Consumer-Care Manager Engagement Sheet

Empowering Consumers and Families in Care Management: Questions and Statements Consumers/Families Can Use During the Comprehensive Assessment and Beyond

Background Information: As a Medicaid member of a Standard Plan, you may or may not have a care manager but, as a Medicaid member of a BH/IDD Tailored Plan you are automatically assigned a care manager. Care management provides Medicaid beneficiaries with a multi-disciplinary approach to coordinating physical healthcare, mental health, substance use disorder services, pharmacy needs and long-term services and supports. Care management can also provide you direct linkages to programs and services that address unmet health needs including food, housing, transportation, and interpersonal violence, along with follow-up and ongoing planning.

Care managers are required to conduct a comprehensive assessment of your needs when you begin to receive services and update that assessment every year. Below are questions and statements that you can use to:

- make the comprehensive assessment process as productive for you as possible;
- give your care manager an opportunity to get to know you better;
- formulate goals to meet your needs.

Plan ahead for your first meeting with your care manager by choosing the questions/statements below that mean the most to you. Think about how you want to approach those questions/statements with the care manager and how you want to respond to those questions and statements.

What's Important to Me:

- What name or nickname would you like to be called? What pronoun(s) do you use? Do you go by he/him/his, she/her/hers, they/theirs?
- In understanding barriers to your primary care, and other goals for your life, what intersections of your identity do you want your care manager to better understand?
- What are the three most important things we should know about you or your family member?
- Who else do you want here or talking to the care manager? Who knows you better than anyone? (typically plans only require that a guardian is listed, but you may have cousins, aunts, friends, other people with I/DD/BH needs that are not typically included in the record listings.)
- Who/what are people/things (resources) you would want to include as we move forward with planning? OR who do you trust?
- What are the things you are already doing that have been helpful?

- In what ways do you want to celebrate your community; what communities do you feel responsible to, connected to?
- What makes you most able to cope when you are very upset and in a crisis? (crisis plans should include early options – call a friend, deep breathing, etc., and providers should know what calms you down.)
- When something bad happens, what is your first response likely to be? This question helps the care manager understand what the auto response is for you and teaches staff to watch for this.
- Will there be opportunity for us to meet face-to-face?
- What is NOT working in your life right now? Do you have ideas how to make that better? What needs to happen so this is not a problem for you?

Getting to Know Your Goals in Treatment and Supports:

- My goals for the next 6 months/year or so are….
- My most important goal right now is ….
- How will we know if we are successful? And what would guarantee failure?
- What can a care manager do to help you achieve those goals?
- What has worked best for you in the past to improve your situation?
- Think of a time when you have felt most alive and invigorated. What are you doing? What is in your hands? What are you looking at? How does your body feel? After thinking about this, is there a way for you to do this thing that makes you feel good? If not, what barriers are in the way? A) Time B) Money C) Support in your community D) Transportation E) All of the above
- What are you most worried about now?
- What are you most looking forward to in the future?
- What are some possible roadblocks /challenges that might get in the way of you achieving your goals? OR what has happened in the past that you want to avoid happening in the future?
- Do you use technology? Have a cell phone, computer, smart watch or tablet? Do you need help with any of that? Do you have Alexa?

Consumer/Family and Care Management Agency Communication:

- What is the best way for us to communicate when we are not together in-person? Phone? Email? Text?
- If the care manager sees you are having difficulty doing something, would you like for that individual to ask if you need help or just step in and help you without asking?
- When the care manager is with you in the community, do you want that individual to be a part of the conversation with your family/friends or would you rather that individual hangs back away from the conversation?

Building Resilience Prevention:

- What supports can shore you up in your life? Ex: financial assistance; emotional support; education from physician; more time with my doctor.
- If you could have access to any service that you feel would benefit your care and recovery, what would it be? Ex: Mindfulness Training - Learning how to be in the now; Talk Therapy - Talking with someone about your recovery; Art Therapy - Using

art/writing/photography/etc. as a way of processing emotions; Financial Support - Financial Resources to help you get and remain financially stable; Trauma Therapy - Addressing past and present traumas and healing through them

- Would you like to know about OR what is your perspective on connecting with someone with similar lived experiences (i.e., certified peer support/family advocate/partner, youth advocate etc.)?

For Your Information:

What is care management? A 2019 concept paper published by the NC Department of Health and Human Services distinguishes between care management, care coordination and case management:

For the purposes of its care management strategy, North Carolina has developed the following definitions.

Care Management: A team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions, which includes:

• Management of rare diseases and high-cost procedures (e.g., transplant, specialty drugs)
• Management of beneficiary needs during transitions of care (e.g., from hospital to home)
• High-risk care management (e.g., high utilizers, high-cost beneficiaries)
• Chronic care management (e.g., management of multiple chronic conditions)
• Management of high-risk social environments (e.g., adverse childhood events, domestic violence)
• Identification of beneficiaries in need of care management (e.g., screening, risk stratification, priority populations)
• Development of care management assessments/care plans (across targeted populations)
• Development and deployment of prevention and population health programs
• Coordination of services (e.g., appointment/wellness reminders, social services coordination/referrals)

Care Coordination: The process of organizing patient care activities and sharing information among all the participants concerned with a beneficiary's care to achieve safer and more effective care. Through organized care coordination, beneficiaries' needs, and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate and effective care. Local Management Entities-Managed Care Organizations (LME-MCOs) currently provide care coordination to select groups of beneficiaries. As described below, Tailored Care Management is broader than and inclusive of care coordination.

Case Management: Federal regulations define case management as "services furnished to assist individuals eligible under the [Medicaid] State Plan who reside in a community setting or who are transitioning to a community setting, in gaining access to needed medical, social, and other services" (42 CFR 44.169). See section II for information on avoiding duplication between care management and case management embedded in enhanced behavioral health services. Case management provided within the Innovations and TBI waivers, which currently addresses only waiver services, will be incorporated into Tailored Care Management.