CARE MANAGEMENT

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I. Statement of Philosophy and Purpose

Care Management Services are intended to assist older adults with complex care needs by identifying, accessing and coordinating services which are necessary to enable the individual to remain in the least restrictive environment. Care Management Services maximize the individual's ability to function independently and assist with preserving his/her personal dignity.

II. Legal Base

Older Americans Act of 1965 as Amended: 42 U.S.C. 3001; {Public Law 100-175, Section 306 (a) (2) (A) }

G.S. 143B-181.1 (c)

G.S. 143B-181.1 (a) (11)

III. Definition of the Service

A. Primary Service:

Care Management is a coordinated care function which incorporates case finding, assessment/reassessments, negotiation, care plan development and implementation, monitoring, and advocacy to assist functionally impaired older adults with complex care needs in obtaining the services necessary to be safely cared for within the home and community setting.

B. Target Population:

The target population consists of functionally impaired older adults who are at risk of abuse, neglect or exploitation, and/or have complex care needs and who, due to a critical time factor and/or the complexity of services needed, are unable to access the services needed to remain safely at home.

1. Priority Groups

Individuals should be provided Care Management Services in the following order based upon the level of functional impairment.

Individuals who have:

a. Impairments in at least three (3) activities of daily living (ADL), *and* have complicated medical, mental, social or behavioral impairment(s), *and*

whose needs cannot be net with services currently available to them and who prefer to be cared for at home; or

b. Impairments in at least one (1) activity of daily living, *and* have complicated medical, mental, social or behavioral impairment(s) *and* whose needed cannot be met with services currently available to them and who preper to be cared for at home; or

c. Impairments in a least two (2) instrumental activities of daily living (IADL), *and* have complicated medical, mental social or behavioral impairments(s), *and* whose needs cannot be met with services currently available to them and who prefer to be cared for at home.

Activities of daily living and instrumental activities of daily living are listed in Section V, A-2 b and c.

IV. Client Eligibility

Care Management Services are limited to older adults 60 years of age or older and/or their spouses who meet the above identification priority groups.

V. Service Provision

Care Management Services are intended to enable functionally impaired older adults to remain in the least restrictive environment and maintain the greatest amount of independence and human dignity possible by providing an appropriate, comprehensive, coordinated, and timely response to the person's needs.

A. Primary Tasks

1. Screening/Intake

Screening/intake is a preliminary process to determine if an individual appears to belong in the targeted priority groups. A screening/intake instrument must be completed for each person requesting service. The screening/intake instrument may be completed in person of by telephone. The screening/intake instrument must address the following categories:

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a. Individual identifying information;
b. Individual's ability to perform activities of daily living;
c. Individual's ability to perform instrumental activities of daily living;
d. Individual's perception of health problems;
e. Individual's perception of well-being (e.g. happy, sad, forgetful, confused);
f. Individual's living arrangement (e.g. alone/with family);
g. Availability of caregiver support;
h. Services currently being received.

Care Management provider agencies may use the Division of Aging and Adult Service Outcome Screen (SOS Profile) of their own screening/intake instrument provided it addresses all of the above listed categories. The Division of Aging and Adult Services SOS Profile (DOA-403) is included as Appendix A. An instructional manual which corresponds to the SOS Profile is available from the Division of Aging and Adult Services upon written request.

2. Assessment/Reassessments

The assessment/reassessment is a comprehensive multidimensional method used to determine the client's level of functioning and confirm eligibility for Care Management Services. Information regarding the following components must be addressed in the assessment/reassessment.

The Components are:

a. Client identifying information including: name, address, telephone number, date of birth, social security number, and emergency contact person;
b. Performance of activities of daily living (ADL's) including: eating, dressing, bathing toileting, bowel and bladder control, transfers, ambulation, and communication (ability to express needs to others e.g. speech, written word, signing, gestures, communication devices);
c. Performance of instrumental activities of daily living (IADL's) including: meal preparation, medication intake, house cleaning, money management, telephone use, laundering, reading, writing, transportation, mobility, shopping, and going to necessary activities;

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d. Medical status including: past medical history, permanent impairment, review of bodily systems, tobacco, alcohol and drug use, use of prescriptions and over-the-counter products, compliance with medication regimens, side effects, and client's description of how medications are to be taken;

e. Social status including: members of household, family, family situation, visitation, and informal support systems;
f. Mental status including: orientation, memory-short and long-term, reasoning, judgment, and emotional status;
g. Economic status including: work status, work history, regular available income, regular expenses, client's ability to pay for services, and ability to pay bills/handle own finances;
h. Environmental status including: adequacy and accessibility of home, living conditions, health and safety of the neighborhood, identification of transportation needs, and access to transportation.

The assessment/reassessment shall be conducted in the client's home by the Social Worker and the Registered Nurse. The assessment/reassessment shall be signed, dated, and maintained in the client's file.
Reassessments shall be completed at least every 12 months or as the client's condition warrants.
Information obtained from the completed screening/intake instrument may be utilized to complete portions of the assessment.

3. Care Planning

Care plans identify the course of action to be followed. Care plans for an eligible client shall be developed within 12 working days of the initial screening/intake. The care plan must, at a minimum, provide for the client's health and safety, identify client/family social support systems, define the service goals and determine the appropriate services needed to assist the client.

If the client's health and safety cannot be adequately addressed with the home setting and the client refuses assistance with alternative housing arrangements, the client is inappropriate for Care Management Services and must be referred to appropriate services (e.g. protective services, crisis intervention).

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The care plan shall include, at a minimum, the following information:

a. Outcome oriented goal statements and conditions for case closure;
b. Both formal and informal services to be provided;
c. Agencies responsible for service provision;
d. Frequency of service provision;
e. Duration of service provision;
f. Signature of the client/designated representative indicating agreement with the care plan;
g. Signature of the Registered Nurse and the Social Worker developing the care plan;
h. Date of care plan development.

Care plans shall be reviewed at least quarterly or more frequently as the client's condition warrants by both the Social Worker and the Registered Nurse.

All plan reviews and/or changes to the care plan must be documented and dated on the care plan.

4. Monitoring

Monitoring must be completed on a regular basis in order to guarantee continuity of services and to evaluate the client's continued eligibility for Care Management Services.

a. *Frequency:*

At a minimum, a monthly contact, (e.g. telephone, home visit, office visit) must be made to the client. At least one contact per quarter must be conducted in the client's home to determine if services are being provided in accordance with the care plan and to review the client's functional capacity, progression toward established goals and the client's satisfaction with services.

b. *Staff Responsible for Monitoring Activities:*

For those clients with health related needs, a Registered Nurse shall conduct the quarterly home visit. The Social Worker may conduct quarterly home visits if the client does not have health related needs.

All monitoring activities (e.g. contacts, visits, reviews) must be documented in the client's file by the appropriate professional.

5. Case Closure

Case closure is the discontinuation of Care Management Services when the goals of the care plan have been met or the client is no longer eligible for Care Management Services. The Care Manager must discuss with the client/family the discontinuation of Care Management Services and must provide the client/family with appropriate information (e.g. agency/name, telephone number and contact person(s) for services currently being received).

B. Care Manager's Responsibilities

The Care Manager is responsible for conducting assessments/reassessments, developing and implementing care plans, monitoring to guarantee quality and continuity of services and evaluating the client's continued eligibility for Care Management Services. The Care Manager is responsible for ensuring that client records are documented as required.

Either a Registered Nurse of a Social Worker may service as the Care Manager.

C. Voluntary Contributions

In Accordance with the requirements of the Older Americans Act, agencies must provide all individuals receiving Care Management Services the opportunity to contribute to the cost of service. Agencies must establish written policies and procedures governing the collection of voluntary contributions.

VI. Documentation of Client Records

Client records for Care Management Services shall include:

- A completed copy of the screening/intake instrument;
- A completed copy of the multidimensional assessment and 12 month reassessment which address the client's functional capacity, mental, social, medical, economic and environmental status;

- Individual care plans that identify the client's problems, establish goals, and service interventions;
- Monitoring activities;

- Conditions for case closure;
- Denial/termination/reduction of service when appropriate;
- Release of information form signed by the client;
- Copy of initial registration form and all updates.

The Care Manager must document that the client has been made aware of Client/Patient Rights. A sample copy of Client/Patient Rights is included as Appendix B.

VII. Confidentiality

Agencies which provide Care Management Services shall ensure that all information collected is maintained in accordance with the Division of Aging and Adult Services' Confidentiality Policies and Procedures as outlined in the Division of Aging and Adult Services Home and Community Care Block Grant Procedures Manual for Community Service Providers.

VIII. Staffing Requirements

A. Care Management Unit:

The Care Management Unit must have a Social Worker and a Registered Nurse available who have experience working with the target population. Qualifications for the Social Worker and Registered Nurse are as follows:

1. The Social Worker must hold a Master's degree in Social Work or meet State Personnel requirements for a Social Worker.

   North Carolina State Personnel requirements for a Social Worker are as follows:

   "Must hold a Bachelor's degree from an accredited school of social work; or four-year degree in a human service field or related curriculum including at least 15 semester hours in courses related to social work or counseling and six months of social work or counseling experience; four-year degree and one year of experience in counseling or in a related human service field which provides experience in techniques of counseling, casework, group work, or community organization, or an equivalent combination of training and experience."

2. The Registered Nurse must be a graduate of an accredited school of nursing and have a (current) valid license issued by the North Carolina Board of Nursing.

B. In-Service Training:

It is recommended that the Social Worker and the Registered Nurse complete 12 hours of in-service training per year.

IX. Reporting and Reimbursement

A. Reporting

All providers, except local departments of social services, shall submit a Management Information System (MIS) Client Registration Form (DoA-101) for clients receiving Care Management Services. The completed form (DoA-101) shall be forwarded to the Area Agency on Aging for entry into the MIS. If a local department of social services is administering the program, clients shall be registered via the DSS-2515 form and the information entered into the Services Information System (SIS).

In order to maintain accurate client data, agencies must conduct an update of client registration information during regularly scheduled service reassessments. Depending upon the type of agency providing the service, information will be updated on either DoA-101 or the DSS-2515 and entered into the appropriate information system. Only the signature of the agency staff person completing the update is required. Updated information must be documented in each client's record.

B. Reimbursement

Care Management Services are a non-unit service and shall be reimbursed based upon line item expenditures.

Specific procedures for reporting client data and service reimbursement information are outlined in the Division and Aging and Adult Services Home and Community Service Providers.

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APPENDICES

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APPENDIX A

The Service and Service Outcome Screen Date:_____

SOS PROFILE

Client' Name_____ _____
Last First MI Agency Use

Problem Summary

☐ Health ☐ Cog/MH ☐ IADL ☐ ADL ☐ Help ☐ S.Support ☐ Housing ☐ Income ☐ Agency ☐ Refund ☐ **URGENT**

1. Basic Information From: Self Other
   a. Client Phone _____
   b. Street Address _____
   c. City/Township _____
   d. County _____
   e. Zip Code _____
   f. Date of Birth _____
   g. Mother's maiden name _____
   h. S.S. number _____
   i. Client Needs/Preferences for Services
      _____
      _____

   j. Sex: Female Male

   k. Racial/Ethnic Identity:
      White Black Native American
      Asian Hispanic Other _____

   l. Mention of Unmet Skilled Need Y N
      (e.g., help with oxygen/sterile dressing, electronic equip./I.V./monitoring
      Comment _____

   Appropriate for Agency
   ☐ Perhaps appropriate for agency
   ☐ Not appropriate for agency

2. Emergency Contact?
   Contact _____ Doctor _____
   Phone: Days _____ Nights _____ Phone _____

3. Complete ONLY IF CALLER IS OTHER THAN CLIENT
   a. Caller's name _____
   b. Caller's phone _____
   c. Relation to client _____

   d. Reason not to call client _____
   e. Caller sees situation as URGENT:

      Problem ☐

4. Health Perceptions and Services
   a. Diagnosed or Perceived Health Problems
      _____
      _____
      _____

   b. Would you say in general your/his/her health is:

      Excellent Very Good Good Fair Poor

5. Cognitive/Mental Health

   Sense of Well-Being
   How much time in the past month?

   a. Nervous All Some None
   b. Sad/nothing cheers All Some None
   c. "In touch" If client answered Section I, were answers a. through h.:
      ☐ Appropriate

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c. How much bodily pain during past month?

None Very Mild Mild Moderate Severe

d. Hospital (past year) yes no
e. Doctor's care (past month) yes no
f. Nurse in home (Past month) yes no
g. Service agency involvment (Past yr.) yes no
h. If YES, agency (ies)? _____

Problem ☐

☐ Questionalby Appropriate
☐ Clearly Inappropriate

d. Insection 3, was reason not to call client given as confusion, Alzheimer's Disease, dementia or related disorders?

Yes No

Problem ☐

Client's Name _____
Last First MI

Functional Activities

	Able To	Has Help	Enough Help
6. IADL			
a. Use Transport	y n	y n	y n
b. Use phone	y n	y n	y n
c. Take medicine	y n	y n	y n
d. Manage money	y n	y n	y n
e. Do shopping	y n	y n	y n
f. Do housework	y n	y n	y n
g. Do laundry	y n	y n	y n
h. Prepare meals	y n	y n	y n

Add "no" in "able to" Column

☐ Problem

9. Social Support

a. Client lives alone Yes No
b. If NO, with whom? _____
c. If YES, is client in regula contact with anyone other than caregivers? (Listed in section 8) Yes No

Contact's name _____
Relationship _____
Phone number (if known) _____

☐ Problem

7. ADL

a. Bath	y n	y n	y n
b. Dress	y n	y n	y n
c. Walk outside	y n	y n	y n
d. In/out bed	y n	y n	y n
e. Use bathroom	y n	y n	y n
f. Eat	y n	y n	y n

Add "no" in "able to" Column

☐ Problem

10. Housing

a. Indoor Plumbing Yes No
b. Heat okay Yes No
c. Cool okay Yes No
Is toilet convenient:
d. To bedroom Yes No
e. To living quarters Yes No

☐ Problem

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8. Help with ADL/IADL	11. Income
a. Name of Caregiver b. Phone number c. Relation to client d. Hrs/wrk e. Help: paid or unpaid f. Other helpers g. Relation to client h. Hrs/wk i. Help: paid or unpaid ☐ Problem	a. Gets SSI (gold) check Yes No b. Enough to pay for needs and extras Yes No c. Estimated income (monthly) $_____ d. Possible self pay Yes No e. Receive Medicaid (blue card) Yes No ☐ Problem

Directions to Home _____

_____

PROBLEM

☐ Referred to _____ Date _____

☐ URGENT ☐ Agency Follow-up

Completed by: _____

Assigned to: _____ Date _____

DOA-403 (1/91) This SOS Profile was prepared by Duke Long Term Care Resources
LTC 1/91

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APPENDIX B

CLIENT/PATIENT RIGHTS

1. You have the right to be fully informed of all your rights and responsibilities as a client/patient of the program.

2. You have the right to appropriate and professional care relating to your needs.

3. You have the right to be fully informed in advance about the care to be provided by the program.

4. You have the right to be fully informed in advance of any changes in the care that you may be receiving and to give informed consent to the provision of the amended care.

5. You have the right to participate in determining the care that you will receive and in altering the nature of the care as needs change.

6. You have the right to voice grievances with respect to care that is provided and to expect that there will be no reprisal for the grievance expressed.

7. You have the right to expect that the information you share with the agency will be respected and held in strict confidence, to be shared only with your written consent and as it relates to the obtaining of other needed community services.

8. You have the right to expect the preservation of your privacy and respect for your property.

9. You have the right to receive a timely response to your request for service.

10. You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level if intensity needed.

11. You have the right to be informed of agency policies, charges, and costs for services

12. If you are denied service solely on your inability to pay, you have the right to be referred elsewhere.

13. You have the right to honest, accurate information regarding the industry, agency and of the program in particular.

14. You have the right to be fully informed about other services provided by this agency.