

CHAPTER 2

Intake, Prioritization and Case Management

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PURPOSE AND GOALS OF CASE MANAGEMENT:

PURPOSE OF CASE MANAGEMENT:

The purpose of case management is to coordinate the delivery of community care services in accordance with the following principles:

- A. Gatekeeper:** The case manager is the community care service system "gatekeeper" with the knowledge and responsibility to link clients' needs to the most beneficial and least restrictive array of community services and resources.
- B. Client Centered:** Case management is client centered. Case managers should make every effort to link clients with appropriate formal and informal support, regardless of the agency or organization offering the services and advocate on the client's behalf to help the client to receive the assistance needed.
- C. Limiting Services:** Case managers should not limit services only to those services offered by their agency.
- D. Coordination:** Case managers should ensure full coordination of services provided by various agencies and individuals and pay particular attention to the scheduling of services in the home of the client.
- E. Linking Services:** Case management is the link between social services programs, home and community-based service providers and health care delivery systems, such as physicians, hospitals, health maintenance organizations (HMO's) and nursing homes.
- F. Informal Support Systems:** Case management provides the contact through which the family, caregivers, neighborhood help organizations and voluntary services assist the client. The case manager is a developer of informal support systems, one of the most necessary and productive components of long term care. Case managers should actively pursue informal resource development.
- G. Assistance to Families:** Case managers assist clients' families as well as clients. Allowing for legally competent clients to choose who participates in decisions about their care, case managers will encourage families to be involved and link them with respite care resources as needed.
- H. Family Training:** Case managers should encourage family members to receive training in caregiving methods.

GOALS OF CASE MANAGEMENT:

The goals of case management are:

- A. Self-Sufficiency:** To coordinate services that assist clients in becoming more independent, remaining in the least restrictive environment, and attaining or maintaining the highest level of physical, mental and psychosocial well being.
- B. Quality Assurance:** To ensure effective and efficient client care through the following activities:
1. Initiating or terminating services;
 2. Increasing or decreasing services;
 3. Assessing client needs in a comprehensive manner;
 4. Determining client satisfaction with services.
 5. Planning and arranging for appropriate services (duration, scope, frequency) provided to clients within a reasonable time period and that produce effective results.
 6. Coordinating services through community care service systems and eliminating unnecessary overlap of services, as possible.
 7. Documenting gaps between services that are needed and those presently being received for planning and budgeting purposes.
- C. Continuum of Care:** To provide access to holistic care, ranging from services in the home to institutional care.

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LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

| <u>Program:</u> | <u>Specific Legal Authority:</u> |
|-----------------|--|
| ADI | Chapter 430.501-504, F.S. |
| CCE | Chapter 430.201-207, F.S. |
| Abuse Hotline | Section 827.07, F.S. |
| HCE | Chapter 430.601-608, F.S. |
| LSP | Specific Appropriations |
| OAAIIB | Older Americans Act, Title III, Part B, Section 321 (a)(5)(A) 42 U.S.C. 3030d |

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SERVICE REQUIREMENTS

SECTION 1: CASE MANAGEMENT AND THE ROLE OF THE CASE MANAGER

BASIC FUNCTIONS AND RESPONSIBILITIES:

Functions and responsibilities of the case manager include the following:

- A. Investigating Community Resources:** The case manager is responsible for knowledge about all formal and informal community resources in order to coordinate client services.
- B. Receiving and Documenting Referrals:** Agencies may use a separate intake worker or a case manager to receive referrals for services.
 - 1. Receiving:** The intake worker/case manager shall determine whether the client appears to meet program eligibility guidelines or must be referred to another agency.
 - 2. Documenting:** All referrals to other agencies shall be documented.
- C. Networking with other Agencies:** The case management agency shall develop a network with other agencies to assist clients in obtaining needed services.
 - 1. Networking:** This network will provide valuable information, save valuable time coordinating client services and prevent service duplication. .
 - 2. Referring:** The case manager is responsible for making referrals when appropriate. This may include such agencies or offices as Department of Children and Families (Food Stamps), Social Security Administration or Veterans Administration.
- D. Completing the Client Assessment:** The case manager shall complete the Assessment Instrument (DOEA 701B). The assessment will determine the client's level of functioning, existing resources, and gaps in service provision (see Assessment Instructions 701D for details).

- E. Obtaining an Authorization for Release of Information:** The case manager will request the applicant to sign an authorization for release of information form.
1. This authorization will ensure that necessary information is shared with service delivery staff and agencies involved to aid them in providing appropriate services.
 2. A sample release form is included as Attachment 1 to this chapter. Agencies may use this form or may develop an agency specific form using the same content. This form shall be completed annually during reassessment.
- F. Developing a Care Plan:** If the client is determined eligible for services after the assessment instrument is completed, a care plan and confidential file must be developed for each client. The case manager shall use the uniform care plan (DOEA 203A and DOEA 203B) to develop with the client and important others (such as spouse or caregiver) ways to address service needs. :
- G. Arranging Needed Services:**
The case manager shall complete the care plan within two weeks after completion of the client assessment. The case manager must arrange needed services offered by agencies in the community care service system and organize informal sources.
- H. Referring to Other Sources:** Services not arranged through agency contracts should be obtained through referrals to other community resources. Referrals may be made to volunteer agencies, informal networks, and proprietary agencies that charge fees.
- I. Providing Follow-up:** The case manager or case aide must conduct a follow-up contact on service arrangements and referrals within two weeks following such arrangements to ensure that services have begun.

J. Communicating with Other Agencies:

1. **Agency Involvement:** It is very important for all agencies involved to know when a client's needs change or when an agency, for whatever reason, modifies its services.
2. **Assistance:** Some agencies may be able to provide assistance or know of other resources to help the client.
3. **Staffings:** One way to ensure communication and coordination of services is to meet on a regular basis with other agencies for particular case staffings.

K. Documenting Case Activities: A good case record serves as an invaluable aid in rendering services to the client and documenting the outcomes. The record serves as the tool for relevant information regarding the client's progress. The case manager has the responsibility for the following:

1. Initiating and maintaining the case record;
2. Documenting pertinent information in the case record and updating the record when conditions change or following periodic contacts with the client; and
3. Writing in a fashion to enable an independent reviewer to fully understand the client's status and services and obtain a good overview of case management. Legibility of handwriting or use of word processing along with a legend of abbreviations used are vital to a good case record. (See Section 5 of this chapter, Case Record, for required documentation.)

L. Contacting the Client to Review and Monitor the Care Plan: The case manager must make a home visit to review the care plan at least every six months, or more frequently, based upon the individual client's needs and program requirements.

1. **Continuity of Care:** The case manager will oversee the care plan for continuity of services and changes in the client's functioning that warrant increases, decreases, or other changes in the recommended care plan.

**Section 1: Case Management and the Role of the Case Manager:
Basic Functions and Responsibilities**

Service Requirements

-
- 2. Care Plan Review:** The review is not a complete reassessment, but a review of service goals and changes in the client's status that may warrant modification to the care plan. The case manager will discuss any changes in the care plan with the client and caregiver for acceptance prior to changes in service provision. The case manager will verify service quality and client satisfaction.
- M. Client Reassessment:** For case management as well as planning and coordination purposes, the case manager must perform a face-to-face client reassessment at least once every year.
- 1. Reassessment Form:** The case manager shall complete the Assessment Instrument (DOEA 701B) form in accordance with the instructions in Section 3 of this chapter, Client Assessment.
 - 2. Reassessment Results:** Reassessment results are to be used to evaluate and modify the care plan, if needed.
- N. Discontinuing or Modifying Services:** The decision to discontinue or modify services shall include the client, family members or caregiver after a review and update of the client's situation.
- 1. Improvement of Condition:** If the client's health or functional status improves, then the case manager shall modify the care plan accordingly, accommodating assistance from family members or other community supports. If formal services are no longer needed, the case manager shall terminate services.
 - 2. Deterioration of Condition:** If the client's health deteriorates to the extent that more extensive care is needed, then the case manager shall assist the person in locating the most appropriate, least restrictive, and most cost-effective alternate living arrangement.

3. **Client Behavior Problems:** The case manager may close the case when the client exhibits either of the following behaviors:
 - a. Refuses to continue services; or
 - b. Is uncontrollable, uncooperative, or combative.
 - c. The case manager will document in the case narrative circumstances of the situation and the progression of the behavior problems.
 4. **Documentation:** The case record must reflect adequate documentation for service modification or termination. The client must be notified in writing 10 calendar days in advance of the termination of services, except in the case of death, the client moving out of the service area, the client moving to an assisted living facility or nursing home, or the client requesting the termination.
- O. Referrals to Protective Services (Florida Abuse Hotline):** Agency staff or their subcontractors must report any suspicions of abuse, neglect, or exploitation to the Florida Abuse Hotline.
1. **Florida Statutes:** The Florida Abuse Hotline was established by Section 827.07, F.S., to record all such incidences.
 2. **Hotline:** On-call coverage for reporting of abuse, neglect, or exploitation of disabled or infirmed, aged adults is provided 24 hours a day, seven days a week by the Florida Abuse Hotline staff at a TOLL-FREE NUMBER:
1-800-96 ABUSE (1-800-962-2873).
 3. **Investigation:** Each complaint of alleged abuse, neglect, or exploitation accepted by the hotline is phoned to the designated adult protective services investigator in the respective district for contact and action.

RECOMMENDED STAFFING AND CASELOAD STANDARDS:

Listed below are recommended staffing, caseload and case manager supervision standards:

- A. Caseload:** A caseload consists of those clients determined eligible and receiving case management services.
 - 1. Average Caseload:** DOEA suggests maintaining a caseload of 60-70 clients per case manager full time equivalent (FTE).
 - 2. Over Average Caseloads:** Caseloads exceeding 100 clients per case manager require a waiver from the area agency on aging.

- B. Case Manager Supervisor:** Case manager supervisors may be established in larger agencies employing five or more case managers.
 - 1. Supervisor's Caseload:** The case manager supervisor may handle a small number of cases, not to exceed half of the size of a case manager's caseload (30-35 clients).
 - 2. Alternate Supervision:** In smaller projects, supervision may be provided by the project director or other project staff with direct service experience.

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JOB DESCRIPTION INCLUSION REQUIREMENTS:

A. CASE MANAGER:

1. Major Functions: Major functions of the case manager's job description are:

- a. Referral and Assessment:** Receives referrals and completes initial and annual client assessments.
- b. Information:** Provides information as needed in order to involve the client and/or primary caregiver in the care plan.
- c. Care Plan:**
 - i.** Develops care plans, arranges for and follows-up on services provided; and
 - ii.** Reviews care plans with other professionals involved with service provision.
- d. Follow-up:** Provides follow-up as needed.
- e. Home Visits:** Makes home visits.
- f. Case Records:** Maintains individual case records.
- g. Informal Support Network:** Develops informal support network (relatives, volunteers, friends, etc.) when there is no caregiver or when additional help is needed.
- h. Expanded Support Network:** Builds an expanded support network with members of the client's immediate community.

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2. Major Duties: Case managers' major duties are as follows:

- a. **Client Assessment:** After the new client is screened and it is determined that funding is available to provide services, the case manager will schedule a face-to-face visit with the client to complete the Assessment Instrument (701B). The form will generate a priority rank to prioritize the client in comparison with all other clients waiting for services. If the applicant can be served, the Assessment Instrument (DOEA Form 701B) will be completed within fourteen business days after receiving the referral. In all cases, the Assessment Instrument (701B) will be completed face-to-face with the client before services are begun. The assessment helps to identify the client's conditions and resources in relation to:
 - i. Mental Health/Behavior/Cognition;
 - ii. Physical Health;
 - iii. Activities of Daily Living (ADLs);
 - iv. Instrumental Activities of Daily Living (IADLs);
 - v. Nutrition Status;
 - vi. Health Conditions/Special Services/Medications;
 - vii. Caregiver Status;
 - viii. Social Resources; and
 - ix. Environmental Risks.
- b. **Care Plan Development:** Develops care plan in conjunction with the client/client's representative, spouse or family, obtaining the client's concurrence and signature or that of the client's representative if the client is unable to sign the care plan. If the client is legally incompetent, his/her guardian must sign the care plan.
- c. **Care Plan Review:** Reviews care plan with supervisor at initial development. This may be a team activity for subsequent reviews.
- d. **Services:** Arranges for services and coordinates service delivery.

Service Requirements:

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Job Description Inclusion Requirements

- e. **Respite Care:** Arranges respite care for caregivers as needed. Refers caregivers to, or arranges for, counseling/support groups in order to relieve the stresses of the caregiver role.
 - f. **Training:** Encourages and may arrange for caregivers, family members or friends to attend training where possible.
 - g. **Client Reassessment:** Completes written client reassessment at least annually and more frequently if conditions warrant.
 - h. **Client Record:** Completes and maintains a client record with progress reports and forms related to service provision and ongoing documentation.
 - i. **Supervisory Role:** May supervise other personnel.
 - j. **Other Duties:** Performs other duties as necessary.
3. **Minimum Qualifications:** A case manager must meet one of the following qualifications:
- a. A bachelor's degree in social work, sociology, psychology, nursing, gerontology or a related social services field; or
 - b. Year for year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA.

B. CASE AIDE:

1. **Major Functions:**

- a. Case aides are para-professionals who complement or supplement the work of case managers.
- b. Case aide activities are billed as case aide services and not case management services.

2. Major Duties:

- a. Providing direct follow-up contacts.
- b. Assisting with the implementation of the care plan.
- c. Arranging for services in accordance with the care plan.
- d. Determining client satisfaction with services provided.
- e. Documenting activities in the case record.
- f. Maintaining a weekly schedule for services.
- g. Delivering supplies and equipment to client.
- h. Assisting the client or caregiver in compiling information and completing applications for other services and public assistance.
- i. Recording telephone and travel time associated with billable case aide activities.

3. Provider Qualifications:

- a. Minimum qualifications for case aides include a high school diploma or GED.
- b. Job related experience may be substituted for a high school diploma or GED upon approval of the AAA.

C. CASE MANAGER SUPERVISOR:

1. Major Duties: Case manager supervisor's major duties are as follows:

- a. **Supervision:** Supervises case managers and case aides;
- b. **Care Plans:** Reviews care plans at initial development, and as necessary, and ensures follow-up on all care plans;

- c. **Reviews, Reassessments, Case Records:** Ensures completion of semiannual reviews and annual assessments for clients and that appropriate case records are maintained.
- d. **Service Delivery:** Ensures that providers deliver services as scheduled, within specified time frames and without negative incident.
- e. **Coordination:** Resolves service delivery problems and ensures coordination among community care providers.
- f. **Problem Resolution:** Resolves problems between the case manager and client or caregivers.
- g. **Quality Assurance:** Reviews service provision to ensure effective and efficient client care.
- h. **Home Visits:** Makes random client home visits for the following objectives:
 - i. To ensure that service plans are followed;
 - ii. To become familiar with the client's environment; and
 - iii. To ensure accuracy of case recordings.
- i. **Respite Care:** Ensures that respite care is arranged for caregivers as needed.
- j. **In-Service Training:** Arranges for in-service case manager training.
- k. **Informal Support Systems:** Ensures that case managers are actively developing informal support systems among clients' neighbors and community volunteers.
- l. **Caregiver Training:** Ensures that caregivers, family members or friends receive training where possible.

IN-SERVICE TRAINING PROGRAM:

- A. Program Development:** Each provider agency shall develop an in-service training program for case management staff.
- B. Minimum Standards:** Each provider agency shall conduct at a minimum an annual in-service training of six hours and will document the duration and content in case management staff records.
- C. Description and Allocation of Funds:** Each provider agency shall describe and allocate budget funds for training in the provider application.
- D. Minimum Standards:** Training will include, at a minimum, the following topics:
 - 1. Overview:** Overview of community care services;
 - 2. Relationship:** Relationship of case management to the community care services system;
 - 3. Completion of Forms:** Use and completion of assessment instruments and care plans;
 - 4. Interviewing:** Interviewing skills and techniques;
 - 5. Record Keeping:** Record-keeping procedures;
 - 6. CIRTS:** Client Information and Registration Tracking System (CIRTS) procedures;
 - 7. Aging Network Overview:** Overview of the aging network (AAA, DCF, AHCA, DOEA and other agencies) and the agency's relationship to the community care service system;
 - 8. Caregiver Training:** Caregiver training regarding responsibilities and resource development techniques; and
 - 9. Coordination Training:** Interagency coordination and informal network development training.