APPENDIX 2

Multnomah County
Department of County Human Services
AGING AND DISABILITY SERVICES DIVISION
RFP P05-8444
DISTRICT CENTER SERVICES

STANDARDS FOR SINGLE-ENTRY CASE MANAGEMENT

(UPDATED DECEMBER 2003)

The following Standards for single-entry case management apply to all case management services and functions administered through the Aging and Disability Services Division (ADSD). Case Management functions are in effect when:

- An individual needs service planning and coordination, and/or
- The agency must authorize the purchase of publicly funded services for the individual.

ADSD and district senior centers are to develop procedures to implement these standards within six (6) months of training on the Standards. Compliance with these Standards is expected; any deviation should be documented.

PREAMBLE

The aging and disability services system in Multnomah County is a coordinated system promoting the well-being and independence of the elderly and persons with disabilities. The system is based on the following principles:

1. The Aging and Disability Services System is Client-Focused.
   The primary function and purpose of the aging and disability services system is to provide services to those elderly and disabled who are in need. These services can be provided through the case management system or by linking the person to another needed service.

2. The Aging and Disability Services System is a Single-Entry System.
   Facilitating people's access to services and helping people obtain services through other agencies is the responsibility of each participating agency. Participating agencies have an active role in making sure that an individual reaches the appropriate resources. At a minimum, the agencies provide information on services available and facilitate people's access to those services. Communication and coordination with other service providers are key elements in a single-entry system.

3. The Aging and Disability Services System is Neighborhood Oriented.
   Responsiveness to the social, cultural, and economic characteristics of the people to be served is expected of the system and its participating agencies. Participant agencies function within the standards of the countywide aging and disability services system and adjust their actual services and service delivery procedures to the characteristics of the individual districts for which they are responsible.

DESCRIPTION OF TERMS

The standards for the Multnomah County aging and disability services system are based on the following concepts:

1. Assistance Request. Assistance request refers to a request for help from an individual or other person or agency on behalf of that individual. The help being requested may be for service planning, prior-authorized services, counseling or problem solving (e.g. help with identifying and deciding upon options for retirement living) or financial support.

2. Case Management. Case Management is a service to an individual who is experiencing difficult and/or multiple problems. Trained case managers screen the call for assistance, assess the need for services, determine financial eligibility, develop and implement a plan of care, evaluate or monitor the ongoing success of that plan, and reassess the needs of the client when indicated and on a regular basis. Case managers also serve as advocates to get the help their clients need. They may negotiate with other agencies to provide the needed services or they may order (prior-authorize) services funded through the aging and disability services system. Case management is a holistic service in that it attempts to find an array of services for the total needs of the client and is not restricted to services an agency provides. The elements of case management include:

    a. Assessment and Entry. Assessment and entry refers to the process of determining eligibility and initiating services for a person. It involves an initial screening to determine the appropriateness of the agency for the service request, a needs assessment to identify the problems the individual is having, and an eligibility determination to assure that the agency can legally provide the services to that individual.
    b. Case Planning. Case planning refers to the process of identifying the services needed by the client, writing a plan, and implementing that plan.
    c. Ongoing Case Monitoring. Ongoing case monitoring refers to the continuing management of "cases" (that is, clients and their service plans). It includes advocacy with other agencies to get services for their clients; counseling and problem solving with the client, family, friends, neighbors, service providers and others to resolve problems; evaluation of services to assure their quality and appropriateness for the client's needs; and reassessment of the client's needs and financial eligibility.

3. Client

    A person who requests assistance becomes a client of the participant agency when their request has been screened and the request seems appropriate for the participating agency. A case management client is:

    a. A person who has multiple and/or complex problems requiring assessment, service planning and monitoring, who is unable to provide these for him/herself, and who has no family/friends to carry out the case management functions; and/or

    b. A person who has a need for services offered through the agency when those services must be purchased (authorized) by staff of that agency.

4. Financial Eligibility. Financial eligibility refers to an income-based criterion established by a funding program to determine whether an individual may receive

services through that specific program. The financial eligibility criterion is based on the individual's income level, but also may be affected by other factors such as assets, fixed expenses, medical expenses, family support, etc. Determining financial eligibility for services is required by law for the Title XIX (Medicaid), General Assistance and Oregon Supplemental Income Payment, and Oregon Project Independence programs. Income is considered for Title III (Older Americans Act) services, but no one may be denied a Title III service on the basis of income.

5. Information and Referral. Information and referral is a service provided to individuals to help them locate desired resources and/or answer questions they may have. It consists of two primary functions:

    a. Information. This involves the answering of questions posed by an inquirer. A skilled information and referral provider will be able to elicit unstated questions or concerns of the inquirer and provide the appropriate information.

    b. Referral. This involves the information and referral provider contacting a service provider on behalf of the inquirer and assuring a linkage is made. Usually the referrer will need to collect basic information from the inquirer and carry out a preliminary assessment of the inquirer's problems in order to evaluate available service options and select the appropriate resource. A follow-up call to the inquirer to determine whether the inquirer's needs were met is part of the service. If the needs were not met, the referral process is started over.

6. Outreach. Outreach is a specific service conducted by trained persons from the district senior centers to locate isolated seniors and let them know the types of assistance available in the community. Outreach is also part of the underlying philosophy of the aging and disability services system, in that the system is responsible for actively seeking and helping seniors in need.

7. Participant Agency. Participant agency refers to an agency which provides case management services to elderly and/or persons with disabilities in cooperation with the Aging and Disability Services Division (ADSD). Current participant agencies are the nine district senior centers and ADSD.

8. Primary Care Manager. The primary case manager is the staff person assigned responsibility for a client. The primary case manager may call on specialists to carry out specific functions of case management (e.g. assessment of needs or financial eligibility determination), but the primary case manager is the contact for the client and is responsible for assuring that the client gets served in a timely manner. The intent is to have as few people working with the client as possible. The ideal is for the primary case manager to be the only individual to have personal working contact with the client. As part of this concept, the primary case manager is staff of either an ADSD branch or a district senior center. Only one staff member is designated primary responsibility at a time. The Aging and Disability Services Division stresses the primary case manager concept but allows for transfer of that responsibility on a temporary basis to another individual as circumstances dictate. The goal, however, is to have as much continuity for the client as possible.

9. Prior-Authorized Services. Prior-authorized services refers to assistance given to people to help them carry out activities of daily living, which is paid for through ADSD and which may be purchased only by authorized representatives of ADSD (i.e. ADSD case managers and staff of the district senior centers). Prior authorized services

include home care, personal care, substitute living arrangements and nursing home placements.

10. Short-Term Intervention Clients. Short-term intervention client refers to a person who receives one or two discrete services from a district senior center or ADSD Branch. This type of client does not need ongoing case management. Examples include: someone who has a one-time medical expense or needs help obtaining a Social Security disability payment. The short-term intervention client receives help from the participant agency, but much of the documentation and follow-up that are part of case management are not required.

11. Single Entry. Single entry is a process by which an individual, through one contact to any participating agency, gets linked up to appropriate services. It involves the participant agency taking responsibility for responding to an inquiry or request for assistance and essentially walking a client through the assessment and entry process.

STAFF QUALIFICATIONS

Staff hired to carry out the case management service functions are expected to be qualified. Special qualifications include:

1. Ability to relate to clients;
2. Skill in casework techniques, i.e. interviewing, listening, assessing, planning, developing resources, and implementing plans;
3. Skill in clearly communicating, both orally and in writing;
4. Knowledge of community resources, medical terminology and service implications of medical diagnoses.
5. Knowledge of program eligibility requirements and ability to apply them in specific situations.

I. SCREENING AND REFERRING INQUIRES FOR ASSISTANCE

This section refers to the initial contact made by the inquirer regarding service planning, prior-authorized services, or financial assistance. It includes general inquiries for information, requests for assistance, information on which agency or program is the appropriate resource, and referrals for further action. It does not refer to information and referral type inquiries or to inquiries for non-ADSD programs administered by an agency, e.g. LIEAP. It differs from information and referral in that the inquirer has indicated a need for assistance or a desire to obtain services from the participating agency. An inquirer may be either an individual or an agency calling on the individual's behalf.

A. STANDARDS

1. The participant agency will respond to an inquiry within one working day (or eight (8) hours). "Response" refers to action initiated to resolve whatever questions or concerns were expressed in the inquiry.

    a. A response may include notification to the inquirer on the status of the inquiry if the information or assistance will not be available within the one-day time frame.

    b. If an application is being made for prior-authorized services, a response may be a call to determine the urgency of the request, or an appointment

scheduled at the time of the initial contact for a visit at a later date. (Refer to section II on "assessing needs" for timelines for client visits.)

2. The participant agency will actively assist the inquirer in obtaining the desired information and/or services.

   a. Inquirers requesting services provided through the participant agency will be screened for eligibility and appropriateness for case management and followed up with an assignment to a primary case manager within one working day if the request appears to be appropriate. (This does not apply to service requests from another participant agency where a primary case manager has already been assigned).

   b. Inquirers requesting services not provided through the participant agency or prior-authorized services, for which the inquirer is clearly ineligible, will be either given information on or referred to other appropriate resources. Referral to other agencies includes direct contact between the participant agency and the other resources on behalf of the inquirer. Information about other service agencies without further assistance by the participant agency is provided when the inquirer appears able to manage his/her own affairs, and assistance by the participant agency would not be helpful but considered as interfering or unnecessary.

3. When the participant agency refers the inquirer to another agency, it will minimize the amount of duplicate assessment and information gathering the other agency will need to do. The goal is to have basic client information collected only once.

   Client confidentiality policies will be maintained. Only information necessary for service delivery should be exchanged. Written client information will be obtained from the client.

4. **When the participant agency has made an appointment with another agency on behalf of an inquirer the participant agency will follow up to determine that the appointment has been kept and the need has been addressed. This follow-up on referrals will be within five (5) working days.**

   (Follow-up is not required when the individual, another agency, or family member/friend is functioning as case manager and the participant agency has provided information on services available through other agencies.)

B. <u>RECOMMENDED PROCEDURES</u>

1. Screening Requests for Service Planning, Prior-Authorized Services and/or Financial Assistance

   a. Ascertain the nature of the request (what is being requested) and its appropriateness for the agency (does the participant agency provide those services; does the inquirer appear eligible for services).

   b. Determine the appropriate agency.

   c. If the participant agency is not the appropriate agency, direct the inquirer to another resource. If the inquirer seems to be confused, angry, frustrated, or otherwise unable to follow through, call the other agency for the inquirer to obtain help from the agency. If the inquirer expresses a preference to follow

through by him/herself, provide the inquirer with the pertinent information on the other agency.

d. If the participant agency is the appropriate agency to provide the assistance requested, assign a case manager who will be responsible for assessing needs and getting services to the inquirer. This case manager is called the "primary case manager."

e. If a request has been made for a specific service, which can be provided without assigning a case manager (e.g., transportation), arrange for the service but do not assign a case manager.

2. Sharing Information on Assistance Requests

a. Collect as much information on/from the inquirer as needed to determine the appropriateness of the assistance request. This information usually includes:

- Name
- Address
- Birthdate/age
- Income level
- Presenting problem
- Significant others
- Social Security number

b. If the assistance request appears inappropriate for the agency, indicate this to the inquirer and request approval to give the information to an appropriate agency.

c. If approval is granted by the inquirer, call an appropriate agency and give them the information on the inquirer.

d. If the other agency is the appropriate one for the inquirer (i.e. it opens the case), send a copy of the screening form for their files.

e. If a referral is being made to the participant agency by another service provider on behalf of an individual, request any written information on the client that is available and can be shared. Screening forms with common elements should be used by agencies providing case management.

3. Following Up Referrals

a. If a request for prior-authorized services or financial assistance results in a referral to another agency (i.e., an appointment was made for the individual), follow up the referral to determine whether the inquirer received the assistance requested. The person making the referral should either follow up with a call to the inquirer within five (5) working days or request and expect notification within five (5) working days from the agency to which a referral was made as to the status of that referral.

b. If the service request has been made by another service provider, notify that provider within five (5) working days as to the status of the referral.

c. Record the prevalence of inappropriate referrals. A follow-up call is important to evaluate the quality of the referral. If a referral was inappropriate or resulted in

dissatisfaction, investigate the problem and take whatever corrective active may be indicated. Examples of corrective actions include:

- Terminating service referrals to a particular agency;
- Notifying the agency's management that referrals are being neglected;
- Revising the participant agency's screening practices to collect more appropriate information with which to improve the referral process.

II. ASSESSING NEEDS

This section refers to the evaluation of the client's physical, mental, social, financial and environmental conditions as they relate to the ability of the individual to function on a daily basis.

A. STANDARDS

1. The needs assessment will be a holistic appraisal of the functional needs of the client. This will include the psychological, social, health, financial and environmental conditions of each client as needed for care planning. When appropriate an evaluation by a specialist may be required as part of the assessment.

2. The needs assessment will provide an overview of the needs of the client. It will not be limited to areas in which the participant agency or ADSD offers services.

3. The needs assessment will include a face-to-face contact with the individual, preferably where the person is currently residing.

4. A face-to-face needs assessment will be held within five (5) working days of a service request. When the need for a response is imminent (e.g., hospital discharge), the assessment will occur as soon as possible but no later than three (3) working days from the initial request. When the client's condition demands immediate attention the visit will occur within one (1) working day. (See protective services mandates for timelines in abuse/neglect situations.) These timelines may be adjusted to particular circumstances identified during the services request, with adjustments and reasons documented.

5. The needs assessment will be carried out by trained persons under the direction of a primary case manager.

B. RECOMMENDED PROCEDURES

1. Collect data available on the client from all relevant sources, (e.g. client, screeners, referral source, etc.)

2. Make an appointment to go out to visit the client.

3. Arrange for specialists to visit, if a need is indicated. Specialists who may be needed include a registered nurse, social worker, mental health specialist, financial eligibility worker, and other case managers.

    a. Use other specialists' assessments, when possible, as a base for more in-depth evaluation.

b. All specialists who contact the client separately from the primary case manager will tell the client that they are acting in the case manager's behalf.

4. Use necessary assessment tools to evaluate the total condition of the client. Supplementary forms to ADSD required forms (e.g. the PIB) should be included in the client's file.

5. Include the family, neighbors, other care providers, and significant others in the assessment visit(s) if at all possible. The intent is to get as complete a picture of the client's ability to function as possible.

III. DETERMINING ELIGIBILITY

This section refers to the examination of specific circumstances to assure that the client meets eligibility criteria.

A. STANDARDS:

1. The participant agency will assume that inquirers referred for assessment and eligibility determination by the participant agency are eligible for services and are therefore considered clients or applicants unless and/or until ineligibility is proved.

2. The participant agency will apply mandated eligibility criteria, including such factors as age, income level, and service need. Priorities for service will also apply.
3. The participant agency will determine the most appropriate funding source for the client's service needs. Every effort will be made to assure that individuals are provided services for which they are eligible.

4. The participant agency will continue to address the client's/applicant's needs while financial eligibility is being determined. This may include referral to other agencies for short-term services.

5. The participant agency will review eligibility for ongoing clients within required timeframes.

B. RECOMMENDED PROCEDURES

1. Consider the extent of needs, value of family support, cost of medical care, etc. when evaluating the individual's financial eligibility.

2. Use appropriate eligibility manuals for more specific procedures and timelines.

3. Refer the individual to another resource if the person is ineligible, and facilitate access or provide follow-up, if appropriate, within forty-five (45) working days of the assistance request. (Note: reflects maximum time frame for determination of Title XIX eligibility.)

4. Refer to another resource for services while the application is pending, if indicated. Resources to consider include risk intervention, OPI, district senior center services, etc. Referrals should be made within five (5) working days of the assistance request.

IV. DEVELOPING AND IMPLEMENTING CASE PLANS

This section refers to the processes of translating problems of an individual into a package of services and arranging for those services to be delivered.

A. STANDARDS

1. The case plan will address all needs of the client and include services that take care of at least the major needs of the individual, whether or not the participating agency provides those services.

2. The case plan will draw on relevant resources available in the community.

3. The case plan will define frequency and duration of service(s) to be provided.

4. The case plan will supplement the family and other support systems of the individual. The intent behind the case plan is to encourage independence and to maintain family support to the degree possible while advocating for a safe environment for the individual.

5. Each case plan will be individually developed to reflect the unique needs of the client.

B. RECOMMENDED PROCEDURES

1. Match the needs of the individual with the resources available.
2. Arrange for public payment as a last resort for services when private resources are inadequate or unavailable.

3. Organize family, neighbors, friends, volunteers or others to provide some of the services, if possible.

4. Arrange with other participating agencies to provide services.

    a. Share information on the client to facilitate record keeping and improve service delivery. This may include sharing portions of the client file, with the knowledge and consent of the client.

    b. Hold a joint staffing, if needed. A joint staffing may be appropriate if the other participating agency will be providing a number of services but not case management.

5. Schedule a date for reassessment.

V. MONITORING ONGOING SERVICES

This section refers to the staff work involved in maintaining services to the client. It includes providing advocacy and counseling to the client, monitoring his/her condition, working with significant others and other providers to resolve difficulties, and formally reassessing the individual's needs.

A. STANDARDS

1. In addition to formal reassessments, the participant agency will establish and maintain a regular schedule for contacting each client. Contacts may include face-to-face visits or telephone calls or communication with providers. Contacts regarding non-responsive clients (e.g. comatose nursing home residents) may be with providers and/or significant others. The regular schedule will be based on the client's needs and preferences, but the

expected time frame is once a month. Reasons for deviation from this schedule will be documented.

2. The participant agency will carry out a formal reassessment of each client, including a face-to-face contact, at least every six months for community-based residents and once a year for nursing home residents.

3. The participant agency is responsible for maintaining up-to-date case plans for clients.

    a. Services are to be appropriate for clients.

    b. Services delivered are to be of good quality.

    c. Natural support systems are to be maintained and encouraged where possible. Respite may need to be arranged.

    d. A regular schedule for contact with the service providers to resolve problems and assure quality will be established and maintained.

    e. If the client's needs change markedly during the monitoring process, a reassessment will be initiated.

4. If prior-authorized services will no longer be provided to a client who still has service needs, the participant agency will attempt to arrange for the needed services from other sources. The goal is to maintain continuity in assistance for the client.

B. RECOMMENDED PROCEDURES

1. Include schedules for client and provider contacts in the case plan.

2. Document each contact with the client and with the service providers.

3. Document case staffing, if a specialist (e.g. nurse) or other staff members has contact with the client.

4. If a client is no longer eligible for services but still needs some care and/or monitoring, refer the client to other service providers who may be able to provide the needed assistance. Follow up the referral within five (5) working days to determine if the client has kept the appointment and has received assistance.

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VI. TRANSFERRING CLIENT AMONG CASE MANAGERS

This section refers to the transfer of cases between participant agencies, between case managers in the same agency, and between the aging and disability services system agencies in different counties (Area Agencies on Aging).

A. STANDARDS

1. The participant agency will minimize the number of transfers of clients among its case managers. A transfer from an intake to an ongoing case manager will generally be made only when the client has stabilized in his/her new living situation.

2. The participant agency will provide for a transition period when it transfers a client.

a. If the transfer is within the participant agency, the new primary case manager will be involved in the case planning as early as possible.

b. If the case is being transferred to another participating agency, a transition period will be granted to all for joint case planning/staffing and transfer of relevant client information (with client permission). The goal is to minimize duplicate assessments and case planning.

c. Responsibility for responding to the client and his/her service providers remains with the initiating case manager until he/she has been notified that the new case manager has received the case.

d. Documentation from the case file will be forwarded within five (5) working days to the new case manager.

3. The participant agency will notify the client and his/her service providers of a pending case transfer prior to its enactment. If possible, the new case manager will be introduced in person (preferably) or through written communication.

4. The participant agency will work closely with similar agencies in other countries when transferring case in order to ease the transfer and assure continuity of services to the client.

B. RECOMMENDED PROCEDURES

1. Notify the recipient case manager or agency as soon as a client transfer is expected. Notification may be through a telephone call or letter.

2. Involve the new case manger in case planning, client and provider visits, and review of case files, prior to case transfer.

3. Arrange for transfer of documentation to the new case manager. Send copies of current forms and recent (e.g. last three (3) months) service logs.

4. Notify the service providers of the transfer.

5. Call the new agency (case manager) within thirty (30) working days to see that everything is satisfactory.

6. The new case manager should make a client contact (preferably a visit) as soon as possible but no later than five (5) working days. The case manager should make a second telephone contact if an on-site visit will not occur within the thirty days, with reasons for the deviation documented.

GUIDELINES FOR SCREENING APS REFERRALS

1. Obtain complete, relevant information regarding who, what, where, why, when and whether this might fit one of the three APS categories:

a. NF abuse: Physical harm or neglect to any patient in a nursing home;

b. Elder abuse: Physical harm, neglect or abandonment to anyone 65 or older by someone else (hospital abuse referrals are included here); and,

c. Community
Protective

Services (CPS): Aged, blind or disabled person unable to protect own interests and harmed or threatened with harm due to self or others.

2. Take responsibility for getting the referral to the APS designee, that person's backup or any professional staff person in the correct geographical branch (map attached). As a mandatory reporter under the NF abuse and Elder abuse laws, you are legally responsible to assure that the time frames are met!

3. The receptionist's responsibility is to assist the caller by connecting the caller with someone who can help. Acceptable actions are to transfer the call to the appropriate protective service or backup worker in the branch, to transfer the call to the receptionist or screener in the correct branch, or to take the caller's name and phone number, and assure that an appropriate person calls them back (unless otherwise arranges, within 10 minutes or so).

4. An unacceptable response is "that would be the responsibility of X branch; their phone number is 123-4567." It is never acceptable for an ADSD employee to tell a protective service caller to call somewhere else.

5. The receptionist's job is not to screen the call, take information or otherwise attempt to resolve or provide I & R to a information to a protective service caller; the critical function is to get the caller connected with a case manager or other professional staff member who can help.

6. It is never the case that no one is available to help. Each manager should outline for his or her receptionists who is backup, next backup and on and on. If for any reason, all staff in one office can't be reached, another ADSD office will provide backup. Managers must make arrangements for responding to protective service calls during all-staff events. 8:00 a.m. to 5:00 p.m., ADSD and all its programs and offices are to be open for business.

7. Staff should remember that protective service callers may be afraid, have limited time to make a phone call (e.g. while the abuser is out of the house), or be otherwise inhibited or reluctant to share information. An attitude of helpfulness and minimizing the bureaucratic run-around is critical when dealing with these callers.

8. Ask for feedback from the APS designee or investigator. Did you gather the correct information? Enough information? Did you refer them to the right place? The right person? How could you have done it better? What did you do especially well? ASK!!

9. If you can't do what you think you need to do in getting a referral to the right person, talk to your boss or talk to that person's boss. Do it in a positive way.