Waivered Case Management (WCM) Best Practice Tips for Success

Updated: Nov. 25, 2025

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Oregon Administrative Rule (OAR)

- OAR 411-028 for Case Management Services for Older Adults and Adults with Disabilities

WCM Tools Webpage

- https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Pages/tools.aspx
    - On this page you will find the following tools:
        - WCM Best Practice Tips for Success
        - WCM Case Manager Statistics Tracking Spreadsheet (for local management)
        - Ongoing Monthly/Yearly WCM Statistics by Branch
        - WCM No Contact Letter Template Form DHS 2504
        - Waivered Case Management PowerPoint
        - WCM Definitions and Examples
        - Transmittals related to WCM contact

WCM Background and Overview

- WCM services are a component of an individual's comprehensive, person-centered plan for services.
- Direct and Indirect contacts are mandatory and are required each month to maintain Medicaid eligibility.
- WCM contacts are intended to help ensure individuals are receiving quality services and their safety and well-being is being protected.
- WCM contacts can be the only service an LTSS individual receives.
- WCM contacts are not simply a contact with an individual, but a service provided to individuals that adds value to their plan.

Two Types of WCM Services

- Direct Contacts (DC) -
    - Contact is with the individual, their Client Representative as designated on the APD 0737, or their representative as defined in OAR 411-028-0010(13).
        - 'Representative' is a person either appointed by an individual to participate in service planning on the individual's behalf or a person with longstanding involvement in assuring the individual's health, safety, and welfare.
        - When contact is with one of the representatives listed above rather than directly with the individual, be sure to include the name of the representative.
        - Priority is to always speak directly with the individual, when possible.
    - Must be completed at least once every calendar quarter in which LTSS are received.
        - These are not 'rolling' but are calendar quarters (see chart below).
    - A DC may count as an Indirect.
    - Contacts with Providers may not be used for DCs.
    - An Authorized Representative assigned on MSC 0231 is not a DC unless they also meet one of the definitions in the first bullet above.
- Indirect Contacts (IDC) –
    - Contact is with a collateral contact (e.g. family member or provider)
    - Must be completed at least once every month and can be replaced with a DC.
    - An IDC does not count as a Direct.

This is only an example to demonstrate possible distribution of contacts.

EXAMPLES	1ST QUARTER			2ND QUARTER			3RD QUARTER			4TH QUARTER		
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
#1	DC	DC	DC	IDC	IDC	DC	IDC	DC	IDC	DC	IDC	IDC
#2	IDC	IDC	DC	DC	DC	IDC	IDC	DC	IDC	DC	IDC	IDC
#3 - High Risk	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC
#4 - Not OK	IDC	IDC	IDC	DC	*DC	IDC	DC	IDC	**DC	IDC	IDC	IDC
NOTE:	*A missed Direct Contact cannot be made up the following quarter **An extra DC in a quarter does not eliminate the need for a DC the following quarter											

WCM Reports

- **CM Service(s) Due and Coming Due** report is viewed in Oregon ACCESS (OA) by selecting the [CM Alerts] button on the OA Main Menu screen.
    - Alerts will continue to appear on the report until the service is completed and logged on the CM Service(s) screen.
    - Direct CM Service alerts will begin to appear on the 20th day of the third month of the quarter.
    - Indirect CM Service alerts will begin to appear on the 20th day of each month.
- **CM Service(s) Due** report includes service contacts that are past due from previous months.
    - Tier 1 users (Case Managers) may only run this report for their own caseload.
    - Tier 2 users (Managers/Supervisors/Lead Workers) may run this report for any Case Manager in their branch.

- **APD-1034 Waivered Case Management Statistics** report is sent to leadership in each branch at the beginning of every month and includes any contacts that were missed the previous month. This report is intended to:
    - Allow CMs the opportunity to capture any contacts made the previous month that have not yet been logged in OA.
    - Track why contacts were not completed during that month as required.

CA/PS Benefit / Category Types Requiring WCM Services

- APD – Residential
- APD – In Home
- ICP – Independent Choices Program
- APD – SPH Spousal Pay
- MAGI
    - DCs are required quarterly for Risk Assessment/Monitoring unless the individual is assessed as High Risk.
    - If assessed as a High Risk, DCs are required monthly.
    - Monthly IDCs are not required.

Direct CM Service Definitions and Narration Examples

- Crisis Response and Intervention - Assisting an individual with problem resolution.
    - Individual called with concerns that her power was going to be shut off in a few days because she cannot afford to pay her bill. Provided information on how to contact utility company to discuss her situation, possibly a payment plan, and resource information on various energy assistance programs.

- Diversion Activities – Assisting an individual with finding alternatives to Nursing Facility admission.
    - Individual has expressed concern that she is unable to have her needs met at home. She believes that her only option is to go into a nursing home. Discussed options for increasing her in-home hours and provided her with a list of CBC facilities in the area that can meet her needs. Offered to assist her with calling facilities, but she said she was comfortable with making those calls on her own.
- Face to Face - The contact was made face-to-face with either the individual or their representative.
    - I was unable to contact the individual by phone, so I did a home visit and was able to visit with her face-to-face. We discussed her service plan, and she states she is very happy with her new HCW and that the number of hours she is receiving is meeting her needs.
- LOC / Assessment / Reassessment - An assessment that determines SPL.
    - The service assessment has been completed at the individual's home on 8/2/2021. Present for the assessment was the individual and their HCW. Individual participated throughout the assessment. SPL continues at an 11; see CA/PS for details. Follow-up will occur after the service plan is completed.
- Other Program Coordination – Helping an individual navigate or coordinate with other social, health and assistance programs.
    - Individual called to see if there are any local food box resources. I provided list of places that she can contact.

- Risk Assessment / Monitoring - This includes the following: Identifying and documenting risks; working with an individual to eliminate or reduce risks; developing and implementing a risk mitigation plan, monitoring risks over time; and adjusting an individual's service plan as needed.
    - I called the individual to follow-up on an identified issue of being unsafe while walking up and down her outside stairs by herself. She stated that she is working on getting bids to have a ramp installed. She also stated that she sometimes calls her neighbor to help her outside when her HCW is not with her; however, she would still prefer to use the stairs on her own. I encouraged her to finish getting the bids, as well as always asking for assistance while using the stairs to prevent injury. Documented continued risk concern with a plan to follow-up next month.
- Svc Options Choice Counseling – Presenting service options, resources, and alternatives to the individual and ensuring the individual understands all available Medicaid home and community-based service options to assist them in making informed choices and decisions.
    - I discussed potential placement options that are available to the individual, which included nearby ALFs, RCFs and AFHs as well as the need to contact me should he feel his in-home service plan was no longer working for him.
- Svc Plan Development & Review – Developing or reviewing the service plan with the individual. This includes determining eligibility for specific services, presenting service options and resources, identifying goals,

preferences, and risks, and assessing the cost effectiveness of the service plan.

  - I discussed the service plan hours with the individual that she is eligible for and to confirm that this will meet her needs. We also discussed the option of signing up for home delivered meals, which she is interested in. Referral for HDMs completed on this day.

- Service Plan Monitoring – Activities that are necessary to ensure that the service plan is effectively implemented and adequately addresses the needs of the individual.
  - I called the individual to confirm that he is satisfied with the care that he is receiving and to see if he has any concerns regarding the services he is receiving. He indicated that he is satisfied with how his care is being received and appreciates the care that the HCW provides to him.
- Service Provision Issues – Assisting an individual with problem solving to resolve issues that occur with providers, services, or hours that don't meet the individual's needs.
  - The individual called with concerns over the HCW not showing up at her scheduled time again. Discussed options such as having the individual discuss this concern with the HCW or deciding to find a new HCW. I also offered services with an IHCA. She wishes to give the HCW one more chance in coming during her scheduled times. Individual agreed to an ERC referral to learn how to best manage her HCW's schedule and concerns.

Indirect CM Service Definitions and Narration Examples

- APS Referral – APS referral including a collateral contact.
    - Spoke with individual's daughter. Based upon what she reported, an APS referral has been completed on this day.
- Diversion Activities – Finding alternatives to Nursing Facility admission. This does not include transition activities.
    - Called multiple AFHs to see who can meet the individual's needs to avoid placement to a NF. I provided this information to the individual's daughter for continued follow-up.
- Monitoring Svc Plan Implementation – Reviewing and comparing authorized and billed services to ensure that adequate services are being provided or communicating with a collateral contact to ensure that the service plan is effectively implemented and addressing the needs of the individual. When reviewing and comparing services, it must include a need for the CM to determine whether there are any service provisions that require attention or intervention.

Note: It is not only the Case Manager or a Manager/Supervisor who can contact the individual or provider for monitoring purposes. However, resulting information must be passed on to the Case Manager. In all instances, all required follow-up must be completed by the Case Manager or higher-level staff. If a Case Aide does speak with an individual about their service plan, it does not count as an IDC until the Case Aide communicates that information to the Case Manager allowing the Case Manager to determine if there are any service provision issues that require attention or intervention.

- I reviewed notes that were provided from the LTCCN who has been authorized. Services are being provided as authorized without any

further concern. Case Aide spoke with the individual regarding her service plan. The individual noted that he is thinking he may need more hours due to a change in condition. The Case Aide provided the information to me, the Case Manager, so I may follow-up with the individual.

- Other Case Management – Activities not included in any criteria in this section of the rule. The activity must be a service that benefits the individual.
    - Individual called on this day stating that they were moving to a new area at the south end of town and wants to find a new doctor. She does not wish to change her HCW but requested that I send her a list of doctors in the area that are currently taking new Medicaid patients, which I have done.
- Other Program Coordination – Helping collateral contacts navigate or coordinate with other social, health, and assistance programs.
    - Spoke with individual's daughter regarding information on how to apply for housing assistance. Provided contact information for local housing authority.
- Risk Assessment/Monitoring – Working with a collateral contact to review and individual's risks, eliminate or reduce risks, develop and implement a risk mitigation plan, and adjusting an individual's service plan as needed.
    - With permission, I spoke with the individual's neighbor regarding checking in on the individual each evening. She agreed to do this to ensure the individual is not left alone for extended periods of time.

- Svc Opt Choice Counsel – Assisting an individual's caregiver, family member, or other support person with understanding all available Medicaid home and community-based service options.
    - With permission, I spoke with the individual's daughter regarding what kind of services that an ALF typically offers so she can help her mom decide if she would like to tour some of the facilities in town.
- Service Provision Issues – Assisting with problem solving issues that occur with providers, services, or hours that do not meet an individual's needs.
    - I spoke with the HCW issues regarding the tasks that she is authorized to assist the individual with. Reminded her that she is not authorized to provide any pet or yard care.

General Tips

- Avoid putting off contacts until the last part of the month. It is best to get started on them early in the month.
    - It has been shown that getting contacts completed earlier in the month will substantially reduce stress. The more contacts that are left to the end of the month increase stress levels exponentially.
- You can either use the CM Services Due Report each month to determine which type of contact is required for each individual or you may find it more useful to complete DCs the first month of each quarter.
    - That way you get all your DCs completed early and the following two months of the quarter you only need to worry about IDCs

(except for those individuals with high risks who must have DCs every month).

- Always log each contact as soon as it is completed. If you don't log it, it didn't happen! Then you won't get credit for the work you've done.
    - It's OK to log multiple contacts per month. The more data, the better!
- If you missed logging a WCM contact that you did complete, Tier 2 users may backdate and log that contact for you on the CM Service(s) tab up to 365 days from the current date. But **do not** log a contact if it did not happen.

Best Practice Tips for Organizing and Completing Contacts

- Print your caseload list at the beginning of each month.
    - Take your total caseload and divide it by the number of days you're working that month. For example: 110 individuals in your caseload divided by the 22 days you'll be working that month = five contacts per day. If you want to get ahead of the game double that to 10 per day and get done early.
    - Organize the list to prioritize:
        - Individuals with High Risks and contact them first.
        - Individuals who have a history of being difficult to contact and begin attempts at contacting them early each month.
    - Determine if you have multiple individuals residing in the same facility. You can then either see them all during one trip (for a DC) or

schedule time to speak with facility staff to discuss their care plans all at the same visit (for an IDC).

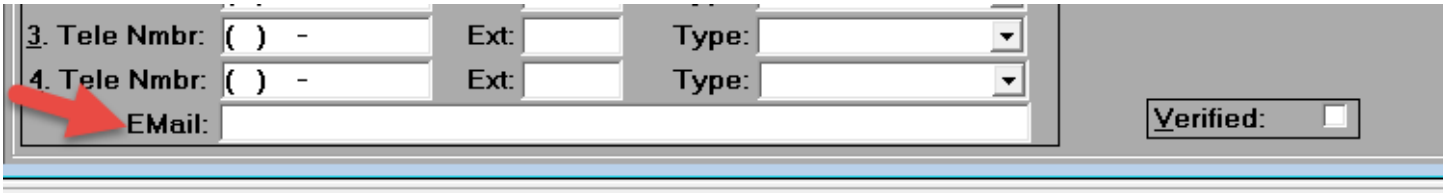
  - Determine if you have individuals who live in the same geographical area when home visits are needed. Especially if you need to travel long distances and you will want to schedule them during the same trip.

- Designate one or more specific day(s) each week to check for transfer-ins (Email box, Un-assigned Case report, etc.).
  - Assign to a CM immediately and notify the CM so they can contact the individuals as soon as possible.
- If you are transferring a case to another APD/AAA office, and the individuals will continue to receive LTC services, complete a WCM contact and log it before you transfer the case to the new branch.
  - Also, as you narrate or take the action to transfer the case to the new branch you must notify the receiving branch so they can be aware of the transfer to assign the case to a new CM, as that CM will be responsible for continuing the WCM contacts.
  - Here is a link to the Transferring Cases in OA instructions. Please be careful when doing a transfer that you are selecting the correct receiving branch.
- If an individual passed away and you communicated with a provider or family member, be sure to log that IDC for the month before taking the death action.

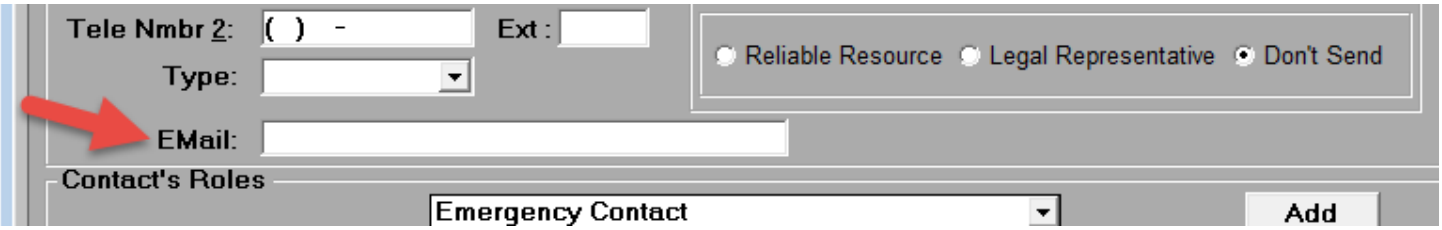
- If you are in a branch that uses PointClickCare (previously known as PreManage/Collective) and you receive notification of an admission or discharge viewed in PointClickCare, it can be considered an IDC if:
    - You, as the CM, then consider the individual's situation and

Methods of Contact

- Contacts can be in person (face-to-face), by phone, via email, or video (Zoom, Facetime, etc.).
- Contacts must involve two-way communication. For example:
    - Leaving a message is not a contact
    - Leaving a message and the individual calls back and leaves a message with information, then it is considered a contact as it is two-way communication and information has been exchanged.
- WCM contacts can also take place via email communication, so be sure to update the email addresses for those individual and/or contacts who like to communicate via email.
    - For individuals, you can find the email text box on the 'Person' tab and for other contacts you can find the email text box on the 'Contacts' tab.
- For Medicaid individuals (on the 'Person' tab):



- For other contacts (on the 'Contacts' tab):



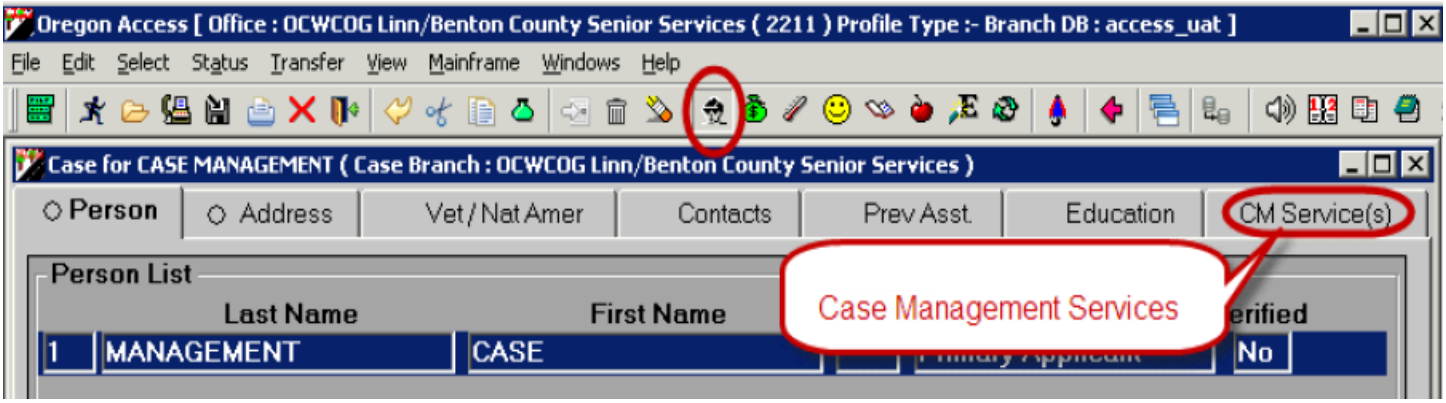
Process for using WCM No Contact Letter (form DHS 2504)

- **Month one –**
  - When unable to make contact with an individual or their Representative after multiple attempts, the CM must send the "WCM No Contact Letter" (form DHS 2504) to request that the individual or their Representative contact them immediately.
- **Month two –**
  - If there is no response to the letter by the next month, the CM must make additional attempts to contact the individual again, which should include visiting the individual in-person by the end of month two.
- Month three –
  - If the individual or their Representative fails to respond to the letter and the in-person visit was unsuccessful, the CM must then prepare and send a timely Notification of Planned Action (form APD 0540) to close the individual's Long Term Service case at least 10-days before the effective date of the action.
  - A separate notice must be sent for individual's medical benefits as well.

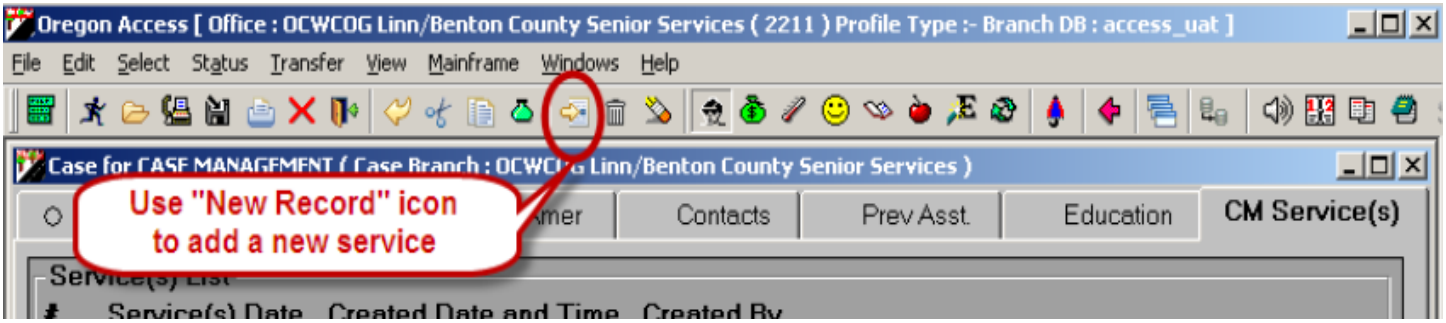
- See APD-PT-20-013 for the full process and timeliness to close a case for no contact.

Instructions for Logging WCM Service(s)

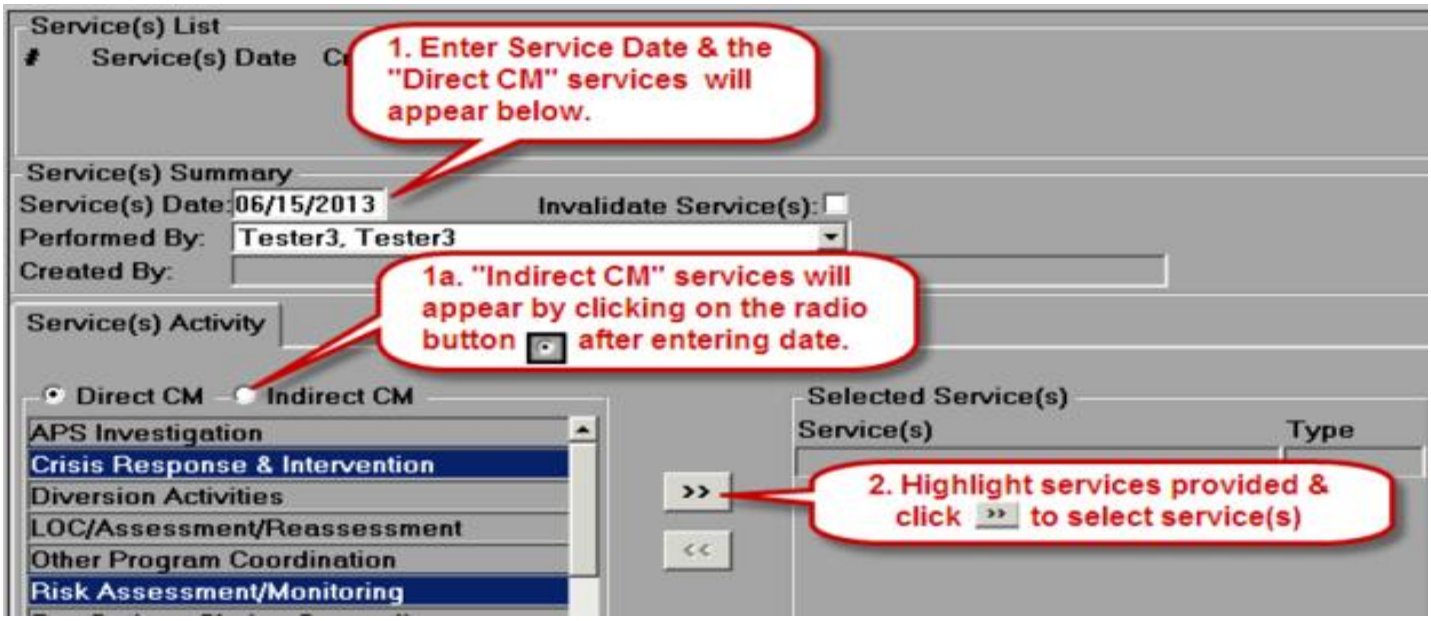
- On the Person page in OA click on the CM Service(s) tab.



- ON the CM Service(s) page click on the New Record icon to add a new service.

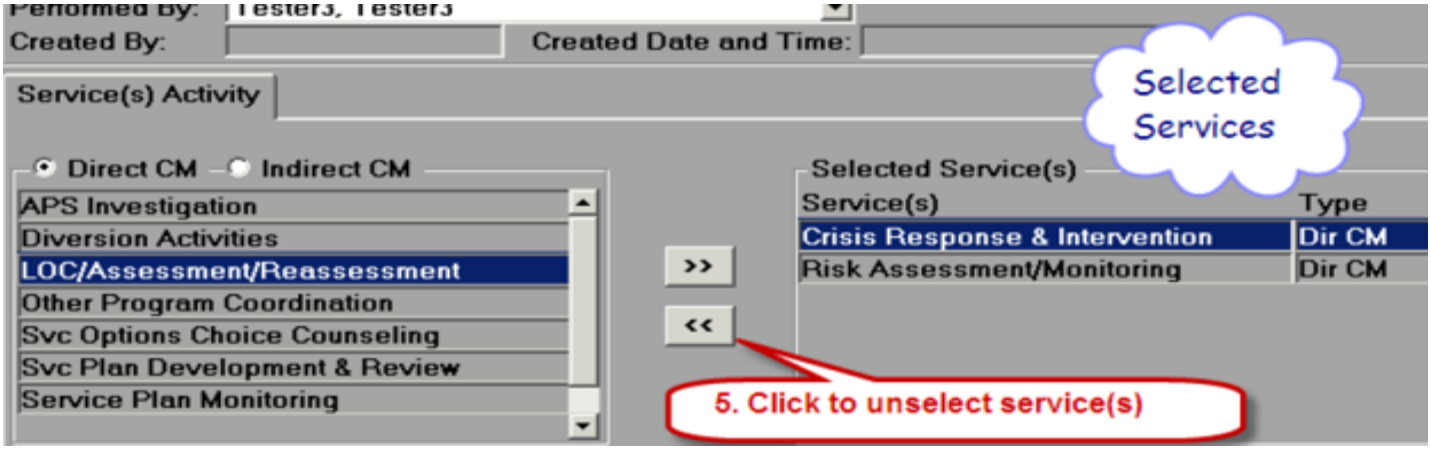


- Enter the date the service was completed in the 'Service(s) Date.
- Select who the service was performed by from the drop-down list.
- Select the type of service (Direct or Indirect) from the Service(s) Activity lists.
- Highlight the specific services that were provided (by clicking on each service) and move them over to the Selected Service(s) column.

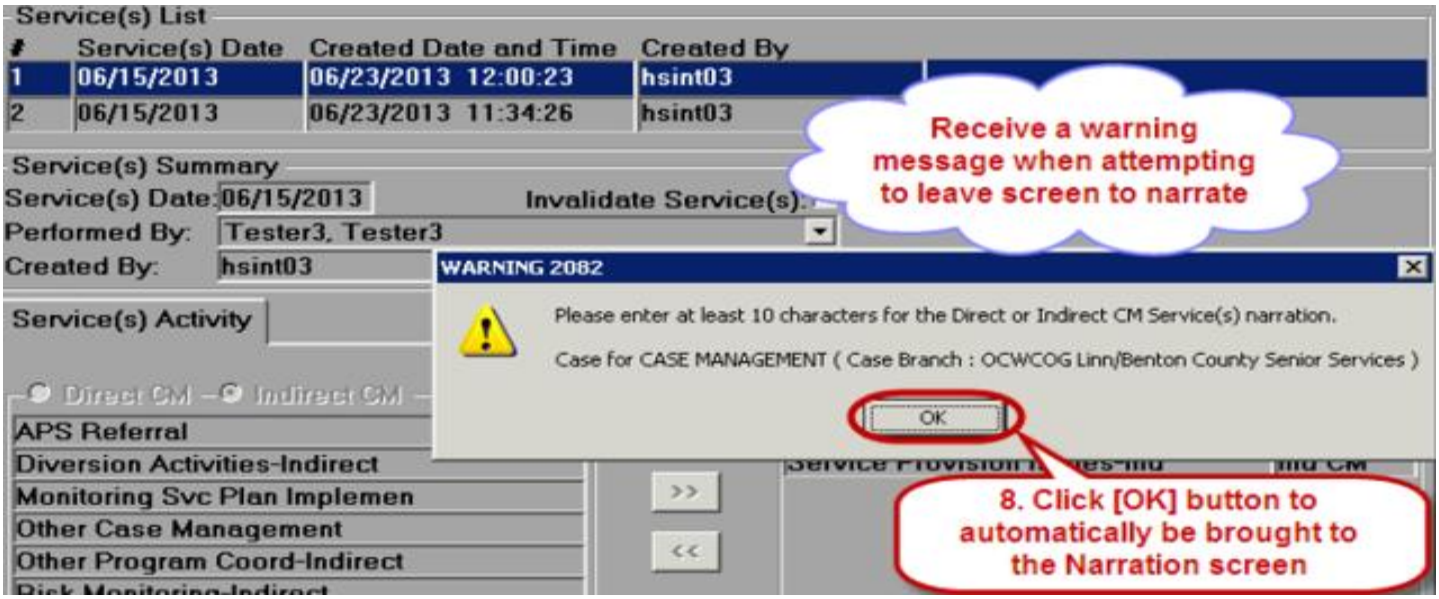


How to unselect services:

- You must narrate each time you enter a WCM service.
- You will be automatically directed to a new narrative screen after entering a CM Service.



- You will receive a warning message when you attempt to leave the CM Service(s) screen without narrating the service entered.



You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Aging and People with Disabilities at apd.ltss@odhs.oregon.gov or **503-945-5600**. We accept all relay calls.

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