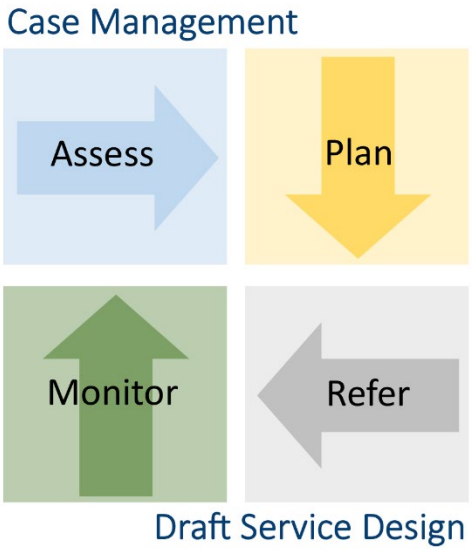
In addition, DHS will use an equity analysis process, in collaboration with partners, stakeholders and communities, as policies are developed. The analysis will include the following questions:

- What groups are impacted by the proposed changes?
- What is the nature of the impact?
- Have representatives from these groups been consulted and collaborated with in order to determine how to address these impacts?
- Is the change intended to reduce or eliminate disparities?
- Are there potential positive or negative impacts on the identified groups?

Next steps in 2019

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

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*[9].

Federal law also provides broad definitions of each of these activities. The draft service design aligns with and builds upon federal definitions for each service area, and further identifies 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 delivery of the service component.

The draft 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

[9] 42 C.F.R. §440.169

While the service design is organized by these four components, case managers often do not engage in each component in a distinct and linear fashion. Each occurs on an ongoing basis, based on the needs of people being served.

The draft service design identifies the expectations of and standards for case managers. 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 "service provider." The term "provider" meaning provider organization, rather than case manager, applies to this document only and should not imply that is how the term is used in state or federal law. Service provider organizations will be required through statute to ensure 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 draft service design document focuses on the expectations and standards foundational to all case management. The next phase of case management redesign policy and financial analysis will focus on identifying where the foundational service of case management and standards for service delivery need to be expanded, based on population needs, expertise necessary to provide the service or federal requirements for specific service areas. For example, the expectations and standards outlined in the draft service design do not address what activities trigger payment. The requirements for face-to-face contact included in this document are related to the initial needs assessment and development of a case management plan. Face-to-face contacts and other requirements for billing will be developed after the service design is reviewed by stakeholders and communities, and may vary based on type of service.

Another example is the expertise of case managers and the education and experience needed to serve varying populations. The draft service design addresses the basic competencies all case managers should have in delivering the service. The expertise, education and experience needed based on the needs of the populations served will be expanded upon in the next phase of the work.

The development of the foundational service design also included:

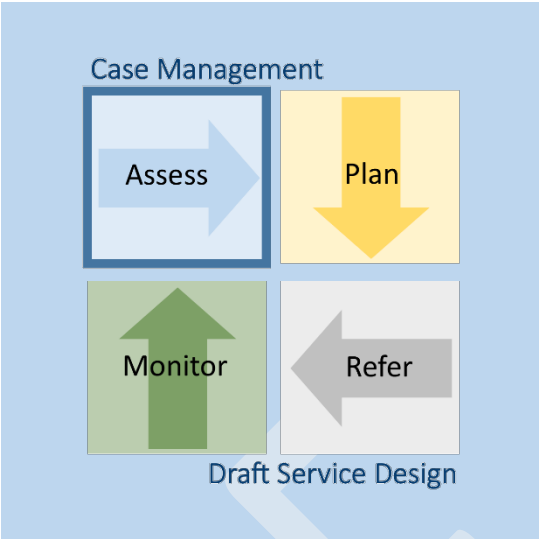
- Identifying roles and responsibilities.
- Ensuring policies support the development of trusting relationship, resiliency and self-advocacy skills.
- Assessing equity impact — considering the impact of a decision on various populations, with a focus on communities experiencing inequities.

Dual case management

Under case management redesign, the foundational expectations for 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 any other case manager working with a person. In addition, each case manager must ensure that any 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 Determination and Needs Assessment

Assessment of a person's needs, preferences, and strengths is a core service component of case management. There is often intersection between eligibility determination and case management assessments. Although challenging, it is important to separate these two types of assessments. An eligibility assessment determines whether someone is eligible to receive case management services. An eligibility determination is not considered a component of case management services under federal regulations. A *needs assessment* is an inventory of what supports and services a person needs. The needs assessment is actually the first component of case management services.

Eligibility for case management services is often based on an assessment of how a person's condition impacts his or her functioning. For example, to qualify for adult mental health targeted case management (AMH-TCM), an adult must meet the diagnostic and functional criteria for serious and persistent mental illness. Eligibility for HCBS waiver case management is based on a determination that the person would require hospital or residential level of care if home and community based services were not made available. Alternatively, eligibility for child welfare case management is based on a determination of whether the child meets the specific eligibility criteria, such as being at-risk for, or experiencing, maltreatment. It is important to keep in mind that an assessment to determine eligibility for case management is different and separate from the ongoing assessment component of case management services. In all cases, information gained about a person through an eligibility determination should be used by a case manager during case management assessment.

Purpose

The purpose of assessment in case management is to identify a person's goals, preferences and need for services and supports, including medical, behavioral health, educational, social and other services. Assessments performed as part of ongoing case management services are different from other processes used to determine eligibility for case management services.

Case management services, regardless of the population served, are expected to address a person's basic physical and behavioral health needs, social service needs, and educational and employment needs. The development of standard elements required for assessment service component reflects the commitment to create clear

expectations of how any case management service supports a person in meeting needs and reaching his or her identified goals.

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. Case managers conduct ongoing informal assessments as a key function of their work and apply their expertise to help identify needed supports. The initial and ongoing information gathered should inform all other case management activities.

A case management assessment must include the following:

- Demographics
    - race
    - ethnicity
    - tribal enrollment
    - tribal residence
    - veteran and military status
    - age
    - gender identity
- A person's strengths, desires, preferences, needs, and goals
    - Information gathered during the eligibility determination (or other information-gathering processes) must inform the case management assessment
    - When case management and other services are mandated, there may be mandated goals that are identified in addition to goals identified by the person
- Identification of a person's formal and informal services and supports including:
    - Formal supports: financial and social service benefits, health care coverage, housing, physical health, behavioral health and transportation
    - Informal supports: the person's identified support[10] system (e.g. family, friends, guardian who provide unpaid services or support)
- Employment and education
- Cultural and spiritual beliefs and practices
- Barriers the person is currently experiencing

Standards

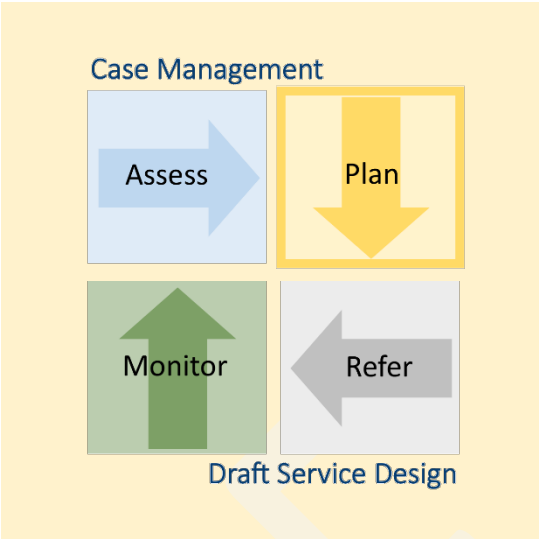
A case manager must

- Place the person at the center of discussions and decisions.
- Meet face-to-face with the person and, his or her identified supports, parent(s), or guardian(s), as applicable, to complete the initial case management assessment, which should inform the case management plan.

[10] Please see glossary definition of *identified support* in Appendix B.

- Review eligibility determination and related documents that may have been completed prior to 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 his or her identified supports, parent(s) or guardian(s), as applicable, such as active listening, providing clear and unambiguous information and respecting privacy and confidentiality.
- Use a trauma-informed approach when engaging with people, families, and communities.
- Use techniques to assess a person's readiness for change and his or her capacity to integrate care or community supports into his or her life, such as motivational interviewing.
- Work with the person and his or her identified supports, parent(s) or guardian(s), as applicable, to determine if there is any other case manager or care coordinator already working with them.
- Develop a trusting relationship with the person and his or her identified supports, parent(s) or guardian(s), as applicable, to gather the most accurate information to be used in the person's plan.

Plan



Purpose

The purpose of an individual's case management plan is to document the person's needs, goals, strengths, supports and preferences 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 for the person.
- Name of person's formal and informal supports (regardless of whether paid or unpaid).
- Description of the amount, frequency and duration of formal and informal supports and services provided.
- Frequency and type of monitoring activities that will be used to determine if formal and informal supports and services are adequate to meet the person's needs and goals.
- Person's identified
    - strengths
    - goals
    - needs
    - preferences
    - risks
- Mandated goals (if case management is a court-mandated service).
- 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 needed services not currently available, and action to be taken to obtain alternative services that could meet that need.
- If and how cultural and spiritual beliefs identified during the assessment impact the person's preferences for interaction with his or her case manager or the types of referrals they would like.
- 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 professional and who will support each activity.
- Identification of other professionals involved in the person's life, such as a care coordinator or financial worker.
- Person's desired method of contact with case manager (for instance, face-to-face, interactive video, or telephone) and frequency of contact.

Standards

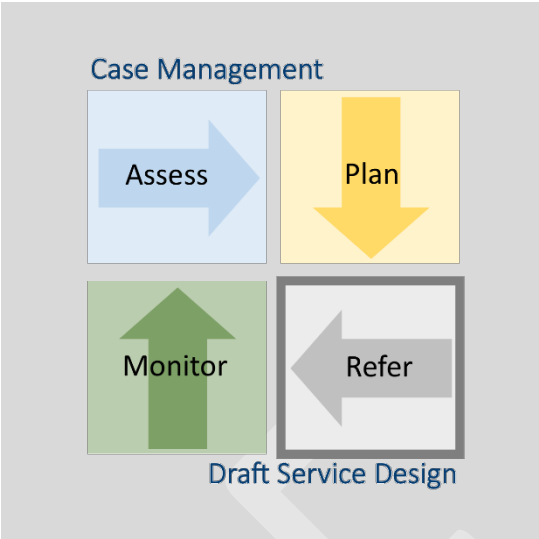
A case manager must:

- Develop the plan face-to-face with the person and his or her identified supports, parent(s) or guardian(s), as applicable. The plan may be *completed* outside of the face-to-face meeting, but initial plan development must be done face-to-face and could occur along with the initial case management assessment.
- Develop a plan, in partnership with the person and his or her identified supports, parent(s) or guardian(s) as applicable, that is:
    - Simple and carried out with mutual respect.
    - Informed by the case management assessment and attempts to match the person's preferences.
    - Culturally appropriate, as identified by the person.
    - Designed to build the person's skills and ability to navigate and advocate for themselves.
    - Clear about the case manager's role and what the case manager is accountable for, as well as what the person and his or her identified supports are responsible for.
- Use processes that ensure:
    - The person is at the center of discussions and decisions.
    - The focus is on the relationship and partnership between the case manager and the person.
    - Service and support options, including the benefits and risks of each, are clearly explained so that person can make an informed choice.
    - When case management and other services are mandated[11], 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 his or her identified supports, parent(s) or guardian(s), as applicable, about how to communicate and coordinate with the case manager if the person is in crisis, discharged from a hospital, residential treatment, foster care or other formal setting.

[11] Please see glossary definition of *mandated* in Appendix B.

- Provide the opportunity for the person, and his or her parent(s) and guardian(s), as applicable, to sign the plan. The purpose of the signature is to indicate 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 his or her parent(s) or guardian(s), or other case manager, as applicable.
- Focus on developing a trusting relationship with the person and his or her identified supports, parent(s) or guardian(s), as applicable, by supporting shared decision-making and collaboration.

Refer



Purpose

The purpose of referral is to help the person obtain and fully utilize the services and supports identified in the person's case management plan.

Expectations

The case manager must carry out the following referral activities:

- Work with the person and his or her identified supports, parent(s) or guardian(s), as applicable, to prioritize needs and preferences.
- Review and explain options to the person and his or her identified supports, parent(s) or guardian(s), as applicable.
- Clearly explain how referrals will be made and who will make referrals to specific services or supports.
- Identify barriers and possible solutions or alternatives for accessing services and supports.
- Follow through to confirm the person has access to the services or supports they were 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 personal and cultural preferences whenever possible.

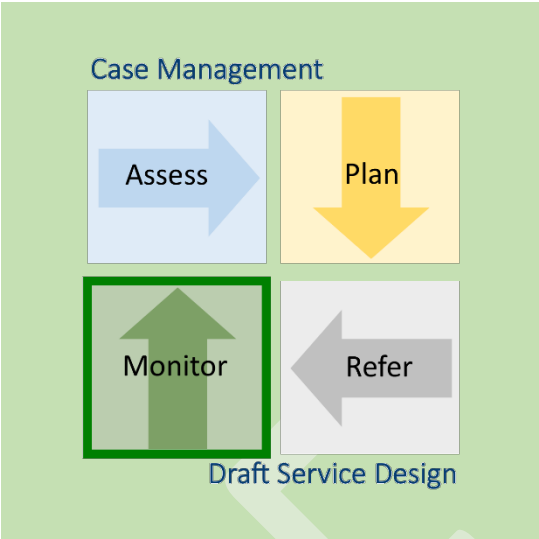
Standards

The case manager must:

- Be knowledgeable about agencies and resources, and aware of options by geographic area.
- Understand eligibility requirements and processes necessary to receive the referenced services and supports.
- 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 his or her identified supports, parent(s) or guardian(s), as applicable, to decide what and when information is shared with other service and support providers.
- Work with the person and his or her identified supports, parent(s) or guardian(s), as applicable, to determine the level of assistance the person needs to contact referral sources and obtain services.
- In partnership with the person and his or her identified supports, parent(s) or guardian(s), as applicable, develop a clear plan for communication about the process and status of referral, including preferences and expectations around method and frequency of communication.
- Focus on developing a trusting relationship with the person and his or her identified supports, parent(s) or guardian(s), as applicable, by supporting shared decision-making and following-through on commitments.
- When case management and other services are mandated, 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 a person receives meet the person's needs and preferences, and to assist the person in meeting his or her goals. The process of monitoring informs the ongoing assessment process. Information gathered should be used to make any necessary changes to the case management plan and direct needed referrals.

Expectations

A case manager must carry out the following monitoring activities:

- Regularly review and adjust the plan, in partnership with the person and his or her identified supports, parent(s) or guardian(s), as applicable, to meet his or her needs or to address changes in his or her life.
- The review should include whether or not:
    - The person's needs are being met.
    - Services are timely and being delivered in a manner consistent with the plan.
    - 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 plan, based on the person's level of need and other factors which might affect the type, amount, or frequency of service.
- Establish a clear plan for communication so that the person and his or her identified supports, parent(s) or guardian(s), as applicable, can effectively communicate questions or concerns to the case manager.

- Monitor the goals identified by the person, and any mandated goals or requirements if case management is a court-mandated service, the activities for accomplishing each goal, and progress towards achieving the outcomes
- Focus on developing a trusting relationship with the person and his or her identified supports, parent(s) or guardian(s), 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 to deliver case management as a foundational set of services, a case manager must have or develop the following competencies:

- Strong written and verbal communication skills, including
    - active listening,
    - building rapport,
    - non-verbal cues to build relationships,
    - interviewing,
    - emotional intelligence, including empathy, anger and crisis management and conflict resolution,
    - negotiation skills and
    - collaboration.
- An orientation toward cultural humility and cultural responsiveness.
- An understanding of historical trauma and its impact on people, families and communities.
- An understanding of systems[12] theory or person-in-environment theory.
- Knowledge of strategies to put the person at the center of the work.
- Critical thinking skills, including
    - flexibility in thinking,
    - proactive and ability to plan,
    - problem solving,
    - solution focused and
    - good judgement.
- Organizational 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

[12] Please see glossary definition of *systems theory* in Appendix B.

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, trainings and skill development processes needed to support the competencies of all case managers to inform the final design.

The expertise, education and experience needed, based on the needs of the populations served, will be expanded upon in the next phase of the work and will also inform the final proposal to the legislature.

Intersection with other reform initiatives

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

An overarching goal at DHS is 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 initiatives aimed at achieving this goal through simplification and integration. Others include 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 (excluding elderly waiver). 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 HCBS disability waiver programs. The programs will be responsive to a person's needs, circumstances and preferences.
    - Aligned 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 waivers for people with disabilities. (Report deadline: December 2018)
- Different budgeting models for people receiving HCBS waiver services. (Report deadline: January 2019).

Uniform Services and Standards

The Uniform Services and Standards (USS) project aims to comprehensively reform and simplify the service requirements for MA-funded mental health services by aligning common standards across different services and eliminating requirements that do not add value or treatment quality.

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 legislature directed DHS to develop recommendations for a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process. The experience gained through the USS project will be leveraged to inform the decision about whether DHS will pursue a case management licensure process.

System Modernization

DHS has complex information technology systems 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[13] 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)[14] 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 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, however the families define themselves.
- 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.

[13] Please see glossary definition of *person-centered* in Appendix B.
[14] Please see glossary definition of *MACSSA* in Appendix B.

With the ISBM, there is the potential to create more consistent and streamlined services, reduce administrative burden associated with duplication of 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.

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 or to continue case management services. Operationally, this means there is an assessment required to determine eligibility. Assessments used to determine a person's initial or ongoing eligibility for case management services are different from the required case management assessment, an activity where the case manager determines a person's need.

The initial design team was charged with creating recommendations for the foundational service of case management. For this reason, the initial design team addressed only assessment activities performed by a case manager for a person *already* determined eligible for the service. Moving forward, DHS and its partners may need to consider changes to the eligibility criteria for different types of case management services.

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 has been referred to as "local governance" requirements. Local governance requirements must be understood and accounted for in the development of MA-funded case management services because Minnesota counties do not operate an "MA-funded" case management service and a separate "other payer or uninsured" case management service for county residents. This means any changes to MA-funded case management requirements will directly impact counties in terms of both financial obligations and staff resources.

Intersection of case management and care coordination

Both case management and care coordination include activities to ensure people are effectively connected to appropriate medical, social, educational and other services. However, there are important differences between care coordination and case management. In order to ensure that case management and care coordination services meet the needs of the people receiving these services, it is crucial to understand the differences between the two services and how they intersect.

Care coordination occurs along a spectrum. Some care coordination service delivery models require coordination of all medical, behavioral health and social services. However, many care coordination services address a particular condition, or a person's needs when transitioning from an inpatient setting to community setting. Care coordination is a fundamental component of managed care. Because it can be provided in a variety of settings and for a variety of reasons, a person may receive several forms of care coordination and case management services.

For example, a person who has been certified disabled enrolled in a Special Needs Basic Care (SNBC) health plan might receive care coordination from the MCO, care coordination when she is discharged from the hospital, and CADI case management. Each person delivering case management or care coordination services should have

distinct roles and responsibilities and should work cooperatively with the person's other care coordinators or case managers to ensure there is no duplication of activities.

The draft service design outlines expectations when a person is working with more than one case manager or care coordinator. The overall case management redesign initiative includes work to understand the array and scope of care coordination services provided through MA and how they interact with case management services.

Choice

The legislature directed DHS to develop recommendations 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 among 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 geographic distance and low population density in some counties, it is not economically feasible for other case management provider organizations to operate.

The majority of people who have MA coverage are enrolled in managed care. People enrolled in managed care face limitations on choice because they must choose a provider from within their managed care organization's network. Home and Community Based Services (HCBS) waiver case management relies on counties to serve as "lead agencies" and conduct eligibility determinations 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 only a single entity provides case management services within the county. One option discussed was to establish a person's ability to impact his or her choice of case manager. This could be operationalized by providing a formal opportunity, such as an appeal or other administrative process, 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 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, or providers contracted by managed care organizations. 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 person's managed care organization's provider network, or person's lead agency using federal authority under section 1915(b)(4) of the Social Security Act.

Stakeholder and Community Engagement

In January 2017, DHS adopted an equity policy that directs staff to incorporate equity analysis into the development of all policies and to authentically engage persons from cultural and ethnic communities before policy decisions are made. An equity analysis is a review of the impact of proposals, policies, and programs on various populations, with a focus on the impact on communities experiencing inequities.

In 2016, Governor Dayton created a civic engagement plan outlining an expectation that we as a government entity must intentionally engage with all members of the public when developing policy. This includes meaningful engagement with communities that have been historically underrepresented in the policy process.

In commitment to this equity policy and civic engagement plan, community engagement is a core focus of the case management redesign initiative. The experiences and perspectives of people, families, and communities will inform decision-making, program and policy development, implementation, and evaluation.

Community engagement is identified in this document separately from overall stakeholder engagement because we recognize different approaches are needed to ensure people receiving services and their families and communities are intentionally represented. Those approaches include working with local community leaders to lead outreach and coordinate the events, having meetings in locations and at times that work best for people, and structuring the conversations in ways that best meet the community's needs.

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

These themes have emerged from stakeholder conversations in the past year:

- Stakeholders want to continue to be engaged in case management redesign. 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 how individuals 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 large role in payment, and the different payment mechanisms must be understood in order to redesign the system.
- Many case management activities are focused on meeting regulatory and compliance requirements, which takes time away from directly supporting a person receiving services.
- Case managers should have a consistent role, job title and job functions. Roles and responsibilities need to be clearer when someone has more than one case manager.
- Case managers want more training, need more time and resources, and need a caseload mix which doesn't cause burnout, feedback about their work, flexibility on the job and clear expectations.
- The case management redesign effort should be coordinated with other related human service initiatives to support alignment of goals and advancements.

Stakeholders provided solutions and requested these approaches for redesigning case management:

- Create a system that allows case managers to serve the family, not just the child.
- Figure out how specialization can help case managers, but not perpetuate the many layers which currently exist in the system.
- Evaluate procedural steps to increase efficiency.
- 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 to flexibly serve the unique needs of each individual.
- Have a more flexible 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 support systems.
- People that do not currently receive case management services but may be eligible.
- Members of the community receiving direct services, as well as their family members, caregivers, and identified supports.
- Trusted community leaders.

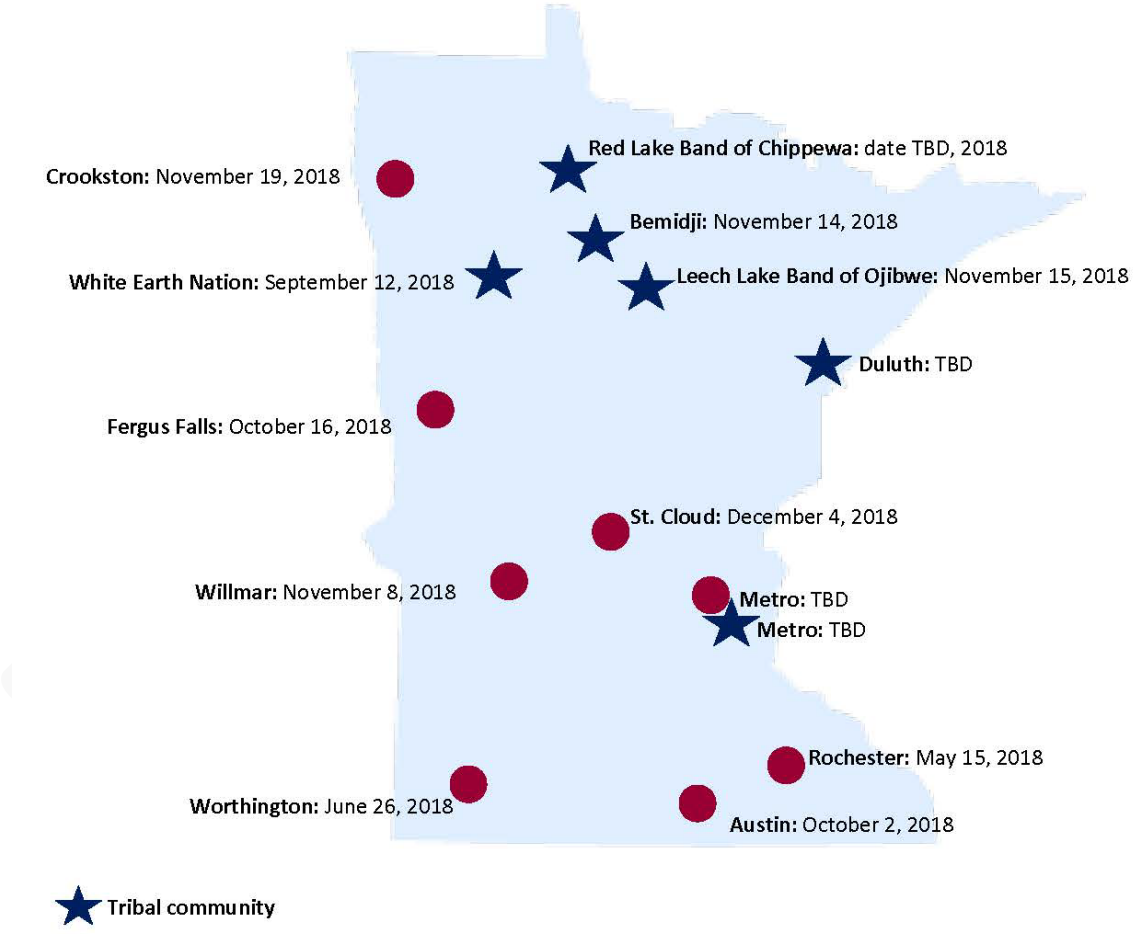
Approach to community engagement

DHS is using the following strategies for community engagement:

- Local community events throughout Minnesota. (Refer to map for locations of events.)
    - For each event, DHS will partner with area community agencies to coordinate outreach and structure conversations to meet community needs.

  - DHS will provide funding for refreshments and gift cards for people who attend the events, as an incentive for 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 the DHS Office of Indian Policy and DHS tribal liaisons.
- Surveys — DHS will partner with organizations to gather feedback from people receiving services.

Scheduled local community events as of January 2019:



Additional sites for community events may be added.

Emerging themes

To date, certain themes have emerged 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. Some are nervous about potential changes to the services they receive.

- 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 support them as a whole person.
- People want their case manager to be knowledgeable, resourceful, compassionate, prompt, flexible, nice, polite, friendly, honest, trustworthy, willing to get the person's needs met and clear in communication via email, phone and text.
- 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 to review the draft service design and to inform final decisions.

Next steps

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

DHS will share and gather feedback on the draft service design with stakeholders and community members.

At the same time, tribal leaders will convene parallel groups who will provide a set of recommendations to be incorporated into a final proposal.

While this work is being finalized, the draft service design will 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 contracted with Navigant Consulting to:

- 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. To receive periodic information about redesign efforts and updates, please sign up for email updates on the case management redesign webpage.

During this time DHS will work with internal and external partners and stakeholders to build upon the foundational policies and expectations of case management services to reflect additional expectations based on

the needs of a specific population, expertise needed to provide the service to specific populations, or the federal requirements for specific service areas.

Finally, DHS will continue to work on the development of specific recommendations and language for proposed reporting measures to determine outcomes for case management services. A proposed measurement strategy will be developed as a component of the redesign, and will allow DHS to evaluate whether the redesign is creating any meaningful changes and whether the goals of case management services are being met. Demonstrating the outcomes of case management services is essential to demonstrating the value of the service itself.

Legislative plans

Implementing the case management redesign initiative will require legislative changes. Tentative plans for future legislative sessions include:

2021 legislative session

- Finalize the foundational service design for case management as a Medicaid service.
- Consolidate targeted case management (TCM) statue to align with the foundational definition.
- Establish a payment methodology and rates for service delivery and county administrative oversight.
- Redefine target populations under federal TCM authority, utilizing broader eligibility categories.

2023 legislative session

- Align waiver case management services with the foundational service design and payment methodology.

Stay informed

To receive periodic information about redesign efforts and updates, please sign up for email updates on the case management redesign webpage.

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.

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

Appendix B: Definitions

Minnesota's complex network of case management services has resulted in the use of many words with similar meanings. These words, plus the words needed to describe case management service design, are defined here. These definitions were created based on feedback from the initial design team and Minnesota Statute and Rule.

Term	Definition
advocacy	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 and proactively assisting people to maintain eligibility when appropriate.
Minnesota Department of Human Services (DHS)	The Minnesota Department of Human Services 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.
identified support	Refers to whomever the person identifies as his or her support.
informal support	Refers to a person who provides support to someone who receives the case management service without being reimbursed such as friends, family, and community members. All informal supports should be documented in the person's case management plan.
integrated or integration	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.

Term	Definition
involuntary or mandatory	This term covers anyone required to participate in the human services system. Examples include individuals subject to civil commitment and children in need of protective services (CHIPS).
Minnesota Association of County Social Service Administrators (MACSSA)	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.
person-centered	Person-centeredness is an important concept in 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 practices*: Strategies that align resources to promote choice and to help achieve the person's goals. • *Person-centered thinking:* A process of understanding what is important to, and for, a person so his or her supports and services reflect his or her choices, preferences, dreams, and needs. • *Person-centered planning*: A way to assist people in describing what they want to bring purpose and meaning to their lives, as well as how they will get there.
systems theory (also known as person-in-environment 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 this context, services are what make up the overall provision of case management to a person. Service components 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.