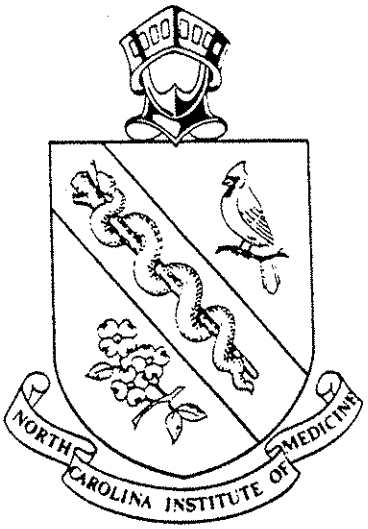
CASE MANAGEMENT AND CARE COORDINATION IN NORTH CAROLINA

PRELIMINARY RECOMMENDATIONS



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Introduction

The attached findings represent the leading principles and program recommendations which are believed to underlie the development of a coordinated, case managed system of long-term care for the elderly in North Carolina. The principles were developed by examining the experiences of other states and are reflective of the collective opinions of key individuals spread throughout North Carolina's long-term care network. Program recommendations build on these principles and draw again from the experiences of other states in forging a comprehensive, case managed home and community care program which is suitable for the North Carolina context. For ease of referencing, program recommendations are organized and referred to by the acronym COPE, Community Options Program for the Elderly.

The attached preliminary recommendations are made available now to assist the North Carolina Study Commission on Aging in its upcoming deliberations. The final report on Case Management from the North Carolina Institute of Medicine will include two documents: 1) an in-depth background paper on issues and options associated with developing a comprehensive program for North Carolina and 2) a highlighted summary of key principles and program recommendations for such a program. An earlier condensed examination of state options for case managed home and community care was presented to the Study Commission at its November 11th meeting. Its anticipated that both of these final documents will be ready by March of 1989.

The attached recommendations address case management issues pertaining to the elderly, as requested by the Study Commission. It should be noted, however, that many of those individuals who were interviewed as well as members of the Institute of Medicine Subcommittee on Case Management feel that a long-term care case management program should ultimately address the needs of all qualifying individuals, irrespective of age. With this caveat in mind, the following principles and recommendations address only the task of developing a case management long-term care program for North Carolina's elderly citizens.

KEY PRINCIPLES GUIDING THE DEVELOPMENT OF A CASE MANAGEMENT SYSTEM OF LONG-TERM CARE IN NORTH CAROLINA

The following are the key principles that are believed to underlie the development of a coordinated, case managed system of long-term care in North Carolina. These principles were derived from the experiences of other states which have developed model systems of care and from the collective experience and opinions of key individuals spread throughout North Carolina's long-term care network.

- A committee should be established at the state level with authority to plan, set standards and guidelines for a coordinated, case managed system of long-term care.
- A lead agency should be designated in each county to assure the provision of case management and coordinated long-term care. The decision as to which agency should be the lead agency should be a local decision.
- There should be a standardized assessment of functional need and provision of services based on the objective of maintaining the individual in the least restrictive environment of their choice.
- The case management functions of client assessment and care planning should be provided as universal services, free of charge, to all clients deemed appropriate for the service.
- Income eligibility guidelines for long-term care services should be expanded to ensure access to services for moderate income clients on a sliding scale basis.
- All North Carolinians should have access to a minimum set of long-term care services irrespective of county of residence.
- Case management services should be supported by public funding.
- A long-term care planning group should be charged with developing recommendations for optimizing the use of current long-term care resources and investigating new sources of financing.
- Quality assurance standards and guidelines should be established for the provision of case management services and the selection of service providers.

SUMMARY OF PRELIMINARY RECOMMENDATIONS

COMMUNITY OPTIONS PROGRAM FOR THE ELDERLY(COPE)

1.0 Purpose

The impetus behind the concept of a Community Options Program for the Elderly(COPE) is to change the way we think about, understand and deliver long-term care services in North Carolina. The overriding purpose of a COPE type program is to provide elderly individuals in need of long-term care with real options. A central option to be emphasized through a COPE program is the option for the elderly to remain in their own homes with supportive services made available through a case managed system of long-term care. COPE represents the belief that elderly disabled individuals who qualify for nursing home care and those afflicted with Alzheimer's disease or other forms of severe chronic mental illness should have the option of living in a safe community environment of their choice or that of their families.

A second purpose or objective of a COPE type program is to encourage more coordinated long-term care planning. Such planning should reflect increased attention to client preferences for services, easier access to needed services, and a cost efficient utilization of current and new resources available for the provision of long-term care.

A third purpose or objective of a COPE program is to build on current program strengths and initiatives in North Carolina's long-term care network. Such an approach should emphasize the state's role to provide policy direction and administrative oversight, the regional role of Area Agencies on Aging to conduct strategic planning and resource advocacy for the elderly, and the role of public and private county agencies in the direct provision of quality services.

1.1 Time Sequence

A time sequence needs to be identified for necessary state level planning, the funding of Pilot COPE counties, the evaluation of initial findings, and an ultimate phase-in for remaining counties.

2.0 Administration

2.1 State

The North Carolina Department of Human Resources should develop an ongoing inter-agency long-term care planning committee with authority to develop guidelines, standards, and procedures for implementing the COPE Program. Standards should minimally address the issues of lead and affiliated agency responsibilities, uniform assessments, client eligibility, financing, and standards and procedures for the practice of case management. The Program should first be initiated in a select number of volunteer pilot counties. The state planning committee would be responsible for the administrative oversight of pilot counties and putting in place a system of quality assurance. The long range goal would be to expand the COPE program beyond the initial volunteer pilot counties to all counties in the state within a reasonable period of time.

2.2 Regional

- Area Agencies on Aging would be responsible for conducting strategic planning and providing technical assistance in the development of services and resources central to the mission of county COPE programs in their respective regions. Area Agencies on Aging would also be responsible for facilitating cooperation among counties to plan and develop those services which may span county boundaries or are too expensive for any one county to support.

- Area Agencies on Aging would assume a primary responsibility for administrative oversight and quality assurance activities in keeping with state guidelines, standards and procedures associated with the COPE program. Methods to be employed to discharge these responsibilities would include but not be limited to program monitoring activities, technical assistance, and training.

2.3 Local

- o County Commissioners would have the following responsibilities:

  - Designate a COPE lead agency or joint agencies in the volunteer pilot counties with the responsibility for providing case management for elderly individuals who qualify for nursing home care and those who are afflicted with Alzheimer's disease or another severe chronic mental illness.
  - Create an Interagency Long-Term Care Planning Committee with the responsibility to advise the COPE lead agency in the development and provision of case managed, coordinated long-term care services to elderly disabled individuals in their county.
  - Appoint the members of a Long-Term Care Planning Committee in a manner which ensures representation of key public and private agencies and elderly consumers and consumer groups.
  - Approve and submit the county developed COPE Plan outlining the provision of coordinated long-term care services to the disabled elderly in the county.

- o COPE lead agencies will have the following case management responsibilities:

  - Organize client screening and intake activities;
  - Organize comprehensive functional assessment activities;
  - Develop service care plans;
  - Arrange for necessary long-term care services;
  - Conduct ongoing monitoring of client care plans;
  - Perform client reassessments; and
  - Assure for follow-up and continuing care.

- o COPE lead agencies will be responsible for developing and implementing a quality assurance plan.

- o Interagency agreements will be developed between the COPE lead agency and other key county programs regarding the coordination of service activities and funding sources for the long-term care.

- The COPE lead agency will develop an annual county plan for coordinating long-term care services for the elderly.

3.0 Targeting

3.1 Program Eligibility

- The COPE program should be targeted to individuals 60 plus who qualify for nursing home care or who seek to return to the community from a nursing home. Such targeting recognizes the high frequency of disability within the elderly population.
  - Program eligibility for a thorough functional assessment and recommendation for care plan options would be established through the administration of a standardized screen to ascertain those who qualify for nursing home care or by present residence in a nursing home.
  - Both the nursing home screen and the subsequent assessment would be standardized according to state guidelines.

- The COPE program should be targeted to individuals 60 plus who are diagnosed with a severe disabling chronic mental illness, including Alzheimer's Disease and related disorders.

3.2 Client Target Numbers

- Target client numbers will be specified for participating counties. An estimation formula should be developed which would reflect realistic client target numbers for each county, changing each year to reflect the growth in this service population. Target numbers would reflect the number of COPE participants that will be supported under state funding beyond those already eligible for Medicaid waiver services or existing services through the Social Services Block Grant, Older Americans Act, or other long-term care supportive service funding sources.

3.3 Financial Eligibility

- The COPE program would provide the initial screen for program eligibility and subsequent assessment and recommendation of care plan options free of charge to individuals 60 plus who qualify for nursing home care or are afflicted severe disabling chronic mental illness, including Alzheimer's Disease and related disorders.

- o COPE participants who do not qualify for medicaid waiver services would participate in the costs of services according to a standardized cost-sharing plan which reflects different client abilities to pay for services.

3.4 Target Budgets

- o Average care plan option budgets will be established for COPE supportive service packages. The average COPE budget would be multiplied by the client target numbers for a county to yield an annual COPE service budget.

4.0 Services

- o COPE programs shall perform an information and referral service to all elderly individuals 60 plus who inquire about services options available to them within the county's continuum of long-term care.

- o COPE programs will provide case management services to all elderly individuals 60 plus who qualify according to the program eligibility guidelines.

4.1 Basic Aging Services

- o The state planning committee, the regional Area Agencies on Aging, and the COPE lead agency and its affiliated planning committee will work collaboratively to ensure access on the part of the elderly to basic or core aging supportive services irrespective of the elderly individual's county of residence.

  - The state planning committee will identify a set of services which shall constitute a core of Basic Aging Services for each county throughout the state.
  - Area Agencies on Aging should have their strategic planning and resource development capacities enhanced so that they may identify gaps in their county's Basic Aging Services and work with involved parties to fill those gaps.
  - COPE lead agencies through their planning commissions and in coordination with the regional Area Agency on Aging will identify service gaps and plans of action to fill those gaps. Activities to address service gaps and put in place a core of Basic Aging Services will be reflected in the COPE plan for long-term care services.

4.2 Partnerships with Families and Caregivers

- o COPE lead agencies must reflect a "partnership with families and caregivers" in the design of the assessment, the client care plan and the ongoing service relationship with the client's family. COPE case management practices and care plans are intended to complement and not compete with or displace involved family caregivers.

4.3 Quality Assurance

- o Efforts should be undertaken to ensure the quality of both the practice of case management and the provision of services in the client's care plan.

  State
  - The state long-term care planning committee should develop necessary guidelines and standards for the practice of case management and the provision of direct services. Adherence to these standards would be essential to the renewal of state contracts with the COPE lead agency.
  - The state long-term care planning committee should, in concert with the regional Area Agencies on Aging, be responsible for COPE administrative oversight functions and quality assurance activities associated with the monitoring of agency practices, procedures and quality of care.

  Regional
  - Area Agencies on Aging in the discharge of their oversight and quality assurance functions should provide COPE lead agencies with appropriate training, technical assistance, planning data and guidelines for the establishment of COPE quality assurance committees consonant with the overall COPE program mandate.

  Local
  - COPE lead county agencies would be responsible for developing quality assurance committees and plans to ensure the quality of both the practice of case management and the services provided to elderly individuals.

5.0 Finance

- COPE county lead agencies should seek to expand the service options available to elderly disabled individuals through a more efficient, case managed coordination of existing resources and through the judicious use of new resources for case management and community care services.

5.1 Maintenance of Effort

- COPE counties would not be allowed to reduce or replace existing community resources for the disabled elderly through the Older Americans Act, Social Services Block Grant, Medicaid or other sources of funding. COPE case management and community service funding is intended to expand the capacity of counties to assist the disabled elderly.

5.2 COPE and Funding for Case Management

- COPE counties shall receive additional funding for the provision of case management services to qualifying disabled elderly individuals.

5.3 COPE and Authorization for Services

- COPE lead agencies will be authorized to fund care plan packages to individuals who are programmatically eligible for services but unable to access existing community care funding sources.

5.4 Client Cost-Sharing in COPE

- COPE lead agencies will in keeping with state guidelines develop and participate in a COPE uniform eligibility and cost-sharing plan for COPE services. The objective of this plan is to enable clients who have an ability to pay for a portion of their care plan, to do so.

5.5 COPE as Gap Filling

- COPE service funds are intended as gap-filling funds to be used in partnership with private income, state-county supplements to SSI for rest home care, local, state and federal funds currently available, including the Medicaid waiver funds, for community services for the disabled elderly.

5.6 COPE as Funding of Last Resort

- COPE service funds are the funding of last resort. All traditional and nontraditional sources of funding and aid must be investigated and used as part of the funding and service package before a determination that a "gap" exists and COPE funds are necessary.

6.0 Case Management Practice and Standards

- State standards establishing criteria regarding who qualifies as a practitioner of case management as well as what constitutes the basic activities to be associated with case management are needed.

6.1 Case Management Practitioners

- The team model of nurse/social worker is recommended as ideal model for the practice and delivery of case management services to the disabled elderly.

6.2 Case Management Steps and Activities

- The following steps and activities are recommended as the essential procedural components to be associated with case management practice method.

Case Finding	outreach, screening, and intake
Assessment	comprehensive functional assessment/problem identification
Care Planning	client goal setting and service planning
Plan Implementation	advocating, coordinating, and arranging services
Monitoring	monitor client services
Reassessment	client reevaluation
Follow-up	termination planning and periodic monitoring