



**SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU**

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: CASE MANAGEMENT SYSTEM
	Subject: Case Management Team Requirements

TEAM COMPOSITION

Case Management Teams (CMTs) consist of the following:

- A Registered Nurse licensed to practice in the State of Montana;
- A Social Worker;
- Appropriate support staff; and
- Staff must be sufficient to appropriately meet the needs of the CMTs Home and Community Based Services (HCBS) members. Staffing levels should take into consideration the population served, the acuity levels of the members served, the rate of turnover in waiver slots, and the travel requirements of the team. The Department will routinely evaluate the appropriateness of staffing levels and will formally monitor these levels as a part of Quality Assurance Reviews (QARs).

**TEAM MEMBER
REQUIREMENTS**

1. The Registered nurse must:
 - a) Have a Bachelor’s Degree in nursing and three years of professional nursing experience, plus two years of long-term care experience and be licensed to practice in the State of Montana. Any request for an exception to this requirement must be made in writing to the Department
 - b) Have knowledge of case management methods, procedures, and practices.
 - c) Have knowledge of the application of diagnostic and crisis intervention skills.
 - d) Have knowledge of the problems and needs of long-term care members; and

e) Have the ability to:

- Promote member's self-determination.
- Assess member needs.
- Develop and implement individual plans of care which reflect the services most appropriate to fit each individual member within specified cost limits.
- Monitor service delivery including cost of services provided.
- Evaluate service effectiveness.
- Re-assess continuing members need; and
- Provide guidance to assist members in utilizing services effectively and appropriately.

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2. The Social Worker must have:

A Bachelor's Degree in social work or a related behavioral science and one-year experience in a health care or community-based services setting. Any request for an exception to this requirement must be made in writing to the Department.

- a) Knowledge of case management methods, procedures and practices.
- b) Knowledge of the application of diagnostic and crisis intervention skills.
- c) Knowledge of the problems and needs of long-term care members; and
- d) The ability to:
 - Promote member self-determination.
 - Assess member needs.
 - Provide input into the plan of care with respect to social and other non-medical covered services.
 - Monitor service delivery including cost of services provided.
 - Evaluate service effectiveness.
 - Re-assess continuing member need;
 - Provide guidance to assist members in utilizing community services effectively and appropriately; and
 - Identify and participate in the development or improvement of community resources as related to finding alternatives for long-term care and promote community access for members.