CONFLICT FREE CASE MANAGEMENT

INTRODUCTION

VISION STATEMENT

All individuals with I/DD will be empowered to direct and control their own services with the support they choose to live a fulfilling, self-directed life in the community of their choosing with equal access to employment, social activities, safety & security, advocacy & citizenship afforded to all others.

GUIDING PRINCIPLES

1. A positive approach using the lens of what an individual CAN do, will guide the process to promote health, safety, employment, community, socializing, spirituality, advocacy & citizenship
2. Fidelity to a person-centered process will help individuals build self-determined, self-directed lives
3. Cultural beliefs, values and needs of the individual will inform and guide connections to services, supports and resources
4. Plans that are self-determined and written down help individuals achieve their goals
5. Process and Plan are communicated in a way that is meaningful
6. Person-directed plans are only as good as their implementation
7. Confidence and building self-esteem empower individuals to grow and take charge of their lives

CONFLICT FREE CASE MANAGEMENT STANDARDS

1. Person-centered planning will be considered person-directed planning. All power is held by the individual. The facilitator chosen by the individual, along with trusted allies chosen by the individual, have a duty to ensure that the power and decision making remains with the individual.
2. A facilitator for this process can be anyone the individual chooses, providing that person meets qualifications under HCBS rules. "Someone who approaches people with deep respect, presumes competency and seeks possibility, listens with curiosity and compassion, finds a way to host conversations that suits them and learns to do a bit better with each experience, encourages deliberate action, and only makes promises they can keep will be a good enough facilitator. These are qualities of character and commitment to learning that are passed on through membership in communities of practice rather than transmitted through curricula." ("Dissent from Consensus" by Blessing, Brost, Gallagher, Hinkelman, Leidy, Mount, O'Brien)
3. The capacity of individuals to participate in planning is directly related to preparation. Preparation includes understanding and expanding communication, providing instruction in self-determination, identifying and broadening community opportunities & personal networks, and understanding that you can change any part of your plan at any time.
4. Access to conflict free case management will be timely and available to all.
5. Funding and selection of services (both state and private) are the individual's to control. No portion of funding will be considered the domain of another individual or organization, unless specified through law (such as a trust agreement).
6. All actions should be aligned with the decision of the individual. When requested, support will be given to assist the individual making their decision. This may require time and effort to support self-determination and decision-making of the individual and to understand the communication of those who communicate in non-traditional ways. (Interpreters for any conversations and translation of any documents are provided if the individual or their key supporters do not speak/read English.)
7. Control of the planning process and budget is only a small part of the individual being in control of their life.
8. Focus remains on family, friends, community, possibilities, creativity, and flexibility. Natural supports and community inclusion are a priority. The process involves sensitivity to and respect for the unique culture of each individual, their family & community.
9. All involved recognize that individuals have different perspectives, hopes, needs, desires, fears, and vulnerabilities.
10. The individual can make changes any time they wish.
11. The "community is not a place, but individual and groups of interpersonal relationships based on various commonalities. Individuals need support to form relationships, not just to attend activities.
12. Consideration is not given to "system" terms such as units/hours of support or billing codes-individual support needs and goals will drive the services and supports.
13. There is a commitment to self-determination, citizenships, community, and personal connections.

ORGANIZATION AND ADMINISTRATION

ORGANIZATIONAL REQUIREMENTS

- Providers of HCBS for individuals or those who have an interest in or are employed by a provider of HCBS for individuals must not provide case management or develop the person-centered plan
- Case management Organizations will develop policies and procedures that comply with State and Federal regulations, including Home and Community Base Services regulations, and Disability Disclosure guidelines
- Case Management Organizations are responsible for ensuring individuals are provided informed consent for all aspects of support and understand their rights
- Case Management organizations will participate in efforts towards recruitment and retention of staff and independent contractors and ongoing training and personnel development, including communities of practice
- Case Management Organizations will utilize State supported data systems and provide reports as required
- Case Management Organizations will participate in measuring and reporting quality and in continuous quality improvement activities
- Case Management Organizations will have clear guidelines for conflict of interest for all participants

RESPONSIBILITIES

- Utilize staff and/or independent contractors to provide a continuum of available case management supports
- Ensure all staff and independent contractors meet established standards for qualifications and trainings
- Can demonstrate capacity to meet language of individual with I/DD and families
- Maintain a list of qualified independent Contractors
- Collect and submit all required documentation
- Serve as billing agent between Medicaid and all roles of facilitation/case management

SOURCES OF FACILITATORS/ CASE MANAGERS

- A friend or colleague
- An independent Facilitator/Case Manager
- A Registry of Independent Facilitator/Case Manager
- An Organization
- A combination of any of the above

*all roles of case management must meet qualifications and training standards

ACCESS
State will {contract with/license/certify} organizations to provide a continuum of case management functions. Access will be available to all DD eligible individuals. Services, supports and resources can be chosen and directed by the individual.

ROLES AND RESPONSIBILITIES

State Functions:

- Entry into the system and information sharing
- Eligibility determination
- Level of Care assessment
- **Referral to Case Management**
- Review the plan approved by the individual and approve Medicaid Plan of Care and Budget
- Triage urgent care needs
- Facilitate housing needs for individuals in critical need
- Oversight of Case Management Organizations

DDO Functions:

- Develop and share information about services and supports they offer
- Attend meetings with potential referrals
- Accept referrals
- Participate in assessment and ISP meetings at the request of individuals
- Provide services and supports as indicated in ISP and in alignment with certification standards
- Track outcome data
- Coordinate with case management as needed

Individual's Functions:

- Identify goals and actions steps in chosen life domains
- Develop plan and budget with chosen team
- Approve the plan
- Engage and advocate

Facilitator/Case Management Functions

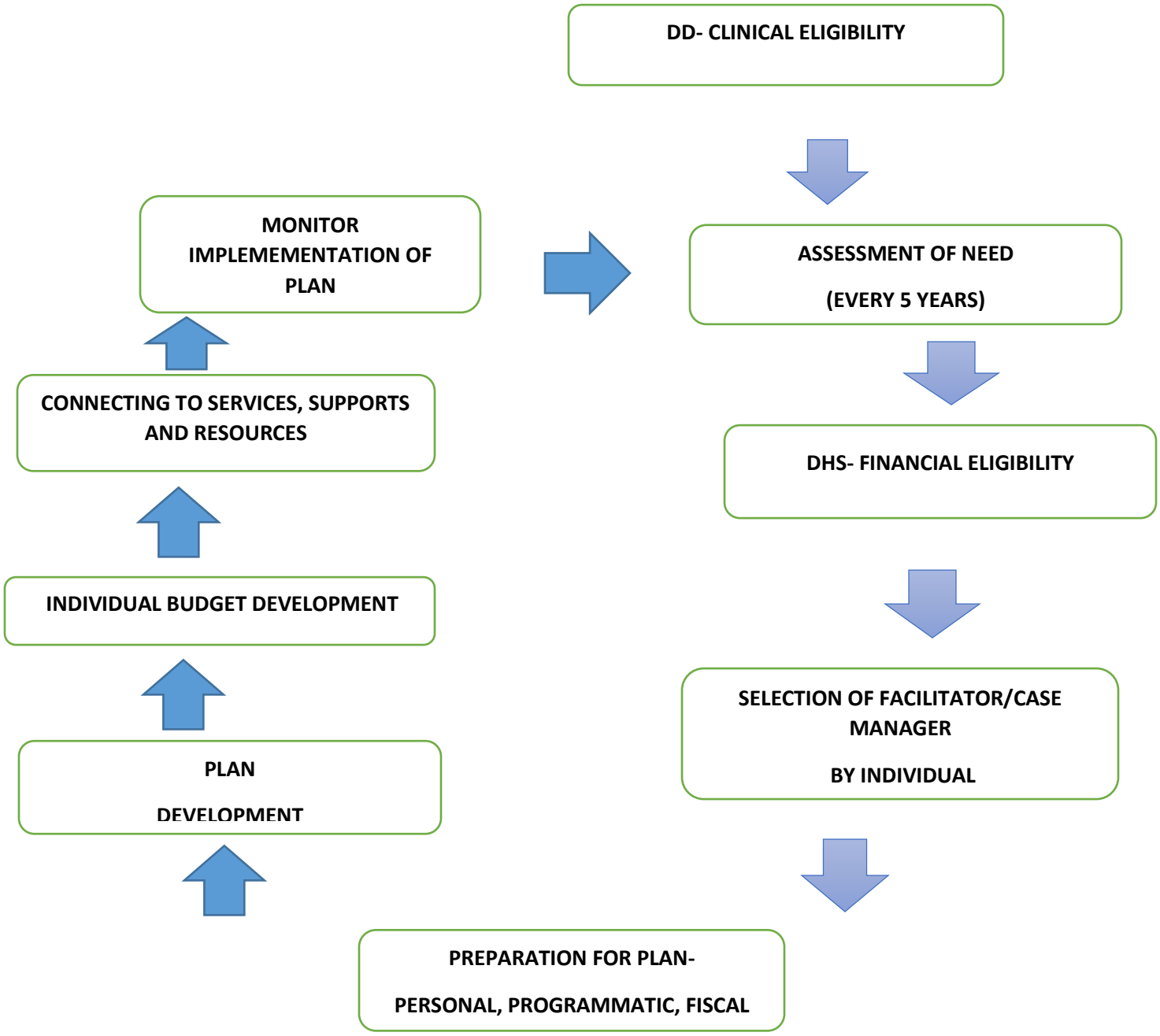
- Preparation and Personal Profile
- Plan Development and Writing
- Referral- identify and create connections to Formal and Informal Services, Supports and Resources to assist the individual in identifying opportunities in the community
- Monitoring and Follow-Up

This illustration demonstrates the flexibility each individual has to choose, direct and control their pathway.

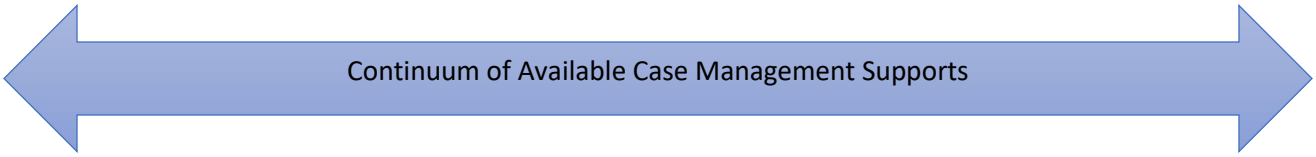
You (the individual) are in control of this process at all times. All decisions must be made by your direction, your knowledge and your consent.

I **Self Direct with a Fiscal Intermediary** and don't need to change anything right now	I would like to **hire my own people** to perform all of the chosen HBCS PCP Functions	I would like an **organization to provide me with the people** to perform all of the chosen HCBS PCP Functions
I will meet at least annually with my plan writer My social caseworker can be invited to the annual meeting (optional) I will monitor my own plan implementation and provide my social case worker with required information to help me monitor the implementation Plan writer will submit Medicaid approved plan of care document (ISP)	An organization will pay for all roles of case management the individual selects to complete the HCBS PCP functions (serve as billing agent) Monitoring plan implementation is completed (as directed by the individual) to collect and record required information This organization would maintain a list of independent contractors Individuals have the option of self-directing some or all of their services and/or utilizing provider agencies *This is similar to what fiscal intermediaries do for individuals who self -direct, but it would be only for this process	An organization will pay for all roles of case management the individual selects to complete the HCBS PCP functions (serve as billing agent) Monitoring plan implementation is completed (as directed by the individual) to collect and record required information This organization will provide staff or contractors to provide all of HCBS PCP functions selected by the individual Individuals have the option of self -directing some or all of their services and/or utilizing provider agencies

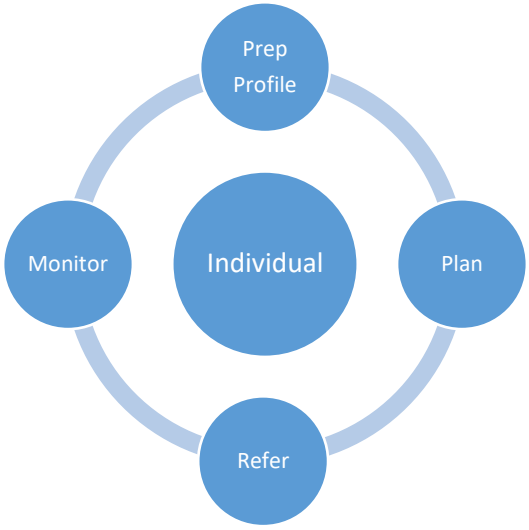
PARTICIPANT FLOW



SERVICE DELIVERY



Component # 1 **Preparation and Personal Profile**	**Component #2** **Plan Development and Writing**	**Component # 3** **Referral to Formal and Informal Services and Supports**	**Component # 4** **Monitoring and Follow-Up Activities**
-Support and assist individual to identify preferences for planning meeting(s) -Identify and support an individual's mode of communication, including need for interpreters -Together with the individual, gather information and complete informal assessments of individuals abilities, needs natural supports and family systems -Review previous assessments and relevant information -Observe individual-spend time in a variety of settings -Assist the individual with driving their own process -Assist the individual to identify: What is important to me, What is important for me how to support me, and things others admire about me -Facilitators will utilize strategies for solving conflicts or disagreements within the process -Build a personal profile	-Assist individual to consider all life domains and consider areas to focus on -Assist individual to identify goals based on assessed wants and needs identified -Build specific and measureable action steps -Create a timeline for action steps -Identify which members would assist with each action step -Assist individual to explore community opportunities related to identified interests and goals -Describe benefits and risks involved (risk assessment) and describe strategies to ensure informed decision making -Develop, with the individual and their supporters, a person-centered Plan and an Individual Service Plan -Assist individual to identify measurement strategy to review and document progress towards goals. -Determine follow-up frequency and method.	-Provide information, education, linkage and referrals to formal and informal services, supports and resources -Discuss the need for full transparency and disclosure -Confirm connections are made -Troubleshoot any problems connecting to services -Assist the individual with assessing need for enhanced funding	-Touch base as directed by individual to review progress towards goals and determine if services, supports and resources are meeting individual's needs and wants. -Address and problem solve issues over service provision between individual, family and service providers -Assist the individual to amend the PCP/ISP as desired in a timely manner -Coordinate with members of individuals' support team -Respond to crisis using community resources, natural supports and DD funded support services to stabilize crisis and refer to State SCW team as appropriate



Service Delivery Standards

General

- Interpretation of conversations and translation of documents are provided for individuals and their key supporters as needed
- Bilingual communication and/or procuring of interpreters will be present/available as needed to ensure someone understands the individual's non-traditional communication
- Individual's cultural beliefs and values are considered in planning process and matching to community opportunities and referrals
- Use practices that support the development of respectful relationships with the individual and their supports
- Have broad general reporting to including any suspected neglect or abuse
- Individual is provided copies of profiles, plans, and other relevant documents in language/manner that they understand
- Individual is supported to direct the process of information sharing, planning, goal setting, and choosing supports
- Planning process includes people and format chosen by the individual
- Meetings are scheduled at times and locations convenient to individuals and their key supporters

Component # 1 Preparation and Personal Profile

- Individual preferences for planning are determined by the individual, documented, and drive the process
- Individual is supported to identify their strengths, abilities, interests, goals, needs, and supports
- Guided by the individual, information is gathered into one place through the review of previous assessments, including discussions with the individual and their key supporters, and time spent observing the individual in a variety of settings
- A personal profile is developed with individual and documented

Component # 2 Plan Development and Writing

- Self-determined goals and desired outcomes are identified that align with personal profile
- Goals are specific and achievable
- Specific, detailed, and measureable action steps to meet goals are identified and documented
- Timelines are identified for each action step
- Individual/organization identified to provide support with each action step
- Community exploration is explained and offered
- Plan describes strategies and supports that will be used to ensure individual is making informed choices
- PCP is documented and an ISP is developed from PCP with adherence to state required components and timelines
- A follow-up schedule/plan is agreed upon and documented

Component # 3 Referral to Formal and Informal Services and Supports

- Referrals – connections are self-determined and align with the individual's goals, cultural beliefs and values
- Resources and opportunities are identified in the community in which the individual lives and that match their interests and preferences
- Information about a variety of possible informal and formal resources is shared, including the option to self-direct all or a portion of formal supports
- Unbiased information about multiple potential referral sources is shared based on identified goals
- Responsible for identifying referrals to the following types of resources including but not limited to:
    - Assistive Technology- evaluation and or provision of AT
    - Communication Aids- evaluation and/or provision of aids
    - Community Support
    - Personal Care/Home Health
    - Nursing Care
    - Counseling
    - Consultation Services
    - Job Development
    - Home Accessibility Adaptations
    - Occupational Therapy
    - Physical Therapy
    - Community Housing Resources
    - Respite Services
    - Specialized Medical Equipment and Supplies
    - Speech Therapy
    - Transportation Services
- Responsible for maintaining a Directory of Services (beyond DD funded services) that identifies and describes resources
- Responsible for discussing the need for full transparency and disclosure of any information that would delay or prevent timely and appropriate access to services, supports and resources

- Responsible for developing and sharing knowledge of community resources and maintaining a network of community contacts
- Follow-up contacts with referrals to ensure connections are documented

Component # 4 Monitoring and Follow-Up Activities

- Documentation of follow-up consistent with follow-up schedule agreed upon
- Frequency of follow-up based on individual's personal preferences and needs
- Progress toward goals is discussed and barriers addressed as requested by individual
- Changes to plan are made upon request and shared as indicated
- Responsive and flexible- able to amend plan as needed, with a simple and clear process for changes to be made in a timely manner
- Coordination with team members is evident
- Outcomes are measured

QUALITY INDICATORS

Quality Indicators are an evidence based means to measure performance & outcomes and identify areas with a possibility for growth. It also provides a means for monitoring progress over time and justifies the work performed on a daily basis. This process strives to provide a pathway for individuals to attain:

1. Freedom to choose things, places and people you love
2. Access to financial security
3. A safe and secure place to call home and control over who enters for any purpose
4. Real membership in the community sharing ordinary places
5. Preservation or development of strong relationships
6. Planning to avoid or emerge from personal impoverishment
7. Support to organize resources in ways that are life enhancing and meaningful
8. Being respected and valued for what you have to offer
9. Making a contribution through paid and non-paid work
10. Individual chooses who they want to spend time with
11. Families and Caregivers feel supported