State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF AGING AND COMMUNITY SERVICES
PO BOX 807
TRENTON, N.J. 08625-0807

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

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SUPERSEDES: **NJ EASE Care Management Program Standards for Senior Services – Jan. 2002**

SUBJECT: **Care Management Services – Quality Focus Areas for DACS Funded Programs**

DISTRIBUTION CODE: **IX d, e, f; X a**

EFFECTIVE: **Immediately**

APPLICABILITY: **Aging and Disability Resource Connection (ADRC) sites, Care Management Service Agencies managing HCBS programs operated by the DACS**

BACKGROUND: The Division of Aging and Community Services (DACS) is committed to the premise that there are fundamental core values that must be incorporated into the development and implementation of strategic priorities, goals, and objectives. To ensure consistency with these core values, DACS has established these five guiding principles:

1. Leadership
2. Advocacy
3. Consumer Direction
4. Cultural Competency
5. Quality Assurance/Quality Improvement

PURPOSE: Supported by these guiding principles, and based on CMS' Home and Community-Based Services (HCBS) Quality Framework, the former New Jersey EASE Care Management Program Standards were updated to establish the following Care Management Services – Quality Focus Areas providing a common set of principles to serve as a guide to care management agencies when rendering services as well as designing their own internal Quality Management Strategy.

The attached Care Management Services – Quality Focus Areas concentrate on participant-centered 'Desired Outcomes' along these seven dimensions:

- Participant Access
- Participant-Centered Service Planning and Delivery
- Provider Capacity and Capabilities
- Participant Safeguards
- Participant Rights and Responsibilities
- Participant Outcomes and Satisfaction
- System Performance

POLICY:

Developing a Quality Management Strategy

One of the primary intentions of these standards is to provide guidance to care management agencies in developing a comprehensive and continual quality improvement process to enhance the quality of services for older adults and individuals with physical disabilities.

The Division recognizes that no two care management agencies are identical; they each provide different services to different populations in different geographic areas and have different stakeholders and different organizational cultures. Therefore, these Standards suggest that care management agencies consider these differences and include these Desired Outcomes when developing performance measures and indicators in their Quality Management Strategy, and when deciding on data collection methods for their own internal quality improvement process.

Each care management agency has, and if not shall develop, a comprehensive Quality Management Strategy that reflects its uniqueness. These Care Management Services – Quality Focus Areas illustrate for agencies how key concepts, such as outcomes based on overarching visions, values, and guiding principles, come together so that they can directly correlate how information and data is reviewed and acted upon by various parts of their organization; and how internal agency staff fit into these processes to form a continuous quality improvement system.

Providers are expected to develop or modify their plans to engage in continual quality enhancement activities.

Each care management agency's Quality Management Strategy is subject to review by the Division of Aging and Community Services.

Patricia A. Polansky, Assistant Commissioner
Division of Aging and Community Services

Care Management Services - Quality Focus Areas for DACS Funded Programs

March 2011

State of New Jersey Department of Health and Senior Services
Division of Aging and Community Services

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NOTE: The Care Management Services – Quality Focus Areas set forth in this guide do not include a description of Provider Qualifications, Case Mix Ratios or Rates of Reimbursement, nor do they supersede established policy, procedures, rules or regulations, established by federal and/or state programs which cover care management services.

These Care Management Services – Quality Focus Areas are general in nature, broad enough to pertain to the quality of care management services provided regardless of payor source and/or a participant's program of enrollment.

Introduction

ADRC DELIVERY SYSTEM OVERVIEW

In New Jersey, the Aging and Disability Resource Connection (ADRC) delivery system serves as single entry into the long-term supports and services system for older adults and people with disabilities. Sometimes referred to as a "one stop shop" or "no wrong door" system, ADRCs address many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, counseling and assistance, and empower people to make informed decisions about their care needs, and help people more easily access public and private long term supports and services programs.

To provide a framework for the expansive system change in delivering services to both the aging and disabled population of New Jersey, the Division of Aging and Community Services (DACS) developed an algorithm to serve as a platform for county ADRC implementation. Each of these phases represent a core component of the ADRC delivery system and describes the client flow through the system. The algorithm structure (client pathway) permits each county to focus on steps to development and concurrently allows the state to assess progress in each of the phases. The ADRC algorithm phases include: infrastructure, initiate, identify, indicate, implement, and inquire. A synopsis of each stage is provided –

Phase 1 – INFRASTRUCTURE: Organizational preparation.

Phase 2 - INITIATE: To determine the immediate potential for linkage with the ADRC by framing the initial motivation and cause for outreach and connection.

Phase 3 - IDENTIFY: To gather information and identify the wants, needs and potential eligibility of the client and/or caregivers.

Phase 4 - INDICATE: To provide pathway counseling with all the appropriate options and opportunities that will satisfy the identified needs.

Phase 5 - IMPLEMENT: To authorize, arrange and deliver system services in concert with consumer directed efforts.

Phase 6 - INQUIRE: To assess through integrated checkpoints the quality of the service by benchmarking and monitoring: (1) system structure, (2) system process and (3) stakeholder reports.

CARE MANAGEMENT SERVICE OVERVIEW

The population for which care management services are discussed in this guide of quality focus area standards includes the elderly and adults with physical disabilities. Not every consumer who is assessed and counseled through the ADRC will result in an identified need for care management services. Rather, it is expected that individuals at highest risk of institutionalization, with the greatest needs for social support and chronic problems, are most likely to benefit from care management. Furthermore, care management services are available through a variety of programs and funding streams in New Jersey. The ADRC delivery system must serve as an effective means to facilitate access to such services through the most effective an efficient venue established. This requires a broad understanding of not only the individual's multiple needs, but also the services available across programs and the varied systems' overall mechanisms of action.

For example, care management services can be provided in both the public and private sectors, and are defined and provided differently based on consumer needs. In the private sector, much of care management has operated within the context of, first, cost containment, and more recently, managed care and disease management. In the public sector, although not all care management services are funded by Medicaid, Medicaid has been responsible for many of these programs. Sections 1915(c) and (g), as well as section 1903 (a) of the Social Security Act, have provided the regulatory basis for the establishment of many care management programs.

New Jersey provides care management services not only through a number of State and County funded programs, but also through federally funded programs such as the Medicaid State Plan.

The state also administers a number of 1915(c) home and community based Medicaid Waiver programs which provide care management services and other community supports to specified target populations such those who are elderly or physically disabled, or those with developmental disabilities, mental retardation, autism, HIV and AIDS, or traumatic brain injuries.

No matter the funding stream, care management services (under various names) generally have two key features: providing a connection between individuals and the system of publicly funded services and supports, and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals.

ADRC DELIVERY SYSTEM AND REFERRALS FOR CARE MANAGEMENT SERVICES

The complexity of the ADRC delivery support system requires ADRC Assessors and staff who are thoroughly familiar with all of the options available to the consumers to maximize the system's ability to best respond to each consumer's needs. The ADRC is a not a program, rather a "doorway" to information and assistance, to connect seniors age 60 and older and people with physical disabilities 18 years of age and older with the services they need to continue living independently in the community for as long as possible. To that end, it is imperative that ADRC staff be knowledgeable of the full range of public and private home and community-based services available in New Jersey, including the alternative methods by which to obtain care management services.

Care management services, accessed through the ADRC delivery system, must focus on assisting consumers to maximize their ability to use available resources to improve their quality of life. The Care Manager serves as a:

- Broker, arranger and coordinator, who identifies and coordinates services
- A gatekeeper, who contains costs and monitors resource allocation
- An evaluator, who assures that care management goals are attained
- An educator
- A counselor
- A monitor

The Care Manager also acts as a mediator between the ADRC delivery system and the consumer and as an advocate on the behalf of the consumer. An Interdisciplinary Team (IDT) care management method, based on person-centered care strategies, is used, whereby there is a team approach to assessing the needs of a consumer and if applicable, the family, establishing a comprehensive plan for addressing all care needs and using service integration to deliver required services. "Person-centered" care management is based on a person's preferences and needs, includes the person's responsibilities and increases the person's capacity to manage their own needs. "Service integration" refers to a process by which a range of social services is delivered in a coordinated and seamless manner to provide consumer-oriented services, increase early intervention, wellness, and prevention opportunities, improve consumer outcomes and establish provider accountability through performance measures.

Referrals made through the ADRC to any and all willing and qualified care management agencies must not restrict an individual's free choice of providers. In addition, while federal policy does not prohibit entities that might furnish other direct waiver services from having responsibility for assessment or service plan development, safeguards should be established when an ADRC entity also provides care management services and assessment to avoid problems such as self-referral, that may arise when options counseling is provided to ADRC consumers. These safeguards must include full disclosure to consumers and assuring that consumers are supported in exercising their right to free choice of providers and are provided information about the full range of services available to them, not just the services furnished by the ADRC entity that is responsible for assessment and interim service plan development.

Vision

Care Management is a core service accessed through the ADRC delivery system and is central to the National and State Vision for the ADRC model.

Centers for Medicare and Medicaid Services (CMS) & Administration on Aging (AoA)
Vision for ADRC
To have Aging and Disability Resource Centers in every community serving as highly visible and trusted places where people of all incomes and ages can get information on the full range of long term support options and a single entry system for access to public long term support programs and benefits.

There are three broad mandates for States implementing the ADRC model -

1. Increase Awareness and Provide Reliable Information
2. Provide Consumers Assistance in Seeking Services and Making decisions; and
3. Simplify and Streamline Access to Public Programs through a Physical or Virtual One Stop Shop

Definition

Care Management:

Services that assist participants in gaining access to needed home and community-based care, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care management promotes the ability of the participant and as applicable, his or her caregiver, to make informed decisions addressing needs and direct their own care needs.

Philosophy

Each person is unique with specific needs, goals, and preferences. All individuals have a right to autonomy, a right to make their own choices and decisions, and a right to exercise control over their own lives.

Consumer's Bill of Rights and Responsibilities

In working with a Care Manager, participants have certain rights:

- The right to be treated with respect.
- The right to privacy and confidentiality.
- The right to self-determination.
- The right to direct the development of the plan of care.
- The right to receive assistance to access needed and available health and social services.
- The right to know the cost of service prior to receive the service.
- The right to access your case record.
- The right to refuse any portion of the plan of care.
- The right to voluntarily withdraw from the program by which care management services
- are provided.
- The right to a grievance procedure.

By the same token, participants have certain responsibilities:

- The responsibility to treat his or her Care Manager and service providers with respect.
- The responsibility to provide accurate and complete information about matters pertaining to his or her care, including changes as they occur.
- The responsibility to ask questions until he or she understands.
- The responsibility to work with his or her Care Manager to develop the Plan of Care.
- The responsibility to work with the people who carry out the Plan of Care.
- The responsibility to pay any agreed upon costs.

How to Use These Standards

The Division of Aging and Community Services (DACS) is committed to the idea that there are fundamental core values that must be incorporated into the development and implementation of strategic priorities, goals, and objectives. To ensure consistency with these core values, DACS has established these five guiding principles:

1. Leadership
2. Advocacy
3. Consumer Direction
4. Cultural Competency
5. Quality Assurance/Quality Improvement

Supported by these guiding principles, and based on CMS' Home and Community-Based Services (HCBS) Quality Framework, the following Care Management Services Quality Focus Areas were created to provide a common set of principles and values to serve as a guide to care management agencies.

The Care Management Services Quality Focus Areas concentrate on participant-centered **Desired Outcomes** along these seven dimensions:

Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Developing a Quality Management Strategy

The intention of these standards is to provide guidance to care management agencies in developing a comprehensive and continual quality improvement process to enhance the quality of services for older adults and individuals with physical disabilities. No two care management agencies are identical; they provide different services to different populations in different geographic areas and have different stakeholders and different organizational cultures. Therefore, these standards suggest that care management agencies consider these differences and include these Desired Outcomes when developing performance measures and indicators in their Quality Management Strategy, and when deciding on data collection methods for their own internal quality improvement process.

Each care management agency has or should develop a comprehensive Quality Management Strategy that reflects its uniqueness. These Care Management Services – Quality Focus Areas will show the agency how key concepts, such as outcomes based on overarching visions, values, and guiding principles, come together so that they can directly correlate how information/data is reviewed and acted upon by various parts of their organization; and how internal agency and ADRC staff fit into these processes to form a continuous quality improvement system. Providers are expected to develop or modify their plans to engage in continual quality enhancement activities.

CARE MANAGEMENT SERVICES - QUALITY FOCUS AREAS

Not every consumer assisted through the Aging and Disability Resource Connection (ADRC) will be assessed to need care management services. If such services are warranted, however, to any extent, all qualified and approved care management agencies shall utilize the same core principles of service delivery as posed in these quality focus areas.

Participant Access
Desired Outcome: Individuals, through the service of care management, have strengthened access to home and community-based services (HCBS) and supports in their communities.

Information/Referral
Desired Outcome: Individuals and families can readily obtain information from the Care Manager concerning the availability of home and community based services, how to apply and, if desired, offered assistance to make a referral.

Intake and Eligibility

- **Individual Choice**
  Desired Outcome: If warranted, once a care management agency is designated, with the assigned Care Manager, each individual is given timely information about available services to exercise his or her choice in selecting options.
- **Prompt Initiation**
  Desired Outcome: Care management services are initiated promptly when the individual is determined eligible and selects his or her desired option.

Participant-Centered Service Planning and Delivery
Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

Participant-Centered Service Planning

- **Assessment**
  Desired Outcome: Based on the NJChoice/MDS-HC assessment, comprehensive information concerning each participant's preferences and personal goals, care needs and abilities, health status and other available supports are gathered and used in developing a personalized Plan of Care.
- **Participant Decision Making**
  Desired Outcome: Information and support is available to help participants make informed selections among service options.
- **Free Choice of Providers**
  Desired Outcome: Information and support is available to assist participants to freely choose among qualified providers, including care management agencies.
- **Service Plan**
  Desired Outcome: Each participant's Plan of Care comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.
- **Participant Direction**
  Desired Outcome: Participants have the authority and are supported to direct and manage their own services to the extent they wish.

Service Delivery

- **Ongoing Service and Support Coordination**
  Desired Outcome: Participants have continuous access to care management assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.
- **Service Provision**
  Desired Outcome: Care Managers assure that services are furnished in accordance with the participant's Plan of Care.
- **Ongoing Monitoring**
  Desired Outcome: Regular, systematic and objective methods – including obtaining the participant's feedback – are used by the Care Manager to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.
- **Responsiveness to Changing Needs**
  Desired Outcome: Significant changes in the participant's needs or circumstances promptly trigger reevaluation and modifications in his or her Plan of Care.

Provider Capacity and Capabilities
Desired Outcome: There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.

Provider Qualifications
Desired Outcome: Before services are authorized the Care Manager will verify that each agency and individual provider possesses the appropriate approval by the State as a qualified provider.

Provider Performance
Desired Outcome: In order to remain an approved entity, every care management agency meets the specified provider qualifications, maintains current contractual provider agreements, and demonstrates the ability to provide care management services and supports in an effective and efficient manner.

Participant Safeguards
Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

Risk and Safety Planning
Desired Outcome: Participant health risk and safety factors are considered by the care management agency and potential interventions are identified that promote health, independence and safety with the informed involvement of the participant.

Critical Incident Management
Desired Outcome: The Care Manager will work with the participant and family to ensure that there are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.

Housing and Environment
Desired Outcome: The safety and security of the participant's living arrangement is considered, risk factors are identified and modifications are offered to promote independence and safety in the home.

Natural Disasters and Other Public Emergencies
Desired Outcome: There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.

Participant Rights and Responsibilities
Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities.

Civic and Human Rights
Desired Outcome: Participants are informed of and supported by care management agencies to freely exercise their fundamental constitutional & federal/state statutory rights.

Participant Decision Making Authority
Desired Outcome: Care management agencies foster alternatives for participants to receive training and support to exercise and maintain their own decision-making authority.

Due Process
Desired Outcome: Participants are informed of and supported by care management agencies to freely exercise their due process rights.

Grievances
Desired Outcome: Participants are informed by care management agencies of how to register grievances and complaints and are supported in seeking their resolution. Grievances and complaints posed to care management agencies are resolved in a timely fashion.

Participant Outcomes and Satisfaction
Desired Outcome: Participants are satisfied with their services and achieve desired outcomes.

Participant Satisfaction
Desired Outcome: Participants and family members, as appropriate, express satisfaction with their care management services and supports.

Participant Outcomes
Desired Outcome: Care management services and supports lead to positive outcomes for each participant.

System Performance
Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality.

A System Performance Appraisal
Desired Outcome: The care management agency promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.

Quality Improvement
Desired Outcome: There is a systemic approach to the continuous improvement of quality in the provision of care management services

Cultural Competency
Desired Outcome: The care management system effectively supports participants of diverse cultural and ethnic backgrounds.

Financial Integrity
Desired Outcome: Financial accountability of the care management agency is assured and bills for care management services are submitted promptly in accordance with program requirements.