

A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver



Developed by:

**The New Mexico
Department of Health
Developmental Disabilities Supports Division
Acknowledgements**

Many people, agencies, and organizations have contributed to the development of ***A Resource Guide for Independent Case Managers for the Developmental Disabilities (DD) Waiver***. The collaborative nature required of this project was impressive, as was the individual effort put forth by each contributor. All of these individuals are commended for their time, initiative, and commitment to relationships of quality shared by case managers and the individuals and families they serve.

The following deserve special acknowledgement due to the critical roles they played from the inception of this project to its final outcome:

The Case Management Unit, Developmental Disabilities Supports Division

Jennifer Thorne-Lehman, Deputy Director

The Columbus Organization

Many representatives of provider organizations as well as other individuals within New Mexico's service system shared their time and thoughtful consideration of the content proposed for this manual. Their feedback was invaluable to those crafting the final edition and is well deserving of formal recognition.

Table of Contents

Section	Page
Acknowledgements	2
Table of Contents	3
Use of this Guide	9
Introduction	11
Mission	12
Philosophy	19
Components of the Case Management System	21
Case Management Process Flow Chart	26

Use of this Guide



A Resource Guide for Independent Case Managers for the Developmental Disabilities (DD) Waiver was designed as a resource for New Mexico independent case managers (CM) who serve individuals with developmental disabilities. It serves as a ready-reference to information, resources, and tools you can use to enhance individuals' experiences with the service system and, most importantly, to support attainment of outcomes they personally seek to achieve.

This guide is structured in such a manner as to represent key aspects of the CM's role in his/her relationships with individuals and their families, guardians, advocates, all types of service providers, and others involved in the individual's life. Each chapter addresses a different process that the CM and team assist individuals to complete to secure and receive services and supports that are personally important to their health, safety, and growth as human beings. All chapters describe the rationale(s) for the activities described, the necessary procedures to complete them, and references to relevant policies and/or Regulations.

The guide is comprised of an **Introduction**, nine (9) **Chapters** and an **Appendix**.

Chapter	Title
I	How Individuals Become Eligible for Developmental Disabilities Waiver Services
II	Getting to Know the Individual
III	Making the Most of Meetings
IV	Planning with the Individual
V	Community Resources and Supports
VI	Keeping Things on Track
VII	Record Keeping on Behalf of the Individual
VIII	Creating the Individual's Budget & Billing for Services
IX	When an Individual Changes Services

The guide illustrates the role and responsibilities of CMs with the use of scenarios commonly encountered by individuals, their CMs and teams. These are real life examples of personal experience in services and supports.

The material in this guide can be used in different ways. The guide in its entirety can be used as a handy 'desk reference' for guidelines, protocols, tips, and samples of forms a CM uses on a regular basis. In addition, sections within chapters can serve to refresh knowledge and skills of a particular case management function, particularly those that address situations that arise only on occasion.

This guide can also be made available to colleagues, especially provider agency service coordinators, as well as other team members who play different roles in the lives of individuals. It can expand their understanding of CM interactions with and on behalf of individuals served.

Note: *To review regulatory citations, refer to the hyperlink entered by each reference.*

Introduction



◆ Mission

◆ Philosophy

◆ Components of the Case Management System

◆ Case Management Process Flow Chart

Introduction

Mission

Independent case management is committed to promoting quality of life for individuals with developmental disabilities by supporting their personal choices, promoting opportunities for growth, and encouraging participation as active community members by:

◆ Advocating for the Individual's Rights, Choices, and Self-determination

Shane is a lively man who receives twenty-four hour supported living services through the DD Waiver; he recently turned forty. He has lived in the same town and received services from the same residential agency for thirteen years. Shane possesses many skills; he often cooks for his housemates, is able to manage money (if he so chooses), and has been employed by a local business for two years.

Shane's has major health issues (he is obese, and has diabetes, leg edemas, and asthma), but will not make the healthy choices his team, doctor and family have recommended. He refuses to exercise, eats what he wants, and will sit at his computer playing video games for hours, without keeping his legs elevated. Shane does monitor his own sugar levels and schedules his own medical appointments. Although he wants to live alone, the team is caught in the "readiness trap" (Shane has to change his health and behaviors prior to moving) and will not discuss a transition plan into Assisted Living.

After a few visits, the case manager (CM) heard Shane's deep desire and advocated for Shane's right to move into his own place. With support from his CM, Shane was able to speak to his mother about his wishes and inform his team of his vision to live alone within one year and wanted a program implemented now. The CM reminded the team of Shane's rights and his ability to make informed choices. With Shane's input, the team developed a transition plan that includes contacting other providers and researching affordable and desirable apartments close to his job. The CM closely

monitored the plan and kept the team on track; Shane was able to move into his own apartment within 10 months of the initial meeting. Shane is very proud of his new life, loves being independent, and is gaining self-esteem each day. His staff, family, friends, and CM continue to encourage him to eat healthy and exercise, but respect his ability to choose for himself.

***Katie** is a personable, young energetic lady with a diagnosed seizure disorder and mild cerebral palsy. She receives services through the Medicaid Waiver program and is extremely close to her CM, Jill. Jill works for Sunnydale Case Management and has provided case management to Katie since she was sixteen. Katie is now 22 years of age, lives at home with her parents, has a vision of living on her own some day and works at a local jewelry making factory.*

Her parents have been informed of the legalities of guardianship and that per law Katie is now her own guardian. Katie is very close to both parents and an elder sister. Both parents expressed concerns over Katie's vulnerability and her inability to understand what others may tell her. The parents decided to petition for full (plenary) guardianship, after speaking with a lawyer. This upset Katie who felt there were decisions about her life that she was quite capable of making as an adult. She asked to meet with Jill and her older sister. Katie said she wanted to go to court and ask that her parents be allowed to make only some decisions for her. Jill asked her what she would need to do to assure this happens. Katie decided she would work on what she wanted to tell the judge with her speech therapist. She even suggested she would write it down. Katie also asked for a meeting with her parents to inform them of her wishes. Because she did not want them to think she hated them, Katie asked her sister and Jill, the CM to attend the meeting to advocate for her wishes.

The meeting with the parents was a little bumpy because they continued to think of Katie as their little girl and wanted to protect her. Katie informed the guardian ad litem that she wanted to testify during the court proceedings and worked real hard with her speech therapist to formulate her thoughts prior to court. On the day of the hearing, Katie was accompanied by her parents, sister, CM, and speech therapist. She did have the opportunity to explain to the judge what she wanted for her life. Her

parents were assigned limited guardianship over her medical and financial decisions. After the hearing both parents remarked on how proud they were of Katie and how they saw her in a different light in court. They realized their little girl was an adult, who was prepared to exercise her rights.

***Karen** is a pretty woman with Down syndrome. She is now 32 years old and has a very nice boyfriend who lives about an hour away. Neither has a guardian. Karen and Tony met at work and have known each other for several years. Karen is more independent and mature than Tony and really is the "lead" in their relationship. She frequently talks about her deep feelings for Tony with her CM (Peggy), her mom and her team. Although she desires to have an intimate relationship with him, she is also a bit afraid and is willing to accept advice and guidance from her friends and family. Tony wants to live with Karen, have a sexual relationship and get married.*

Because of the intimate nature of the situation, her mom, CM and other team members talk with Karen outside of regular team meetings. Peggy and Karen also meet for coffee every few weeks. During these visits Peggy asks Karen how things are going and talks with Karen about relationships in general and boyfriend-girlfriend relationships in particular. They sometimes go to romantic movies together and then talk afterwards. Peggy also occasionally goes out for a meal with Tony and Karen and they talk openly about their relationship, including issues they want to talk about. Karen's team continues to support the relationship as best they can, providing opportunities to spend time alone as well as with other couples in social situations.

Peggy informs Karen, her mom, and the team that the DDSD office of Behavior Supports OBS can provide some counseling and assistance with these issues. With their approval, she refers them to OBS. A consultant from OBS provides information on birth control, pregnancy, and child rearing. Both Karen and Tony's parents worry about marriage and pregnancy and frequently call Peggy to talk. Peggy listens to the parents' concerns, but maintains Karen's privacy. She does her best to explain their adult children are being educated on the meanings and consequences of

relationships as well as having opportunities to experience a relationship together. Peggy also talks to the couple about birth control and some of the basics of raising a child. When Karen decided she didn't really want a child, OBS provides supports to Karen and her mom to see her doctor for birth control. This relationship is clearly a loving and meaningful one to Karen and Tom; the team continues to be willing to take it one step at a time and support them as it develops.

◆ **Assisting and Supporting the Individual/Family to Direct and Participate in Service Planning and Decision Making**

*The Munoz family recently transferred to the Big Sky Case Management agency; Beth was assigned to be the new CM. When she met with the Munoz family to review the DD Waiver services **Danielle**, who is now twenty-five years of age, was receiving on the DD Waiver, she was informed of the following:*

- ◆ *Danielle had participated in a local day habilitation program for approximately two and a half years.*
- ◆ *Danielle's SLP provides services at the day habilitation site.*
- ◆ *Danielle wants a job at a local bookstore, but the team has been consistently resistant to discuss community employment for Danielle.*
- ◆ *SLP services should be provided occasionally in the home so that the family could learn and reinforce the support plan throughout the day.*

In addition, Mrs. Munoz felt that issues appeared to be settled before the meeting actually started and the team only came to sign papers.

Beth spent the time necessary to review the purpose of the DD Waiver with Danielle and her mother. She emphasized the person-centered philosophy that governed the provision of waiver services and stated that the ISP meeting is Danielle's meeting; the team is there to support her desired outcomes. To encourage Danielle to take ownership of the team process, Beth suggested Danielle may want meetings to be held somewhere other than the agency conference room. Danielle became very excited and said she would like to have the meeting in the clubhouse on the premises of her condo; her mother and CM helped Danielle practice asking for use of

the clubhouse. Beth informed the Munoz family that Danielle could develop an agenda for the meeting, listing the issues she wanted to discuss, and could co-facilitate the meeting. Beth helped Danielle complete a draft agenda for the meeting; Danielle would continue to work on the agenda with her mother and SLP.

The ISP meeting at the clubhouse felt very festive to the family. Danielle facilitated the meeting, with assistance from her mother, CM, and SLP. The day habilitation staff became very excited about community employment for Danielle and committed to complete a DVR referral. After the meeting, Danielle and her mother thanked Beth and both stated that for the first time they left a team meeting feeling empowered.

◆ Supporting Informed Lifestyle Choices

Cathy was quite overweight and had met little success in her efforts to shed pounds. She began having difficulty walking. Her CM and sister talked with Cathy about how important losing weight is to her health and her ability to get around as she likes. They explained how her problems with walking can limit her ability to fully enjoy the things she likes to do. This includes shopping at the mall with her sister, one of her favorite activities. Cathy doesn't like to talk about her weight and is uncomfortable when others raise the issue.

Cathy's CM and sister want to support Cathy any way they can. They met with her to offer suggestions to consider in making decisions about her weight and her health. Other members of Cathy's team were invited to share their insights, including a nutritionist, behavior support consultant, and nurse.

During the meeting, each team member expressed their support for Cathy and her role as a decision maker. They shared their appreciation for how hard it is to make lifestyle changes and gave examples of challenges they faced in their own lives. The team came up with a menu of options for Cathy to think about. These included support groups, programs such as Weight Watchers™, reinforcement for incremental achievements, nutritional counseling for education, menu planning, and meal preparation, scheduled 'mall walks' with her sister, fitness programs such as Curves™, and others.

Cathy knew she would not have to struggle alone and decided to try various suggestions. Over several months Cathy lost weight and had fewer difficulties in getting around. She continues to receive her team's support in maintaining a strong and healthy lifestyle.

◆ **Linking with natural and generic supports and services in the individual's own community**

David, a 22 year old man, talked a lot to his CM and behavior support consultant about abusing alcohol and wanting to stop drinking. He had attended AA meetings in the community yet never felt comfortable participating, even when a staff member accompanied him. David noted that it was hard to understand what people were talking about and often no one spoke about things important to him. He knew there were others like him with similar problems and wished he could find a meeting where those people could share their thoughts and feel supported in not drinking.

David's CM asked if he ever thought about starting his own group. After consideration, David came up with a list of ideas and things he would need to do to get a group up and running. First he needed to find a place for the meetings. His CM obtained permission for the group to use the agency conference room. With assistance from his behavior support consultant, David met a local grocer and described his plans. The grocer thought David's plan was worthy of support and donated snacks and beverages.

David then invited people who were in the same situation to attend the first meeting. David had a volunteer from a local AA chapter help the group set ground rules and answer questions about the program. David's group now has 20+ members who attend regularly. The group has moved from the agency to space in a local church. With the group's support and regular contact with his behavior support consultant and CM, David continues to find ways to support people with disabilities to stop abusing alcohol. David is very proud of his accomplishments. He has made friends for life, become more involved in his community, and stayed sober throughout this personal journey.

◆ Promoting opportunities to develop and maintain significant relationships in their own communities

Josh is 24 years old; next to his grandmother, his music is the most important thing in his life. He loves to play guitar although he has never had a lesson. At the last team meeting, Josh told everyone that he wanted to take guitar lessons at the local community college. He had already done his homework; he could take a continuing education class for \$50.00. His residential program coordinator verified that he had the money in his account. Josh knew the class was on Monday and Wednesday mornings, which would interfere with his job schedule. The team brainstorming session resulted in several strategies that would allow Josh to take the class while maintaining his job. Josh asked his job coach to help him discuss the matter with his employer. As it turned out, the employer was very happy to change his workdays. As Josh also needed transportation to and from class, the CM helped the team to identify transportation supports. One of his favorite staff volunteered to help Josh register. The CM monitored all start up and ongoing supports.

Josh did so well in his class, his instructor John asked him to be one of the volunteers at a weekend guitar class for children. With their shared love of guitar music, John and Josh soon became close friends. John and his family invited Josh to join his family for dinner, holidays, and special community music events. Eventually Josh joined John and his family at out of state workshops and concerts. At times the scheduling and logistics of these trips were difficult, but the CM continued to help the team brainstorm new strategies and monitored their implementation.

◆ Coordinating and monitoring services

Kellie, a 26-year-old recipient of DD Waiver services, lived at home with her parents and wanted to move out on her own. Kellie's uncle moved away from the area and asked if she wanted to rent his small house. Kellie works at a local deli. With the help of her CM she figured out that she could afford the rent, utilities, and other household expenses. Kellie felt she would need help with cooking, laundry, and grocery shopping but was adamant about not needing someone to be with her all the time.

Kellie's CM contacted the Assisted Living providers in Kellie's county and made arrangements for Kellie to interview them. Kellie chose the one she liked best. Kellie's CM scheduled a team meeting with the new provider so that all arrangements for Kellie's move into her new home could be made and finalized. Once she moved, Kellie's CM arranged to visit Kellie at her home every month to monitor the services Kellie was receiving. During these visits she made sure Kellie was comfortable in her new home and that the new Assisted Living provider was meeting Kellie's household needs.

Philosophy

The New Mexico Developmental Disabilities Medicaid Waiver (DD Waiver), a community based program, offers case management as a **core service** to eligible individuals who have developmental disabilities. Case management services are person-centered and quality driven. CMs place the individual's desires, values and preferences as the priorities when planning for and accessing natural and specialized supports.

CMs promote the individual's right to fully participate in the planning process, to be integrated into his/her community and to live a satisfying, safe and productive life. The CM's role extends to supporting the individual to make as many of their own decisions as possible and to ensure that the individual's desires and preferences are known and understood, regardless of guardianship. Emphasis should be placed in promoting the individual's management of his or her own affairs to the greatest extent possible. To this end, an appreciation for '**Person-Centered Planning**' is key.

Person-Centered Planning revolves around the fundamental respect for the individual and a strong commitment to community inclusion. Distinctly different from traditional planning principles that have been deficit-driven, Person-Centered planning focuses on each individual's innate capacities and gifts when envisioning the future. The individual is involved in all aspects of planning and, whenever possible is supported to take the lead in

the process. Family members and friends are heartily welcomed to assist the individual in looking forward in his or her life. The individual's team exists to provide information, support, and encouragement as the individual considers options for the generic and specialized supports needed to achieve his or her desired outcomes in life.

Another critical aspect of the CM's role is that of advocacy. Advocating for the individual may take many forms: breaking through barriers to the individual's personal outcomes, maneuvering through layers of regulatory requirements, and providing a voice for those individuals who may not possess the skills or experience in speaking for themselves. CMs should position themselves as advocates by getting to know what is important to the individual and being a liaison to resources for the services and supports that match those priorities.

A CM is required to have specialized skills, education, and competencies to provide the following functions in conjunction with the team: 1) completion of a comprehensive assessment of the individual's desired outcomes, functional capacity, strengths, abilities, needs and resources; 2) development of an Individual Service Plan (ISP) based on the comprehensive assessment; 3) monitoring implementation of the ISP to promote health, safety, high quality services, and cost-effectiveness; 4) re-evaluation of services for efficiency, effectiveness, and relevance to the individual's desires; and 5) on-going advocacy to promote self-determination by the individual.

⇒ [7 NMAC 26.5; DD Waiver Standards 2.3 ISP Development Process](http://www.nmcpr.state.nm.us/nmac/title07/T07C026.htm)
[http://www.nmcpr.state.nm.us/nmac/ title07/T07C026.htm](http://www.nmcpr.state.nm.us/nmac/title07/T07C026.htm)

Training Resources

DDSD provides training on all of the above topics. The ***Pre-Service Manual*** provides a mandatory self-study guide to basic responsibilities that must be completed within thirty (30) days of hire. The ***Two-Day ISP Training*** provides detailed information on person-centered planning and best practices for the CM. ***ISP Critique*** provides hands-on experience with the process. ***Participatory Communication and Choice-Making***

Training Resources

provides information about promoting communication and choice making throughout the person's life, with the cooperation of the entire team. **Positive Behavior Support Strategies** provides an overview of behavioral supports and the consideration of unusual behaviors as a form of communication. **Promoting Effective Teamwork** is designed to help the CM be an effective facilitator and team member. **Advocacy Strategies for Case Managers and Service Coordinators** is designed to promote rights of individuals and advocacy strategies for teams. With the exception of the 30-day requirement for the **Pre-Service Manual**, each of these courses must be completed within one year of hire. **Level One Health for Case Managers and Services Coordinators** and **Sexuality for People with Developmental Disabilities** must also be completed within the first year.

Components of the Case Management System

The following processes comprise the system a CM uses to coordinate services and supports needed and desired by individuals served.

Assessment: The process of collecting information about an individual's interests, strengths, preferences, needs, desired outcomes, and availability of resources and supports. The CM uses his/her expertise, observations and judgment to synthesize, prioritize and integrate the information and recommendations collected in the assessment process into individual service planning. Getting to know the individual requires spending quality time on an informal basis, as well as completion of the formal assessment process.

Pre-ISP: Greg and the CM prepare for his meeting

Greg had not been happy with his last CM. He has a new CM (Jenny). After reading record information, Jenny schedules a visit with Greg to start to get to know him. She goes to Greg's parent's house when he is visiting and finds out that Greg has always been close to his family. She takes notes and uses the information to fill out as much of the strengths, preferences and needs section of the ISP as she can before the meeting.

*She notes Greg wants to be heard by the team and not be told what to do. He had some bad experiences with being ignored (then having jobs he was not successful or happy with); he is reluctant about the upcoming meeting. Jenny tells Greg she works for him, the team is there to support him in what **he** wants to do and she will honor his decisions and advocate for him. When she leaves they both feel more confident about the upcoming meeting.*

Greg has lots of medical issues; the team who works with him has recommended many evaluations by doctors and therapists. With the recommendations from the therapists the team has helped Greg become healthier and more independent.

Still Greg does not seem happy with his life; the team suggests a fresh look at what Greg likes and who he wants the world to see him as. Jenny lets Greg know he can use his Annual Resource Allotment (ARA) to have an experienced facilitator conduct a personal planning session to help clarify his dreams and identify resources (beyond his waiver services) that can support his success.

⇒ Chapter VIII: Creating the Individual's Budget & Billing for Services

After interviewing several facilitators and discussing various planning methods, he selects the one who has experience with 'Personal Futures Planning' because that process sounds like a good approach to Greg. Greg and the CM work together to schedule the planning session and invite people Greg knows and likes from his past and present life.

At the personal planning session he is the focus of positive attention. The emphasis is on discovering with Greg what roles he is already living and those he wants to develop. His medical needs are not discussed at the meeting. He feels like a regular guy and opens up, telling the group about his love of horses, his dream to someday own a horse, how important it is to him to have a girlfriend and his dream of marrying someday. When his neighbor says they know someone who has a riding stable Greg is open to applying for a job there.

Service Planning: A person-centered ISP must be based on an individual's dreams, aspirations, values, and preferences. The ISP also identifies the individual's challenges and the supports available and/or necessary to address these challenges. A team works with the individual to develop the ISP on an annual basis. A team, identified and invited by the individual, develop the ISP on an annual basis. In addition to the CM, this team may include family members, guardian, friends, and service providers. The ISP is revised as needed to accommodate changes in the individual or in his/her life.

The team then met to develop a new ISP based upon the information from Greg's personal planning session. Now the team sees Greg in a new light. The therapists suggest ways they can help Greg be successful and comfortable at the riding stable. The team can now see how the efforts of working together can help Greg become a truly involved member of his community. It becomes obvious that the medical assessments, evaluations and resulting recommendations are only supports for Greg; they are not the end result.

The team addressed ways to support Greg's personal growth, dreams and aspirations in a safe and respectful way. The CM asked team members to brainstorm ways they could help Greg meet girls, be successful at his new job, and become involved in the ranching community.

They had to really work together to cover all the supports he needed; making sure his health needs were addressed without preventing him from being a part of community groups and activities he was interested in. The residential provider had to make allowances and write an agreement with the Community Access provider so they could pick up Greg and take him to events that take place after 3:00 pm and also on weekends. The Supported Employment provider had to get additional training from the nurse to be sure they could adequately take care of Greg's medical needs at the job site. It took some time, but the team worked it out with the great facilitation the CM provided.

Once the team had information from the personal planning process they knew Greg better and everyone knew their part in making sure his life was

what he wanted it to be. The team now sees how the efforts of all of them working together can help Greg become a truly involved member of his community. The outcome all of them can feel good about (especially Greg) is Greg becoming a member of the local 4-H and Rancher's Association, getting a job he likes and meeting a girl he can have fun with; Greg as a rancher, friend, employee and a full member of his community.

Monitoring: Effective case management requires monitoring to oversee health and safety, identify and resolve issues, and determine if services are 1) provided at an appropriate level of intensity to meet the individual's needs, 2) implemented in accordance with the ISP, 3) of high quality, and 4) provided to the satisfaction of the individual.

Greg's ISP was written including therapy recommendations, medical crisis prevention plans, outcomes and action plans that directly relate to Greg achieving his desired outcomes. The CM then needed to make sure the team kept up with the services. The CM visited Greg at home and found new staff that did not know some of Greg's medical needs. The CM documented this in her notes and contacted the service coordinator. The service coordinator informed the CM that new staff would be trained the following week and they would not be working alone with Greg until completing the training.

When the CM visits Greg at the job site, Greg excitedly showed off his new grooming equipment. It is obvious he was satisfied with this job.

Eligibility/Re-evaluation: Becoming eligible to participate in the DD Waiver occurs when an individual meets criteria for both an Intermediate Care Facility for the Mentally Retarded (ICFMR) and financial eligibility. The individual and/or the family work together with the DDSD Eligibility Unit, the CM, and the Income Support Division (ISD) to establish initial clinical and financial eligibility for Waiver services. Annual re-evaluation is done by the CM and determines the individual's continued eligibility, required frequency and preferences for services. Re-evaluation is based on ongoing or new assessments and the CM's clinical judgment of changes in the individual's situation or condition. In some cases, a change in

the individual's situation or condition may result in a new level of care that must then be submitted to Blue Cross/Blue Shield (BC/BS) for approval. A new LOC packet is completed annually by the CM.

Record Keeping: Accurate documentation on the individual's quality of life, ISP implementation, successes, challenges, medical issues and supports is required for reimbursement of case management services. Timely, thorough and accurate documentation 1) provides legal evidence of the CM's efforts to promote health and safety and support the individual's quality of life; 2) allows coverage by others to continue case management services if the assigned CM is unavailable; and 3) allows the case management supervisor to conduct quality reviews.

The CM enjoys writing about Greg's successes and makes sure to document he is successful because the team provides the supports he needs. If any one of those supports is not in place the whole plan can fall apart. The CM documents Greg's needs and how they are being met. If another CM took over the case they should be able to clearly see his needs and how they are being met with both paid and natural supports.

The flow chart on the following page illustrates the basic components of the case management process. Please note that **continuous monitoring and advocacy** provide support and linkage to all components. They are the glue that cements the process.

Case Management Process Flow

