Acentra HEALTH

Front Porch Chat: CAP Case Management Fundamentals

October 14, 2026

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Housekeeping

- Intended Audience: CAP Beneficiaries
- Today's Presentation will be 30 minutes
- Q&A
  - This portion of the webinar is for beneficiary questions
  - Questions can be entered at any time in the Q&A chat
- There will be a survey at the end of this presentation for you to answer
- A recording of today's presentation and the PowerPoint will be posted on the NCLIFTSS (Linking Individuals and Families for Long-term Services and Supports) Website hosted by Acentra Health

Housekeeping Zoom Quick Tips

How to Ask a Question

- To ask a question, click the Q&A button at the bottom of your Zoom screen (icon below).
  - A box will pop up, and you can type your question there.



How to Turn On Closed Captions

- On the toolbar at the bottom of your screen, look for the captions option (icon below).
  - Click the small arrow next to it.
  - Hover over “Speaking Language” and choose the language you want.
  - After you select your language, the captions will appear at the bottom of your screen.



Topics We Will Cover

- Review of Basic Case Management Concepts, Including:
  - The definition of Case Management
  - The purpose of Case Management
  - Some common Case Management tasks in CAP
  - Tips for Time Management
  - Person-Centered Care Plans
  - Short-term Smart Goals
  - Motivational Interviewing
  - Documentation





Today's Presenters:
Dr. Shenita Ross, CAP/C Program Manager for NCLIFTSS
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Case Management

What is Case Management?

Case Management is a collaborative process that involves assessing, planning, facilitating and advocating for options and services to meet an individual's health and wellness needs. It is aimed at improving quality of care, enhancing outcomes, and ensuring cost-effective use of healthcare resources.

Purpose of Case Management

The primary purpose is to ensure that all the services, resources, support and the care that an individual needs for their wellbeing are provided and working together smoothly.



It involves organizing, coordinating, and monitoring services to address a beneficiary's physical, emotional, social, and sometimes legal needs.

Case Management

Case management is individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused.

The functions of case management include:

Case Management Assessment
Person-Centered Planning
Referral and linkage
Monitoring and follow-up



Common Case Management Tasks in CAP

Assessing beneficiary's needs	Work with beneficiaries and their families to understand their needs and set goals.
Researching resources	Gather information about available services and resources for the beneficiary.
Identifying service providers	Find and arrange for the right workers to deliver services.
Providing information	Inform beneficiaries about their right, responsibilities, and how case management works, including providing a copy of completed assessments to beneficiaries if requested.
Advocating for beneficiaries	Help beneficiaries access necessary services and resources.

Common Case Management Tasks, continued…

Coordinating services	Ensure that services are delivered smoothly and efficiently. Monitoring of authorizations to ensure no gap in services.
Monitoring Progress	Keep track of progress and collect feedback from everyone involved.
Making adjustments	Identify any changes needed and agree on how to make them.
Evaluating outcomes	Review and assess the results of the case management process.
Document	Document all your efforts and interactions with beneficiaries, families, service providers and DHB.

Common Case Management Tasks

Examples of questions that could be asked during Case Management phone contacts and in-home visits include but are not limited to:

- *"Have you started, stopped or changed any of your medications since we last spoke (including prescription, over the counter (OTC) and supplements)?"*
- *"Do you have any new concerns or new/worsening symptoms?"*
- *"Are you able to attend all of your upcoming appointments?"*
- *"Are there any medical appointments that you need help coordinating?"*
- *"What kind of support do you feel you need most right now?"*
- *"Do you feel safe in your current environment?"*

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Time Management

Time Management Tips for Case Managers

1. Prioritize tasks
2. Explain expectations and set boundaries with beneficiaries
3. Schedule time for case notes
4. Limit distractions
5. Don’t let it pile up
6. Use structured templates



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Person-Centered Care Plans

Person-Centered Care Plans

Person-Centered Care Plans empower the individual as the primary decision-maker, focusing on their unique goals, strengths, and social needs rather than just medical diagnoses.

Core Elements for Case Managers:

- **Individual Direction:** The beneficiary drives the vision, choices, and priorities for their daily life and long-term support.
- **Strengths-Based Focus:** Identify and utilize the beneficiary's personal abilities, natural supports, and community connections to reduce isolation.
- **Social Determinants of Health (SDOH):** Address structural inequities, housing stability, food access, and transportation needs as vital components of whole-person care.
- **Collaborative Teamwork:** Involve trusted family members, friends, and multi-disciplinary professionals chosen directly by the beneficiary.

Person-Centered Planning

Person-Centered Care Planning:

- places the individual at the center of the plan of care development process
- should be based on a comprehensive assessment that examines the individual's symptoms, behaviors, needs and preferences
- engages people important to the beneficiary, as well as those who will provide supports and services, to come together and plan the specifics - the "who, what, when, where and why" - related to the supports and services which will be offered
- is an ongoing, interactive, team process

Person-Centered Plan Elements

Each plan should contain the following elements:

- Assessment of Care Needs
- Individualized values and preferences
- Collaborative goals (both long term and short term)
- Individual Risk Agreement (as applicable)
- Signature Page

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Short-term Smart Goals

Short-Term Goals



Short-Term Goals:

- Help the person move closer to achieving their long-term goals
- Reflect concrete changes in functioning/skills/activities that are meaningful to the person and demonstrate that they are making progress
- Focus on what the person can achieve in a relatively brief amount of time
- Build on strengths while also addressing identified needs from the assessment

SMART Goals



Specific
Measurable
Achievable
Relevant
Time-limited

Short-term goals are written in SMART language:

- **Specific/Straightforward/Simple:** What the person wants to accomplish should be clear, specific, and simply stated. What is the concrete step or change that they want to make that will be proof that they are overcoming barriers and making progress?
- **Measurable:** A short-term SMART goal is written in a manner where people involved can reliably determine if it was accomplished. A measurable short-term goal should include how much, how many, and how will I know when it is accomplished.
- **Achievable:** Goals should challenge the individual to think about how they can accomplish the goal if they have the resources needed. What feels like a reasonable first step so that the short-term goal is possible to achieve? Achievable short-term goals consider a variety of personal and environmental factors such as resources, strengths, barriers, skill level, stage of change and motivation.
- **Relevant:** Individuals value short-term goals that are relevant to them and align with their long-term goals. Questions to explore include: “Is this getting in the way of a long-term goal that is important to me?” “Is this worthwhile?”, “Is this the right time?”
- **Time-Limited:** Short-term goals should have a deadline for completion that holds both the provider, individual, and other supports accountable to action steps. The time needed should be based on where the person is currently starting in relation to their desired goal. Timing may be captured by a specific date (e.g., “As of [this date]” or indication of timespan (within 4 months).

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Motivational Interviewing

Motivational Interviewing

Motivational interviewing is a collaborative, goal-oriented method of communication that focuses on implementing positive change.



Motivational Interviewing

Motivational interviewing supports the process of change naturally and respects the beneficiary's autonomy, strengthening their motivation and self-determination.

Principles of Motivational Interviewing:

- **Express Empathy** — see the world from the beneficiary's perspective and share in their experiences to ensure they feel heard and understood.
- **Avoid argumentation** — avoid trying to convince the beneficiary that a problem exists, or change is needed because it could cause more resistance.
- **Roll with resistance** — avoid eliciting resistance by not confronting the beneficiary and when resistance occurs, work to de-escalate and avoid a negative interaction.
- **Address discrepancies** — recognize and examine the discrepancies between a beneficiary's current circumstances or behaviors and their values and future goals.
- **Support self-efficacy** — highlight skills and strengths the beneficiary already has, indicate their ability to change successfully.

Motivational Interviewing Process

It is helpful to start by asking for permission to talk about a topic. You might say, *"I was hoping to connect with you for a few minutes this morning. Does that work for your schedule, or would it be better to find another time to talk?"*

The four parts of a motivational interviewing-based conversation, with examples, are as follows:

- **Engaging:** Establish a trusting and respectful relationship where everyone is equal.
  - *"In our program, we are committed to offering the best support we can for CAP beneficiaries. One of the ways we do that is by giving information about different topics. Right now, we are checking in about (PERS, Home Health services, Equipment, etc.). Would it be okay for me to share this resource with you? I am curious about any thoughts you have about this."*
- **Focusing:** Find and keep a direction. Be clear about the goal or direction for change. This direction is based on the reactions or information they share in the conversation.
  - *"I wonder if there is one of these things you would like to talk about."*
- **Evoking:** Encourage beneficiaries to talk about their own thoughts and motivations.
  - *"Can you share with me what concerns and questions you might have?"*
- **Planning:** Make a specific change plan that everyone is willing to follow.
  - *"May I follow up tomorrow?"*
  - *"What is the next step?"*

Motivational Interviewing Conversation Strategies

Motivational interviewing uses four conversation strategies. The strategies offer a way to respectfully help another person explore their own motivations for changing a behavior.

- **Open-ended questions:** Ask questions that they cannot answer with one word, like yes or no. Open-ended questions have many possible answers and encourage people to reflect.
  - *"Tell me more about … " or "How are you feeling about … "*
- **Affirmations:** Use statements that recognize a person's strengths. Affirmations encourage progress toward positive change. They need to be genuine and relevant.
  - *"I'm so impressed with the way you … "*
  - *"It takes a lot of strength to go through all you have been through."*
- **Reflective listening:** Repeat or summarize what someone says to show you understand. It helps people feel heard and lets you check that you're on the same page.
  - *"It sounds like you … " or "You're feeling like … " or "You sound unsure about … "*
- **Summaries:** Bring together different things someone has been saying. Summaries help tie information together.
  - *"Let me see if I understand so far … "*
  - *"You care for your mom very much and are concerned we might not be meeting her needs."*

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Documentation

Case Management Documentation

If it’s not documented, It’s not done.



Why is documentation in Case Management important?

Documentation in Case Management is the foundation of high-quality care, legal protection, and clear communication across service teams.

Key Reasons Documentation Matters

- **Continuity of care:** Detailed records ensure that every professional on a care team has access to the same up-to-date facts.
- **Progress tracking:** Ongoing notes help monitor a beneficiary's response to interventions, setbacks, and changing needs over time.
- **Legal and regulatory compliance:** Accurate records provide a verifiable audit trail and defend against liability or negligence claims.
- **Funding and accountability:** Proper paperwork justifies services, expenses, and reimbursement requests.

Importance of Documentation continued…

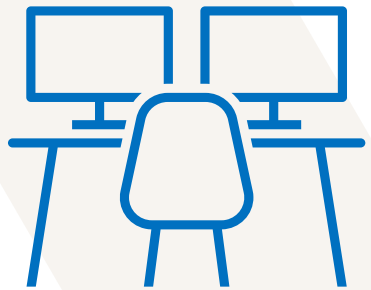
The work you do is crucial for the continuation of CAP Services

Documenting all your efforts, also provides:

- Communication among the care team

safety, quality, and continuity of care for the beneficiary
compliance for your agency

- Includes uploading any required documents in e-CAP



What to include in a Case Note

Remember the 6 “W”s



Who? Document who was present



What? Describe services provided



When? Include when services happened, in the order they happened



Where? Record where the service occurred

Why? State why the call, visit, meeting, etc… happened



What’s next? List the steps

Documenting Transitions

Documenting Transitions in the continuum of care in Case Management helps ensure safety and continuity across healthcare settings.

More Examples of Transitions in the continuum of care:

CAP/C to CAP/DA
CAP/C to Innovations
CAP Waiver to State Plan
Admission to Hospice
Incarceration



Handling Concerns & Complaints

- When concerns or complaints arise, it is important that they are promptly addressed.
- The Case Manager should notify the appropriate agency when there is a concern for Health Safety and Well-Being.
- This could include Child Protective Services (CPS), Adult Protective Services (APS) or local law enforcement.
- The Case Manager should notify NC Medicaid when there is a concern or complaint of Fraud, Waste or Abuse of funds or services by emailing: Medicaid.bic@dhhs.nc.gov
- A Critical Incident Report (CIR) must be filed in eCAP.

Transitions in the continuum of care

Transitions in the continuum of care in Case Management refers to the coordinated process of a beneficiary moving safely from one healthcare setting, provider, or level of care to another.

Examples include but are not limited to the following:

Home to Hospital



Hospital to SNF



SNF to Home



PCP to new PCP



Questions & Answers



Next Front Porch Chat

- Our next Front Porch Chat for CAP Services will be January 21, 2027, at 11:30 a.m.



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