

Case Management Program For Frail Elders

Program Training Manual

August 2008

Table of Contents

INTRODUCTION TO THE CMPFE MANUAL	1
BACKGROUND	1
CMPFE History	1
PROGRAM ADMINISTRATION	3
DEFINITIONS	3
CONSUMER ELIGIBILITY	9
Initial and On-going Eligibility	9
Date of Eligibility	9
Discharge	9
Funding.....	10
PROGRAM STANDARDS.....	11
Covered Case Management Services	11
Program Principles	11
Long Term Goals.....	12
Personnel	12
Confidentiality	16
PROGRAM PROCESSES	17
Referrals	17
Scheduling the Home Visit.....	18
The Interview	18
Obtaining a Signed Release of Information	18
Consumer Assessment.....	21
Developing the Service Plan.....	22
Emergency/Contingency Plan	24
Monitoring Visit	25
On-going monitoring	26
Reassessment.....	27
DOCUMENTATION.....	27
Case Notes.....	27
Content of Consumer Case File	29
Quality Assurance.....	29
Conflict of Interest.....	30
CONTRACTING FOR CASE MANAGEMENT SERVICES	33
ACRONYMS	34

CASE MANAGEMENT PROGRAM FOR FRAIL ELDERES

Program Manual

INTRODUCTION TO THE CMPFE MANUAL

The purpose of this manual is to guide operation of the Case Management Program for Frail Elders. After *Background, Program Administration, Definitions, Consumer Eligibility, and Program Standards*, the order follows the flow of a consumer entering the program from referral through ongoing case activities. The manual is written assuming the reader is the Case Manager.

The effective date will appear in the bottom left hand corner of each page. This manual will be updated as needed via Iowa Aging Program Instructions (IAPI).

This manual is used in conjunction with the Department of Human Services' manuals which provide more detail about policies and procedures within the Medicaid elderly waiver program.

BACKGROUND

The Case Management Program for Frail Elders (CMPFE) is a coordinated comprehensive system that strives to provide Iowa's frail elderly with the opportunity to make their own choices regarding long-term care and to receive services in the home and community setting.

CMPFE gives the Iowa frail elderly population an alternative to a nursing facility and other forms of institutionalized services. CMPFE coordinates the delivery of needed community services which allow elderly Iowans to remain safely in their own homes. Each consumer is monitored by an individual Case Manager who provides assistance to the consumer in making the appropriate choices that best fits the consumer's needs.

CMPFE History

In August of 1984, then Governor Branstad appointed a task force of 14 Iowans to study the long-term care system and identify what would be needed for Iowa to create a more coordinated approach to long-term care services for Iowa's elderly population. In response to the recommendations made by this task force, the 1986 session of the Iowa General Assembly established a Long Term Care Coordinating Unit within the Department of Elder Affairs (DEA). The Long Term Care Coordinating Unit was renamed the Senior Living Coordinating Unit in 2000.

During July of 1988, the Department of Elder Affairs in cooperation with the Long Term Care Coordinating Unit (now called the Senior Living Coordinating Unit) funded the first Case Management Program for the Frail Elderly pilot projects in Cerro Gordo and Linn counties. During that year there were 1,151 pre-screenings performed, 496 comprehensive assessments completed and 156 elderly lowans admitted in the program.

The year 1990 marked an important milestone for the program. Rules were adopted establishing the application process for an area agency on aging (AAA) to become a designated CMPFE entity putting Iowa well on its way to providing a system of coordinated long-term care and community-based services to Iowa's frail elderly.

By the year 1999, CMPFE was expanded to include all 99 Iowa counties and the medical assistance home and community-based services elderly waiver program became available statewide. In 2005, the Iowa Code was modified to more clearly define the Department of Elder Affairs' direct responsibility for the program. On October 1, 2006, case management was added as a waiver-covered service under the Medicaid elderly waiver program.

In May of 2006, DEA revised Chapter 21, the chapter containing the Iowa administrative rules governing CMPFE. Minor revisions to these rules were filed and adopted by the department on July 2, 2008 and were effective on August 6, 2008.

Currently all lowans over the age of 60 can access CMPFE and its services through their local area agency on aging. Services offered through this program make it possible for thousands of Iowa's frail and/or low-income elderly to stay in their home and local communities.

PROGRAM ADMINISTRATION

The Iowa Department of Elder Affairs (DEA) is the state agency responsible for the Case Management Program for Frail Elders. The Department of Elder Affairs' oversight includes policy development and monitoring to ensure adherence to contractual agreements, applicable federal or state laws, regulations, and rules. The department specifies the forms and data processing software systems that must be used. The department has access to all case management records maintained by the agencies and conducts random audits on a percentage of records to ensure that documentation exists to support adherence to administrative rules. Policy and manual changes from the department are issued through an official Iowa Aging Program Instruction (IAPI).

The Iowa Department of Human Services, as the single state Medicaid agency, is responsible for ensuring case management services to elderly waiver consumers meet federal and state Medicaid guidelines. Oversight includes rule development for the elderly waiver program, Level of Care determinations, quality assurance reviews, technical assistance, and other program implementation procedures.

Area agencies on aging are responsible for administering the CMPFE program at the local level and educating the community about CMPFE.

DEFINITIONS

Adult Day Care - Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. Services offered in conjunction of adult day care/adult day health typically include social and recreational activities, training and counseling, meals for adult day care and services such as rehabilitation, medications assistance, and home health aide services for adult day health.

Assessment - Administration of a standardized tool and the use of other procedures to identify existing impairments, situations, and problems which are barriers to a resident's ability to function and to identify strengths and specific needs.

Assisted Living - Provision of housing with services which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living to six or more tenants in a physical structure which provides a homelike environment.

Assistive Devices - Practical equipment products to assist consumers with activities of daily living and instrumental activities of daily living which allow the consumer more independence. These assistive devices may include but are not limited to long-reach

brush, extra long shoehorn, non-slip grippers to pick up and reach items, dressing aids, shampoo rinse tray, inflatable shampoo tray, and double-handled cup and sipper lid.

Case Management – Assistance either in the form of access to or care coordination in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other conditions or other characteristics which require the provision of services by formal service providers. Activities of case management include assessing needs, developing care plans and authorizing services, arranging services, coordinating the provision of services among providers, follow-up and reassessment, as required.

“Case management program for frail elders” or “CMPFE” is a program where qualified case managers assist elders in gaining access to needed medical, social, and other appropriate services. Case management services are provided at the direction of the elder. The Department of Elder Affairs’ oversight of CMPFE includes policy development and monitoring to ensure adherence to contractual agreements, applicable federal or state laws, regulations, and rules. This program is administered at the local area agency on aging level.

Case Plan or Plan of Care - See Service Plan.

Chore – Providing assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work, or sidewalk maintenance. Chore services could include the following activities:

- Window and door maintenance which may include changing screen windows and doors, replacing window panes, or washing windows
- Minor repairs to walls, floors, stairs, railings and handles
- Heavy cleaning which may include cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, or trash removal
- Yard work which may include mowing lawns, raking leaves or shoveling walks

Consumer - A person who meets CMPFE criteria (sixty (60) years or older, with multiple needs) or a person eligible to receive Medicaid elderly waiver services.

Consumer Choice Option – An option available to Medicaid waiver consumers that provides consumers with a flexible monthly budget that is based on functional and service needs to allow consumers to direct and manage their own personal assistance and other support services. In addition, the Consumer Choice Option offers counseling (through an independent support broker) and financial assistance (through a financial management service) to help consumers manage their individual budget and responsibilities by themselves or with the aid of a representative to assist with making decisions.

Consumer Directed Attendant Care - Assistance to the consumer with self-care tasks that the consumer would typically do independently if the consumer were otherwise able. An individual or agency, depending on the consumer's needs may provide the service. The consumer, parent, or guardian is responsible for selecting the individual or agency that will provide the components of the CDAC service agreement.

Coordinator - A qualified person responsible for the implementation and organization of the case management program at the area agency on aging level.

Emergency Response System - Telephonic or other electronic service system that alerts first responders in the event of an emergency.

Home and Vehicle Modification - Physical modifications to the home and/or vehicle to assist with the health, safety and welfare needs of the consumer and to increase or maintain independence. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

Home Delivered Meals - Provision to an eligible client or other eligible participant at the client's place of residence, a meal which: **(a)** complies with the Dietary Guidelines for Americans (published by the Secretaries of the Department of Health and Human Services and the United States Department of Agriculture; **(b)** provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy Sciences; **(c)** provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily RDA, although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second meal shall be balanced and proportional in calories and nutrients; and **(d)** provides, if three meals are served, together, 100 percent of the current daily RDA, although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second and third meals shall be balanced and proportional in calories and nutrients.

Home Health Aide (HHA) Services – Unskilled medical services, which provide direct personal care. This service may include observation and reporting of physical or emotional needs, assisting with bathing, shampoo, oral hygiene, toileting, ambulation, helping individuals in and out of bed, reestablishing activities of daily living, assisting with oral medications ordinarily self administered and ordered by a physician, performing incidental household services which are essential to the individual's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

Homemaker Service - Providing assistance to persons having difficulty with one or more of the following instrumental activities of daily living: medication management,

preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework.

Hospice - An alternative way of caring for terminally ill individuals that stresses palliative care (medical relief of pain), as opposed to curative or restorative care. Hospice care is not limited to medical aspects, but addresses all physical, psychological, and spiritual needs of the patient and the emotional needs of the patient's family.

Intermediate Care Facility (ICF) - Any institution, place, building or agency providing for a period exceeding twenty-four consecutive hours accommodation, board and nursing services, the need for which is certified by a physician, to three or more individuals not related to the administrator or owner within the third degree of consanguinity. These persons by reason of illness, disease, or physical or mental infirmity require continuous nursing services which can be provided only under the direction of a registered nurse or a licensed practical nurse.

Intermediate Level of Care - The consumer requires daily supervision with dressing, grooming, and personal hygiene in conjunction with another daily care need, and/or the consumer requires limited, extensive, or total physical assistance to perform dressing, grooming, and personal hygiene.

Individualized Services Information System (ISIS) - A computer system to assist workers in the facility and waiver programs in both processing and tracking requests starting with initial entry through approval or denial. It also provides payments to providers of facility or waiver services. ISIS is housed and maintained by the Department of Human Services.

Iowa Medicaid Enterprise (IME) - A collection of specific units within the Department of Human Services' medical assistance division that each have an area of expertise, and are housed in a single building. Within IME are DHS policy staff, Provider Services, Member Services, Provider Audit & Rate Setting, Core Services, Medical Services, Pharmacy Medical Services, Surveillance and Utilization Review URS, Pharmacy Point of Sale System, and Revenue Collections. IME Medical Services conducts level of care determinations for elderly waiver consumers.

Iowa National Aging Program Information System (INAPIS) – A system to collect and report service/performance data and related program management information to the federal and state government. NAPIS reports show the number of older Iowans who receive services and the number of units by service category from Title III funding of the Older Americans Act, the Administration on Aging (AoA) and limited state general fund dollars. Additionally, it shows the number of persons served by individual services and total "unduplicated" client count across all services.

Legal representative - A person appointed by the court to act on behalf of the consumer or a person acting pursuant to a durable power of attorney for health care.

Level of Care (LOC) Determination - The determination of the appropriate level of care that would be needed by an individual if he or she were eligible to reside in a nursing facility or ICF-MR. The consumer's physician fills out the Certification for Level of Care Form and mails or faxes it to IME Medical Services.

Long Term Care - A continuum of health and human services provided over an extended period of time for persons in a variety of settings who require some level of assistance to maintain or improve their functioning.

Mental Health Outreach - An outreach program designed to identify, evaluate and provide mental illness treatment, as well as psycho social support, educational activities, and rehabilitative activities to community dwelling elderly who are unable or unwilling because of stigma or physical impairment to participate in services at a Community Health Center.

NAPIS – See Iowa National Aging Program Information System.

Nursing Care - Services provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services must be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation, teaching, training, supervision, therapeutic exercise, bowel and bladder care, administration of medication, intravenous, hypodermocysis and enteral feedings, skin care, preparation of clinical and progress notes, coordination of services, and informing the physician and other personnel of changes in the consumer's condition and needs.

Nutritional Counseling - Nutritional counseling for a severe nutritional problem or condition, which is beyond standard medical management.

-- Provision of individualized advice and guidance to individuals, who are at nutritional risk, because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.

Nursing Facility (NF) - An institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours, accommodations, board and nursing services that would meet the definition for either Intermediate or Skilled Level of Care as appropriate.

Personal Emergency Response System – (see Emergency Response System)

Residential Care Facility (RCF) - Any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours, accommodation, board, personal assistance and other essential daily living activities to three or more individuals, not related to the administrator or owner within the third degree of consanguinity. These persons by reason of illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves, but who do not require the services of a registered nurse or licensed practical nurse except on an emergency basis.

Release of Information - A required form the consumer signs in which the consumer consents to have a screening and/or comprehensive assessment completed if he or she consents to case management. The Release of Information allows information to be shared with others involved with the consumer's care. Consumers may indicate agencies or persons with which information is not to be shared.

Respite - Service which offers temporary, substitute supports or living arrangements for older persons in order to provide a brief period of relief or rest for family members or other caregivers.

Seamless – The software system used in CMPFE to record and track client-specific information and activity.

Screening – Administration of a screening tool by either the area agency on aging or the case manager to determine the complexity of an individual's needs and to identify the need for a further comprehensive assessment.

Service Plan – A written plan of action agreed upon by the consumer and Case Manager which specifies services, responsibilities of each person/entity, and the expected measurable results in the form of goals and action steps for the consumer.

Senior Companion - A companion who provides non-medical care supervision, oversight and respite. Senior companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks.

Skilled Level of Care – The consumer must require and receive skilled nursing services or skilled rehabilitation services daily. Nursing services can be provided 7 days a week if necessary. Therapy services must be provided a minimum of 5 days/wk. Combination of therapy and nursing services can be given 7 days/wk if necessary. Skilled services must be provided as a result of physician orders and they must be reasonable and necessary for the treatment of the consumer's illness or injury. Whether services ordered and provided are medically appropriate based on the consumer's condition and accepted standards of practice will be assessed during utilization review.

Skilled Nursing Facility (SNF) - Any institution, place, building or agency providing for a period exceeding twenty-four consecutive hours accommodation, board and nursing services, the need for which is certified by a physician, to three or more individuals not related to the Administrator or owner within the third degree of consanguinity. These persons by reason of illness, disease, or physical or mental infirmity require continuous nursing care services and related medical services, but do not require hospital care. The nursing care services provided must be under the direction of a registered nurse on a twenty-four hour per day basis.

Title XIX Medicaid Home and Community-Based Services Waiver for the Elderly (EW) - Provides service funding and individualized supports to maintain eligible consumers in their own homes or communities who would otherwise require care in a medical institution.

Transportation - Provision of assistance, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

CONSUMER ELIGIBILITY

Initial and On-going Eligibility

Consumer eligibility requirements can be found in Iowa Administrative Code 321--21.5(231). A person meeting all the following criteria is eligible for CMPFE services:

1. Lives in Iowa.
2. Is aged 60 or older.
3. Needs two or more services.
4. Does not live in, or is within 30 days of discharge from, a nursing facility.
5. Is in need of case management services based on a standardized assessment of needs.

A person who qualifies for the Medicaid elderly waiver is also eligible for CMPFE services.

Date of Eligibility

Case management services begin on the date of the assessment of the consumer.

Discharge

(Discharge criteria 21.7)

A consumer can be discharged from the program for any one of the following reasons.

1. The consumer dies.
2. The consumer moves out of state.

-
3. The consumer moves into a nursing facility and is expected to stay in the facility for more than 90 days. (Note: Consumer's status would remain as "active" up to the 90-day timeline.)
 4. The consumer or the consumer's legal representative requests termination from CMPFE. (Note: This reason for discharge would be used when a consumer moves out of the AAA's Planning and Service Area (PSA) and is choosing another case management entity to provide case management or when the consumer no longer wishes to receive case management services.)
 5. The consumer is unwilling or unable to adhere to the agreed-upon service plan.
 6. The consumer or consumer's legal representative refuses to provide access to information necessary for the development or implementation of the service plan.
 7. The consumer's needs cannot be met in a way that ensures the consumer's health, safety and welfare.
 8. The consumer goals are achieved and the consumer no longer needs case management.

The CMPFE Coordinator must approve all recommendations for discharge prior to initiation of discharge action. If the discharge is due to item numbers 5-8, provide a written notice to the consumer or the consumer's legal representative stating the reasons for the discharge from case management. Include information about your agency's appeal process in the event the consumer would like to appeal the decision. If the consumer files an appeal with your agency but is dissatisfied with the outcome, the consumer can appeal to the Department of Elder Affairs according to the department's rules as defined in 321 IAC 2.9(231).

When a consumer moves out of an AAA's PSA (Planning and Service Area) they would normally be formally *discharged* from that agency's CMPFE program, and if desired by the consumer be referred to the AAA for the client's new PSA (for questions, consult with the department). The discharge reason would be "requests termination".

Because of confidentiality issues and program auditing requirements, consumer files are not transferred to the new case management entity. The consumer is treated as a referral so only their name and necessary contact information should be given to the new entity.

If a consumer moves to another county that is within the area agency's PSA, the consumer's profile would be updated in Seamless to reflect the consumer's new address. The consumer would be assigned to a new case manager. A new release of information would be completed so that it contains the name of the new case manager. A re-assessment would be completed and the service plan updated. The consumer would not be discharged from that area agency's CMPFE program.

Funding

Currently, there is no charge to the consumer for case management. Other services in the service plan are provided based on individual consumer needs and are identified through screening and assessment processes, and approved by the consumer. Payment sources may include, but not limited to: private pay, sliding fee schedules of the agency providing the service, Medicare, Medicaid, and the Senior Living Program.

PROGRAM STANDARDS

This section contains information about the general structure and operational standards.

Covered Case Management Services

Case management services include a variety of activities. These activities are explained in more detail throughout this manual. Case management services may vary by consumer, but in general, covered services under case management are:

- Comprehensive assessment of the consumer's needs.
- Development and implementation of a written service plan to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the individual.
- Arranging or making referrals for appropriate services.
- Coordinating and monitoring the formal and informal service delivery to ensure that services specified in the plan are being provided.
- Ongoing advocacy on behalf of the consumer.
- Ongoing monitoring of changes in the situation, conflict resolution, crisis intervention, and re-assessment of consumer needs with contact with, or on behalf of, the consumer every 30 days initially until the plan of care has been stabilized, and with a face-to-face contact at least quarterly.
- Review of the service plan by the Case Manager at least annually and request special interdisciplinary staffing as needed. This review will be based on an update of the assessment tool and periodic reassessment and revision of the service plan as needed.
- Documentation of contacts and case management activities in the consumer's individual case file.
- Evaluation of outcomes of services.
- Discharge planning.

Program Principles

The principles listed below were created to guide program actions in conducting and evaluating services.

- All consumers have the right to be treated with dignity and respect.

-
- All consumers have the right to actively participate in developing their service plan.
 - All consumers have the right to make final decisions concerning their care and life until clearly incompetent to make these decisions.
 - Services should be designed to maximize each person's total functional capacity or capabilities.
 - Appropriate services should be accessible to all consumers where available.
 - Services should be provided within the least intensive and restrictive environment consistent with a person's needs.
 - Service program should encourage and assist families to accept some responsibility for providing care.

Long Term Goals

1. Consumers and families will have an improved understanding of care needed and services available.
2. Consumers and families will have more informed choices.
3. Consumers and families will have improved freedom of choice.
4. Family and home-based care will be reinforced.
5. Institutional placement will be a matter of choice in the community among other options.
6. There will be a decrease in the number of entry points the consumer must use to access needed long term care services.

Personnel

There are two types of positions in the Case Management system. They are:

1. CMPFE Coordinator
2. Case Manager

Case Management Coordinator

Each AAA shall have a designated CMPFE Coordinator responsible for administering and monitoring the program at the local level. A Case Management Coordinator must meet the following qualifications:

- Bachelors degree in human services field plus one year of full-time equivalent experience involving direct contact with people in overcoming social, economic, psychological or health problems; or
- Licensed Registered Nurse plus one year of full-time equivalent experience in a health care field involving direct contact with people in overcoming social, economic, psychological or health problems.
- Receive formal training in completion of the assessment tool; and
- Attend CMPFE Coordinator training provided by the department within three months of employment.

-
- Attend six hours of long term care or aging-related training per year. For the purposes of meeting this requirement, the year commences with the date of hire.

Duties of the Case Management Coordinator include:

- Managing the CMPFE program for a specific area agency on aging.
- Delegating program responsibilities to case management staff as appropriate.
- Providing case management training for local CMPFE staff.
- Referring consumers for initial assessment to Case Managers.
- Reviewing assessments and other CMPFE forms for program compliance.
- Signing a percent of service plans for quality assurance purposes.
- Conducting internal quality assurance reviews.
- Review CMPFE data in Seamless for monthly reporting purposes.
- Overseeing the performance of contract entities if applicable.

Case Manager

Case Managers must meet all of the following qualifications:

- Currently a licensed Registered Nurse or possesses a bachelors degree in human services field. The Case Manager may substitute up to two years' full-time equivalent work experience involving direct contact with people in overcoming social, economic, psychological or health problems in a human services field for two years of the educational requirement.
- Receive formal training in completion of the assessment tool; and
- Attend case management orientation established by the department within six months of employment. The orientation and assessment tool training is conducted by the local AAA Coordinator.
- Attend six hours of long term care or aging-related training per year. For the purposes of meeting this requirement, the year commences with the date of hire.

Duties of the Case Manager include:

- Contacting consumers to schedule the home visit.
- Completing the Release of Information form with the consumer at the initial meeting and annually thereafter.
- Completing the FASE at the initial meeting with the consumer (optional form).
- Completing the comprehensive assessment with the consumer and/or caregiver or family if appropriate.
- Together with the consumer, developing a service plan based on needs identified in the assessment.
- Coordinating the implementation of the service plan.

-
- Conducting a comprehensive assessment on each consumer whenever there is a significant change in the consumer's status but no less than annually.
 - Conducting a face-to-face visit with the consumer at least quarterly to verify that the consumer is satisfied with all services being provided and to verify that all current needs are being met.
 - Documenting all case management activity in the Case Notes.
 - Obtaining the consumer signature on service plan annually and as needed.
 - Providing consumer advocacy as needed.
 - Maintaining a consumer file.
 - Treating all information regarding the consumer in a confidential manner.
 - Maintaining a current list of available community resources and be knowledgeable about eligibility criteria for programs.
 - Becoming familiar with rules and regulations regarding services provided to CMPFE consumers to ensure knowledge about acceptable standards of practice.
 - Facilitating and mediating the resolution of conflicts that may arise between consumers and service providers.
 - Organizing and facilitating meetings with a consumer's providers when a meeting is needed to address issues that may arise.

Personnel Documentation Requirements

Contained within the personnel file of each Case Manager and Coordinator must be documentation that the person has completed initial and on-going mandatory reporting training as required in Iowa Code 235B. Additionally, documentation must be in the file of each Case Manager and CMPFE Case Management Coordinator that the person has met the training requirements.

Staff Training Guidelines

Case Managers and AAA Coordinators must receive six hours of long term care or aging-related training per year. CEU training required for maintenance of licensure can be used to meet the CMPFE training requirement.

Proof of training must be recorded in the personnel file of each Case Manager and Coordinator. For each training event, the file should contain the program agenda, dates, certificate of attendance or documentation from the sponsor stating the person completed the program, and number of clock hours attended.

To fulfill the training requirements of this section, any training course or event must be approved by the CMPFE Program Manager unless the course or event is:

(A) A conference sponsored by DEA such as the Governor's Conference on Aging

-
- (B) Caregiver Conference
 - (C) Conferences sponsored by N4A, NCOA, ASA, AOA, or the Alzheimer's Association
 - (D) Training sponsored by the Department of Human Services, this includes quarterly ICN trainings
 - (E) A conference sponsored by a university, college, community college, or state agency other than DEA if the conference content is related to long term care or aging issues
 - (F) Elder Law Seminars sponsored by DEA and Iowa Legal Aid
 - (G) Gerontology Society of Iowa - annual educational training

The following must be met for a course or event to be approved:

- Must be above and beyond regular Case Manager duties.
- Must include an evaluation by the participants to assess its effectiveness.
- Trainers must be licensed, certified, or otherwise qualified based on the requirements of the course or by approval of the DEA CMPFE Program Manager.
- The purpose of the program must be clearly defined in terms of its objectives or expected outcomes.
- It must be designed to increase the participant's knowledge or skill regarding the provision of case management.

Approval of a particular course can be obtained by sending the sponsor's name, topic, name and title of trainer, training objectives, outline of the content, length of training, and location of the training to the DEA CMPFE Program Manager. Requests for approval must be submitted at least 14 days prior to the date of the event.

Suggested training topics include:

- Aging and the impact of disabilities and illnesses on aging
- Family and community support
- Local human and health service delivery systems, including support services and public benefits eligibility requirements
- Cultural diversity
- Community and service networking
- Communication or interviewing skills
- Physical & psychological aspects of health and illness
- Wellness and illness prevention concepts and strategies
- Family Caregiver
- Family dynamics
- Psychological aspects of chronic illness and disability

-
- Spirituality as it relates to health behavior
 - Assistive technology
 - Rehabilitation service delivery systems
 - Nutrition and Aging
 - Alzheimer's Disease and Related Dementia

Confidentiality

The use or disclosure by any party of any information concerning a consumer of CMPFE for any purpose not directly connected with the administration of the responsibilities of the department, area agency or service provider is prohibited except with written consent of the consumer or his or her legal representative.

Information concerning applicants and consumers (including names and addresses) constitutes privileged communication, must be considered confidential, and cannot be divulged to anyone not associated with the administration of the program except the consumer, guardian, or other authorized representative of the consumer.

Confidential information is only to be released to persons (unless specifically authorized by consumer or authorized representative) when there is assurance that:

- a. An information release form has been signed by the consumer.
- b. Confidential information will be used only for the purpose for which it is made.
- c. Such purposes are directly related to the administration of the Case Management Program for Frail Elders.

To protect applicants and consumers from the unauthorized release of information to agencies or the public, nothing in this section requires the release by an agency of protected information such as substance abuse information, mental health information, or child abuse information.

Information regarding a consumer may otherwise be disclosed only in summary, statistical, or other form which does not identify particular individuals.

All active and inactive consumer files must be stored in a locked file cabinet. Consumer files should never be left in the open where someone other than a qualified Case Manager could view the file. Case files cannot be removed from the office except when required by subpoena. Only take to the consumer's home the minimum amount of written materials you will need for that particular visit.

All consumer files copied to laptops or tablets must be synched back to the master database and then deleted before the laptops or tablets are checked out for another

Case Manager's use. In the case of a deceased consumer, the consumer's file cannot be shared without a written release from the executor of the estate or attorney for the estate. The written release must stipulate who may obtain the information and what information may be released. If the person requesting information is not representing the estate, no information can be released without a subpoena. This does not restrict a Case Manager from disclosing information to a provider or state agency as necessary to resolve billing or other operational issues pursuant to the death of a consumer.

All laptops and tablets that connect to the CMPFE-Seamless database must be encrypted at the pre-boot level in order to meet the Laptop Data Protection Standard set forth by the Department of Administrative Services – Information Technology Enterprise and adhered to by the Department of Elder Affairs.

PROGRAM PROCESSES

This section includes information about operation of the program. Seamless software forms and protocols must be used for CMPFE activities.

Any case management functions that require professional judgment including assessments, reassessments, care plan development and monitoring cannot be delegated to an individual who is not a qualified Case Manager.

Referrals

Referrals for case management services can come from a variety of sources, such as doctor's offices, family members, public health nurses, or area agency staff. Referrals for case management services for consumers who have applied for the Medicaid elderly waiver will come from ISIS, the Department of Human Services' case tracking and processing system.

When a referral is received for possible case management services from a source other than ISIS, Medicaid Elderly Waiver (EW) eligibility requirements should be explained to the referring party or the applicant. If the potential applicant wants to apply for the waiver, intake staff should advise him/her that a Medicaid application must be submitted. Eligibility for Medicaid will enable the person to receive not only case management services but other medical assistance benefits as well so it is important to encourage individuals to file an application as soon as possible.

If the intake staff person determines that the potential applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or waiver service need, the applicant will be referred to the area agency's case management program.

For referrals involving Medicaid elderly waiver consumers, Medicaid procedural time frames would apply. Non-Medicaid consumer must be contacted within two working days of the referral to arrange an in-person assessment.

Scheduling the Home Visit

Assessment of consumer needs begins with scheduling the home visit. For non-Medicaid consumers, schedule the home visit so that the assessment can be completed within 10 working days from the date you make contact with the consumer. The face-to-face interview can take place in any setting, from the consumer's or family member's resident to a hospital or nursing home. For consumers applying for the elderly waiver the assessment must be completed with 30 days of the ISIS referral date.

The Interview

During the home visit, discuss with the consumer his or her long term care options, including institutional and home and community-based services.

Also during the home visit, provide each consumer with information about your agency's grievance procedures including for Medicaid recipients, Department of Human Services' complaint and appeal procedures. The information must include the names, addresses and telephone numbers for the appropriate agencies.

Other information that must be shared:

- A. Documentation that the consumer was offered the choice from among multiple service providers. Leave a list of local service providers with the consumer.
- B. Documentation of unmet needs of the consumer, including the need for additional services within a community. Unmet needs are documented in the service plan. The AAA monthly unmet needs reports are generated from this form in Seamless.
- C. Documentation that you explained to the consumer how to access assistance in situations of suspected dependent adult abuse. Leave an abuse brochure with the consumer.
- D. Any other information determined to be essential for the proper delivery of services.

Obtaining a Signed Release of Information

A standard Release of Information form is used for each CMPFE consumer. If the consumer agrees to participate, she or he must sign the Release of Information which documents the consumer's permission to share information for assessment

and case management. If another person is designated as the consumer's legal representative, that person may sign the release. Keep all forms with signatures in the consumer's case file.

If a consumer who is not a Medicaid applicant or recipient refuses to sign the release, do not conduct the comprehensive assessment. Contact the AAA Case Management Coordinator.

If a Medicaid applicant or recipient refuses to sign the release, end the assessment and contact the Department of Human Services income maintenance worker.

Conducting the Functional Abilities Screening

The Functional Abilities Screening Evaluation (FASE) is used as the screening tool for CMPFE. A screening tool is used to determine if a consumer's disabilities are great enough that they would benefit from a comprehensive assessment.

NOTE: The use of the FASE is *optional*. In most instances, other types of screening and intake tools are utilized by area agencies on aging to assess needs *before* the consumer is referred to the CMPFE program.

Instructions for completing the FASE are included in the manual for those agencies that choose to use this tool for screening purposes.

General Instructions

The consumer's permission is required before you begin. You might say: "Some of these questions may sound silly, but they will help me understand what you can do and where you may need some help. I work with a variety of agencies that help people stay in their homes as long as possible. If you need additional help and I have your permission, I would be able to put you in contact with other agencies through our local case management program. May I ask you these questions now?" The entire form should be completed.

The interview should be conducted in private and questions asked directly of the consumer. If the consumer is unable to answer the questions without assistance, indicate on the FASE form the name and relationship of the person answering the questions. Note that if the consumer needs assistance, a more comprehensive assessment is indicated.

Each question should be read exactly as it is printed. Ask the questions in the order they appear on the form. If you are unsure about a consumer's answer (for example, a consumer appears confused in answering), check the "No" response.

Mental Health Questions

The mental health questions are designed to assess the consumer's orientation to time and location. A "Yes" or correct response is one that is reasonable and fits the question. For example, a consumer with a new telephone number may not remember, but an oriented person would give that reason in explaining why he or she does not know the number.

Check "Yes" or "No" on the FASE form to indicate the appropriateness of the answer. If the consumer is unable to supply an answer or appears confused, check "No" for an inappropriate response. An incorrect response to one or more of the mental health questions suggests that the consumer may be disoriented and an unreliable informant regarding ability to perform the Activities of Daily Living (ADL).

Activities of Daily Living (ADL)

The questions relating to activities of daily living are designed to assess the ability of the consumer to perform a number of activities necessary for living independently in the community. Check the appropriate response for each question to indicate whether or not the consumer can perform the activity. Some questions include more than one activity; check "Yes" only if the consumer says he/she can perform all of the activities mentioned. For consumers who indicate they can perform the activity only with assistance of another person, check "No." Consumers unable to perform two or more of the ADLs should have the comprehensive assessment completed.

The following tips correspond to the questions on the FASE form:

Q. #5 refers to the ability to dial the phone and communicate understandably. If the consumer does not have a telephone the question should be answered "No."

Q. #6 should be checked "Yes" if the consumer is mobile and/or has available transportation, and if the consumer states that she does or can make purchases unassisted.

Q. #7 should be checked "No" if you know the consumer receives home delivered meals. It should be noted that simple meals should be nutritious and are more than coffee and toast.

Q. #8 should be checked "Yes" only if the consumer can do all 3 activities without assistance.

Q. #9 a "Yes" answer indicates that the consumer has access to and is able to use transportation other than that provided by a friend or family member. Use of a senior citizen van instead of public transportation should also be checked "Yes" if the consumer is able to make the arrangements alone.

Q. #10 should be checked “Yes” if the consumer states a physician has not prescribed any medications and/or special diet.

Referral Decision

A comprehensive assessment should be conducted if:

- The consumer answers one or more of the screening tool "mental health" questions incorrectly; or
- The consumer is unable to perform two or more of the screening tool Activities of Daily Living (ADL) items; or
- Professional judgment of the person completing the screening indicates that the consumer is in need of further assessment regardless of the results of the screening tool.
- The consumer has applied for the Medicaid elderly waiver or is already a Medicaid recipient.

If you did not proceed with a full assessment and subsequent admission into CMPFE, document in the Case Notes the reason for not completing the comprehensive assessment.

Referral Source

Referral source is the consumer, family member, friend, physician or another agency that referred the consumer for case management services.

Consumer Assessment

Assessment is the foundation of the service plan development process. It may take more than one contact with the consumer to complete the assessment. You may contact collateral sources for additional information to complete the assessment tool as needed.

A standardized assessment tool is used for care planning purposes for all consumers. The assessment tool consists of the Outcome and Assessment Information Set (OASIS-B1) and the IOWA CMPFE Assessment.

Use your professional interviewing skills to gather information in a way that is appropriate for a given consumer. You will need to adjust your interview style to the individual and the situation. The questions in the assessment can be asked in any order. It is important that you not only listen to what the consumer says, but also observe the consumer's functional abilities.

Once the comprehensive assessment is completed, you will work with the consumer to determine services needs. There is a wide array of services that are provided in

the home and/or community. Some of the services that may be available to the consumer are adult day care, case management, chore, consumer choice option, consumer directed attendant care, home and vehicle modification, home delivered meals, home health aid services, homemaker services, hospice, mental health outreach, nutrition counseling, nursing, personal emergency response system, respite, senior companion, and transportation.

Developing the Service Plan

During the home visit and upon completion of the assessment, develop an *initial* service plan with the consumer and anyone else the consumer would like to involve. After all necessary information has been obtained and service providers are chosen, an *on-going* service plan is completed.

The *on-going* service plan includes:

- A. Consumer demographic information.
- B. Identification of the consumer's service needs, functioning level, strengths and available family or informal service providers and community resources.
- C. For elderly waiver consumers, notation of the consumer's level of care. IME Medical Services will determine the consumer's level of care.
- D. Individualized consumer goals based on gathered data.
- E. Action steps to meet the goals.
- F. Documentation of outcomes and, where appropriate, re-evaluation of consumer goals and action steps.
- G. All elderly waiver and non-waiver service providers included in the plan, the frequency of service, and the cost. Services should be coordinated to avoid conflicting scheduling or duplication of services.
- H. Identify unmet needs, reason the need could not be met and number of units needed
- I. An emergency and contingency plan.
- J. A planned sequence of follow-up based on an update of the assessment tool. This sequence will include a review of the service plan if indicated due to a change in consumer condition or service needs.
- K. Signature of the consumer or the consumer's legal representative and the date the consumer agrees to the service plan,
- L. Signature of the Case Manager.
- M. Signature of CMPFE Coordinator if the service plan is being reviewed for quality assurance purposes.

From the point at which the *on-going* service plan is completed, you become the consumer's primary contact with the service delivery system for the duration of his or her participation in the program.

Establishing the Need for Case Management Services

Each plan must establish that the consumer has a demonstrated need for case management intervention or coordination of services in order for that individual to continue to live safely in the community. An identified need for case management services is defined as:

- The individual requires coordination of multiple services but does not currently have support available to assist with identifying, accessing and coordinating of these services, and a referral to a formal or informal support system will not meet the individual's needs, or
- An identified problem exists in one of the following areas: physical environment, support system, emotional health or physical health. These problems must be addressed to ensure the individual's health and welfare. Other formal or informal supports have either been unsuccessful in their efforts or are unavailable to assist the individual.

The service plan must identify case management as a service to be provided to the consumer.

Defining Goals

The service plan defines specific, measurable goals. Goals must be specific to the consumer, measurable, and specify action steps to be used to meet the goals and include a timeframe for the attainment of the desired outcome. Goals must be reviewed at each monitoring visit and progress must be documented in the Case Notes. Progress means information regarding changes that need to be made to the goal and/or action steps, and if the goals has been met but will be continued, the reason(s) for this. You can confer with professionals to complete the assessment and service plan.

The service plan should describe a desired achievement, not a therapeutic process, unless it references the expected outcome or goal of the therapy. The goal is the desired end result to be achieved. The goal will specify the skills to be acquired, behaviors to be changed, information to be provided, health or environmental conditions to be met, etc.

Goals should not be confused with services. Services help to accomplish goals. Often there are a number of different ways goals can be accomplished. There may be short-term and long-term goals leading to short and long-term service planning. The identification of goals gives you, the family, significant others, and providers a clearer picture of which services are appropriate, what the services are meant to accomplish, and a framework for identifying when the goals are successfully achieved.

You should look for opportunities to create choices for the consumer even where choices seem limited. It is important for the service plan to build on consumer abilities to help maintain as much independence as possible. Goals should reflect the consumer's input and consider the consumer's preferences.

Indicators of a good goal are:

- It is measurable and includes criteria that will indicate when the goal has been achieved.
- It is relevant and related to a need.
- It is realistic.
- It is behaviorally specific. It specifically identifies what behavior or circumstance needs to change.
- It is consistent with the assessment.
- It is positively stated.

Emergency/Contingency Plan

In order to be responsive to health and safety issues of consumers in the case management program, you need to have a discussion with the consumer about emergency situations and backup/contingency plans. Consumers and their families need to discuss what they need to do ahead of time in order to be prepared for any emergency that may arise. Consumers need to know that it is their responsibility to be prepared in the event of an emergency. Case Managers assist the consumer in creating the plan but are not responsible for responding to an emergency should one occur.

Examples of discussions that you should have with consumers are noted below:

Fire: Have ways to exit the home in case of a fire planned out ahead of time. If you are not able to exit your home safely due to a disability, develop a plan to make your home more accessible or look into housing options that are handicap accessible.

Severe weather: If you are not able to get down stairs to a basement in the case of severe weather, develop a plan as to where you could go in your home to be safe.

Electrical outage: If you are dependent on oxygen, keep a backup supply available in the case of a power outage. If you use a nebulizer, talk to your doctor about inhalers that may be substituted in case of a power outage. If you use a medical alert system, talk to your medical alert provider about backup battery power.

Meal provider: If you use home-delivered meals, keep an emergency supply of frozen meals or shelf-stable meals available in case a meal cannot be delivered to you.

Service provider: If you use a home care agency to provide care to you, develop a back up system in case they are not able to come to your home when they are scheduled. This could include family members, friends or neighbors who could provide care to you.

Private provider: If you have hired a private individual to provide care to you, consider looking into hiring another person who could back them up in the case they are not able to come to your home when they are scheduled.

Individual safety issues should be discussed that are specific to each consumer's particular needs and living environment. For program quality assurance purposes, you must document in the Case Notes that individual emergency/contingency plans were discussed with the consumer. Additionally, the service plan must include at least one goal and actions steps that relate to the consumer's emergency/ contingency plan.

Monitoring Visit

You must meet face-to-face with each consumer at least every calendar quarter to ensure compliance with CMPFE regulations. If the due date falls on a weekend, the face-to-face visits must be completed before the due date. Weekends or holidays do not change the due date of the visit. If the consumer is unavailable for a visit due to hospitalization, a visit out of town, or another reason, document in the Case Notes your attempts to complete the visit in a timely manner. The visit must be conducted as soon as possible when the consumer becomes available. Telephone visits are not acceptable as a monitoring visit.

During the monitoring visit, review the service plan with the consumer. Evaluate each goal to assure that services ordered remain appropriate and determine the consumer's response to each service provided and progress on each goal. Discuss with the consumer any changes in problems, interventions, and goals. Review with the consumer the grievance options available to the consumer. It is essential that the consumer understand the importance of his or her involvement in the provision of service and the quality of service.

Document any changes in the Case Notes and the reason for each change such as:

- Changes in the consumer's physical, emotional, or mental status.
- Changes in medications.
- Changes in the consumer's home environment.

-
- Changes in the consumer's informal support system.
 - Comments regarding problems or concerns identified during the last monitoring visit.
 - Provider information pertinent to the review.
 - Feedback from the consumer regarding services.
 - Information regarding changes in the frequency or delivery of the services required or requested by the consumer.

There may be circumstances when you would want to observe the actual delivery of services.

There must be a clear trail from assessment to service plan to Case Notes.

On-going monitoring

Monitoring is the maintenance of regular contact with the consumer, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the consumer's current needs. In order to ensure the service plan is meeting the consumer's needs, you must monitor the provision of services on an on-going basis.

On-going monitoring consists of:

- Face-to-face and phone contacts with consumers for the purpose of assessing or reassessing their needs or planning or monitoring services.
- Face-to-face and phone contacts, e-mail/voice mail, and faxes with collaterals for the purposes of implementing and coordinating the services specified in the plan. "Collateral" means anyone involved with the consumer, including a paid provider, a family member, a guardian, a housemate, a friend, or a volunteer.
- Recordkeeping necessary for case planning, service implementation, coordination and monitoring. This includes preparing updated case plans, making notes about case activity in the consumer file, preparing and responding to correspondence with consumers and collaterals, gathering data and preparing application forms for community programs, and reports.

"Collateral contacts" include written, telephone, fax, face-to-face, or an email/voice mail exchange. "Exchange" is defined as a two-way transmittal of information directly related to the consumer's service plan or health status. E-mail or voice mail contacts must demonstrate a connection is made between both parties wherein information is transferred by one party to the other who then generates a response or reply that is received by the party who initiated the contact. The contact must result in the acquisition by the Case Manager of information, data, or meaningful insight about the consumer's situation.

Reassessment

The on-site reassessment is the formal review of the consumer's status to determine whether the consumer's situation and functioning have changed in relation to the goals established in the initial care plan. You must conduct a reassessment whenever there is a significant change in the consumer's status or at least every 12 months. A "significant change" is defined as a major change in the consumer's status that impacts one or more areas of the consumer's health status, and requires revision of the service plan.

The annual reassessment must be completed by the 12-month anniversary date of the last assessment or within the 60 days prior to the anniversary date of the last assessment.

The reassessment must include review and modification of the information contained in the most recent assessment. The service plan must be revised to reflect changes, deletions, or additions to services based on any changes in the consumer's needs.

If a service is discontinued or the units of service are changed significantly, a reassessment may need to be done.

DOCUMENTATION

Documentation and record keeping must be timely and complete, address consumer needs and outcomes, and monitor progress and consumer responses. Specified data will be collected including, but not limited to the number and type of contacts which the Case Manager has with or on behalf of the consumer.

Case Notes

Case Notes record all activity pertaining to a consumer's case. Case Notes document any information that you have learned about the relevant activities of others on behalf of the recipient. It sets forth your analysis and decision-making processes and includes any documents that support the care plan.

The narrative must be clear and comprehensively reflect how case management involvement relates to the goals on the care plan and how services provided through the plan (including case management services) are helping the consumer to achieve the defined goals. The case narrative must be sufficient to justify case management reimbursement and to permit effective professional review.

Each entry must include the following:

-
- Date and time of contact
 - Location of the contact
 - Type of contact
 - Duration of contact
 - Description of the contact
 - Billable or non-billable contact
 - Signature of the Case Manager and the Case Manager's professional licensure such as RN or LISW, or job title.

Case Notes need to document your ongoing evaluation of the appropriateness, timeliness, adequacy, and quality of services as defined in the service plan. This also includes recording the consumer's response to and satisfaction with services provided and follow-up as needed.

Case Notes must include:

- Communication with provider(s) regarding the consumer.
- Communication with a consumer/consumer representative/caregiver, including home visits and telephone calls.
- Your observations of the consumer's status.
- A record of all events that affect the consumer and the status or validity of the care plan (e.g., hospitalization)
- Any action you take to follow-up on an identified problem including what needs to be done, when you took the action and the impact of the intervention on the consumer and/or care plan.
- Information used in the completion of the assessment forms.
- Information supporting your decisions and actions regarding the case.
- Information regarding changes in the consumer's condition, environment, support system, or other issues.
- Information regarding the consumer's relationship with family, community or any other information which would impact on the established goals.
- Feedback from the consumer regarding services.
- Information from providers pertinent to the consumer's situation.
- Notations about referrals to adult protective service and follow-up actions.

Case Notes constitute a formal legal document, subject to subpoena and judicial review. It should document in the record when/if it has been photocopied. The sources of all information must be recorded and must clarify whether information is observable, objective fact, or is a conclusion on the part of someone. Case Notes must not contain value judgments or editorial comment about the consumer or the consumer's circumstances.

Case Notes should be written within 48 hours of the provision of the case management service, except for weekends in which Case Notes should be written the following working day.

Content of Consumer Case File

You must maintain a separate file which documents all case management activities for each consumer. The purpose of keeping this record is to promote continuity and quality of care. It is also the basis for quality assurance activities and oversight monitoring.

The following information should be included in the Case Manager's file for each CMPFE consumer:

- Consumer Profile
- Release of Information forms (must be updated annually).
- The FASE screening tool (optional).
- The comprehensive assessment tool (including all reassessments which must be completed annually).
- All CMPFE service plans.
- Case Notes which should include documentation of any referrals for services, case monitoring, follow-up, evaluation of outcomes of services, exit planning, and any other Case Manager contacts such as quarterly face-to-face visits. File a hard copy of Case Notes at least monthly to support claims.
- All letters referring to the consumer.
- All other correspondence related to the consumer and case management.
- For elderly waiver consumers, all Notices of Decision (NOD).

Quality Assurance

Each agency must have an active internal quality assurance program in place. The area agency on aging must provide appropriate quality assurance forms/check sheets to guarantee the requirements are being met regarding the administration of the comprehensive assessment, developing a service plan, implementing the service plan, and providing on-going case management.

Quality Assurance in the Case Management Program for Frail Elders is the process by which documentation is done that the system is in compliance with state regulations. It is achieved by monitoring the program to determine compliance with standards, correcting deficiencies and recognizing quality. Assurance reviews will include at a minimum:

- A random sample of six to ten consumer files per county.

-
- The components of the consumer file are present*. (Profile, release of Information, all assessments, all service plans, case notes, documentation of quarterly face-to-face visits, etc.).
 - Service plans are signed by consumer and case manager.
 - All assessments are completed by qualified case manager.
 - Updated assessments are completed on an annual basis and placed in the consumer file.

*The order in which components within consumer files are placed is not stipulated.
All consumer files must be kept a minimum of five years.

Department of Elder Affairs staff will conduct compliance reviews. Each AAA should conduct an internal quality assurance review at least once each year. The Department of Human Services conducts random quality assurance reviews for elderly waiver consumers.

Conflict of Interest

The Case Management Program for Frail Elders must be operated in a manner that is free of all conflict of interest. Conflict of interest includes both actual and perceived. Each AAA must establish written procedures that detail their local response to potential conflicts of interest.

Conflict of interest exists when any entity or individual:

- Uses an official position for private gain (other than salary).
- Gives preferential treatment to any entity or individual in the conduct of official duties because of personal interest.
- Fails to act impartially in the conduct of official duties because of personal interest.
- Impedes or adversely affects governmental efficiency or economy because of personal interest.
- Engages in conduct that could adversely affect the confidence of the public in the integrity of the case management program.

The term also means that circumstances are such that a public or private agency or person might reasonably conclude that an entity's or individual's judgment could be influenced by the nature of the circumstances.

A Case Manager cannot provide another direct service to a consumer assigned to that Case Manager. See **Oversight of Contracts** for information about conflict of interest policies applicable to agencies that subcontract case management services.

In the context of the Case Management Program for Frail Elders (whether the agency uses an internal or external model of case management), examples of situations in which conflict of interest would exist or could be perceived to exist include:

- The Case Manager involved in assisting a consumer select providers is related to a direct service provider that the consumer could potentially choose. “Related” means that the person is a relative within the fourth degree of consanguinity which includes parents, full or half siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great nephews, grandparents, great-grandparents, and full cousins.
- The Case Manager involved in monitoring the provision of services for a consumer is related to a person providing a direct service. See above definition of “related.”
- The Case Manager is related to the consumer or is the guardian, conservator, or power of attorney for the consumer.
- The Case Manager solicits or accepts any type of gift, loan, favor or other item of value from the consumer or other person on behalf of the consumer.
- The Case Manager uses the consumer’s property for personal use.

Area agencies on aging must have in place local procedures that institutionalize conflict of interest provisions within the agency. The agency’s conflict of interest procedures must be shared with each employee upon hire and whenever there is a change in policy or procedure. The employee must acknowledge in writing receipt of the information as a means to ensure that all staff are made aware of the agency’s expectations and to stress the importance of avoiding and/or reporting potential conflict of interest situations.

The agency’s procedures must include a description of what constitutes a conflict of interest, the steps an employee must go through to report a conflict of interest or suspected conflict of interest, the steps agency staff must undertake when advised of a conflict of interest, and the agency’s sanctions for an employee’s failure to report a conflict of interest.

Specific Conflict of Interest Provisions

Administrative rule 21.8(1)a requires agencies to have a specific process for delegating case management responsibilities to a Case Manager. Compliance with this standard would be evidenced by, at a minimum, establishment of and adherence to a protocol whereby Case Management Coordinators, prior to assigning a Case Manager to a case, consider any known information about a relationship between the potential consumer and a Case Manager, or the existence of a familial relationship between a Case Manager and an employee of a provider currently serving the potential consumer.

Administrative rule 21.8(1)b requires agencies to have a procedure for identification of where conflicts do or could exist. Compliance with this standard would be evidenced by, at a minimum:

- Establishment of a method and schedule for on-going solicitation of feedback directly from each consumer regarding the consumer's perceptions of his or her choice in the selection of providers (including case management providers) and the consumer's perceptions of the provision of case management services.
- A defined process for responding to any consumer feedback that would suggest undue influence by the Case Manager in the selection or continuation of particular service providers.
- Review of service plans to monitor that consumers assigned to each Case Manager are not disproportionately choosing one provider over another provider or any other activity that would indicate a Case Manager may be attempting to influence the selection of a specific provider.

Administrative rule 21.8(1)c requires agencies to have procedures to eliminate or minimize conflicts to the degree possible. Compliance with this standard would be evidenced by, at a minimum, the creation and implementation of procedures that would define the considerations a Case Management Coordinator would use when determining whether a Case Manager involved in an actual or perceived conflict of interest situation should remain on a case or be replaced.

Administrative rules 21.8(1)d and e require agencies to have a process for conflict resolution with the consumer's best interest as the priority and for documenting the outcome of the intervention. Compliance with these standards would be evidenced by, at a minimum:

- Documentation that the coordinator has conferred with the Case Manager involved to determine the nature and extent of the conflict.
- Documentation that the coordinator has contacted the consumer to explain the potential problem, solicited the consumer's input regarding the situation, and determination the consumer's preference for resolution.
- If the consumer chooses to continue the existing service plan and provider selection, documentation that the coordinator has a method to maintain on-going monitoring of the situation to ensure that the dynamics of the case do not change to the point that a conflict does arise.

OVERSIGHT OF CONTRACTS

Area agencies that choose to contract with local provider agencies for the provision of case management must follow procedures defined in 21.16(3). The agency as part of its oversight responsibility must have and follow a written policy by which it monitors

that each contract entity complies with all of the provisions of 21.16(3). The standards outlined above should be included in the agency's monitoring practices.

CONTRACTING FOR CASE MANAGEMENT SERVICES

Area agencies on aging may choose to contract with local provider agencies for delivery of case management services. The AAA must have written policies and procedures established that create a framework for ongoing review of how the contract agency is meeting program standards and the terms of the contract. The department will audit AAA procedures to ensure that the area agency's monitoring is sufficient and timely.

Provider agencies must meet all program organization and personnel requirements of Chapter 21, *Case Management Program for Frail Elders*. The following safeguards must be in place to ensure that service plan development is conducted in the best interest of the consumer:

a. When assigning a consumer to a case management entity under contract, the AAA must attempt to assign the consumer to an agency not currently providing services to that particular consumer if the relationship is known prior to assignment and case management services are available from multiple providers.

b. During the service plan development process, Case Managers employed by an agency that also provides other direct waiver services must inform the consumer or the consumer's legal representative that such a relationship exists and of the specifics of the relationship such as name and services. The Case Manager must emphasize to the consumer that the consumer has free choice of providers and that selection of any particular provider will not influence the services provided by the Case Manager. The conversation and the consumer's response must be documented in the Case Notes.

c. When explaining provider options, the Case Manager must fully provide all known facts about the services and the service provider agencies to the consumer or the consumer's legal representative. The details presented must include, at a minimum, the name, address, and telephone number of the potential provider agencies; the types of services provided; and the amount of service the consumer would be able to receive if there is a cost differential between providers of the same service.

d. All service plans and updates must be reviewed and approved by the AAA prior to implementation.

ACRONYMS

AAA	Area Agency on Aging
ADL	Activities of Daily Living
AIDS/HIV	AIDS/HIV Waiver
BI	Brain Injured Waiver
CDAC	Consumer-Directed Attendant Care
CMPFE	Case Management Program for the Frail Elderly
CMS	Centers for Medicare and Medicaid Services
DHS	Department of Human Services
EW	Elderly Waiver
FASE	Functional Abilities Screening Evaluation
HCBS	Home and Community Based Services
IADL	Independent Activities of Daily Living
ICF level of care	Intermediate Care Facility level of care
IDEA	Iowa Department of Elder Affairs
IFMC	Iowa Foundation for Medical Care/IME Medical Services
IH	Ill and Handicapped Waiver
IHHRC	In Home Health Related Care Program
IM	Income Maintenance
IME	Iowa Medicaid Enterprise
INAPIS	Iowa National Aging Program Information System
ISIS	Individualized Services Information System
NF	Nursing Facility
NOD	Notice of Decision
OASIS	Outcome and Assessment Information Set
OAA	Older Americans Act
PD	Physical Disability Waiver
POS	Purchase of Service
QA	Quality Assurance
QMB	Qualified Medicare Beneficiary
ROI	Release of Information
SLCU	Senior Living Coordinating Unit
SLMB	Specified Low Income Medicare Beneficiary
SLP	Senior Living Program
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SW	Service Worker