Washington State Department of Social & Health Services
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DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: ENHANCED CASE MANAGEMENT PROGRAM POLICY 4.17

Authority:
Title 71A RCW — *Developmental Disabilities*
RCW 71A.12.320 — *Risk of Abuse and Neglect—Process—Home Visits*
Chapter 388-829B WAC — *Enhanced Case Management Program*

Reference: E2SSB 6564 (2016) *Providing Protections for Persons with Developmental Disabilities*

BACKGROUND

During the 2016 legislative session, Senate Bill 6564, *Providing Protections for Persons with Developmental Disabilities*, was signed into law. The Legislature allocated funds to the State Operating Budget for the Developmental Disabilities Administration (DDA) to increase home visits for clients who may be at higher risk of abuse and neglect.

PURPOSE

This policy establishes criteria and operating procedures for the Enhanced Case Management Program (ECMP).

SCOPE

This policy applies to DDA headquarters and field services staff.

DEFINITIONS

Ability to supervise caregiver refers to whether the client can instruct a provider how to meet their needs and whether the client can notify someone when their needs are not being met.

Adult Protective Services or **APS** means the ALTSA Division that receives reports, conducts investigations, and offers protective services related to allegations of mistreatment of vulnerable adults under chapter 74.34 RCW.

ALTSA means the Aging and Long-Term Support Administration.

CARE means the comprehensive assessment reporting evaluation tool under chapter 388-106 WAC.

Caregiver means a person who provides personal care or respite services to DDA clients.

Child Protective Services or **CPS** means the section of the Department of Children, Youth, and Families for responding to allegations of child abuse or neglect.

Client means a person eligible for DDA services.

Collateral contact means a person or agency that is involved in the client's life, such as a legal guardian, family member, provider, or friend.

CRM means the DDA case resource manager or social service specialist.

DDA assessment means an inventory and evaluation designed to measure the individual support needs of persons with intellectual and developmental disabilities over a broad spectrum of life areas and activities.

ECMP committee means a committee of ECMP regional supervisors, ECMP coordinators, and headquarters program managers who review, prioritize, and process transfers on and off the program, based on policy criteria and program capacity.

Legal representative means a parent of a client if the client is under age eighteen and parental rights have not been terminated or revoked, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Necessary supplemental accommodation means a person who is willing to receive copies of planned action notices and other DSHS correspondence in order to help a client understand the documents and exercise their rights.

SER means a service episode record in the case management system, Comprehensive Assessment Reporting and Evaluation (CARE).

POLICY

A. The CRM must:

1. Refer all clients who have an ECMP critical indicator referral in CARE to their supervisor and the regional ECMP coordinator for enrollment consideration; and

2. SER the results of the referral.

B. A client is eligible for the ECMP if the client is currently eligible for community first choice (CFC) services in their home under chapter 388-106 WAC and meets criteria under subsection (1), (2), or (3) below:

1. The client’s DDA assessment indicates that the home environment may jeopardize the client’s health or safety.

2. The client's DDA assessment indicates the client:

   a. Has difficulty communicating their needs and wants to their caregiver or inform someone when their needs are not being met;

   b. Has a limited ability to advocate for themselves or express themselves, and has few documented collateral contacts; and

   c. Lacks additional, independent supports that regularly help the client monitor the care being provided in their home.

3. DDA has concerns that the quality of care may jeopardize the client's health or safety for reasons such as:

   a. The client has been the subject of an adult protective services referral in the past year

   b. The client has been the subject of a child protective services referral in the past year;

   c. The client's DDA assessment indicates the client is underweight;

   d. The client’s DDA assessment indicates that the primary caregiver is age 65 or older or states that they are “very stressed,” and the caregiver states that the caregiving situation is at “serious risk of failure” or there is concrete evidence of reduced care; or

   e. The client has experienced a destabilizing event, such as a loss of a primary caregiver, hospitalization, or victimization.

C. A client is not eligible for ECMP if the client:

1. Is receiving services through the CIIBs or Community Protection Waivers. These waivers require 90-day visits, which are more frequent than the ECMP home visit requirement.

2. Is currently receiving residential services from an adult family home, supported living, group home, or companion home provider. Services in these settings have other oversight.

3. As verified by the ECMP committee:

   a. No longer has any quality of care, isolation, or home environment concerns; or

   b. Has had at least two visits in the past eight months with no concerns or slight concerns and no longer refers in their current assessment.

4. Is a minor eligible for other programs. For minors not living with a paid provider, the CRM must help the client explore community-based services before referring to ECMP. Referrals should be reviewed closely in ECMP committee.

<u>ECMP REFERRALS</u>

A. The CRM must identify any clients they believe meet eligibility criteria for the ECMP. A CRM may refer a client to ECMP at any time.

B. Before referring a client to ECMP, the CRM must record supporting information in CARE and the DDA Assessment as follows:

1. Document in the Planned Living Arrangement screen if the client lives with a paid provider;

2. Document in the Cognitive Performance screen if the client has a limited ability to supervise their caregiver;

3. Document in the Vision/Communication screen whether the client has communication barriers or limited collateral contacts. Supporting information includes:

   a. The client’s support needs related to Protective Supervision, Social Activities, and Protection and Advocacy;

b. The client's Service Level Assessment responses regarding relationships, interests, and speech or hearing comprehension;

c. The client's goals in the Person-Centered Service Plan; and

d. Contact details;

4. Document in the Cognitive Performance screen whether the client has a limited ability to supervise their caregiver. Supporting information includes:

a. The availability of additional paid service providers or unpaid contacts who might help supervise the caregiver in the client's home;

b. Whether DDA has consent to discuss the client's care needs with the person identified to supervise the caregiver in the client's home;

c. Whether the person identified to supervise the caregiver is able to visit the client's home at least monthly; or

d. Credible reports that raise concern about the character, competence, or suitability of the person supervising the caregiver in the client's home; and

5. The CRM must document if:

a. The client is a minor with a history of CPS involvement;

b. The client has a history of screened-in referrals to APS; or

c. DDA has documented concerns that the home environment or quality of care may jeopardize the client's health or safety.

C. If a CRM identifies a client on their caseload who appears to meet eligibility criteria for the ECMP, the CRM must complete DSHS 11-121, *Enhanced Case Management Referral Consideration*, and email the referral form to their Supervisor and the Regional ECMP Coordinator.

D. The Supervisor and Regional ECMP Coordinator will discuss the case with the CRM, determine if the case meets ECMP eligibility, and inform the CRM of the decision.

E. The CRM must document in a SER the results of the enrollment discussion and any necessary next steps.

F. For cases deemed appropriate by the region, the Regional ECMP Coordinator will complete a *Prior Approval for "Enhanced Case Management Program – Enrollment"* and submit the request to the ECMP Committee for approval.

G. The Regional ECMP Coordinator will inform the Supervisor and CRM of the committee's decision.

H. The Regional ECMP Coordinator will maintain a list of clients determined eligible, but who remain unenrolled due to program capacity.

I. The ECMP Committee conducts final reviews and processes transfers onto the program as referrals are received.

J. When a CRM has a client on their caseload who is enrolling in ECMP, the CRM must coordinate with the ECMP CRM to ensure that introductions are made and that concerns regarding the transfer are addressed before the transfer takes place. Such coordination may occur by phone or by scheduling a home visit with both CRMs present.

ECMP CASE RESOURCE MANAGER AND COORDINATOR PROCEDURES

A. The ECMP Coordinator must send DSHS 10-588, *ECMP Enrollment Letter*, to the newly enrolled client and legal representative.

  1. The ECMP Coordinator must attend ECMP committee meetings monthly to review all enrollments and disenrollments.

  2. The ECMP Coordinator is the primary point person for all emergent incident emails and case coordination when a client is in crisis.

B. The ECMP CRM must visit an ECMP client at least once every four months, including unannounced visits when appropriate.

  1. Each of the required visits must not occur more than four months apart. For example, if a visit occurs in January, the next visit must occur by the end of May.

  2. An unannounced visit may replace a scheduled visit.

C. If the ECMP CRM is unable to meet with the client for a scheduled visit, the ECMP CRM must schedule a follow-up visit.

D. A visit can be either declined or refused.

  1. A visit is considered declined if:

a. The client, the client's family, or the individual provider has a scheduling conflict, or forgot about appointment;

b. The client, the client's family, or the individual provider prefers not to have people in their home due to concerns about contagious illness;

c. The client or family did not pass COVID-19 prescreening questions.

2. A refused visit is when the client or representative:

a. Is not allowing a case manager to inspect the living quarters of the client as required by DDA Policy 14.03, *Viewing a Client's Living Quarters*; and

b. Provides no reason, or a reason other than that in subsection (D)(1) above.

E. If a client declines or refuses a visit, scheduled or unannounced, the ECMP CRM must document the reason for the declined or refused visit in a service episode record (SER).

F. The follow-up visit must occur no more than thirty days after the declined or refused visit and may be unannounced.

G. If the ECMP CRM is unable to complete an in-home visit, they may contact local law enforcement or APS to coordinate a wellness check.

H. As required under WAC 388-825-375 and WAC 388-113-0050(i), an individual provider must cooperate with monitoring visits. If the provider does not comply with monitoring visits, the ECMP CRM may contact Consumer Direct Washington (CDWA) and inform them of their concerns regarding the provider for further action.

1. To contact the CDWA when there are concerns regarding the provider, dial 1-866-214-9899, then select #2 to enter ProviderOne ID and be connected to an assigned service coordinator.

2. The ECMP CRM must document in an SER that CDWA has been contacted for not complying with home visits.

I. To determine whether more frequent visits are necessary, the ECMP CRM may consider any of the following:

1. The client is the subject of a current APS or CPS investigation;

2. The client was recently referred for an APS or CPS investigation;

3. Documented concerns about the client's safety, home environment, physical appearance, exploitation, health, or the caregiver's ability to deliver quality services;

4. The ECMP CRM has learned of a destabilizing event involving the client, such as loss of primary caregiver, an arrest, hospitalization, or victimization;

5. The client or caregiver has not followed through with two or more scheduled visits; or

6. The ECMP CRM has attempted to schedule a visit, but neither the client nor the provider has responded via telephone or email.

J. For each home visit, the ECMP CRM must document in the ECMP node:

1. If a client refuses or declines to allow a home visit and the client's reason for refusing or declining the visit;

2. Specific concerns, any referrals made, and outcomes from previous referrals or assistance provided;

3. Observations, including data tracking regarding ECMP CRM level of concern related to:

a. Isolation;
b. Home environment; and
c. Quality of care;

4. Rapport between the client and caregivers, including whether the client is currently requesting services and whether the caregiver is supportive of the client having additional services at this time; and

5. Specific issues, concerns, and referrals addressed during the visit.

NOTE: If the ECMP CRM records all the information in a timely manner (i.e., as required by the DDA assessment) into the ECMP node, it is not necessary to record in duplicate areas.

K. In between visits, the ECMP CRM must enter into the ECMP node any milestones that occur, such as authorizing new services, waiver approvals, guardian appointments, etc.

L. Caseload Transfers Off the ECMP

1. A client may transfer off the ECMP if:

   a. The client no longer meets eligibility criteria; and

   b. After two in-home visits in an eight-month period, the case manager has indicated “no concern” or “slight concern” (as defined in the F1 screen) in the ECMP node in CARE regarding quality of care, the home environment, and isolation.

2. The ECMP CRM must discuss potential transfers off the ECMP with the ECMP supervisor. The region reviews clients who may transfer off the ECMP to ensure the:

   a. Client no longer meets the ECMP eligibility;

   b. CRM has accurate information to submit a *Prior approval for “Enhanced Case Management Program – Disenrollment”* or an *“Enhanced Case Management Program – Archive File”*;

3. The ECMP coordinator must use the appropriate prior approval type as follows.

   a. If a client has moved to another state, fill out the prior approval *for “Enhanced Case Management Program – Archive File”* and only fill out the date of the client move.

   b. If a client has deceased, fill out the *Prior approval for “Enhanced Case Management Program – Archive File” and fill in date client deceased,* and also fill out the *“Justification of Request”* tab questions.

   c. If a client has moved into a residential setting to receive services, such as a supported living program, group home or adult family home, fill out the *“Enhanced Case Management Program – Disenrollment”* and only enter the type of residential and the date the client moved.

   d. If a client has requested to be disenrolled or the CRM or Region is recommending the disenrollment, fill out the *“Enhanced Case Management Program – Disenrollment”* form and answer all the questions on the different tabs.

4. The ECMP Committee conducts final reviews and processes disenrollment off of the program. The CRM must send DSHS 10-597, *ECMP Disenrollment Letter*, to the client and the client's legal representative.

5. If a client loses a paid provider or loses financial eligibility while enrolled in ECMP, the client may remain on ECMP if the client and legal representative are actively working on having services restored.

6. If a client will be transferring off ECMP due to no longer receiving services, the case manager must:

   a. Ensure that all attempts to communicate with the client and legal representative are documented in SERs;

   b. Send a planned action notice to the client, and the client's legal representative and necessary supplemental accommodation, informing them of the plan to stop case management and provide information on who to contact if they decide to resume services with DDA; and

   c. Consult with regional guardianship coordinators when a petition for guardianship may be appropriate.

M. Coordination of Nursing Care Consultant (NCC) consultation

1. If the client appears to need a nursing consultation, the ECMP CRM must complete the NCC Referral on the Nursing Services SharePoint site.

2. An ECMP client may need a nursing consultation if:

   a. The client needs a nursing assessment (may include in-person visit);
   b. The client or provider needs training;
   c. The client needs health care consultation (may not include in-person visit);
   d. The client needs medication management;
   e. The client has a change in nutritional status;
   f. The client has Immobility issues;
   g. The client is experiencing pain;
   h. The client is experiencing depression;
   i. The client has equipment needs;
   j. The client experiences frequent hospitalizations;
   k. The client has skin integrity problems (other than skin observation protocol).

Note: The ECMP CRM must not use this NCC consultation process for Area Agency on Aging referrals, Home Health Agency referrals, nurse delegation, or skin observation protocol. Instead, current processes in place should be used, such as those in DDA Policy 6.15, *Nurse Delegation Services*, and DDA Policy 9.13, *Skin Observation Protocol*.

3. No more than three working days after receiving a request for a nursing consultation, the DDA Nursing Services Unit Manager must review and assign to a Regional NCC.

4. Once the referral is received, the NCC must consult with the ECMP CRM to determine appropriateness of the referral and schedule the consultation.

5. The NCC must:

   a. Consult on the client's situation, which may include a home visit.

   b. Document in an SER the outcome of assessment, which may include consultation with medical providers or the client's managed care organization.

   c. Document the need for subsequent visits, if needed.

   d. Identify "follow-up needed" on the NCC referral and in an SER.

   e. Coordinate follow-up needed with the DDA Case Manager.

COMPLAINTS AND GREIVANCES

If a case resource manager, supervisor, regional administrator or central office employee receives a complaint or grievance from a client, the employee must follow DDA 5.03, *Client Complaints*.

EXCEPTIONS

Any exception to this policy must have written prior approval from the Deputy Assistant Secretary or designee.

SUPERSESSION

DDA 4.17*, Enhanced Case Management Program*
Issued October 15, 2021

Approved: */s/: Shannon Manion* Date: January 1, 2023
Deputy Assistant Secretary
Developmental Disabilities Administration