IPRO
Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
www.atlanticquality.org

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Outline of the Varied Responsibilities and Care Coordination for Case-Managers Including Where They Are Located

The Case Management Society of America defines a case management as a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources.

A Case-manager helps individuals and families cope with complicated situations in the most effective way possible. For the purpose of this guide a Case-Manager and Care Manager are the same. A Case Manager (CM) can be found in a variety of health care settings and depending on their location is whether they are with a patient for a short ("episodic") or long period of time. Here are the most common sites for case-managers:

- **Physician office** "**embedded case-manager"** coordinates the person's care for the person's physician. The case manager monitors when a person requires follow-up and alerts the physician when there is a health care need that requires his attention. (**Long Term**)
- **Insurance case-manager** – **assists and authorizes for payment for the provision of health care services** as a person requires services from a health care provider(s). (**Long Term**)
- **Hospital case-manager or discharge planner** – assists the person and family if post-acute care services are required (**Short Term**)
- **Home Health Agency case-manager** – assists the person and family while they are receiving services from the agency. (**Short Term, but may be Long Term if the person is receiving long term care services**)
- **Community service agency case-manager**, such as Department of Social Services, Office for Aging, The CHOICES Program, or Senior Service organization – these case-mangers usually assist a person and their family with social supports, such as, transportation, aide or companion services, arrange for meal delivery, housing, financial assistance, and other social supports that a person requires to manage at home. (**Short Term but can be Long Term depending on the person's needs**)
- **Health Home case-manager –** assists the person and family based on a comprehensive care plan which includes psychiatric and substance abuse services along with health care needs. (**Long term while the person is on the program**)
- **Mental Health/substance abuse (MH/SA) case- manager –** assists with coordinating mental health and substance abuse services as well as housing. (**provided if there is a substance abuse problem or a severe mental illness**)

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- **Disabilities case-manager** – usually associated with the Office for Persons With a Development Disability (OPWDD) or Independent Living Center (ILC) and assists with services provided by OPWDD or the ILC. Traumatic Brain Injury patients often have this type of case-manager. (**Long term**)
- **Patient Navigator** – guides the person through the health care maze to assist them in meeting their care needs. They usually are not clinicians, but can be a person who has gone through the same experience. The navigator is usually specific to a disease or chronic illness. Examples are Orthopedic Bundled Payment Navigator or a in a specialty area such as oncology, ED, etc. (**Short term**)
- **Community Health Worker/Community Services Worker** – is a para-professional trained to provide basic health information and guidance to a specific community, neighborhood, or person(s) in which they live. They bridge cultural and/or language barriers and provide a link with their health care providers. If they are linked with a person, they often assist the person in managing their chronic illness by assisting them in problem-solving their daily activity needs and contacts with their health care providers.
- **Patient Advocate** – this person is not necessarily a clinician and assists the patient through difficulties with communication or coordination with a service provider. Examples of a patient advocate would be an ombudsman, the Capital District Regional Advocacy Program, or a consumer advocacy group.

Essential Rule for all Case Managers: *Communication is important to coordinate a person's care. When a case manager starts service and ends service the importance of communicating the services that were provided and any required follow-up to the next service provider case-manager, usually via a* ***"warm handoff".*** When a person has multiple case-managers, a recommendation is to identify one case-manager as a ***"primary" case-manager*** for that individual and family and all case-mangers meet regularly to coordinate care. The meeting is usually via conference call and can be as often as weekly, but is based on the individual's needs and complexity.

Warm Hand-off definition – verbal report that includes the case-manager's name, location, and contact information, patient's name and demographic information, primary contact, services/care provided, including medications, discharge date, follow-up care needs and referrals for additional services.

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COMMUNICATION "HANDOFF" LINKS BETWEEN CASEMANAGERS