# Case Management

Chapter 5 explains the philosophy of case management, HCS and AAA case management responsibilities, and the case management tasks required for in-home, residential, nursing facility, and hospital clients.

#### Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Natalie Lehl Care Management Program Manager

 360-725-XXXX office natalie.lehl@dshs.wa.gov

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## Background

### Goals

The primary goals of case management are to assist the client to develop a plan of care to enable them to reside in the setting of their choice and to monitor that plan. Case managers will support the client’s independence by coordinating and offering assistance to access needed services. Case managers are custodians of the state’s resources and must balance a client’s choice with program limits.

Case managers:

* Educate clients, family members, support systems, and other service providers that a comprehensive plan of care is developed within the choices and resources available and that meeting *all* needs may not be possible.
* Must not view limited choice as a restraint on creative care planning. As a manager of state resources, staff should utilize naturally occurring resources or access non-traditional means to assist a client in meeting his/her needs and to develop supports based upon realistic expectations and coordinated problem solving.
* Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.
* Support/maximize client independence and self-direction.

### Functions

**Core functions** may not be waived by the client and include:

* **Assessment.** Perform a face-to-face assessment with the client in the client’s residence to determine service needs and program eligibility at least annually.
* **Planning/Plan Monitoring.** Develop a plan of care with each client, authorize services according to that plan, and authorize the client’s choice of qualified provider. Monitor, through periodic home visits (scheduled and unscheduled) and telephone contacts, to see if the plan is being appropriately implemented and if the services provided are meeting the client’s needs.

**Mandatory Reporting:** Report abuse, abandonment, neglect, or financial exploitation to Adult Protective Services (APS) per [Chapter 74.34 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34). Mandatory reporters are not required by law to report self-neglect by a vulnerable adult.

Social Service Specialists and Case Managers are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults. If information is reported to the SSS/CM about a client or other vulnerable adult ***and the person providing the information to the SSS/CM indicates they have already made a report to APS***, the SSS/CM may consider the following to determine if they too, should make a report to APS:

* An additional report by the SSS/CM is not required if verified that the report was made. This must be done by asking the reporter for a reporting confirmation or intake number or contacting APS to verify a report was made. These steps must be documented in the CARE SER.
* A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.
* See [Adult Protective Services policy and procedure](https://apswa.navexone.com/content/?public=true&siteid=1) and [Chapter 74.34 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34) for detailed information about mandated reporting, including consequences of failure to report.
* **Report Suicide Ideation:** If this client has a plan, the means to carry it out, and a time planned, do not leave the client alone. You may withdraw to a safe distance if you fear for your own safety (loaded gun, etc.) and call 911. Contact the [local County Designated Crisis Responders](https://www.hca.wa.gov/assets/billers-and-providers/designated-crisis-responders-contact-list.pdf), explain what the client has told you and that you are concerned for the client’s safety.
* **Termination Planning.** It is good practice to let all clients know that their services are based on their current needs and can change if their needs change. This is especially true if they are ill with a temporary condition (e.g. post-surgical, broken bone). When the CARE assessment determines that a client is no longer eligible: make necessary referrals (if needed) to transition to other services, provide adequate notice, via a Planned Action Notice (PAN) and close services in the necessary timeframes.

**Examples of assistance:**

* Completing a form.
* Researching a living situation.
* Assistance with moving arrangements.
* Arranging transportation.
* Assisting with Medicaid eligibility review.
* Other services related to the plan of care.
* Assistance with locating, hiring, contracting, and terminating providers of their choice.
* Assistance applying for administrative hearings and access to an administrative hearing coordinator.

**Supportive functions** may be waived by the client and include, but are not limited to:

* **Client Advocacy.**  Support client self-advocacy. Intervene with agencies or persons to help clients receive appropriate benefits or services. Clients may also request assistance with advocacy from their case manager even when they are able to advocate for themselves.
* **Assistance.** Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently.

* **Referrals**. Making and following up on mandatory referrals as identified in the assessment.
* **Family Support**. Assist the family or others in the client’s informal support system to:
* Make necessary changes in the home environment and/or lifestyle that clients have agreed to;
* Encourage changes in high-risk behaviors or choices that may improve the stability of the plan of care or improve health and psych/social outcomes;
* Plan a move to or from residential care, etc.
* Encourage caregiver self-care through support groups, education, and assistance accessing resources.
* **Crisis Intervention**. Assist with short-term crisis intervention in an emergency situation to resolve an immediate problem before a long-term plan is developed or current plan is revised. Crisis intervention may include, but is not limited to:
* Use of an [Exception to Rule (ETR) (see Chapter 3).](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25203.docx&wdOrigin=BROWSELINK)
* Arranging for a temporary move to an AFH or a NF.
* Authorization of Client Training or other waiver or CFC services.
* Calling 911.
* **Access Resources.** Examples of available resources include: discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.

**Handling Challenging Cases.** Follow the [“Challenging Cases Protocol”](#_Challenging_Cases_Protocol) when the recommended plan of care, appropriate to the client’s health, welfare, or safety, cannot be implemented.

### Case Management Responsibilities

Per [RCW 74.39A.095](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.095), case management responsibilities for long-term care clients are shared by Home and Community Services and the Area Agency on Aging.

#### ****Home and Community Services (HCS) Responsibilities****

1. Newly admitted applicants or clients to a nursing facility (NF) who will likely stay in the NF for more than 30 days: Medicaid applicants, Medicaid clients, and dually eligible for Medicare/Medicaid.
2. Long-term Medicaid residents of nursing facilities and those residents who are converting or likely to convert within 180 days to Medicaid (from Medicare or private pay).
3. Newly admitted to or current Medicaid residents in Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facilities, and Adult Residential Care (ARC) facilities.
4. Any adult with prior Adult Protective Services (APS) involvement and in need of ongoing case management and not receiving Core services. See [APS policy and procedure](https://apswa.navexone.com/content/?public=true&siteid=1) for more information on APS.
5. Initial entry into ALTSA-funded in-home or residential long-term care services.
6. Hospital discharge.
7. Private Duty Nursing clients.

#### ****Area Agency on Aging (AAA) Responsibilities****

1. All clients, age 18 and older, receiving ALTSA-funded, community-based services in their home.
2. In-home Medicaid clients who are temporarily in institutional settings. See the [Case Transfer Guidelines Section](#_Transferring_&_Returning) of this chapter for additional information.
3. Based on staff resources, adults age 60+ who reside in the community, and are not receiving LTC Core Services are assessed as able to remain in a non-residential setting, and:
4. Require multiple services and/or related activities performed on their behalf;
5. Are unable to obtain the required services and/or perform the required activities for themselves;
6. Do not have family or friends who are able and willing to provide adequate assistance;
7. Meet a-c above and require ongoing case management after an Adult Protective Services (APS) investigation has been completed.
8. If the AAA wants to limit the criteria outlined in 2, it must be approved by ALTSA and included in the contract.

## Types of Case Management

### In Home

HCS will:

1. Perform an initial assessment.
2. Develop the service plan.
3. Ensure clients are informed of choices among qualified providers.
4. Authorize services.
5. Make a telephone monitoring contact with the client if case is held longer than 30 days. See ‘[Transferring a Case](#_Transferring_&_Returning)’ for more details.
6. Transfer the case to the AAA. Refer to the [Case Transfer Guidelines](#_Guidelines) within this chapter.

**Once the AAA receives the case from HCS or another AAA:**

1. Case managers will make a face-to-face visit in the client’s home within 30 days of assignment to the Primary Case Manager (PCM) in CARE in the following circumstances (case must be assigned to PCM within 5 business days per [Case Transfer Guidelines](#_Guidelines)):
2. Client is identified as Targeted Case Management (TCM) by the receiving office or by the transferring office on the CARE Overview screen; or
3. Client has Behavior Point Score (BPS) >6 as documented in CARE (PCR, PCRC, and/or CARE results); or
4. Client has a documented current pressure ulcer; or
5. The current assessment was performed in a

SNF, or

Hospital, or

A different in- home setting than the one they are currently residing in, or

Residence screen indicates client has been homeless in the past twelve months; or

1. Explicit Terminal Prognosis is documented in CARE or End of Life/hospice is indicated on Case Transfer form or treatment screen; or
2. ***Supervisor or case manager has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.***
3. If annual assessment is due within 2 months, an annual reassessment may be done at the 30-day visit. If the AAA worker participated in a case staffing in the client’s home, this would meet the requirement for a 30-day visit.
4. If a client does not meet the criteria for a 30-day face-to-face visit, the case manager or a case aide must make a **telephone call to the client within 30 days** of initial assignment to the receiving worker and confirm that the client is receiving services as identified in their care plan. The telephone contact must be with the client. A client’s representative may be contacted only if the client is unable to communicate. If someone other than the client is contacted, document the reason in the SER.

If the telephone call results in any concerns that require a face-to-face visit listed in #1 above, the case manager will schedule a face-to-face visit within 45 days from the date the case was initially assigned to a worker in the receiving agency.

**The telephone or face-to-face** **(30-day) contact includes sharing and gathering the following information:**

CM/RN/CA introduction to client and reason for the contact.

Confirming that the care plan is meeting the client’s identified needs and preferences (e.g., personal care, equipment, resource/referrals, follow up appointments, client’s comfort level with the care).

Determining if there have been any changes in the client’s condition, service plan, supports or preferences for case management follow up.

Advising client/client representative to call the CM/RN if there are concerns at any time.

Verifying the client has contact information for the CM/RN and knows how and when to contact the case manager.

Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the “30 Day Visit” Purpose Code, containing a summary of the discussion/results.

**Note:** If the file has been returned to HCS per the Case Transfer policy, a new 30-day period begins on the date of the latest electronic transfer to the AAA.

AAAs wishing to exceed the standard may use the 30-day call to schedule a face-to-face visit within 45 days from the date the case was initially assigned to a worker in the receiving agency, for the lower risk clients.

1. One **annual face-to-face assessment** in the client’s home must be completed at least every annual cycle. Significant Change assessments (if they occur) reset the Plan Period annual clock (See [Chapter 3](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25203.docx&wdOrigin=BROWSELINK) for discussion of assessment Plan Period and when a Significant Change assessment should be considered temporary). A **Plan Period Tickler** will warn 40 days before a Plan Period expires.
2. All clients will also receive regular monitoring contacts to **monitor the plan of care**, especially any issues that were not resolved at the time of the last face-to-face visit. Clients who meet any of the targeted case management (TCM) criteria will receive more frequent contacts (see [TCM section](#_Targeted_Case_Management)).
3. For Non-Targeted clients, **three monitoring contacts** are required annually in addition to the face-to-face assessment. These contacts can be by phone or in person. The 30-day telephone or face to face visit may count as one contact in the first year. Monitoring plan contacts made by HCS will also count in the first year.
4. Contacts with the client to assist them with critical needs related to: health and safety; maintenance of community living status; or the plan of care will count toward the required annual monitoring contacts.
5. Activity that originates around a supportive function can also be used as a monitoring contact if service plan delivery is discussed.
6. You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in the SER.
7. Document all contacts you consider as monitoring contacts in **SER** using **Purpose Code “Monitor Plan”.** This will enable an automated Tickler to notify the CM if more than 4 months have passed since the last Monitor Plan SER entry.

#### Targeted Case Management (TCM)

Targeted Case Management criteria include, but are not limited to the following:

* Has a potential for abuse and neglect as identified in the assessment on the Safety screen or in the SER. This includes all clients who have: had an Adult Protective Service (APS) referral in the last year or had an open APS case.
* Lives in an environment that jeopardizes his/her personal safety, as identified in the assessment on the Environment screen or in the SER.
* Is not always able to supervise his/her paid provider as identified in the assessment on the Cognitive Performance screen and no one is identified on the Cognitive Performance screen as the person responsible for supervision.
* Has thought about suicide in the last 30 days, as indicated on the Suicide screen.
* Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen.

For TCM clients, the purpose of these contacts is to monitor issues related to the client’s targeted criteria as well as client condition and service plan delivery. Document each discussion with the client in the SER. Examples of TCM include:

* Working with the client to find a payee to manage his/her finances when there is evidence of financial exploitation.
* Helping the client locate housing in a safe neighborhood.
* Encouraging the client to consult a mental health specialist about his/her suicidal ideation and depression.

**Contact requirements include:**

* At least one additional face-to-face visit in the client’s home within one year from the beginning of TCM and each year following. If the 30-day visit occurs during the first year, it may count as the additional face-to-face visit. Visits may include AAA nursing assessments and /or collateral professional in-home contacts that have conferred with the case manager and agreed to represent the case manager’s concerns and needs while on-site. These in-home contacts report back to the case manager after the on-site visit.
* In addition to the face-to-face requirements, at least four monitoring contacts with the client are required annually.
* You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in the SER.
* Use the TCM Service Episode Record contact code to designate the date TCM began or was terminated. Document the reason(s) the client was:
* Placed on targeted case management.
* Terminated from targeted case management.
* Not placed on targeted case management if they meet targeted criteria (Possible example: APS investigation in last year of an IP who no longer works for client).
* Use the “Targeted Case Management?” item on the Overview screen to indicate whether the client is currently receiving TCM services.

#### Guidelines to Support Move from In-Home to Residential Setting

If a client desires to move to a residential facility or nursing facility, follow case management guidelines outlined below. Prior to transferring the case to HCS, you will need to:

* Work with the client and family. Inform the client of alternative options, personal needs allowance (PNA) limits, etc.
* Complete the necessary forms, perform another assessment as needed.
* Contact HCS and review the request for admission, residential setting options, and the most current assessment.
* Verify that the facility has a Medicaid bed available and is contracted to provide for any special needs (e.g. dementia).
* Have clients sign an [Acknowledgement of Services form (DSHS 14-225),](https://www.dshs.wa.gov/sites/default/files/forms/pdf/14-225.pdf) if appropriate.
* Request verbal approval prior to authorization of services in the new setting. Document plan approval in the SER and send documents for signature per Chapter 3 policy.
* Review the Assessment Details and Service Summary with the provider prior to the client’s transition to the residential setting and document in the file.
* Notify financial using the [DSHS 14-443](https://www.dshs.wa.gov/sites/default/files/forms/pdf/14-443.pdf) within Barcode and, if applicable, get updated participation amounts from financial. If the client does not enter on the planned date, the participation may need to be adjusted.
* Close all in-home authorizations and open residential authorizations.
* Notify HCS that the client has moved and transfer the case to HCS if the client is expected to stay more than 30 days in the residential or nursing facility.
* If appropriate, ensure current approved Behavioral Health Personal Care (BHPC) Request for Managed Care Organization (MCO) Funding form [(DSHS 13-712](https://www.dshs.wa.gov/sites/default/files/forms/pdf/13-712.pdf)) is in the client’s electronic case record (ECR) file. See Appendix VI of [LTC Chapter 7h](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207h.docx&wdOrigin=BROWSELINK) for more information regarding Wraparound Support services funded by the MCO.

**For Residential Settings (not Nursing Facility):**

Perform either a significant change or interim assessment according to policy.

1. Update the ‘Planned living arrangements’ dropdown in the Assessment Main screen (When residential is chosen, the IADL screens will appropriately be cleared).
2. When the client chooses an AFH, the AFH evacuation level must be selected on the Safety screen.
3. Assign treatments to the appropriate Provider Type in the Treatments Screen.
4. Update the Supports Screen assigning appropriate tasks to the residential provider.
5. Change the ‘Client chose/planned living situation’ setting on the Care Plan screen.

Further information can be found in the [Providing Residential Care Case Management](#_Residential) and [Nursing Facility Case Management](#_Nursing_Facility_Case) sections of this chapter.

### Residential

HCS provides initial and ongoing case management to all Medicaid clients in Adult Family Homes (AFH) and licensed boarding homes who have contracted with ALTSA to provide Assisted Living, Enhanced Adult Residential Care, and Adult Residential Care services.

#### Initial CM Responsibilities

1. Perform an Initial assessment.
2. Complete the:

[Individual with Complex Behaviors (DSHS 10-234a)](https://www.dshs.wa.gov/sites/default/files/forms/pdf/10-234a.pdf) for clients with challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).

[Behavioral Health Personal Care (BHPC) Request for MCO Funding (DSHS 13-712)](https://www.dshs.wa.gov/sites/default/files/forms/pdf/13-712.pdf) for clients who meet the criteria for Wraparound Support services as listed in Appendix VI of the [LTC Chapter 7h.](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207h.docx&wdOrigin=BROWSELINK)

**Coordinating with the Client and Family**

1. Work with the client and the family. If the client does not request the transition to a residential setting (often a member of the client’s family will contact the social service specialist about moving a client), determine if the client is also requesting or agreeable to move to a new setting.
	1. Explain that the client will have a responsibility to pay participation every month and will have only a limited amount of money for personal use.
	2. Have the client sign an [Acknowledgement of Services form (DSHS 14-225)](https://www.dshs.wa.gov/sites/default/files/forms/pdf/14-225.pdf) if appropriate.
	3. Have the client sign the Service Summary or give verbal approval prior to authorization of services in the new setting. Document plan approval in the SER.
2. Use the [AFH/BH Lookup Application](https://fortress.wa.gov/dshs/adsaapps/lookup/AFHAdvLookup.aspx) to identify facilities with available Medicaid beds (Note: The lookup list does not reflect current Stop Placement actions). Send the list to the client and/or the family so they can visit as many as possible before making a choice. For client transitions to an AFH, if you identify clients with:

Dementia or special care needs, they must choose an AFH with that specialty designation.

An Axis I or Axis II DSM IV diagnosis, they must choose an AFH with the Mental Health Specialty designation.

Skilled nursing tasks needs, they must choose an AFH that has Nurse Delegation training. Skilled nursing may need to be provided by visiting nurses. Not all tasks are subject to nurse delegation and the client may need to choose an AFH owned and operated by a Registered Nurse.

**Coordinating with the Residential Provider**

1. Contact the facility to confirm a Medicaid vacancy. Provide and review assessment details and service summary with the facility to determine if the facility can meet the client’s needs. Disclose the rate generated by CARE and discuss possible admission date. Document outcomes in the SER in CARE.
2. Within 30 days of the client’s admit or conversion (as documented in CARE), assigned staff will visit the facility, meet with the client and facility staff to review, discuss, and sign the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) in any of the following circumstances:
3. The client was admitted from a state hospital, Department of Corrections, or another specialized institution; (e.g. Hospital Psych Unit, Eval/Treatment center, etc.); or
4. Client has Behavior Point Score (BPS) >6 as documented in CARE (PCR, PCRC, and/or CARE results); or
5. Has a potential for abuse and neglect as identified in the assessment on the Legal Issues screen or in the SER. This includes all clients who have had an Adult Protective Service (APS) referral in the last twelve months or have an open APS case; or
6. Is coded as making Poor Decisions or No/Few Decisions in the assessment on the Cognitive Performance screen and does not have an authorized representative (AREP) or informal decision maker identified in CARE; or
7. Has thought about suicide in the last 30 days, as indicated on the Suicide screen; or
8. Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen; or
9. Client has a documented current pressure ulcer; or
10. Explicit Terminal Prognosis is documented in CARE or End of life/hospice is indicated on Case Transfer form or Medical screen; or
11. Supervisor or Case Manager/Social Service Specialist has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.

**Note:** For clients converting from private pay to Medicaid, if they have been in a residence more than 30 days prior to conversion, a 30-day visit is not required. The signed NCP or NSA may be obtained by mail or fax.

1. If a client does not meet the above criteria for a 30-day face-to-face visit in the facility, have the facility fax/send the NCP/NSA to the worker. The worker must phone the client and facility staff to review and discuss the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) within the same 30-day timeframe.

If the telephone call results in any concerns that require a face-to-face visit listed in #2 above, the worker will schedule a face-to-face facility visit within 45 days of the client’s admission, conversion, or transfer to their current residence.

**The 30-day telephone or face-to-face contact includes sharing and gathering the following information:**

Introduction to client and reason for the contact.

Discussing whether the NCP or NSA is meeting the client’s identified needs and preferences and determining their satisfaction with it.

Determining if there have been any changes in the client’s condition or preferences for case management follow up.

Advising client/client representative to call the Case Manager/Social Service Specialist if there are concerns at any time.

Verifying the client has contact information and knows how and when to contact the Case Manager/Social Service Specialist.

Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the “30 Day Visit” Purpose Code, containing a summary of the discussion/results.

Include a copy of the NCP or NSA with signatures of the provider and client in the client’s electronic file once received by mail or fax.

**Note: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or** [**online**](https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action)**.**

1. If items were not taken into account during the development of the NCP or NSA, meet with the provider and attempt to resolve these issues prior to signing the agreement. Formal meetings should occur as appropriate to resolve issues of concern.

#### Ongoing CM Responsibilities

**Visiting and Assessing the Client Annually or Sooner**

1. Determine the frequency of contact with each client based on the client’s:

**Care needs.** Does health status change frequently and/or is the client unstable?

**Cognition.** Does the client have impaired cognition and/or communication skills?

**Emotional**, **psychiatric**, and/or **behavioral** problems.

**Support system**. Does the client have a family or social support network?

1. Perform Annual or Significant Change assessments. Obtain and document client consent to services in the SER using the plan approval purpose code. Provide the plan of care (assessment details/service summary) to the provider.

**Coordinating with and Monitoring Providers**

1. Review the NSA at every face-to-face assessment to ensure that the client’s needs are being met. Reassess and ensure the NSA gets updated and is consistent with the DSHS plan of care.

1. Communicate with providers. The HCS Regional Administrator (RA) and the RCS Regional Administrator may arrange for regularly scheduled meetings between staff to facilitate communication about the coordination of their efforts with providers that are having problems meeting a client’s needs.

These meetings:

Provide an opportunity to discuss new homes, new contractors, problem situations and concerns that need to be monitored;

Should include appropriate HCS, RCS, AAA staff (such as social workers, community nurses, etc), adult family home licensors, contract monitoring staff, nursing services personnel, and local ombudsman;

Should explore options which include but are not limited to: nurse consulting or nursing services intervention; referral to other community resources or services; and use of the discharge resources. See the [Nursing Facility Case Management Chapter](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%252010.docx&wdOrigin=BROWSELINK) of the LTC Manual for more details on discharge resources.

1. Review the records kept by the provider to monitor for services provided against the frequency and level of care described in the DSHS plan of care/NSA/NCP.
2. Review with each client the frequency and quality of the service the client is receiving from the provider. If the client is not receiving the services they need or finds the services unsatisfactory, discuss this with the client, their representative, and the provider in order to attempt to resolve this issue. As needed, consult with the CNC, the AAA Nursing service, the Long-term Care Ombudsman, and Residential Care Services staff. Refer to the Move and Relocation procedures, if this intervention is not successful in resolving the issue(s).
3. If needed, document in the SER the services not provided and the reason. Document concerns regarding the quality of the service provided and how the issue was resolved by HCS staff, CNC or Nursing Services.
4. If the facility fails to develop a NSA, report this to Residential Care Services and document in the SER.
5. Consult with Nursing Services about her/his visitation schedule.
6. Refer the client for a nursing assessment to determine the appropriateness of Nurse Delegation services if it is determined that the client needs professional assistance with any nursing tasks.

#### Contacting the Complaint Resolution Unit (CRU)

[Make an online report](https://fortress.wa.gov/dshs/altsaapps/OCR/publicOCR.PubRptInputReporterInformation.executeLoad.action):

* Immediately if there is any indication of abuse, neglect, exploitation, or abandonment of a residential client;
* To enter a complaint if the residential provider does not implement the plan of care or does not achieve the appropriate outcomes;
* To report any issue of concern regarding the quality of life and care for all residents. Provide sufficient information about the issue for RCS staff to initiate an investigation.

Complaint Resolution Unit (CRU) staff or RCS investigators may contact you for additional information. Document in the SER activities or action taken. This information will be available to RCS staff to complete their investigation or to take corrective action.

**Note:** APS investigates allegations of mistreatment of a vulnerable adult living in an AFH, BH, or NH when the alleged perpetrator is not affiliated with the residential setting. The online reporting system may be used to report to APS or CRU. The system will direct the complaint to the appropriate department.

#### Moving a Resident

If a resident chooses to:

1. reside in a nursing facility, follow the guidelines outlined in the [Nursing Facility Case Management](#_Nursing_Facility_Case) section.
2. move to an in-home setting, consider discharge resources and follow the [In-Home Case Management](#_In_Home) section.

### Hospital

To learn more about hospital discharge planning, please see the Acute Care Hospital or State Hospital Assessment chapters of the [Long-Term Care Manual](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/).

#### Nursing Facility Case Management

To learn more about Nursing Facility Case Management, see the Long-Term Care Manual, [Nursing Facility Care and Relocation Chapter.](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%252010.docx&wdOrigin=BROWSELINK)

#### Joint Case Management

Joint case management may occur when there is a case staffing or when there is shared responsibility for a case.

**Case Staffing**

When do I hold a case staffing? Hold a case staffing when:

1. Case management needs arise as a result of a current or past Adult Protective Services investigation.
2. Significant complications or confusion exists that may place the client at risk of premature institutionalization, including concerns about the caregiver or environment.
3. There is a need to discuss and transfer case management oversight for complex cases that meet the criteria for targeted case management.

How do I conduct a case staffing?

1. If possible, hold it in the clients’ residence or wherever they are receiving care.
2. Always include clients unless they choose not to or an extenuating circumstance prohibits them from participating.
3. As needed, include staff from HCS, AAA, other agencies, and formal and informal supports.
4. Ensure that clients have completed and signed a consent form authorizing all case staffing participants to discuss their information.
5. Involve your supervisor and/or administrator if there is disagreement among staff on how to resolve an issue.

**Shared Cases**

A case is “shared” when case managers from multiple offices are part of the client’s team. Follow CARE guidelines when sharing a case, which means you and other team members will need to:

* Coordinate the assessment responsibilities.
* Use the same “look-back” periods.
* Ensure that there is one primary case manager per division (The AAA is considered part of HCS Division).

*Shared Case Example:*

When a Respite client applies for Core services, the case will be transferred to the HCS office. However, the Respite worker will need to remain on the team as long as AAA respite services are in place.

For information on sharing cases with DDA, see the [online tutorial](https://intra.altsa.dshs.wa.gov/CA/CaseSharing/).

#### Non-Core Case Management

If a client is not eligible for Core services, they may qualify for non-core services funded through the Older Americans Act (OAA), Senior Citizens Services Act (SCSA) or through other funding for locally available services. Non-core services could include services such as respite care, nutrition programs, exercise programs, or other locally available services. Clients who may need and be eligible for non-core services should be referred to the local AAA/I&A office for assistance. The AAA provides case management to clients receiving these services.

## [Documentation and Service Episode Records (SERs) in CARE](#DOC)

The intent of the SER in CARE is to document all contacts and activities related to the client’s assessment, service plan, coordination and monitoring of care, and termination of services. Information about the functionality of the SER and a full list of contact and purpose codes can be found in the [CARE Assessor's Manual](http://intra.altsa.dshs.wa.gov/CA/documents/PolicyHandouts/Assessor%20Manual.doc).

**Importance of Documentation**

There are a number of reasons to maintain current and accurate documentation in the SER, including:

* Smoother transitions for the client and receiving CM/SSS/CRM
* Allows current and future CM/SSS responsible for the client’s case to view historic and current interactions with the client and collateral contacts
* Provides a more holistic view of the individual
* Reduces the risk of gaps in service delivery
* Promotes more person-centered case management services to the individual
* Provides a record reflecting appropriate person-centered case management practices, rules and policies were followed

**Documentation Best Practice**

* **Be objective and factual.** Avoid subjectivity, opinions and judgements. Document facts including what was seen, heard, and/or information that was provided.
* **Be clear and concise.** Avoid abbreviations and acronyms only recognizable to the CM or other local staff.
* **Use readable and professional writing style avoiding grammar** and spelling errors
* **Enter SERs in a timely manner.** This will promote accuracy and more accurate recollection of conversations and events.
* **Make sure SER entries are for the correct client in CARE.** Once a SER is submitted, it cannot be deleted. If an error is made, append the SER in error and briefly explain the error without using any other client’s name. Document SER in the correct client record.

**Restrictions**

* Do not document the names of other clients in a SER.
* Adult Protective Services (APS)
	+ It is important to restrict the information about an APS report in the CARE SER due to confidentiality laws around APS information and risk of disclosure of the confidential APS record.
	+ In general, do not document information about APS intakes or outcomes in the CARE SER. This information exists in TIVA2.
	+ Create a SER that includes any observations that you have based on your own interaction with the client or collateral contacts regarding a situation of concern and any APS report that you made as a mandatory reporter.
	+ If there was a conversation with an APS worker, you should only document general information, for example, the conversation happened or there was a general update given on the case. Do not include details about the case in the SER.

## Transferring & Returning a Case

### Guidelines

Use these protocols when transferring a physical and electronic case record and paper file from one office to another. At any point during a case transfer, the Social Service Specialist/Case Manager may request a case transfer consultation or case staffing. The case staffing may be done via telephone or in-person.

### Transfer Protocol

1. The transferring Social Service Specialist/Case Manager is responsible for the electronic case record completeness and accuracy. The Assessment and Care Plan section must meet minimum standards outlined in [Chapter 3](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25203.docx&wdOrigin=BROWSELINK) (The receiving agency will assign the case to an individual Social Service Specialist/Case Manager within 5 business days). Prior to transferring a case where Fast Track Services are authorized, the transferring Social Service Specialist/Case Manager will verify that at least pages 1 and 2 of the Medicaid application has been received by financial services.
2. In Barcode, the transferring office must hold the file and send all required documents listed on the electronic case transfer form to the Hub Imaging Unit (HUI) as “Hot Mail” including:

14-012 DSHS Consent

14-225 Acknowledgement of Services

16-172 Client Rights and Responsibilities

Service Summary signed by the client

Service Summary signed by the provider(s)

* RCL Consent Form

Prior to transferring the case, the transferring Social Service Specialist/Case Manager must have received the CARE Service Summary signed by the client and call the client and/or the authorized service providers to verify that all services have been authorized and have started. Use the phone call to notify the client of the imminent transfer and give the client contact information should they have questions/concerns prior to the receiving worker contacting them.

1. Environmental modifications will be arranged and contracted for prior to transfer. Completion of the modification and payment of the services may be completed after the transfer of the case. Attach the Barcode Social Service Record (SSR) cover sheet before sending to HIU for receipts related to housing modifications.

The transferring Social Service Specialist/Case Manager must complete the Electronic Case Transfer form in Barcode/DMS prior to transferring the case in the Barcode system as required by policy. The Case Transfer form is used to ensure all documents required for a particular program have been completed and included in the client’s record. This form also serves as a means to communicate any special concerns with a case to the receiving office. The financial worker will be able to see the case transfer form in the client’s ECR and will know that the case was transferred.

1. The transferring Social Service Specialist/Case Manager must enter an SER in CARE when a file is transferred, including an overview of client safety concerns.
2. If transferring an initial in-home client, the transferring Social Service Specialist will be responsible for a telephone monitoring contact with the client when the case is held longer than 30 days. This telephone contact is intended to confirm health and safety, maintenance of community living status, and confirm requested services for which the client is eligible, have been coordinated or are in place. This telephone contact may count as one of the required contacts in that plan period. This contact does not replace the AAA 30-day visit/contact.
3. The transferring Social Service Specialist/Case Manager will verify record completeness using the Electronic Case Record Form before submitting to the supervisor for transfer. Once the “Submit To” supervisor field is enabled, the date sent to the supervisor is populated. The supervisor will receive notification that they have a transfer on their To-Do List. The supervisor will approve for transfer. If the supervisor determines additional items are needed prior to transferring the case, the supervisor will communicate this to the transferring staff from the electronic case transfer form with a note. The worker will resolve and resubmit to the supervisor for transfer. See LTC Manual Quality Assurance, [Chapter 23](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%252023.docx&wdOrigin=BROWSELINK) for supervisory file review requirements.

### Barcode

DMS is a system that bases all assignments on the current case manager of record. Once a case has been transferred in CARE, and until the receiving office has identified a new primary case manager on the Client Overview screen, DMS creates duplicate document assignments to the default worker at the receiving office and the former case manager to ensure someone takes an action on a document. To alleviate this, the receiving office should assign a case manager as quickly as possible when cases are transferred between offices. However, case transfer policy states that the receiving agency will assign the case to an individual Social Service Specialist /Case Manager within 5 business days.

Once the Case Transfer Form is submitted, the receiving office will verify all required program documents are in the electronic case file (or paper file if one still exists) and will have 5 days to assign the client to a case manager in CARE. During this time, assignments in Barcode are made to the default worker in both the sending and receiving office according to the matrix until the case is assigned in CARE.

### Returning a Case

If the transferred case does not meet the minimum standards or has payment/authorization errors:

1. The receiving agency will notify the transferring agency within 5 business days of receipt of the file.
2. The transferring agency is expected to make necessary corrections to the file documents. Whenever possible, this will be done electronically. In rare instances, it may be necessary to return the physical file to the transferring agency for correction. During this time, new assignments in Barcode will be made to the office of the case manager assigned in CARE. Necessary changes will be made by the transferring agency within 10 business days from the date notification was received. Unless the transferring agency is notified within the timeframe, the transfer will be deemed complete.
3. Track returned cases, using the form in the following section.
4. The transferring and receiving supervisors are responsible for resolving issues related to case transfers. If any disagreement occurs, it will be addressed through the chain of command established by both the transferring and receiving agencies. Unresolved differences between the HCS regions and AAAs should be referred to the Chief of the State Unit on Aging and Assistant Director of Home and Community Services Division or their designees for resolution.

**Note:** Additional information regarding the case transfer of in-home, Nurse Delegation clients can be found in [Chapter 13](http://adsaweb/docufind/CoreServices/default.htm) of this manual.

#### Tracking Returned Cases

Use the format listed below to identify trends and patterns in files that are identified as needing correction. It is the responsibility of the receiving agency to document the reasons transferred files do not meet the transfer protocols. Use the forms in discussions between AAA and HCS at local coordination meetings. The identified trends and patterns will be used to determine training needs and to address personnel related issues.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE** | **CLIENT NAME/** | **AGENCY CASE TRANSFERRED FROM** | **WORKER CASE TRANSFERRED FROM** | **REASON RETURNED****CODE** | **COMMENTS** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Reason Return Codes**

* + 1. Assessment/care plan does not meet minimum standards
		2. Provider not qualified
		3. Authorization not accurate

### Guidelines for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings

The intent of this case transfer policy is to encourage coordinated discharge/treatment planning in the best interest of the client. The AAA Case Manager, DDA Case Resource Manager, or HCS Residential Social Service Specialist should collaborate with the HCS NFCM to determine if, and when, a case transfer is appropriate for a client who intends to return to a community setting.

In that regard AAA, DDA, and/or HCS staff may:

* Assess a client in the SNF or hospital;
* Determine NFLOC in the NFCM screen of CARE (DDA does not have access to this screen);
* Attend care conferences at the hospital, SNF, or ICF/MR;
* Access discharge resources for clients, including MIIE for HCS clients;
* Review charts and/or files for discharge planning purposes.

#### Timelines

* The client file may remain with AAA/DDA for 30 days from initial admit to SNF, regardless of subsequent changes in institutional setting (hospital, SNF, ICF/MR). The client may be kept longer if a return to the in-home setting is imminent.
* If a hospital stay goes beyond 30 days, the AAA Case Manager will coordinate with the HCS Social Service Specialist regarding possibility of transfer to HCS.
* AAA/DDA Case Manager may transfer the client to HCS immediately if the client does not intend to return to the in-home setting.

## Challenging Cases Protocol

### Introduction

Federal home and community services rules (42CFR440.180) and 1915 c waiver rules (42CFR441.302(a)) require that the state must assure that, “…necessary safeguards have been taken to protect the health and welfare of the recipients of the services” (page 323). If the plan of care cannot assure the health and welfare of the client due to client environment or resource issues, invoke this protocol.

The purpose of the “Challenging Cases Protocol” is to promote statewide consistency in dealing with difficult to serve clients before denying or terminating services. The protocol promotes that service termination does not abdicate standard case management practice. The protocol recognizes the client’s preferences of care, services, and life choices. Any one factor or several factors of such a magnitude to jeopardize the health, welfare, and safety of the client and others may invoke the protocol. However, every effort must be made toward resolution of issues that may lead to denial or termination of services.

HCS and AAA staff will implement the “Challenging Cases Protocol” when the recommended plan of care, appropriate to the client’s health, welfare, or safety, cannot be implemented due to, but not limited to:

1. Client issues such as:

capacity (per [RCW 11.88](https://app.leg.wa.gov/RCW/default.aspx?cite=11.88));

behaviors;

refusals of services vital to health, welfare & safety;

illegal/criminal activity;

safety of caregivers, staff, and other residents.

1. Physical and social condition of the client’s environs

hazards, such as:

* methamphetamine laboratories;
* animals;
* sanitation;
* poor housing structure.

caregiver issues, such as:

* poor quality of caregiver of client’s choice.

other person(s) in home, such as:

* illegal/criminal activity;
* demonstrated dangerous behaviors (physical/sexual) to caregivers, staff, or other residents;
* verbal/physical threats;
* interfering with interview/service delivery;
* hinders worker access to client.
1. Resource issues, such as:

lack or inadequate informal supports;

cost of care exceeds allowable costs;

care needs that exceed allowable costs in current setting, which threatens the client’s health, welfare, and safety.

Client safety is a shared responsibility involving the client, family, friends, neighbors, the social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team (Regional Resource Team, A-Team, ad hoc team) as the vehicle for community entities to review and make recommendations for a challenging case. The interdisciplinary/interagency team differs from the ‘multidisciplinary case staffing’ in that all case management options/activities have been exhausted and the case is in jeopardy of closure.

You must complete all standard case management activities prior to invoking the protocol, including targeted/intensive case management and an APS referral if you have reason to believe that the client is abused, neglected, abandoned, or financially exploited. Continue services pending the outcome of the APS investigation and case management responsibilities.

### Services Denial

Discuss with your supervisor identified hazards and/or compliance issues preventing services implementation. Refer to the *Challenging Cases Protocol Introduction* for a list of possible hazards and compliance issues (NOTE: Functional or financial ineligibility are not criteria to deny services under the ‘challenging case’ definition).

1. Contact the client to discuss obstacles to implementing services:

Identify a plan to remedy obstacles;

Inform the client of possible options or denial of services if obstacles are not corrected;

If appropriate, make a law enforcement referral if imminent danger exists;

If appropriate, make an APS referral if you have reason to believe that abuse, neglect, abandonment, or financial exploitation exists;

If the client agrees with the remedy and problems are resolved, proceed with the assessment/plan of care development/implementation.

1. If non-compliance or the problems continue, your supervisor *may*:

instruct you to convene an interdisciplinary/interagency team (refer to procedure for the team under *Interdisciplinary/Interagency Team*):

* Identify options for the client;
* If no options exist or client/representative refuses options offered, then, with your supervisor, refer to RA/AAA Director (or their designee) for a decision to deny services;

refer the case directly to the Regional Administrator/AAA Director (or their designee) for a decision to deny services;

follow client notification policy in [Chapter 27](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%252027.docx&wdOrigin=BROWSELINK)

1. The Regional Administrator (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Chief of the decision.

**If an individual with a history of services termination/denial due to ‘challenging cases’ issues, reapplies for services:**

1. Assess whether the issues that caused the termination/denial of services still exist.
2. Discuss the case with your supervisor including the previous reasons for termination/denial.
3. Review the following with the client:

Reason for the previous termination;

Responsibility of the client to notify the provider and/or provider agency (if used) and the social services worker about problems related to the plan of care implementation.

1. With supervisor approval, authorize services if the client agrees to follow the plan of care.
2. If the client does not agree to resolve issues that caused past services termination, follow the Services Denial procedure.

### Service Termination

1. Consult with your supervisor. The supervisor may:

Perform a file review;

Make further suggestions for approaches or services not yet tried, such as nursing services, intensive case management, etc;

Recommend further monitoring and visits; and/or

Recommend contacting other collaterals and/or other entities with shared responsibilities.

1. If you and your supervisor feel all options have been exhausted, the supervisor may:

Confer with the AAG/agency attorney;

*In rare instances*, refer the case directly to the RA/AAA director (or their designee) for a decision to terminate the case (bypassing referral to the interdisciplinary/interagency team). The supervisor must document the reasons why the case was not referred to the interdisciplinary/interagency team; and/or

Instruct you to proceed with the protocol and refer the case to the inter-disciplinary/agency team:

* Current, active teams, such as the A-Team and APS Regional Resource Teams, may be utilized;
* The supervisor chooses the relevant team members.
1. The supervisor reviews the team’s recommendations with you and may recommend:

Visit the client to discuss the issues and possible consequences:

* The ‘team’ or relevant members of the team may choose to visit the client to resolve health, welfare, and safety issues;

Determine if the client is able to understand the issues and consequences. Consider making a referral to obtain a capacity evaluation if you believe the client’s capacity is significantly impaired;

Determine if other services are appropriate, such as a referral to counseling;

Determine if other supports are available, such as any informal supports.

1. Notify the client in writing (with supervisor approval) that his/her services will be terminated if she/he does not comply with service delivery provisions:

The client or other person must be given the opportunity to comply after the written notification is mailed.

1. If non-compliance continues, your supervisor will refer the case to the Regional Administrator/AAA Director for a decision to terminate services.
2. The RA (or designee) must notify the HCS Assistant Director of the decision to deny services and the AAA Director must notify the State Unit on Aging Chief of the decision.
3. Follow client notification of adverse action as [LTC Manual Chapter 7](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dshs.wa.gov%2Fsites%2Fdefault%2Ffiles%2FALTSA%2Fhcs%2Fdocuments%2FLTCManual%2FChapter%25207%2520Intro.docx&wdOrigin=BROWSELINK) regarding use of the Planned Action Notice (DSHS 14-405).

### Assessment Setting

When the initial assessment is not conducted in the setting in which services are authorized:

There may be instances when the social services worker authorizes services but does not observe the client’s environment, for example, when a client is discharged from a hospital. Environmental or social hazards may exist that may jeopardize the client’s health, welfare, and safety, that the social services worker may discover after authorizing services.

1. If information is identified during the first face-to-face visit in the setting the client is receiving services that jeopardizes the client’s or the provider’s health, welfare, and safety, AND this face-to-face visit occurs 30 days or less after the case was transferred to the receiving agency, THEN follow the protocol for SERVICES DENIAL procedure.
2. If the first face-to-face visit occurs after 30 days after the case was transferred to the receiving agency, follow SERVICES TERMINATION procedure.

**NOTE:** The situation must meet the ‘challenging case’ criteria.

### Documentation

1. Document all actions, consultation, and statements by the client and/or others in the SER.
2. Determine and document whether the client is aware of and able to understand the consequences of their or others’ actions:

Request a capacity evaluation with the client’s consent ([DSHS 14-012](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3676)(X) Rev. 2/03);

Determine if the involvement of a County Designated Mental Health Professional is appropriate;

Determine if an APS referral is in order;

If the client is not aware of others’ behaviors in their home, inform them of the behaviors.

### Hazardous Conditions

The client’s living environment may pose hazards that may threaten the safety of the provider or social services worker. These **hazards** may include, but are not limited to:

* Threatening, uncontrolled animals, such as dogs;
* Illegal drugs used by the participant or others in the home when the social services worker is in the home;
* Evidence of a methamphetamine lab;
* Presence of hazardous materials, such as exposed sewage in the home.

Services may be terminated when the client refuses to resolve the hazardous conditions that may **pose a danger to others.**

1. Determine whether the client is capable of understanding the hazards and consequences and whether a referral for a capacity evaluation is appropriate.
2. Give the client ample opportunity to remove the drugs and/or users in the presence of providers and the social services worker. If the hazard is a methamphetamine lab, neither providers nor the social services worker should go into the residence. Immediately call 911.
3. Discuss with the client the potential of the termination of services due to the presence of the hazards.
4. If the client refuses to remove the specific hazard, discuss the case with your supervisor for referral to the interdisciplinary/interagency team.
5. Follow Challenging Cases Protocol.

If the home contains sewage, vermin, lice, or other contaminants to such a degree that **may be harmful** to anyone, determine whether the client understands the danger of such hazards.

1. Make a referral to the local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled, or a danger to self or others.
2. Follow target/intensive case management policy—see LTC Manual, Chapter 5.
3. Consider making a referral to APS if you have reason to believe that the client is experiencing self-neglect and APS services may help them.
4. If the client’s situation jeopardizes his/her health, welfare, or safety, follow the Challenging Cases Protocol.

### Imminent Danger

 “Likelihood of serious harm” and “imminence” are defined as per [RCW 71.05](https://app.leg.wa.gov/RCW/default.aspx?cite=71.05) and the CDMHP Protocols:

* "Likelihood of serious harm" means (RCW 71.05.020(19):
* A substantial risk that: (i) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
* The individual has threatened the physical safety of another and has a history of one or more violent acts;
* “Imminence” means “the state or condition of being likely to occur at any moment; near, at hand, rather than distant or remote” (CDMHP Protocols, p. 16).

Services may be terminated if the “likelihood of serious harm” or “imminent” danger is present to the client or provider. For example, the situation where an extremely frail elderly client threatening to harm someone or kill them, when there are no weapons in the home, and it would be physically impossible for the client to carry out these threats, is not imminent danger and is not a cause for service termination or denial. However, the situation where a client or individual in the client’s home brandishes a weapon, or has a history of physical violence and makes threats that the individual is clearly capable of carrying out, MAY be imminent danger. Having or using illegal drugs in the home may not be imminent danger. Evidence of a methamphetamine laboratory places anyone in close proximity in imminent danger.

If you receive information that the client or the provider is in imminent danger or the likelihood of serious harm is present:

1. Determine whether you need to call the police immediately and/or medical assistance; and/or
2. Determine if you have reason to believe that abuse, neglect, abandonment, or financial exploitation of a vulnerable adult is present and an APS referral is warranted.
3. Make a referral to the Local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled or a danger to self or others.
4. If the individual is applying for services or is a services recipient, and:

you have determined that the client is capable of understanding the issues impacting his/her or provider’s health, welfare, and safety; and

you have listed the possible consequences of those issues; and

you have consulted with your supervisor regarding services termination and your supervisor agrees that you pursue termination of services; then

follow the Services Denial procedure.

### Refusal to Comply

When clients refuse to comply with mandatory program requirements and service delivery provisions:

Services can be terminated if the client demonstrates a *substantial pattern* of behavior that prevents the determination of eligibility, carrying out the plan of care, or monitoring the services to assure the health, welfare, and safety of the client. First exhaust all standard case management activities.

Examples of refusal to comply with the service delivery provisions include, but are not limited to:

* The client is frequently away from his/her home when the provider arrives (without prior arrangements), so that services cannot be performed;
* The client has prevented or refused multiple providers’ attempts to perform vital, authorized services;
* The client, or others in the home, has demonstrated verbal abuse, discrimination, or sexual harassment toward providers on numerous occasions.

If such a pattern of behavior resulted in resignation of multiple providers:

1. Visit the client to discuss the behaviors and inability to deliver services due to the behaviors.
2. Refer the client (or others in the home) to other services, such as counseling.
3. Monitor the client to determine if the client (or others in the home) has stopped the offensive behaviors. A monitoring schedule may be recommended by the interdisciplinary/interagency team; confirm the monitoring schedule with your supervisor; and/or
4. Determine whether another provider of another gender is appropriate (e.g., a male client insists on female providers and has demonstrated a substantial pattern of sexual harassment).

If the behavior is directly related to the client’s disability, seek appropriate service referrals. Services cannot be terminated or denied under such reasons.

### Interdisciplinary/Interagency Team

#### Introduction

Client safety is a *shared responsibility* involving the client, family, friends, neighbors, the social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team (Regional Resource Team, A-Team, ad hoc team) as the vehicle for community entities to review and make recommendations for a challenging case. The interdisciplinary/interagency team differs from the ‘multidisciplinary case staffing’ in that all case management options/activities have been exhausted and the *case is in jeopardy of termination/denial* because of, but not limited to (see introduction to Challenging Cases Protocol):

* client issues;
* physical and social condition of the client’s environs; and/or
* resource issues.

The interdisciplinary/interagency team is responsible for:

* considering all available assessment information in its deliberations;
* identifying the services needed to meet the client’s needs;
* identifying strategies for resolving obstacles that are preventing the implementation of the plan of care;
* estimating the costs for the types and amounts of services identified as necessary to meet the client’s needs;
* determining whether the individual can be served safely in the community;
* developing the plan of care recommendations, including case closure.

#### Procedure

1. When the supervisor, RA/AAA Director (or their designee) instructs the social services worker to convene a team:

Current regional teams may be used for the purpose of reviewing a challenging case, such as Regional Resource Teams or A-Teams. The supervisor must review existing team membership to determine if all disciplines/agencies relevant to the case are represented. If appropriate disciplines/agencies are not represented, the supervisor will identify such members;

If the need to convene a team is immediate and other existing teams meeting dates are not convenient or such a team does not exist in the local community, the supervisor may arrange for an *ad hoc* team;

The RA/AAA Director (or their designee) may also arrange for an interdisciplinary/ interagency team to be convened.

1. The social services worker will attempt to obtain a signed release of information from the client. If the client refuses, the social services worker will:

Send notice of the challenging case review at the interdisciplinary/interagency team only to those entities with case management responsibility, giving the client’s name and other identifying information. If there are team members present not affiliated with the case, the social services worker will discuss the case using the client’s initials and not use the client’s name.

1. The social services worker will complete a referral form. The social services worker may use existing referral forms specific to the team, or use the Interdisciplinary/Interagency Team Documentation form as a referral form for an ad hoc team.
2. A supervisor/program manager and the social services worker will present the case at the team meeting.
3. All team members must sign an oath of confidentiality.
4. The social services worker presents and facilitates the case presentation, using initials only if team member not affiliated with the case are present.
5. The team may:

decide for the social services worker and/or relevant team members to visit the client to:

* clarify safety/welfare issues;
* review rights and responsibilities with the client;
* discuss with the client consequences of not accepting services vital to health, welfare and safety;
* involve family and informal supports;

decide if multiple, frequent visits are necessary;

* develop a monitoring schedule involving the social services worker and/or relevant team members;

coordinate with other community resources;

decide to recommend that services be terminated, identifying what other services must remain open or be put into place.

1. The team will develop the plan of care recommendations;

the social services worker will document the team’s recommendations on the team’s documentation form;

the social services worker will distribute copies of the team’s documentation form to all team members;

1. The supervisor will discuss with the social services worker whether all, some, or none of the team’s recommendations are to be implemented.
2. Continue with the Challenging Cases Protocol.

#### Team Members

Relevant team members include those entities with shared responsibility. Such members may include but are not limited to:

|  |  |
| --- | --- |
| * HCS/AAA/DDA supervisor (*required*)
 | * HCS/AAA/DDA worker (*required*)
 |
| * law enforcement (e.g., tribal police, local sheriff, etc.)
 | * home care agencies
 |
| * home health agencies
 | * adult day health
 |
| * hospice
 | * Department of Corrections
 |
| * Mental Health/CDMHP
 | * Adult Protective Services worker
 |
| * Other DSHS divisions
 | * health care provider
 |
| * hospital/NF social services worker
 | * Residential Care Services
 |
| * emergency response team
 | * fire department
 |
| * Division of Alcohol and Substance Abuse
 | * local health department
 |
| * governing entities (i.e., tribal counsel)
 | * other informal supports
 |

#### Team Outcome Documentation

The social services worker presenting the case is responsible for documenting team recommendations and actions chosen based on these recommendations.

1. Choose the following forms to document a referral to a team or document the team’s outcomes:

Team specific form such as:

* Regional Resource Team Referral Form;
* A-Team Referral Form;

Interdisciplinary/Interagency Team Documentation Form.

1. At the very minimum, documentation of the team’s recommendations must include:

team member names, organizations, and phone numbers;

person presenting the case;

case name;

reason for the referral (what is jeopardizing the client’s health, welfare, and safety);

the services in place;

the interventions tried and failed;

the needs not being met; and

recommendations and reasons why the needs cannot be met.

1. If consensus on recommendations cannot be reached, document the reasons given and by whom.
2. Send each team member a copy of the completed form.
3. File the form in the case record.

## Resources

### Related WACs and RCWs

|  |  |
| --- | --- |
| [RCW 74.34](https://apps.leg.wa.gov/RCW/default.aspx?cite=74.34) | Abuse of Vulnerable Adults  |
| [RCW 74.38.010](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.38.010) | Legislative recognition—Public policy |
| [RCW 74.38.040](https://apps.leg.wa.gov/RCW/default.aspx?cite=74.38.040) | Scope and extent of community based services program |
| [RCW 74.39.005(7)](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39.005) | Long-term Care Service Options – Purpose (Case Management) |
| [RCW 74.39A.040 (3)(c)](https://app.leg.wa.gov/RCW/default.aspx?cite=74.39A.040)  | Department assessment of and assistance to hospital patients in need of long-term care. |
| [RCW 74.39A.090](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.090) | Discharge planning—Contracts for case management services and reassessment and reauthorization—Assessment of case management roles and quality of in-home care services—Plan of care model language |
| [RCW 74.39A.095](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.095) | Case management services—Duties of the area agencies on aging—Consumers' plans of care—Notification to consumer directed employer |
| [RCW 70.41.310](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.41.310) | Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients |
| [RCW 74.42.057](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.42.057)  | Notification regarding resident likely to become Medicaid eligible |
| [RCW 74.42.058](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.42.058)  | Department case management services |

### Acronyms

AAA Area Agency on Aging

AAG Assistant Attorney General

AFH Adult Family Home

APS Adult Protective Services

ALTSA Aging and Long Term Supports Administration

ARC Adult Residential Care

AREP Authorized Representative

BH Behavioral Health

BHPC Behavioral Health Personal Care

BPS Behavior Points Score

CA Case Aide

CDE Consumer Directed Employer

CDWA Consumer Direct Care Network Washington

CM Case Manager

CNC Community Nurse Consultant

CPS Child Protective Services

CRU Complaint Resolution Unit

DMHP Designated Mental Health Professional

DMS Document Management System

DOC Department of Corrections

DSHS Department of Social and Health Services

EARC Enhanced Residential Care

ESH Eastern State Hospital

HCS Home and Community Services

LTC Long Term Care

MCO Managed Care Organization

NCP Negotiated Care Plan

NF Nursing Facility

NSA Negotiated Service Agreement

PAN Planned Action Notice

PASRR Pre-Admission Screening and Residential Review

PCM Primary Case Manager

PCR Personal Care Results

PCRC Personal Care Results Comparison

PNA Personal Needs Allowance

RA Regional Administrator

RCS Residential Care Services

RN Registered Nurse

SER Service Episode Record

SNF Skilled Nursing Facility

SSS Social Service Specialist

TCM Targeted Case Management

WSH Western State Hospital

## Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Made By** | **Change(s)** | **MB #** |
| 10/2020 | Beth Adams | Moved to new template and edits to improve grammar and aesthetics,  |  |
| 2/2021 | Rachelle Ames | Repaired broken links, added form links and replaced the term “placement” with more person-centered language |  |
| 2/2021 | Rachelle Ames | Updated “Social Worker” terminology to “Social Service Specialist” |  |
| 2/2021 | Victoria Nuesca | Updated language related to MCO and Behavioral Health Personal Care |  |
| 2/2021 | Rachelle Ames | Replaced “placement” language with person-centered language |  |
| 2/2021 | Rachelle Ames | Added guidance about SER documentation |  |
| 5/2022 | Kellie Nelson | Updated required documents/process for conversion to CDE |  |
| 2/2023 | Sun-Young Pak | * Replaced the “APS Chapter” with "[Adult Protective Services policy and procedure](https://apswa.navexone.com/content/?public=true&siteid=1)”
* Updated language related to “Mandatory Reporting”
* Replaced “local Designated Mental Health Professional (DMHP)” with “[local County Designated Crisis Responders](https://www.hca.wa.gov/assets/billers-and-providers/designated-crisis-responders-contact-list.pdf)”
* Updated the outdated CARE screens names
 |  |
| 08/2023 | Natalie Lehl | * Fixed broken links
 |  |

## Appendix

For Word version or other languages, visit [DSHS Forms Finder](http://forms.dshs.wa.lcl)

[DSHS 05-246](http://forms.dshs.wa.lcl/formDetails.aspx?ID=10343) **Notice of Action Exception to the Rule** (Excluding AFH)

[DSHS 10-234](http://forms.dshs.wa.lcl/formDetails.aspx?ID=9849) **Individuals with Challenging Support Issues**

* For any clients entering a residential facility who have challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).

[DSHS 13-712](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3563) **Behavioral Health Personal Care (BHPC) Request for MCO Funding**

[DSHS 14-012](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3676) **Consent for Services**

[DSHS 14-225](http://forms.dshs.wa.lcl/formDetails.aspx?ID=7215) **Acknowledgment of Services**

[DSHS 14-300](http://forms.dshs.wa.lcl/formDetails.aspx?ID=6599) **PASRR Level One**

DSHS 14-405 Planned Action Notice (in CARE)

[DSHS 14-443](http://forms.dshs.wa.lcl/formDetails.aspx?ID=6473) **Financial/Social Service Communication**

* For communication with the financial worker regarding the status of the client (e.g. placed in a NF).