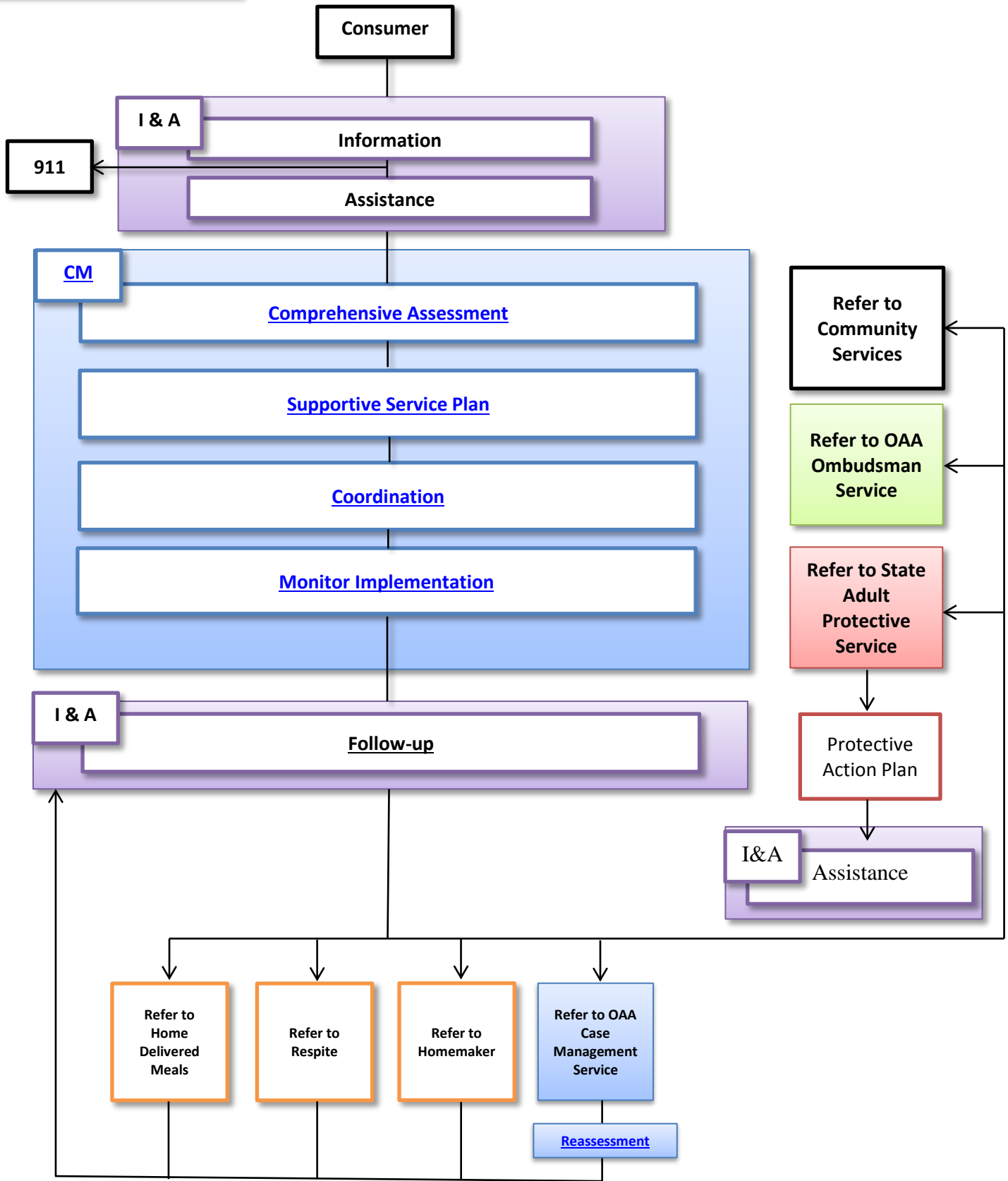


**OAA Case Management (CM) Service**



# Case Management Implementation Guide

## Case Management Services

Case management (CM) is a consumer directed service provided through activities of assessment, coordination and monitoring. CM service assists the consumer in gaining access to medical, social, educational and other needed services necessary to support the consumer in the living environment of their choice.

Case Management service is conducted during working hours of which the Area Agency on Aging (AAA) office is open for transaction of normal business each day except weekends and holidays.

## Referrals for Case Management Service

- A. All referrals for CM service must be screened by Information and Assistance (I&A).
- B. Referrals to CM are made when results of screening or follow-up meet all requirements for CM service referral.
  1. Referrals accepted by CM will include:
    - a. The ICOA approved assessment instrument (Intake Assessment) and the appropriate Eligibility, Consent and Referral documentation for the requested service.
    - b. Supporting documentation
- C. Referrals that are made but do not meet all requirements for CM service referral are returned to I&A.

## CM Program Intake

- A. CM Program Intake is a task of CM that is conducted within appropriate time frames.
  1. Normal Intake – requires consumer contact to be initiated within 5 days of receipt of the referral, and an in-home assessment to be conducted within 2 weeks of receipt of referral from I&A.
  2. Emergency Intake – requires a home visit and assessment within 2 working days of receipt of referral from I&A.

## Comprehensive Assessment

- A. A comprehensive assessment is completed during program intake as a task of CM.
- B. A comprehensive assessment is conducted to collect information necessary for development of an individual supportive service plan (SSP).
  1. Determine level of need and type of service needed utilizing the ICOA approved assessment instrument (Intake Assessment) and the appropriate Eligibility, Consent and Referral for the requested service.
  2. Only eligible clients may be authorized for services funded through the OAA or Idaho Senior Services Act.

## Denial of Service

Notify an applicant in writing of the reason for denial of service, and the right to appeal.

- Service may be denied for any of the reasons listed for Denial of Service per IDAPA

## Supportive Service Plan

- A. Supportive Service Plan development is a task of CM and completed during an in-home assessment.
- B. A SSP is developed from information documented in the following areas of the consumer file.
  1. ICOA approved assessment instrument (Intake and Screening):
    - a. Unmet needs and service gaps identified during the assessment
  2. Eligibility, Consent and Referral:
    - a. Justification for service authorization
    - b. Components of each service authorized (i.e. units of service)
    - c. Anticipated duration of service (i.e. start date and end date)

3. Case notes:
  - a. Unmet needs identified during the assessment
  - b. Exploration of informal and formal opportunities
  - c. Those involved in service planning
4. Supportive Service Plan:
  - a. Overall goals and objectives to be achieved
  - b. SSP actions tasked to CM
  - c. SSP actions tasked to consumer, family and other informal services
  - d. References to formal services arranged as part of SSP
  - e. Document the anticipated schedule for:
    - CM monitoring
    - I&A follow-up
    - SSP review

### Coordination

- A. Coordination of formal and informal service delivery is a task of CM.
  1. Provide coordination through implementation of the SSP by means of telephone conversation or written correspondence.
  2. Coordinate formal and informal resources identified in the SSP with any other plans that exist for various formal services, such as:
    - a. With hospital discharge plans; and
    - b. With the Information and Assistance (I&A) services

### Monitoring

- A. Monitoring is a task of CM.
  1. Monitoring is conducted by means of telephone conversation or written correspondence with the consumer, family, formal providers and others identified in the supportive service plan.
  2. Monitor to make sure formal and informal services are provided.
  3. Monitor until the SSP is fully implemented.

### Reassessment of SSP

- A. Reassessment of an SSP is a task of CM that is conducted by means of telephone conversation.
- B. CM may be authorized to conduct a reassessment of a SSP when the following conditions have been met:
  1. Information gathered through follow-up indicates a necessity for reassessment of the SSP due to changes in the consumer's circumstances.
  2. The consumer agrees to accept CM service and follow-up findings meet all requirements for CM service referral.
 

Note: If the consumer's needs can be met through I&A do not authorize CM service.
- C. SSP reassessment includes:
  1. Review of ICOA approved assessment instrument (Intake and Screening)
  2. Review of Eligibility, Consent and Referral documentation
  3. Review Supportive Service Plan
 

Note: Update the Supportive Service Plan only with consumer consent.

### Termination of CM service

- A. CM service will be terminated when:

1. Implementation of SSP results in an increase of family or other available formal or informal supports to the consumer.
  2. The consumer's needs can be met through I&A; or
  3. Any reason has been met to discontinue AAA authorized service per IDAPA.
- B. Notify a consumer in writing of the reason for termination of service, and the right to appeal at least 2 weeks prior to termination.
1. AAA authorized service may be discontinued for any reason listed per IDAPA, or at the discretion of the AAA director.
    - a. Maintain documentation of notice in consumer file.

**Case Management Qualifications**

**A. Provider Qualifications**

1. Case Management services funded through the OAA or through the Idaho Senior Services Act are provided by employees of the Area Agencies on Aging.

**B. Case Manager Qualifications**

1. Case management services shall be provided by individuals that have participated in all training necessary to ensure proficiency of the program, services, rules, regulations, policies and procedures.
2. AAA employees who provide case management services must meet the qualifications as defined in IDAPA:
  - a. Case Management Supervisor
  - b. Certified Case Manager
  - c. Supportive Services Technician

**Tasks of Case Management:**

Case Management  Tasks	Qualified		
	Case Management Supervisor	Case Manager/ Certified Case Manager	Supportive Services Technician
<b>A. CM Program Intake</b> 1. Initiate contact with the consumer and complete an in-home assessment within appropriate time frames. 2. Normal intake requires: a. Consumer contact initiated within 5 days, and b. An assessment conducted within two weeks of referral to CM. 3. Emergency intake requires: a. A home visit and assessment within 2 working days of referral to CM.	<b>-Yes</b>	<b>-Yes</b>	<b>-Yes</b>
<b>B. Comprehensive Assessment</b> 1. Form a complete assessment of the consumer: a. Determine the level of need and type of service needed. b. Identify availability of others to assist with those needs. c. Update ICOA approved assessment instrument	<b>-Yes</b>	<b>-Yes</b>	<b>-Yes</b>

<p>d. Complete Eligibility, Consent, Referral e. Complete Supportive Service Plan</p> <p><b>C. Supportive Service Plan</b></p> <p>1. Develop a SSP that:</p> <p>a. Is based on the information collected during client assessment.</p> <p>b. Specifies the goals and actions to address the health, social, educational and other service needs of the consumer;</p> <p>c. Includes active participation of the consumer, and working with the consumer’s family or others to develop such goals, and identify a course of action to respond to the assessed needs of the eligible consumer; and</p> <p>d. Includes a schedule for monitoring; and</p> <p>e. Includes a schedule for anticipated SSP reassessment.</p> <p>2. Document within consumer’s file, all pertinent information related to the development of the SSP, including but not limited to:</p> <p>a. Those involved in service planning;</p> <p>b. Service needs and details of eligibility including:</p> <ul style="list-style-type: none"> <li>• Goals</li> <li>• Justification for service authorization</li> <li>• Referrals</li> <li>• Components of each service authorized</li> <li>• Intended outcome</li> <li>• Anticipated implementation dates, and</li> <li>• Anticipated duration of service</li> </ul>	-Yes	-Yes	-Yes
<p><b>D. Coordination of formal and informal services</b></p> <p>1. Coordinate formal and informal resources identified within the SSP with any other plans that exist for various formal services, such as:</p> <p>a. Hospital discharge plans, and</p> <p>b. The AAA I&amp;A services</p>	-Yes	-Yes	-Yes
<p><b>E. Monitor formal and informal services</b> Make sure formal and informal services specified in the SSP are being provided.</p>	-Yes	-Yes	-Yes
<p><b>F. Reassessment of SSP</b></p> <p>1. Document changes in:</p> <p>a. Functional or cognitive ability</p> <p>b. Living conditions</p> <p>c. Availability of supports</p> <p>d. Make sure formal and informal services are being provided</p> <p>2. Review and update:</p>	-Yes	-Yes	-Yes

<ul style="list-style-type: none"> <li>a. ICOA approved assessment instrument (Intake and Screening)</li> <li>b. Eligibility, Consent and Referral <ul style="list-style-type: none"> <li>• Update Supportive Service Plan only with consumer approval</li> </ul> </li> </ul>			
<b>G. Records</b>			
1. Consumer records shall be maintained for three (3) years following service termination.	<b>-Yes</b>	<b>-Yes</b>	<b>-Yes</b>

## FEDERAL AND STATE CODE

### CASE MANAGEMENT SERVICES

1. **Access Services.** (IDAPA 15.01.21.010.01) Transportation, Outreach, Information and Assistance and Case Management. (7-1-98)
2. **Policy.** (IDAPA 15.01.01.056.01) Case management is a consumer-driven, social model case management service that empowers individuals and their families to make choices concerning in-home, community-based or institutional long-term care services. (4-5-00)
3. **Case Management Services.** (OAA Section 102(a)(11))
  - A. A service provided to an older individual, at the direction of the older individual or a family member of the individual—
    1. By an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described in subparagraph (2); and
    2. To assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs, of the older individual; and
  - B. Includes services and coordination such as—
    1. Comprehensive assessment of the older individual (including the physical, psychological, and social needs of the individual);
    2. Development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the resources and services—
      - a. With any other plans that exist for various formal services, such as hospital discharge plans; and
      - b. With the information and assistance services provided under this Act;
    3. Coordination and monitoring of formal and informal service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided;
    4. Periodic reassessment and revision of the status of the older individual with—
      - a. The older individual; or
      - b. If necessary, a primary caregiver or family member of the older individual
    5. In accordance with the wishes of the older individual, advocacy on behalf of the older individual for needed services or resources.
4. **Case Management Services.** (IC 67-5006(9))
  - A. Means a service provided to an older individual at the direction of the older individual or a family member of the individual:
    1. By an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described in section (2) of this subsection; and
    2. To assess the needs and to arrange, coordinate and monitor an optimum package of services to meet the needs of the older individual; and
  - B. Includes services and coordination such as:
    - a. Comprehensive assessment of the older individual, including the physical, psychological and social needs of the individual;

- b. Development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the resources and services:
    - a. With any other plans that exist for various formal services such as hospital discharge plans; and
    - b. With the information and assistance services provided herein;
  - c. Coordination and monitoring of formal and informal service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided;
  - d. Periodic reassessment and revision of the status of the older individual with:
    - a. The older individual; or
    - b. If necessary, a primary caregiver or family member of the older individual; and
  - e. In accordance with the wishes of the older individual, advocacy on behalf of the older individual for needed services or resources.
5. **Registered Client.** A registered client is an individual who received at least one unit of the following specified services within the reported fiscal year. The services include:
- A. Congregate meals,
  - B. Nutrition counseling,
  - C. Assisted transportation,
  - D. Personal care,
  - E. Homemaker,
  - F. Chore,
  - G. Home
  - H. Delivered meals,
  - I. Adult day care/health, or
  - J. Case management
  - K. Services for Caregivers- Case Management and Respite
6. **Long-Term Care.** (OAA Section 102(a)(34)) means any service, care, or item (including an assistive device), including a disease prevention and health promotion service, an in-home service, and a case management service –
- A. Intended to assist individuals in coping with, and to the extent practicable compensate for, a functional impairment in carrying out activities of daily living;
  - B. Furnished at home, in a community care setting (including a small community care setting as defined in subsection (g)(1), and a large community care setting as defined in subsection (h)(1), of section 1929 of the Social Security Act (42 U.S.C. 1396t)), or in a long-term care facility; and
  - C. Not furnished to prevent, diagnose, treat, or cure a medical disease or condition.
7. **In-home Services.** (IC 67-5006(2)) Provide care for older persons in their own homes and help them maintain, strengthen, and safeguard their personal functioning in their own homes. These services shall include, but not be limited to case management, homemakers, chores, telephone reassurance, home delivered meals, friendly visiting and shopping assistance, and in-home respite care.
8. **Case Management.** (IDAPA 15.01.01.010.10) Case management is a service provided to older individuals and disabled adults, at the direction of the individual or a family member of the individual, to assess the needs of the person and to arrange, coordinate, and monitor an optimum package of services to meet those needs.
- A. Activities of case management include:
    - 1. comprehensive assessment of the individual;
    - 2. development and implementation of a service plan with the individual to mobilize formal and informal resources and services;
    - 3. coordination and monitoring of formal and informal service delivery;
    - 4. and periodic reassessment. (3-30-01)

#### PROGRAM INTAKE

- 1. **Referral for Case Management.** (IDAPA 15.01.01.056.05) Referrals shall be accepted from any source and may include eligible clients who are seeking or already receiving other services. (4-5-00)
- 2. **Program Intake.** (4-6-05) (IDAPA 15.01.01.056.08)

1. **Normal Intake.** Except under circumstances where a case management waiting list exists, client contact shall be initiated within five (5) days of receipt of the referral, and an assessment shall be conducted within two (2) weeks of referral. (4-6-05)
2. **Emergency Intake.** Referrals indicating a crisis or potential crisis such as a marked decline in health or functional status, hospital discharge, or Adult Protective Service referral require a home visit be conducted to assess service need within two (2) working days of receipt of referral. If appropriate and available, a homemaker shall be assigned and service shall be initiated immediately. Referrals assessed to need emergency service shall take precedence over applicants carried on a waiting list. (4-6-05)

#### COMPREHENSIVE ASSESSMENT

1. Client assessment shall be conducted during a home visit and shall utilize the ICOA approved assessment instrument. (5-3-03) (IDAPA 15.01.01.056.09)
2. **Client Assessment.** To determine the level of need and the type of service needed, an AAA Case Manager or SST shall conduct an in-home assessment using the ICOA approved assessment instrument. Service alternatives shall be discussed and referrals initiated as appropriate. (5-3-03) (IDAPA 15.01.01.056.08)
3. **Self-directed Care.** (OAA Section 102(a)(46)) means an approach to providing services (including programs, benefits, supports, and technology) under this Act intended to assist an individual with activities of daily living, in which –
  - A. The needs, capabilities, and preferences of such individual with respect to such services, and such individual's ability to direct and control the individual's receipt of such services, are assessed by the area agency on aging (or other agency designated by the area agency on aging) involved;

#### SUPPORTIVE SERVICE PLAN

1. **Individual Supportive Service Plan (SSP).** (IDAPA 15.01.01.056.09) A supportive service plan shall be signed by the client or legal representative prior to initiation of services. (4-6-05) An approved plan shall reflect needed services to be provided by available family or others. (7-1-98)
2. **SSP.** Based on the information obtained during the client assessment and input obtained from family or professionals familiar with the client, the case manager shall develop a written SSP which shall include at least the following: (4-5-00)
  - A. Problems identified during the assessment; (7-1-98)
  - B. Exploration of opportunities for family and other informal support involvement to be included in development of the SSP; (7-1-98)
  - C. Overall goals to be achieved; (7-1-98)
  - D. Reference to all services and contributions provided by informal supports including the actions, if any, taken by the case manager to develop the informal support services; (4-5-00)
  - E. Documentation of all those involved in the service planning, including the client's involvement; (7-1-98)
  - F. Schedules for case management monitoring and reassessment; (4-5-00)
  - G. Documentation of unmet need and service gaps; and (7-1-98)
  - H. References to any formal services arranged, including fees, specific providers, schedules of service initiation, and frequency or anticipated dates of delivery. (7-1-98)
    1. A copy of the current SSP shall be provided to the client or legal representative. (7-1-98)
    2. Case files shall be maintained for three (3) years following service termination. (7-1-98) (IDAPA 15.01.01.056.09)
3. **Core Services.** (IDAPA 15.01.01.056.07) Case management provides responsible utilization of available informal (unpaid) supports before arranging for formal (paid) services. The case manager and client, or client's legal representative, shall work together in developing an SSP to establish the frequency and duration of needed services. Services shall be arranged subsequent to approval by the client or legal representative. Services provided shall be recorded and monitored to ensure cost effectiveness and compliance with the SSP. (5-3-03)
4. **Supportive Service Plan (SSP).** (IDAPA 15.01.01.010.43) An individual support plan outlining an array of services or the components of an individual service required to maintain a client at home or to reduce risks and meet the care needs of a vulnerable adult. (4-6-05)



5. **Self-directed Care.** (OAA Section 102(a)(46)) means an approach to providing services (including programs, benefits, supports, and technology) under this Act intended to assist an individual with activities of daily living, in which –
  - A. Based on the assessment made under subparagraph (3), the area agency on aging (or other agency designated by the area agency on aging) develops together with such individual and the individual’s family, caregiver (as defined in paragraph (27)), or legal representative –
    1. A plan of services for such individual that specifies which services such individual will be responsible for directing;
    2. A determination of the role of family members (and others whose participation is sought by such individual) in providing services under such plan; and
    3. A budget for such services; and
    4. The area agency on aging or State agency provides for oversight of such individual’s self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under this Act.
6. **Informal Supports.** (IDAPA 15.01.01.010.29) Those supports provided by church, family, friends, and neighbors, usually at no cost to the client. (7-1-98)
7. **Formal Services.** (IDAPA 15.01.01.010.22) Services provided to clients by a formally organized entity, including, but not limited to, Medicaid HCBS. (5-3-03)

#### COORDINATION, MONITORING & CASE CLOSURE

1. **Other Supportive Services.** (7-1-98) (IDAPA 15.01.01.056.10)
  1. Necessary Services. Case managers shall assist clients to obtain available benefits, services, medically related devices, assistive technology, necessary home modifications, or other services required to fulfill unmet needs. (4-5-00)
  2. Social-Emotional Support. Case managers shall link clients and their families with available services which facilitate life adjustments and bolster informal supports. (4-5-00)
  3. Unmet Needs. To assist the AAA in future planning, case managers shall identify and document unmet client needs. (4-5-00)
  4. Other Resources. In all cases, other available formal and informal supports shall be explored prior to utilization of formal Aging Network services. (5-3-03)
2. **Core Services.** (IDAPA 15.01.01.056.07) Case management provides responsible utilization of available informal (unpaid) supports before arranging for formal (paid) services. The case manager and client, or client’s legal representative, shall work together in developing an SSP to establish the frequency and duration of needed services. Services shall be arranged subsequent to approval by the client or legal representative. Services provided shall be recorded and monitored to ensure cost effectiveness and compliance with the SSP. (5-3-03)
3. **DENIAL OF SERVICE.** (IDAPA 15.01.01.027) An applicant shall be notified in writing of a denial of service and the right to appeal in accordance with IDAPA 15.01.20, Section 003, “Rules Governing Area Agency on Aging Operations.” The request for services may be denied for any of the following reasons listed below, or at the discretion of the AAA director: (5-3-03)
  1. **Applicant Not in Need of Service.** The applicant’s functional or cognitive deficits are not severe enough to require services. (7-1-98)
  2. **Family or Other Supports Adequate.** Family, or other available formal or informal supports are adequate to meet applicant’s current needs. (4-6-05)
  3. **Other Care Required.** The applicant’s needs are of such magnitude that more intensive supports, such as Medicaid HCBS, attendant care, or referral for residential or nursing home placement are indicated. In such instances, alternatives shall be explored with the applicant and the applicant’s legal representative and family, if available. Referrals shall be made by the provider, as appropriate. (5-3-03)
  4. **Barriers to Service Delivery Exist.** The applicant’s home is hazardous to the health or safety of service workers. (7-1-98)

5. **Geographical Inaccessibility.** The AAA determines that the applicant's home is geographically inaccessible from the nearest point of service provision of home-delivered meals, homemaker, chore, or respite and the provider can document efforts to locate a worker or volunteer to fill the service need have been unsuccessful. (5-3-03)
  6. **Lack of Personnel or Funding.** Services are unavailable based on a lack of available service personnel or funding. When an eligible applicant is denied service based on a lack of available service personnel or funding, the applicant shall be placed on a waiting list. For services other than Case Management, the applicant shall receive an in-home assessment prior to placement on a waiting list. Applicants on a waiting list for services shall be prioritized according to IDAPA 15.01.20, "Rules Governing Area Agency on Aging Operations," Section 053. All applicants placed on a waiting list shall be notified of this action in writing. (4-6-05)
4. **TERMINATION OF SERVICE.** (IDAPA 15.01.01.028)
1. **Documentation.** Documentation of notice of termination shall be placed in the client's case record, signed, and dated by the provider. (7-1-98)
  2. **Appeals Process.** The client shall be informed of the appeals process, in accordance with IDAPA 15.01.20, "Rules Governing Area Agency on Aging Operations," Section 053. (4-6-05)
  3. **AAA Services.** AAA authorized services may be discontinued by the provider for any of the reasons listed below, or at the discretion of the AAA director: (5-3-03)
    - A. Services proved ineffective, insufficient, or inappropriate to meet client needs. (7-1-98)
    - B. Other resources, including, but not limited to, formal and informal supports, became available. (5-3-03)
    - C. Client withdrew from the program or moved. (7-1-98)
    - D. Family or other available formal or informal support to client increased. (5-3-03)
    - E. Client placed in a long-term care facility. (7-1-98)
    - F. Client died (no notification of termination required). (7-1-98)
    - G. Client's functioning improved. (7-1-98)
    - H. Client refused service. (7-1-98)
    - I. Client's home is hazardous to the service provider (requires prior notification of the AAA Director with final approval being at the discretion of the AAA Director). (7-1-98)
    - J. Client's home is not reasonably accessible. (7-1-98)
    - K. Client's behavior is a threat to the safety of the provider (requires prior notification of the AAA Director with final approval being at the discretion of the AAA Director.) (7-1-98)
    - L. Client verbally abuses or sexually harasses service provider. (7-1-98)
    - M. Client refuses to pay fee determined for service. (7-1-98)
    - N. Service provider is not available in locale. (7-1-98)
    - O. Services are no longer cost effective. (7-1-98)
  5. **Notification of Termination and Right to Appeal.** At least two (2) weeks prior to termination, the client shall be informed in writing of the reasons for provider initiated service termination and the right to appeal in accordance with IDAPA 15.10.20, "Rules Governing Area Agency on Aging Operations," Section 053. Exceptions to the two (2) week advance notification of termination will be justified to the AAA Director with final approval being at the discretion of the AAA Director. Appeal actions are the responsibility of the AAA. The client shall be referred to other services as appropriate. (4-6-05)

#### REASSESSMENT OF SSP

1. **Revision of the SSP.** After services have been in place for one (1) month, the provider shall inform the AAA of any modifications it suggests be made to the SSP, such as changes in hours of service or tasks to be performed. (4-6-05) (IDAPA 15.01.01.056.09)

2. **Reassessments of SSP.** Case Management shall update the SSP at least annually. Any revisions to an SSP shall be initiated by the client prior to being put into effect. An SSP may be updated more often than annually if changes in a client's circumstances (i.e., functional or cognitive ability, living conditions, availability of supports) indicate a necessity for re-assessment. (4-6-05) (IDAPA 15.01.01.056.09)
3. **Assessment Coordination.** A client need not be re-assessed if an assessment completed within the past ninety (90) days by the Department provides the same information as the ICOA approved assessment instrument and the client signs a Release of Information form. A client assessment shall be completed if no current assessment from another agency is available. In either case, a home visit shall be included in the process of developing the client's individual SSP. (5-3-03) (FO.AD.03. Release of Information) (IDAPA 15.01.01.056.08) (IDAPA 15.01.01.056.09)

## CASE MANAGEMENT QUALIFICATIONS

1. **Qualifications.** (IDAPA 15.01.01.056.02) Any person hired to fill the position of case manager or case management supervisor on or after July 1, 1998, shall have the qualifications identified in Subsections 010.09 and 010.11 of these rules. (4-6-05)
2. **Supportive Services Technician.** (IDAPA 15.01.01.010.44) AAA employee working under the supervision of a licensed social worker or case manager assisting with investigation of Adult Protective Services reports, completion of the ICOA approved assessment instrument for services of clients of ICOA funded in-home services, or development and initiation of SSPs. The employee shall have a High School diploma and at least two (2) years' experience delivering services to the elderly or at-risk populations. (5-3-03)
3. **Case Management Supervisor.** (IDAPA 15.01.01.010.11) An individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse/RN) with at least two (2) years' experience in service delivery to the service population. (4-5-00)
4. **Certified Case Manager.** (IDAPA 15.01.01.010.12) A Case Manager who has met the requirements for certification as established by the National Academy of Care/Case Managers or other professional association recognized by the Idaho Commission on Aging. (5-3-03)
5. **Case Manager.** (IDAPA 15.01.01.010.09) A licensed social worker, licensed professional nurse (RN), or Certified Case Manager, or an individual with a BA or BS in a human services field or equivalent and at least one (1) year's experience in service delivery to the service population. (3-30-01)

## RECORDS

1. **Evaluation.** (IDAPA 15.01.01.056.13) Evaluation is required to assure quality control. The AAA is responsible for monitoring case management activities for quality control and assurance. The AAA shall review client records to determine: (4-5-00)
  1. Services are being provided as outlined in the SSP; (7-1-98)
  2. Services are meeting the goals established in the SSP; (7-1-98)
  3. The client is satisfied with the service being provided; (7-1-98)
  4. Changes in service have been authorized; (7-1-98)
  5. The SSP continues to be cost-effective; (7-1-98)
  6. Providers are noting observations and relating information about informal caregivers, additional actions required by the case manager, re-evaluations, amendments to the SSP, and client contacts. (4-5-00)
2. **Area Plans.** (OAA, Section 306(a)(8)) Case management services provided under this title through the area agency on aging will— (Attachment: FO.AD.06. PSA AAA Area Plan Instructions)
  1. (A) not duplicate case management services provided through other Federal and State programs;
  2. (B) be coordinated with services described in subparagraph (A); and
  3. (C) be provided by a public agency or a nonprofit private agency that—
    - A. (i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;
    - B. (ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

- C. (iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
  - D. (iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);
3. **Standards of Performance.** (IDAPA 15.01.01.056.12) AAAs shall assure case management meets the requirements for service neutrality. AAAs shall not be a direct provider of other in-home services, other than Adult Protective Services, without proper written justification and approval by the Administrator of the ICOA. (5-3-03)
  4. **Structure and Role.** (IDAPA 15.01.01.056.11) Case management is a centralized evaluator and arranger of services and provides those activities previously outlined under "Service Functions." AAAs shall be the direct provider for case management services. The AAA is responsible for the implementation of the case management program. (4-5-00)
    1. Case managers shall coordinate service delivery between multiple agencies, individuals, and others. (4-5-00)
    2. Each AAA shall carry insurance covering case management services in the types and amounts which meet acceptable business and professional standards. (5-3-03)
    3. Each AAA shall conduct an orientation program for all new case management employees which covers, at least, local resources available, case management service delivery, confidentiality of information, and client rights. (4-6-05)
    4. In addition to the development and maintenance of the SSP, program and client records shall be maintained to provide an information system which assures accountability to clients, the Case Management Program, and funding agencies, and which supplies data for AAA planning efforts. The information system established shall comply with the following the ICOA requirements: (4-5-00)
      - A. NAPIS Registration Form; (7-1-98) (Attachments: FO.NU.02. Congregate Meal Registration)
      - B. Completed the ICOA approved assessment instrument; (5-3-03)
      - C. Pertinent correspondence relating specifically to the client; (7-1-98)
      - D. A narrative record of client and community contacts, including problems encountered and SSP modifications developed in response; (7-1-98)
      - E. Completed SSP, signed by the client; (7-1-98)
      - F. Written consent and acceptance of Case Management Services and release of information forms; (4-5-00) (Attachment: FO.AD.03. Release of Information)
      - G. Any other documentation necessary for systematic case management and SSP continuity. (4-5-00) (Attachments: FO.AD.04. Standard Income Declaration; GU.AD.01. Sliding Fee Scale)
  5. **Working Agreements.** (7-1-98) (IDAPA 15.01.01.056.06)
    1. The Case Management Program is encouraged to enter into working agreements with primary community resources utilized by older persons. These resources may include AAA service providers, mental health centers, hospitals, home health agencies, legal services providers, and others. (4-6-05)
    2. Working agreements should address at least the following: (4-6-05)
      - A. How long each party will take to respond to a request for service; (4-6-05)
      - B. Release of information procedures; (7-1-98)
      - C. Referral and follow-up procedures; (7-1-98)
      - D. How each party will notify the other of program changes and non-availability of service; and (4-6-05)
      - E. Procedures for working out problems between the two (2) parties. (7-1-98)
  6. **National Aging Program Information System (NAPIS).** (IDAPA 15.01.01.010.33) Standardized nationwide reporting system that tracks: (7-1-98)
    - A. Service levels by individual service, identifies client characteristics, State and AAA staffing profiles, and identifies major program accomplishments; and (4-5-00)
    - B. Complaints received against long term care facilities and family members or complaints related to rights, benefits and entitlements. (7-1-98)
  7. **Fiscal Effectiveness.** (IDAPA 15.01.01.010.21) A financial record of the cost of all formal services provided to insure that maintenance of an individual at home is more cost effective than placement of that individual in an institutional long-term care setting. (7-1-98)

