

Case Management Policies and Procedures

I. Intake & Eligibility

Policy: The Aging & Disability Resource Center Coordinator has the responsibility for receiving and reviewing initial referrals. The ADRC Coordinator will screen potential applicants for the Homecare program.

Procedure:

The ADRC Coordinator will utilize the ADRC Screening Tool and the ADRC Homecare Program Determination Worksheet to verify the applicant is not eligible for the same or similar services through Medicaid as required by 910 KAR 1:180 Section 4.(b)1-2. Once the ADRC Coordinator determines the applicant to be a possible client for Homecare services, the referral is then given to the appropriate case manager. When the case manager receives a referral, a waiting list will be established and prioritized based on need. The waiting list shall be purged on a quarterly basis. Individuals shall be screened for Medicaid eligibility at least annually. He/she will make referrals to all appropriate agencies. Care is taken to assure that clients are given the list of all available service providers. Only an individual who meets case manager qualifications as defined by Homecare Policy shall perform assessments and reassessments.

II. Assessment

Policy: An in-depth, comprehensive assessment will be completed utilizing forms developed by the Department for Aging and Independent Living. The baseline assessment, utilizing the approved DAIL tool, will be used to determine the client's level of functioning, the existing support in the home, and the need for additional services. The assessment will also include the fee determination worksheet. This assessment will be entered into the SAMS program and transmitted to the DAIL monthly.

Procedure: The assessment will be completed in person in the client's home, or other appropriate settings where the client's confidentiality can be maintained. The assessment will be recorded on standardized forms, noting demographics; physical health; activities of daily living and instrumental activities of daily living; mental and emotional status; assistive devices, sensory impairment; and communication abilities; formal and informal resources; and a summary and judgment, which will include the client's observation for every level of functioning. The case manager must view an awards letters, recent bank statement and or other official documentation that state the client's income. Client responses to the assessment will be recorded at the time of the interview. If the client is unable to provide the needed information, a proxy will be used when necessary. Clients deemed eligible for Homecare services will be placed on schedule and services will be delivered per the care plan. Case manager will

provide a copy of care plan for Homecare Aide and in as much as practicable will meet aide at the client's home and introduce the aide to the client.

III. Reassessment

Policy: The re-evaluation of the client's situation and functioning to identify changes which have occurred since the initial or most recent assessment and to measure progress toward the desired outcomes stated in the care plan will be completed in a timely manner. Clients shall be assessed initially and reassessed annually there after, or earlier if the client's situation warrants. The reassessment will also include the fee determination worksheet. The case manager must view an awards letters, recent back statement and or other official documentation that state the client's income.

Procedure: The client's original or assigned case manager will be responsible for the re-evaluation of the client's situation. The reassessment will be completed in person in the client's home, or other appropriate settings where the client's confidentiality can be maintained. This process will use the standardized assessment form developed by the DAIL and will be entered into the computer system and transferred to DAIL according to policy. The case manager must view an awards letters, recent back statement and or other official documentation that state the client's income. Reassessments may also be done when there is a change in the client's status or there is a need for increased/decreased services.

IV. Priority

Policy: Cases will be prioritized at the following times:

- Telephone Screening
- Initial Assessment
- Event based reassessment/ or when client's condition has significantly changed as evidenced by a reassessment or home visit.

Procedure: To prioritize a client, case managers will use ADRC Screening Tool completed by the ADRC Coordinator on intake that includes all ADL/IADL. Case managers will call the potential clients upon receiving the ADRC screening tool to review and revise if needed for eligibility and prioritizing. On both sides of this document is a chart for degree of assistance needed and whether needs are met. If none is checked, then a score of zero, not impaired, will be given. If minor assistance needed, then, 1 will be given on the priority. If it is much physical assistance, it is moderate and shall be given a score of 2. Finally, when complete or total assistance is required, the resulting score will be 3 for severe. If the need is met then 0 will be given on the priority. If the need is being partially met then a score of 1 will be given. If the need is being unmet a score of 2 will be given. Both sides of the document will be totaled in together along with the total number from nutrition risk assessment score

and the targeting special population score on the document to reach the potential client's priority score.

The following definitions/guidelines are to be used for completing the Homecare Priority Rating form.

NONE – (no assistance required to complete the task) The individual can perform the activity independently without supervision or assistance of another person or special equipment/supplies.

MINOR – (minor assistance required to complete the task) – In order for the individual to perform the specified task, he/she needs the following:

1. Limited assistance of another person
2. Visual Supervision, and.or
3. Use of Special Equipment/Supplies less than 50% of the time.

MODERATE – (much assistance needed to complete the task) – In order for the individual to perform the specified task, he/she needs the following:

1. Considerable assistance from another person
2. Supervision with cues and/or prompting, and/or
3. Dependent on the use of special equipment/supplies more 50% of the time.

TOTAL – (complete/total assistance required to complete task) – The individual cannot perform this task nor can the individual participate in its performance without assistance.

NEED MET- The support (either formal or informal) provided to the individual completely meets the need. No other assistance is required to complete task.

PARTIALLY- The support (either formal or informal) provided to the individual meets a portion of need. However, additional assistance is required to complete task.

UNMET- The individual does not have support (either formal or informal) to meet the need. Additional assistance is required to complete task.

V. Care Planning

Policy: Care Planning is the desired outcome of the in-depth assessment or reassessment. It is an agreement between the client and the case manager regarding problem areas identified outcomes to be realized, and services to be obtained in agreement with stated goals. Client input and involvement is essential in the development of the care plan. Accordingly, each client shall receive services in accordance with an individualized care plan developed cooperatively with his/her case manager and revised whenever appropriate.

Procedure: The plan shall relate to the assessed problems, identify the goal(s) to be achieved and desired outcomes, identify the scope, duration, and units of service required, identify the source(s) of service, include a date for reassessment and be signed by the client and case manager. These plans will be documented on the standardized form.

(1) The Homecare applicant / participant shall participate in the assessment and development of an individualized plan of care with the case manager, natural supports and other care or service providers (person centered planning team).

(2) The person centered planning team shall determine the service needs of the participant.

(3) The person centered planning team shall develop the plan of care that shall identify the assessed needs of the individual and the services needed to assist with the identified needs.

(4) The plan of care shall:

(a) Relate to the assessed problem(s);

(b) Identify the goal(s) to be achieved;

(c) Identify the scope, duration and units of service required including services provided by informal supports;

(d) Identify the source(s) of service, including natural or informal supports;

(e) Include a plan for reassessment;

(f) Be signed by the client or the client's representative and case manager; and

(g) Be documented on the standardized form.

(5) Clients' individual goals shall be documented and updated according to clients' self-report.

VI. Arranging for services

Policy: Each client shall be referred to all services deemed appropriate by the client and case manager. The case manager will negotiate with informal and formal service providers for the delivery of services in accordance with the problem areas identified in the assessment or reassessment. These referrals include but are not limited to: home health agencies, hospice health departments, APS, Community Based Services, CAP, LIHEAP, transportation, weatherization, home repair, or other miscellaneous services that the client may need. All service providers of Homecare services will document on a service ticket the time in/time out as well as task performed for each client served.

Procedure: Referrals will be made by phone, fax, email, or in person. All referrals will be documented on either the Referral/Screening Form for those on the waiting list and/or in the case file for those active cases. Information shared with service providers concerning the client's situation will be based on the providers' "need to know." The case manager will use the client's entitlements and other eligible benefits as considered necessary for service delivery. In cases where an emergency exists, the case manager may initiate the appropriate actions to meet the client's immediate needs. All services referred to shall be listed on the application or a separate Release

of Information shall be on file. All referrals will be documented in the case file. Formal services will be arranged which complement rather than replace informal support. The case manager will maintain and enhance the informal support that is currently being provided. Volunteer programs will be utilized prior to referring for other services. All volunteers and/or volunteer programs shall meet qualifications and established for each specific service by the DAIL. The case manager will do a follow up to make certain that service delivery has begun and is continuing as planned.

VII. Reporting of Abuse, Neglect, or Exploitation

Policy: All case managers or Aging staff will report abuse, neglect, or exploitation as per KRS 209.030 (2) and (3).

Procedure: CM/staff will phone, fax, or email referrals of all suspected abuse, neglect, or exploitation to Centralized Intake at 1-877-597-2331. They will provide the intake staff the required information necessary to investigate the allegation and document in the file that the call was made, the date, and whom they spoke with regarding the allegation. CM/staff will also notify their immediate supervisor of the report.

VIII. Monitoring

Policy: The case manager will continue contact with service providers and clients to assure services are being provided in accordance with the plan of care and whether these services meet the client's needs.

Procedure: The case manager will continually review the activities and assess the progress toward meeting the goals and objectives of the client's plan of care while maintaining a good relationship with the client, informal supports and service providers through frequent contact as required. Homecare case managers shall monitor each client monthly, including face-to-face contact as determined by the DAIL-HC-01 Scoring Service Level.

(a) Level I – A home visit shall be conducted every other month and a telephone contact between home visits.

(b) Level II – A home visit shall be conducted every four months and a telephone contact between home visits.

(c) Level III – A home visit shall be conducted every six months and a telephone contact between home visits.

The purpose of the monitoring is to follow-up on the referrals, monitor health status, monitor appropriateness of services and to assure safety and consistency. Each case manager's contact with a client or on behalf of a client shall be documented in the case record. These entries are to include the date of the entry, any meetings or telephone contacts concerning the client, and/or changes in the client's condition or situation.

IX. Advocacy

Policy: Each time the case manager contacts a service provider to arrange services on behalf of the client they serve as a direct advocate for the client. Case Managers should serve as an advocate to each client they are responsible to case manage.

Procedure: Case managers should be aware of gaps in services, identify services in the greatest demand and identify areas that influence continuing informal and formal support systems. If problems that are common to a number of older people surface, the case manager will communicate this information to the Area Agency on Aging.

X. Recording

Policy: Recordkeeping is one of the most important responsibilities of the case manager. Good recordkeeping is essential to the continuation of client care as well as administrative accountability.

Procedure: All required information must be reported in a timely manner, in the proper format and using the proper information. To be efficiently used, the case manager must be familiar with the forms, reports and procedures necessary to the job and be willing to complete them accurately and promptly. Case managers will input all notes regarding their case listing into the computer system by the 5th of each month. All assessments and reassessments as well as monitoring visits will be recorded with the proper units assigned.

XI. Case Notes.

Policy: Documentation shall include the following types of information:

Facts
Observations
Interpretations
Decisions

Procedure: This information is defined as follows and shall be documented in the case notes:

Facts are client activities, agency actions or information from official records or documents. In addition, facts may be straightforward descriptions of circumstances.

Observations are recorded notes about the client, condition of the home, physical injury and/or behavior seen by the case manager or seen and reported to the worker by others. When recording observations, the source of the information must be clear.

Interpretations are the case manager's opinions or conclusions, based on facts and observations. When recording an opinion, document clearly that this is an opinion and supply ample evidence to support it.

Decisions in cases are based on program policy and good practice principles. They are supported by documented facts, observations and interpretations. It is also important to document supervisory consultation and approval, staffings, and other consultation received in making a decision. The four-step assessment process of 1) gathering information 2) analyzing information 3) drawing conclusions and 4) making decisions would be applied in this process. These decisions provide the basis for actions in a case.

Judgmental terms shall not be used in case recording. Exception: Judgmental terms may be used ONLY when quoting someone. Avoid words/phrases such as "appeared", "seems to be", "apparently", which may indicate observations are uncertain.

All mandated face-to-face monthly contacts with the client will include:

- 1) Month, day and year of contact
- 2) Worker's full name on each page and title.
- 3) Type of activity (telephone contact, home visit, collateral etc.) and where it occurred. Use words to indicate who initiated the contact, such as "to", "from", "received", "sent".
- 4) Who was contacted
- 5) Purpose of the contact
- 6) Significant information or observations
- 7) Assessment of the progress on care plan goals
- 8) The result of the contact, justification for services and when applicable, the plan for the next contact
- 9) The time that a case manager spends with a client should be recorded as the total amount of time spent.

When correcting or making changes in the case record the following shall be done: Draw a single line through the original entry so it can still be read, and make the correction above the case recording. In the margin, where the correction starts, initial and enter the date the change is made. Never use white-out/color out when making corrections.

All case files are to be kept in an AAA office or at a satellite office that is a secured location where the office is locked. All case files are also to be kept in a locked file cabinet.

XII. In-Housing Monitoring of Case Files

Policy: The Big Sandy AAA will monitor the KY Homecare Program's case files in-house for accuracy, completeness, and content.

Procedure: 10% of each case manager's caseload will be monitored once a quarter by a random sampling. Monitoring will be done by the Case Manager Supervisor/Homecare Coordinator. Case Manager Supervisor will provide follow up with each case manager as necessary with results of the file monitoring. If problems or issues are found during monitoring, lead case manager will issue a corrective action plan. Specified time will be given for correction. If plan is not met in specified time and corrections made, Case Manager Supervisor will discuss with Director of Aging for next step in disciplinary action. Monitoring will be done by utilizing the DAIL monitoring tool.

XIII. Confidentiality - The client's right to privacy.

Policy: Clients have a right to expect that information about them, provided or discovered in the course of accessing for services, will be held in confidence. Without assurances about confidentiality, clients may be reluctant to provide information and this could lead to unnecessary restrictions on what most people rightly perceive as the essential purpose of providing it: the delivery of appropriate and effective services to themselves.

Procedure: It is essential that no information be shared without the informed written consent of the client. Confidentiality is the long-established standard of good social service practice and will be strictly followed. Interviewing the client in the presence of others will not be allowed except with the permission of the client. Exceptions may include the client's incapacity to understand a request for consent or the client's inability to hear or speak. Information received or shared with others can only be used when meeting the needs of the client or as required by law. Information about individuals, including photographs, may not be shared with the media without the client permission. Information about clients may not be shared for any commercial or marketing purposes.

In sharing client information, the case manager will be careful in determining exactly what the relevant information is, and needs to be shared with providers. Discussion of the information between the case manager and client, in determining what is to be shared with others, may elevate the client's uneasiness about the process. Exceptions where client confidentiality cannot be maintained are situations where the client is a danger to self or to others. These situations will be reported to the proper authorities. Talking with a supervisor is essential when these situations do appear.

XIV. Transition Planning

Policy: When a client is transferred to another service provider for services, case records will be maintained in a secured location and appropriate information copied and sent to the new service provider. Client records must be kept securely – any paper records will be in locked filing cabinets.

Procedure: All written and verbal communication concerning the client's situation will remain confidential throughout the process. The information will be stamped confidential before the transfer of documents. When documents are no longer required they must be disposed of in confidential waste, (i.e. burning or shredding). The case manager will discuss the transfer process with the client. The client will be assured that services will be continuing in a timely manner and the quality of services maintained. The case manager will complete transfer summaries and relevant information will be shared with the new case manager. The goal of this process is a well-organized transfer, which, if achieved, will lower the anxiety of the client.

XV. Termination or Reduction In Services

Policy: The case manager and client shall decide to terminate services. Services shall be terminated when:

1. The program can no longer safely meet the client's needs;
2. The client refuses to follow the plan of care;
3. The client does not pay the copay for services; or
4. The client or family member has exhibited abusive, intimidating, or threatening behavior and the client or representative is unable or unwilling to comply with the corrective action plan.

Homecare services may be reduced if:

1. The client's condition or support system improves;
2. Program funding has been reduced; or
3. The client refuses to follow the plan of care for a particular service.

Procedure: When services are terminated or reduced, the case manager will:

- 1) Complete page two (2) of the Application for Homecare Services, Notification to Client.
- 2) Inform the client of his rights to file a complaint.
- 3) Assist the client and family in making referrals to other agencies if applicable.

If services are terminated or reduced due to reasons unrelated to the clients or condition, (i.e. budgetary constraints) the homecare coordinator, along with the case manager, in consultation with the Aging Director shall determine reduction or termination on a case-by-case basis.

If the client becomes ineligible or services are no longer needed, the case shall be closed with the reason documented in the case record. The client will be notified in writing of the closure date, closure reason, and be advised of the grievance procedures. The lead case manager, who assists with the supervision of case managers, will review and sign all closures and be responsible for the monitoring of the case manager's caseload.

XVI. Voluntary Contribution

Policy: Contributions or donations, as pertains to Homecare, made by participants and other contributors shall be considered program income and shall be utilized to expand services.

Procedure: All non-billed clients will be given the opportunity to donate to the Homecare program. The Homecare aides will distribute donation envelopes at the first of every month. Donations or contributions by clients will be placed in a sealed envelope and the name of the client shall be documented on the outside of the envelope and on the Homecare Aide service ticket. Donations will be utilized to expand services.

XVII. Case Management Qualifications/Salary

As per attached job description with entry salary range at \$20,000 dependent upon experience and education.

XVIII. Grievance

Policy: Big Sandy Area Development District and Area Agency on Aging, has assured the Kentucky Cabinet for Health and Family Services that it comply with the provisions of Title III of the Older Americans Act, Section 504, Rehabilitation Act of the 1973, as amended, for appeals and fair hearings and for presentation of grievances with respect to service programs for older adults.

Procedure:

- (1) Upon enrollment into the Homecare Program, each participant shall be given a copy of the DAIL-HC-02 Quality Service Agreement. Use of the standardized form is required and no changes or alterations can be made to the form.
- (2) The DAIL-HC-02 shall be read and explained to the participant upon enrollment.
- (3) The participant shall acknowledge receipt of the DAIL-HC-02 by signing a copy of the form.
- (4) A copy of the DAIL-HC-02 shall be provided to the participant, and the original placed in the participants file.
- (5) Participants shall be informed of their right to file a complaint utilizing the DAILHC-03 report of Complaint or Concern.
- (6) The identity of the complainant shall be kept confidential when requested.
- (7) A copy of the DAIL-HC-03 shall be maintained in both the participants file and in a centralized log.
- (8) Documentation of any investigation and efforts to resolve a complaint or service improvement efforts shall be documented in the participant's file and centralized log.

(9) The centralized log and participant's files shall be available for monitoring by the Department.

The Homecare client may also file a complaint on the designated Big Sandy ADD form (BSA-154) and Agency staff shall assist in preparation upon request; however, staff is not to assume responsibility for mailing the form. The complaint is to be filed by the complainant with the Big Sandy Area Development District, Area Agency on Aging, 110 Resource Court, Prestonsburg, KY 41653. The written complaint shall be filed within 30 days of the alleged act. In cases where the complaint is filed after the 30-day period, a decision as to whether to accept will be made by the Executive Director, Big Sandy Area Development District. The interested parties will schedule a meeting at a neutral site in every effort to try to resolve the complaint. If the complaint can't be resolved on a local level then the complaint is sent to the state level.\

XIX. Incident/Accident Reporting

Policy: All Homecare Incidents/Accidents will be reported and investigated, and will take immediate steps to prevent incidents and accidents from occurring.

Procedure: Any incidents/accidents known or observed by Homecare staff will be reported as soon as possible to their immediate supervisor, case manager, or Co-Director of Aging. Staff should immediately implement any measures needed to eliminate any immediate concerns with threatening behavior toward staff or participants, potential safety hazards or abuse/neglect of a participant. The staff reporting or the staff receiving the information should make written documentation of the events including the following:

- (a) Who was present at time of the incident;
- (b) What caused the incident to occur, if known;
- (c) Description of environment at time of incident;
- (d) Condition of participant at time of incident;
- (e) Action taken to stabilize participant after incident.

Documentation should be filed in the participants record and in an incident/accident log. All significant incidents/accidents (*A significant incident is defined as any incident that is unexpected or has an unexpected outcome*) will be forwarded to DAIL. Investigation, resolution and follow up will occur on an as needed basis, dependent upon the incident/accident. If incident/accident requires further investigation by outside sources, those will be referred to the appropriate agencies such as Office of the Inspector General, law enforcement, adult protective services, etc.

XX. Nutrition Screening

Policy: Each client shall be screened to assess their risk of nutritional deficiencies and provide a nutritional assessment, counseling or other intervention when necessary to assist the individual with their nutritional health.

Procedure: Each client will be screened for nutritional risk using the nutrition screening initiative checklist upon initial assessment and at each annual reassessment. Case Managers should address any deficiencies the client may have in their nutritional health. If the client scores a 6 or higher, he/she will be offered assistance with referrals for nutrition counseling. A Homecare Nutrition Risk form will be completed on those clients scoring a 6 or higher to document their acceptance or refusal for nutrition counseling.

XXI. Participant Rights and Responsibility

Policy: All Homecare clients have rights and responsibilities for participation in the program and will be informed in writing of their requirements as well as the requirements of the Homecare agency.

Procedure: Homecare clients will be given a written copy of their rights and responsibilities as well as the requirements of the Homecare agency. The copy will be signed off on by the client and a copy placed in the client's file.

(1) The participant shall be informed in writing of his/her rights which shall include the right to:

- (a) Be treated in a considerate and respectful manner;
- (b) Be treated with respect;
- (c) Have property and personal belonging treated with respect;
- (d) Know the name, work telephone number and duties of any staff person providing the participant with services;
- (e) Participate in the decisions made to develop and implement the plan of care and services;
- (f) Know the cost of services prior to accepting services;
- (g) Designate a power of attorney, family member or other individual to act on their behalf in developing and participating in the plan of care;
- (h) Be provided with services without discrimination as to age, race, religion, sex, national origin, sexual orientation, or source of payment;
- (i) Voice grievances and suggest changes in service or staff without fear of restraint or discrimination;
- (j) Privacy; and
- (k) Confidentiality of records, unless the participant signs for the release of information to a specific individual, agency or entity, or the staff have reason to believe the participant is being abused, neglected or exploited and then the staff shall report the situation to the Department for Community Based Services or law enforcement.

(2) The participant shall be informed in writing of the responsibilities required to remain in the Homecare program which shall include:

- (a) Treating all workers, provider agency and case management, Aging and Disability Resource Center (ADRC) or other staff members with respect. Physical or verbal abuse toward others, by the participant, participants family members or guests or of the participant is prohibited. Violations of this may result in the termination of services;
- (b) Provide all information necessary to determine eligibility for the Homecare

program;

(c) Allowing the case manager, social service assistant or independent care coordinator to complete the required home visits.

(d) Participating in the assessment of ongoing needs and eligibility for services, provide information to update annual paperwork, including, but not limited to the Financial Assessment Form;

(e) Participate in the decisions involved in developing and implementing the plan of care and services;

(f) Sign forms upon receiving a full explanation as to their content and purpose;

(g) Provide any needed documents;

(h) Submit payment of the participant's share of the cost of the services;

(i) Informing the Case Manager or Social Service Assistant and provider agency when the will be away from home on dates of scheduled services;

(j) Informing the Case Manager or Social Service Assistant and provider agencies of any plans to relocate or move from the current residence;

(k) Refraining from offering gifts, tips, donations or bribes to the workers who provide homecare services;

(l) Reporting inappropriate behavior of provider agency staff , including:

1. Consuming alcoholic beverages in the home or appear to be intoxicated;

2. Smoking in the home;

3. Use of the participant's phone to make personal calls or request the use of the participant's automobile;

4. Solicit money or goods from the participant for any purpose or cause;

5. Treat the participant disrespectfully or in any other manner the participant feels is inappropriate or offensive.

(m) Pursuing all other funding sources for similar services for which the participant may be eligible.

(n) Refusal to pursue or participate in services provided by other funding sources may result in termination of Homecare services;