

*Case Management Program
for the Frail Elderly*



Coordinators' Manual

June, 2005

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CASE MANAGEMENT PROGRAM FOR THE FRAIL ELDERLY

Area Agency on Aging Coordinators' Manual

BACKGROUND

The Case Management Program for the Frail Elderly (CMPFE) is a coordinated comprehensive system that strives to provide Iowa's frail elderly clients 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 Iowa's frail elderly to remain safely in their own homes. The program takes a multidisciplinary approach to providing community-based services in which each client is monitored by an individual case manager. The individual case manager provides assistance to the client in making the appropriate choices that best fits the client'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 which 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 (CMPFE) 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 Iowans 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 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 home and community-based services Elderly Waiver program became available statewide.

Currently all Iowans over the age of 60 can access CMPFE and its services through their AAA. 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 the Frail Elderly with direction given from the Senior Living Coordinating Unit (SLCU). The membership of the SLCU consists of the director of the Department of Elder Affairs, the director of the Department of Human Services, the director of the Department of Public Health, the director of the Department of Inspections and Appeals, two members appointed by the governor, and four non-voting members of the general assembly.

The SLCU has several responsibilities including to implement a case-managed system of long-term care based on a comprehensive assessment tool, develop common intake and release of information procedures for services, develop coordination procedures at the state and local level, and develop a long-range plan for long-term care.

The Area Agencies on Aging are designated by the Senior Living Coordinating Unit as the local administrative agencies for CMPFE. The Area Agencies on Aging are accountable to DEA for all their CMFPE-related activities.

The Area Agencies on Aging agree to adhere to certain program assurances. A copy of these assurances is included at the end of this section. Additionally, local provider agencies and local administrative entities that participate in the case management program sign a Memorandum of Agreement that defines expectations of these agencies. A copy of the Memorandum of Agreement is including at the end of this section.

The Iowa Department of Human Services, as the single state Medicaid agency, monitors activities involving Medicaid recipients enrolled in CMPFE. This includes rule development for the Elderly Waiver program, Level of Care determinations, Quality Assurance reviews, technical assistance, and other program implementation procedures.

CASE MANAGEMENT PROGRAMS for the FRAIL ELDERLY (CMPFE) -- ASSURANCES

These assurances are based on the Senior Living Coordinating Unit (SLCU) Case Management and Administrative Standards that the Case Management Programs for the Frail Elderly (CMPFE) has incorporated into their procedures manuals.

ADMINISTRATION:

1. A client of the CMPFE will be a person who at a minimum resides in Iowa and has multiple needs and:
 - A. Is 60 years of age or older and enters the system through the prescribed screening tool and assessment tool and meets the established guideline of possibly needing two or more services, or
2. The CMPFE is accountable to the Iowa Department of Elder Affairs (IDEA), the state administrative entity designated by the SLCU to administer the program. The activities of the CMPFE will be monitored and directed by the AAA. All case management records, including client case management files and records, will be available for AAA review upon request.
3. AAA and state case management administrative procedures will be followed.
4. Case management budget will include purchase or printing costs for the screening forms, the assessment forms, screening and assessment tool manuals, the referral and care plan forms, and additional forms as needed.
5. After the initial training, the AAA is responsible for conducting training on the use of screening tool, assessment tool and other forms, and case management.
6. A plan will be developed and implemented to increase client/family involvement in the care planning process. At a minimum, clients will be invited to attend and participate in the care planning process, and the client may invite others to play a part in the care plan process.
7. The AAA agrees to follow procedures for reimbursement for completed assessment tools (including annual assessment updates).
8. The AAA agrees to follow procedures for reimbursement for case management.

PARTICIPATING AGENCIES:

1. The AAA will establish written procedures that address potential conflicts of interest within the local CMPFE. These will include:
 - A. A process to delegate case management responsibilities to a team-appointed case manager.
 - B. Identification of where conflicts do or could exist.
 - C. Procedures to eliminate or minimize the conflicts.
 - D. A process for conflict resolution keeping in mind the client's best interest.
 - E. A process for documenting conflict resolution.
2. Each participating agency in the CMPFE shall have a supervisory component that includes: written job descriptions, regularly scheduled supervisory conferences, performance reviews, and oversight through direct observation of the services and review of care plans.
3. Each participating agency shall have an internal quality assurance program in place and active for each service it provides.
4. Procedures for receiving and resolving client appeals of CMPFE decisions shall be in place and extend beyond the service of all participating agencies. Procedures shall specify a process for handling client complaints and for informing the client that procedures are available for the client to appeal decisions.
5. An interdisciplinary case management team will be in place and will provide ongoing monitoring of client needs and the services to meet those needs. This interdisciplinary team will include, at a minimum, an AAA CMPFE designee, a currently Iowa-licensed, registered nurse and a person with a bachelors degree in a human services-related field. The team will meet at least monthly.

PERSONNEL QUALIFICATIONS:

1. Staff for the CMPFE will meet the following qualifications.
 - A. Intake workers using screening tool:
 1. Orientation to aging process and training in completion of the screening tool.
 - B. Assessors using assessment tool:
 1.
 - a) Bachelors' degree in human services field, such as gerontology, human services, social work, sociology, or family services; or
 - b) Bachelors' degree in a non-human services field with 12 credit hours in gerontology; or
 - c) Two years full-time equivalent experience in a human services field may be substituted for up to two years of the educational requirement; or
 - d) Currently Registered Nurse; and
 2. Formal training in completion of the assessment tool.
 - C. Case Managers
 1.
 - a) bachelors degree in human services field; or
 - b) Currently a licensed Registered Nurse; or
 - c) Up to four years full-time-equivalent work experience in a human services field may be substituted for the educational requirement; and
 2. Formal training in completion of the assessment tool; and
 3. Formal case management training from the local CMPFE.
 - D. CMPFE Coordinators
 1.
 - a) Bachelors degree in human services field plus one year of full-time equivalent work experience in a human services field; or
 - b) Licensed Registered Nurse plus one year of full-time equivalent experience in a health care field; or
 - c) Two years full-time equivalent work experience involving direct contact with people in overcoming their social, economic, psychological or health problems may be substituted for two years of the educational requirement under subsection a; and
 2. Formal training in completion and transmission of the assessment tool; and
 3. Case Management for the Frail Elderly orientation from IDEA staff within three months of employment.

DATA AND RECORD KEEPING:

1. Documentation and record keeping must be timely and complete; address needs and outcomes; and monitor progress and client responses. Specified data will be collected including, but not limited to:
 - A. The number and type of contacts that the case manager has with or on behalf of the client.
 - B. Cost information as prescribed by the SLCU.
2. Data including completed screening and assessment tools shall be sent to the Iowa Foundation for Medical Care (IFMC) within five days following the staffing meetings for:
 - A. All clients age 60 or over who are currently Medicaid eligible or intend to apply for Medicaid.

3. Case managers will maintain a separate file, or a separate section of a service provider's file, which documents all case management activities. The file (section) will include the following completed forms: screening tool, assessment tool, (including updated assessments), referral form, care plan, release of information forms, and documentation of referral to services, case monitoring, follow-up, evaluation of outcomes of services, exit planning, and any other case management contacts or activities. *[NOTE: THIS MAY CHANGE AFTER SEAMLESS IMPLEMENTATION SINCE ALL HARDCOPY FORMS MAY NOT BE REQUIRED.]*

SYSTEM ENTRY:

1. The Functional Abilities Screening Evaluation (FASE) or similar screening tool as prescribed by the SLCU will be used as the screening tool.
2. Standard release of information forms as prescribed by the SLCU will be used by each CMPFE.
3. Permission to share information will be obtained from the Client for screening, assessment and case management.
4. Local service providers, who have agreed to administer the screening tool, may designate specific service(s) within their agency or specific target group(s) of clients whom their agency serves with whom they will administer the screening tool. The local agencies agree to administer the screening tool with all persons 60 years of age or older who are requesting the specific service(s) or from the specified target group(s). The intent is that the participating service provider will screen the client where they first request services regardless of their qualifications or actual needs for that particular service.
5. A client, who agrees, will be referred for a comprehensive assessment if:
 - A. He/she answers one or more of the screening tool "mental health" questions incorrectly; or
 - B. He/she is unable to perform two or more of the screening tool Activities of Daily Living (ADL) items; or
 - C. Professional judgment of the person completing the screening indicates that the client is in need of further assessment regardless of the results of the screening tool.
6. Referral for comprehensive assessment will be made within two working days of completion of the screening tool.
7. The assessment tool prescribed by the SLCU will be used as the assessment tool.
8. The assessor will make contact within two working days of the referral to arrange to complete an assessment in person with the client.
9. The assessment and summary form will be completed within 10 working days after assessor makes contact with the client.
10. The CMPFE will develop procedures regarding scheduling, assessing, and handling emergency referrals.

CARE PLANNING:

1. The CMPFE coordinator is given responsibility and authority to develop and coordinate the implementation of a plan of care in conjunction with the interdisciplinary team. Staff from each agency providing services in the plan of care is responsible for managing and providing its services to the client.
2. A mechanism for informing clients about the availability of a competitor's service will be in place and implemented.

1. The written plan of care will be maintained in the CMPFE-designated format and will include:
 - A. Client demographic information;
 - B. Summary sheet listing client problems or needs, developed based upon the information gathered by the assessment tool;
 - C. Client goals based on gathered data;
 - D. Client objectives to meet the goals;
 - E. Identification and establishment of service linkages. This includes coordinating services to avoid conflicting scheduling of services and duplication of services.
 - F. Documentation of outcomes and, where appropriate, re-evaluation of client goals and objectives;
 - G. Planned sequence of follow-up based on an update of the assessment tool. This sequence will include a review of the plan of care with the interdisciplinary team annually or more often, if indicated due to a change in client condition or service needs.
 - H. Documentation that the client was offered the choice from among multiple service providers,
 - I. Documentation of unmet needs of the client, including the need for additional services within a community;
 - J. Client's signature and the date the client agrees to the plan of care,
 - K. Signature of CMPFE Coordinator indicating review of the plan of care; and,
 - L. Documentation that a CMPFE coordinator or AAA designee, a currently licensed registered nurse and a person with a bachelors degree in a human services related field were present at the interdisciplinary team staffing and that they participated in the care planning process. If the client or family member attends the staffing, this should also be documented.

CASE MANAGEMENT:

1. Case Management responsibilities include:
 - A. Implementation of the plan of care;
 - B. Arranging for appropriate services;
 - C. Ongoing advocacy on behalf of the client;
 - D. Ongoing monitoring of changes in the situation, conflict resolution, crisis intervention, and re-assessment of client needs with contact with, or on behalf of, the client every 30 days initially until the plan of care has been stabilized; and with a face-to-face contact at least quarterly;
 - E. Review of the plan of care by the case manager with all providers of services and the client at least annually and request special interdisciplinary staffing as needed. This review will be based on an update of the assessment tool.
 - F. Ongoing monitoring of outcomes; and
 - G. Documentation of contacts and case management activities in the client's individual case file.
2. Continuation or dismissal of both clients and services is based on ongoing monitoring, interagency staffing review, and update of the assessment tool.
3. A mechanism is in place for local review and evaluation of data regarding need, over/under utilization of service and significant increase/decrease in service, outcomes, and placements.

AGREEMENTS/EXCEPTIONS:

1. Written agreements in order to ensure compliance with these assurances will be in place between the AAA and the participating CMPFE agencies.
2. Exception from the SLCU CMPFE assurances may be granted by the SLCU or its designee when the need for exception has been established, no danger to the welfare of a client results, the exception will be in the best interest of the clients, and the exception applies only to the AAA filing the request.
3. To request an exception, the AAA shall follow the procedure as defined by the SLCU.

MEMORANDUM of AGREEMENT
between the
LOCAL ADMINISTRATIVE ENTITY and LOCAL AGENCIES
for the
SLCU Case Management Program for the Frail Elderly

I. Terms of Agreement

A. This Memorandum of Agreement is between the Senior Living Coordinating Unit Case Management Program for the Frail Elderly local administrative entity and the local provider agencies designated below:

B. Background

In response to recommendations by the Governor's Task Force on Long-Term Care, the Older Iowans' Legislature and the Community Based Adult Services Committee, the 1986 session of the Iowa General Assembly established a Long-Term Care Coordinating Unit within the Department of Elder Affairs. The Unit was composed of the Executive Director of the Department of Elder Affairs, the Director of the Department of Human Services and the Director of the Department of Public Health and two non-voting members appointed by the Governor.

In 1989, the Unit was expanded to include the Director of the Department of Inspections and Appeals and the Governor appointees became voting members. In 2000, the 79th General Assembly changed the name of the Long Term Care Coordinating Unit to the Senior Living Coordinating Unit (SLCU) as part of the 2000 Iowa Acts, Senate File 2193 - Senior Living Trust Fund legislation. This legislation also added a senator and representative from each political party as four non-voting members of the Coordinating Unit.

The Unit has the responsibility to:

- Develop mechanisms and procedures to implement a case-managed system of long-term care based on use of a comprehensive assessment tool.
- Develop common intake and release procedures for services.
- Develop coordination procedures at the state and local level.
- Develop a long-range plan for long-term care.
- Develop rules and procedures for long-term care.
- Provide oversight of the Senior Living Trust Fund to assure that the monies expended result in fulfillment of the Fund's mission.

The Senior Living Coordinating Unit appointed the Iowa Department of Elder Affairs to be the state administrative entity. The Area Agency on Aging will be the local administrative entity.

C. Purpose of Agreement

The undersigned member agencies seek to conduct a case managed system to assist older persons to determine and access the most appropriate services for their specific set of conditions.

D. Program and Service Principles

The undersigned agencies agree, with the understanding that this is consistent with available resources, that the principles listed below will guide program actions in conducting and evaluating services. These principles should not be viewed as client entitlements.

1. The functionally-impaired and dependent adult has the right to be treated with dignity and respect.
2. The functionally-impaired and dependent adult has the right to actively participate in developing their service plan, and to make final decisions concerning their care and life until clearly incompetent to make these decisions.
3. Services should be designed to maximize each person's total functional capacity or capabilities.
4. Appropriate services should be accessible to all functionally impaired and dependent adults.
5. Services should be provided within the least intensive and restrictive environment consistent with a person's needs and sound treatment protocol.
6. Service program should encourage and assist families to accept some responsibility for providing care.
7. Essential regulation of services should be coordinated and conducted efficiently and consistently.

E. Long Term Goals

The undersigned agencies will work towards achieving the program goals listed below:

1. Clients and families will have an improved understanding of care needed and services available.
2. Clients and families will have more informed choices.
3. Clients 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. State, area, and local agencies will establish mechanisms for policy and services coordination.
7. Common definitions will be adopted for key components of the case-managed system.
8. There will be a decrease in the number of entry points the client must use to access needed long term care services.
9. Case managers will coordinate service plans that meet the assessed needs of the clients.

F. Statement of Program Assurances

The undersigned agencies agree to implement and conduct the case management program in accordance with the attached Assurances for Case Management Programs. Any deviations from these assurances must be explained in writing and are subject to prior approval of the Iowa Department of Elder Affairs and, as appropriate, the Senior Living Coordinating Unit.

G. Conditions of Participation

- 1) Agree to use prescribed screening tool.
- 2) Agree to use prescribed comprehensive assessment tool.
- 3) Agree to accept prescribed case management concept and follow prescribed procedures and criteria of objectivity.
- 4) Agree to participate in interagency training necessary to implement assessment and case management.
- 5) Agree to accept state level monitoring and technical assistance.
- 6) Agree to collect and report data as prescribed.

H. Role of Local Administrative Agency

The AAA as local administrative entity will assure:

- The use of the Functional Abilities Screening Evaluation (FASE) or similar screening tool as prescribed by the Senior Living Coordinating Unit.
- The use of the comprehensive assessment tool as prescribed by the Senior Living Coordinating Unit.
- That the local agencies understand the prescribed case management concept, follows prescribed procedures and criteria of objectivity, and has signed agreements stating the same.
- Participation of appropriate staff in the interagency training necessary to implement assessment and case management.
- Acceptance of state level monitoring and technical assistance.
- The collection and reporting of data as prescribed.
- Adherence to the established Assurances for Case Management Programs.
- The monitoring, evaluation, and direction of the activities of the area case management Program.
- That all persons receiving Title XIX Medicaid Home and Community-Based Waiver services for the elderly will receive case management services regardless of program criteria.

I. Role of Local Agencies

The local agencies will:

1. Agree to implement the program goals.
2. Agree to implement the Conditions of Participation.
3. Agree to implement the Assurances for Case Management Programs.
4. Agree to implement program directives.
5. Provide appropriate staff who will:
 - Participate in interagency staffing meetings.
 - Conduct screening and/or assessments on clients for whom they receive referrals, or have initial contact.
 - Provide case managers for clients whose primary needs are met by the agency, or as assigned by the local coordinating committee.

J. Confidentiality

This Agreement provides for an exchange of information as permitted by the respective rules and regulations of the Departments of each of the parties to the Agreement.

Information concerning applicants and recipients (including names and addresses) obtained by either party can be shared between the parties to this agreement for the purpose of administration of the program. Such information shall constitute privileged communication, shall be considered confidential, and shall not be divulged to anyone not associated with the administration of the program except the client, guardian, or other authorized representative of the client. There shall be no release to other individuals or entities not associated with the administration of the program without the informed consent of the client, guardian or other authorized representative of the client.

It is understood that confidential information is only to be released to persons (unless specifically authorized by client or authorized representative) when there is assurance that:

- (a) An information release form has been signed by the client;
- (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.
- (d) Standards of protection established by the inquiring person or agency to which the confidential information is released are equal to those established by the Department of Human Services.

To protect applicants and clients 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, illegitimate births, or child abuse information.

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

II. IMPLEMENTATION OF MEMORANDUM

A. Duration of Memorandum

This Memorandum of Agreement shall become effective on the date of signature and shall remain in effect for a period of one (1) year, subject to the provisions of the termination clause below. It is understood that the agreement shall be updated annually unless any party thereto shall give a thirty-day written notice prior to the end of the one (1) year agreement period.

B. Termination and Modification of the Agreement

Modifications and specifications may be added to this memorandum, or a new agreement developed, as relationships become further defined and extended.

This agreement may be amended by mutual consent of the parties herein as subject to modification in accordance with amendments to the appropriate state statutes or federal legislation and regulations and/or general instruction issued by the appropriate agencies of federal or state government. This agreement is not intended to preclude supporting contracts and agreements among the parties hereto for the performance of services not covered by this agreement.

Involvement in this agreement may be terminated by mutual consent or by a member agency or by the Area Agency on Aging by giving written notice to other parties thirty (30) calendar days prior to such termination.

IN WITNESS THEREOF, we the undersigned, hereby execute this Memorandum of Agreement between the local Administrative Entity and local agencies for the Senior Living Coordinating Unit Case Management Program for the Frail Elderly.

Area Agency on Aging _____ Date _____

Name/Title (please print) _____

Signature _____

Member Agency _____ Date _____

Name/Title (please print) _____

Signature _____

DEFINITIONS

Adult Day Care - An organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Assessment - Administration of a required standardized comprehensive assessment tool and other procedures to determine the physical, mental, emotional, social, and environmental factors which influence an individual's ability to function independently, and identify existing strengths and deficits in order to develop a service plan to meet the individual's needs and goals.

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 clients with activities of daily living and instrumental activities of daily living which allow the client 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 - A comprehensive system in which each client's care is monitored by an individual case manager, who assists clients to make appropriate use of the long term care continuum, ranging from care in the home to institutionalization. This system includes the following functions: screening; assessment; interdisciplinary team meetings; a written service plan; information about and referral to, or provision of services; case monitoring, ongoing follow-up and reassessment to assure proper placement within services; evaluation of outcomes of services; and exit planning.

Case Manager - A direct care service worker assigned by the interdisciplinary team to monitor clients on an ongoing basis.

Case Plan or Plan of Care - See Service Plan.

Chore - Chore services are limited to 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

Client (Consumer) - A person who meets case management criteria (sixty (60) years or older, with multiple needs) and who is assigned a case manager.

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 client, parent, or guardian is responsible for selecting the individual or agency that will provide the components of the CDAC service agreement.

Coordinator/Facilitator - A qualified person responsible for the implementation and organization of the case management program at the Area Agency on Aging level.

Emergency Response System - An electronic device connected to a 24-hour staffed system which allows the consumer to access assistance 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 - Meals prepared outside of the client's home and delivered to the client. Each meal must ensure that the client receives a minimum of one-third of the daily-recommended dietary allowance as established by the Food and Nutrition Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement which meets the minimum one-third standard.

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 - Homemaker services are those services provided when the consumer lives alone or when the person who usually performs these functions for the consumer needs assistance. Homemaker service is limited to the following components: essential shopping, limited house cleaning, accompaniment to medical or psychiatric services, meal preparation, and bathing and dressing for self-directing consumers.

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.

Interdisciplinary Team - A team that provides on-going monitoring of client needs and the services to meet those needs including development of client service plan. This interdisciplinary team will include, at a minimum, an AAA CMPFE designee, a currently Iowa-licensed, registered nurse and a person with a bachelor's degree in a human services-related field. The team will meet at least monthly.

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 client requires daily supervision with dressing, grooming, and personal hygiene in conjunction with another daily care need, and/or the client 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. ISIS is housed and maintained by the Department of Human Services.

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

Level of Care Certification - If the probable level of care on daily report is intermediate or skilled and the client applies for the Elderly Waiver within 60 days of the date the assessment was completed or is already on the Elderly Waiver (in the case of an annual update), the Department of Human Services and the Area Agency on Aging will receive a Level of Care Certification from the Iowa Foundation for Medical 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.

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 - Services provided in a consumer's home to identify, evaluate and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the Case Management Program for the Frail Elderly (CMPFE) interdisciplinary team.

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, hypodermocystis 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.

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.

Physician Review - If the IFMC nurse cannot approve the level of care applied for, a letter requesting additional information is sent to the attending physician. The attending physician has ten days to respond to the letter. All information submitted is provided to a physician reviewer. A physician reviewer is a licensed, practicing doctor of medicine or osteopathy. The physician reviewer used his/her medical judgment and expertise to make a determination based on the medical information submitted to IFMC.

Probable Level of Care - When the Iowa Foundation for Medical Care (IFMC) receives an original assessment or annual update the Review Coordinator utilizes Assessment Service Evaluation (ASE) criteria to determine level of care. The ASE criteria are physician-developed criteria which are screening criteria and do not constitute physician standards of care. Each Area Agency on Aging will receive a report stating the probable level of care which can be skilled, intermediate, and below intermediate.

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 re-

lated 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 client signs in which the client 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 participating agencies. Clients may indicate agencies with which information is not to be shared.

Respite - Services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

- Specialized respite means respite provided on a staff-to-consumer ratio of one-on-one or higher for individuals with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- Group respite means respite provided on a staff to consumer ratio of less than one to one.
- Basic individual respite means respite provided on a staff to consumer ratio of one to one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Screening – Administration of a required screening tool, including an interview 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 client, provider(s) and case manager which specifies services, responsibilities of each person, and the expected measurable results in the form of goals and objectives for the client.

Senior Companions - 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.

Senior Living Coordinating Unit - The Unit consists of the Director of the Department of Elder Affairs, the Director of the Department of Human Services, the Director of the Department of Inspections and Appeals, and the Director of the Department of Public Health. Two public representatives appointed by the Governor also serve on the Unit. The Unit has the responsibility to develop mechanisms and procedures to implement a case-managed system of long-term care based on use of a comprehensive assessment tool, common intake and release procedures for services, coordination procedures at

the state and local level, a long range plan for long-term care, and rules and procedures for long-term care.

Skilled Level of Care (SNF) – The client 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 client's illness or injury. Whether services ordered and provided are medically appropriate based on the client's condition and accepted standards of practice will be assessed during utilization review.

Skilled Nursing Facility (NF) - 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 - Services provided for consumers to conduct business errands, to complete essential shopping, to receive medical services not reimbursed through medical transportation and to reduce social isolation.

CLIENT ELIGIBILITY

Initial and On-going Eligibility

Client eligibility requirements can be found in Iowa Administrative Code 321--21.6(231). A person meeting all the following criteria is eligible for CMPFE services:

1. Lives in Iowa, and,
2. Is an elderly person or a person 60 years old or older, and
3. Needs two or more services, and,
4. Does not live in, or is within 30 days of discharge from, a nursing facility, and
5. Is identified through the use of the Senior Living Coordinating Unit designated screening tool and completion of a full assessment by an interdisciplinary team.

Date of Eligibility

Case management services begin on the date of the initial interdisciplinary team meeting during which the client is accepted into the case management program.

Discharge

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

1. The client achieves goals and no longer needs case management.
2. The client moves out of the county/state.
3. The client moves into a long term care facility and is expected to stay in the facility for an extended period of time.
4. The client or his or her legal representative requests discharge.
5. The client is unwilling or unable to accept further services.
6. The client or his or her legal representative refuses to provide access to information necessary for the development or implementation of the services plan.
7. The client's needs cannot be met due to lack of a provider of a needed services or lack of funding for services.
8. The client needs a higher level of service than can be provided in the community to ensure the client's health, safety and welfare as determined by the case management team.
9. The client dies.

In the case of number 8, all providers must agree that the client's safety is in question and the members of the interdisciplinary team at that staffing all agree that discharge should be done. Alternatives will be presented to the client and family. The Case Management Coordinator/Facilitator will then write a letter to the client stating the reasons for his or her discharge from Case Management and include the process for appeal.

Funding

Currently, there is no charge for the case management function in the Case Management Program for the Frail Elderly. Services other than case management services are provided based on individual client needs and are identified through screening and assessment processes, planned by the interdisciplinary team, and approved by the client. Payment sources for these services may include, but not limited to: private pay, sliding fee schedules of the agency providing the service, conventional Medicare or Title XIX Medicaid, Elderly Waiver, and Senior Living Program. The following chart reflects some of the differences between CMPFE and the Medicaid HCBS Elderly Waiver program.

	CMPFE AAA-CM Service Coordination	HCBS-EW Service Payment
Age	60 years	65 years
Iowa Foundation for Medical Care (IFMC)	Determines probable level of care for persons age 60+	Determines actual level of care for persons ages 65+
I-OASIS Assessment Tool	Yes, required	Same
Income	No limits	Limited to 300% of *SSI amount for one person \$579.00 X 300% = \$1737.00 per month
Resources	No Limits	Limited to \$2,000.00 for single recipient. \$3,000 for married couples (may benefit from spousal impoverishment guidelines)
Payment for Services	None – Client pays for services received	Waiver services are paid by Medicaid dollars, up to \$1,052.00 per month, if LOC is Intermediate and up to \$2,480.00 if Skilled
Service Needs	Must need two or more services -or- one service and have complex needs	Must need one service billable to the elderly waiver quarterly
ACS	No involvement	Fiscal intermediary to pay waiver claims
Funding	Program supported by numerous funding sources, including State and Local Funds	100% Medicaid Funds

*SSI rate in effect January, 2005. Adjusted annually

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. In general, covered services under case management are:

- Comprehensive screening and assessment of the client's needs.
- Coordination of interdisciplinary team meetings.
- 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.
- Evaluation of outcomes of services.
- Exit planning.

Program Principles

The principles listed below were created to guide program actions in conducting and evaluating services. These principles should not be viewed as client entitlements.

- All clients have the right to be treated with dignity and respect.
- All clients have the right to actively participate in developing their service plan, and 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 clients.
- Services should be provided within the least intensive and restrictive environment consistent with a person's needs and sound treatment protocol.
- Service program should encourage and assist families to accept some responsibility for providing care.
- Essential regulation of services should be coordinated and conducted efficiently and consistently.

Long Term Goals

1. Clients and families will have an improved understanding of care needed and services available.
2. Clients and families will have more informed choices.

3. Clients 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. State, area, and local agencies will establish mechanisms for policy and services coordination.
7. Common definitions will be adopted for key components of the case-managed system.
8. There will be a decrease in the number of entry points the client must use to access needed long term care services.
9. Case managers will coordinate service plans that meet the assessed needs of the clients.

Personnel

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

1. Case Management Coordinator
2. Assessor
3. Case Manager
4. Service Provider

Case Management Coordinator Responsibilities:

- Manage the CMPFE program for a specific Area Agency on Aging.
- Delegate certain program responsibilities to a Facilitator in a specific county or counties.
- Provide case management training for local CMPFE staff.
- Refer clients for initial assessment to assessors and case managers.
- Organize and facilitate interdisciplinary team meetings.
- Review all assessments and CMPFE forms for completion.
- Collect and submit completed assessments to IFMC within 5 days of team staffing for clients who are Medicaid eligible and for clients who intend to apply for Medicaid.
- Be responsible for service plan development in conjunction with the interdisciplinary team.
- Sign finalized service plan before submitting to local DHS office.
- Coordinate the implementation of the service plan.
- Approve requests for an emergency staffing.
- Conduct quality assurance reviews in each county annually.
- Submit monthly CMPFE data report.

Assessor Responsibilities:

- Take referrals from the CMPFE Coordinator/Facilitator or from the community.
- Complete Release of Information form with the client.
- Complete FASE at initial meeting with the client.
- Complete comprehensive assessment with the client and caregiver or family if appropriate, following completion of the FASE.
- Determine the client's need for case management based on the referral criteria.
- Send completed Release of Information, FASE and comprehensive assessment forms to CMPFE Coordinator/Facilitator.
- Present the client's case at the initial interdisciplinary team meeting on behalf of the client.
- Treat all information regarding the client in a confidential manner.

Case Manager Responsibilities:

- Take referrals from the CMPFE Coordinator/Facilitator or from the community.
- Complete a comprehensive assessment and Release of Information form on each client annually.
- Conduct a face-to-face visit with the client at least every three months to verify that the client is satisfied with all services being provided and to verify that all current needs are being met. Document on Coordination Case Notes.
- Obtain the client signature on service plan annually and as needed.
- Contact other service providers and the CMPFE Coordinator/Facilitator of changes in the client's status.
- Provide report to interdisciplinary team for each assigned client who appears on the team meeting agenda. Note: Each client must be reviewed at a team meeting at least annually and request special interdisciplinary meetings as needed.
- Provide client advocacy as needed. Contact the CMPFE Coordinator/Facilitator to update the client's service plan, arrange to add the client to the team meeting agenda when needed, or if any questions arise.
- Maintain a client file
- Treat all information regarding the client in a confidential manner.

Service Provider Responsibilities:

- Attend multidisciplinary team meetings and participate in development of the client service plan.
- Provide service as determined by the service plan or document reason why it is not provided.
- Notify the case manager of changes in the client status.

- Establish and maintain a case management file for each client to include documentation of all services provided and a copy of all DHS Notice of Decisions.
- QA activities that may include client satisfaction surveys.
- Treat all information regarding the client in a confidential manner.

Confidentiality

The use or disclosure by any party of any information concerning a client of the 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 client or his or her legal representative. The Confidentiality Agreement provides for an exchange of information as permitted by the respective rules and regulations of the Departments of each of the parties to the Agreement. More information about requirements related to confidentiality can be found in the Assurances.

PROGRAM PROCESSES

This section includes information about operating procedures within the program.

Referral Intake

The client is informed about case management by a staff person with a participating agency and is asked to sign a release of information for screening, assessment and or service planning.

If the client refuses to sign the release, this will be noted on the FASE screening tool and the case will not be referred for case management (although this will not affect regular service delivery by that agency). The screener/assessor will keep a copy of the FASE for agency files and send an original to the Case Management Coordinator/Facilitator.

Client Assessment

If the client agrees to participate, she or he will sign the Release of Information. If another person is designated as the client's legal representative, that person may sign the release. The screener/assessor should retain a copy for his or her own files.

A client will be referred for a comprehensive assessment if:

- he/she answers one or more of the screening tool "mental health" questions incorrectly, or
- he/she 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 client is in need of further assessment regardless of the results of the screening tool, or
- the client will be referred for the Title XIX Medicaid Home and Community-Based Services Waiver for the Elderly.

Referral for comprehensive assessment must be made within two working days of completion of the screening tool. The comprehensive assessment tool prescribed by the SLCU will be used as the comprehensive assessment tool.

The assessor must make contact within two working days of the referral to arrange to complete an assessment in person with the client.

The comprehensive assessment and summary form must be completed within 10 working days after the assessor makes contact with the client.

Interdisciplinary Team Meetings

When a client is identified by a participating agency, that staff person will inform the Case Management Coordinator/Facilitator so that the client will be placed on the next team meeting agenda. Interdisciplinary team meetings must be held at least once each month. Many counties meet twice a month. An agenda with the name of each client to be discussed will be sent by the CMPFE Coordinator/Facilitator to all participating agencies prior to the meeting.

The Coordinator/Facilitator will notify the team members who are actively involved with the client and others who may have information that could reflect on the situation. The interdisciplinary team consists of staff members from the participating agencies. When feasible, the staff person who works directly with the client should attend. Clients and/or family members are notified of the team meetings and are encouraged to attend.

The staffing will be held at the earliest time convenient to all, and may be held through a phone conference with the client.

The Sign-in Sheet provides documentation that a CMPFE Coordinator or AAA designee, a currently licensed registered nurse and a person with a bachelor's degree in a human services-related field were present at the interdisciplinary team staffing and that they participated in the development of the service plan process. If the client or family member attends the staffing this should also be included on a confidential Sign-In Sheet. The Sign-In Sheet should include the participants' full name, credentials (RN, SW, AAA representative, etc.) and the agency they are representing.

Client cases are reviewed and discussed by the team. Information included should only be that which is relevant to the client's current problems. An individualized service plan is developed and a case manager is assigned to each client.

Presenting a New Client

Information to include when presenting a client to the team:

- Name and age of the client
- Source of and reason for the referral
- Areas of concern from the comprehensive assessment
- Available support systems (family, friends, neighbors, etc.)
- Referrals needed, including any made prior to the team meeting.

Following the presentation about the client, other agencies involved with the client may present additional information and other referrals may be made. A case man-

ger will be assigned. A service plan will be developed based on the information provided at the team meeting.

Data including completed screening and assessment tools must be sent to the Iowa Foundation for Medical Care (IFMC) within five days following the staffing meetings for all clients age 65 or over and clients age 60 or over who are eligible or plan to apply for Medicaid.

Emergency Staffing

While completing the initial assessment with the client, the assessor/case manager may make a determination that a client is in critical need of services. The assessor/case manager must contact the CMPFE Coordinator/Facilitator to discuss the critical need and ask for an “emergency staffing.” The CMPFE Coordinator/Facilitator holds the emergency staffing with required staff, which at a minimum includes an AAA CMPFE designee, a currently Iowa-licensed registered nurse and a person with a bachelor’s degree in a human services-related field. The emergency staffing can be held by phone.

If the client is Medicaid eligible, or intends to apply for Medicaid, the assessment can be faxed to IFMC for level of care determination. IFMC staff is contacted to let them know an emergency staffing has taken place and the completed assessment is being faxed to them. The case manager contacts the local DHS office to let them know of the emergency staffing. The DHS income maintenance staff will be determining financial eligibility. Once elderly waiver eligibility has been established, a service plan will be developed. Required signatures need to be obtained on the signature page and can be obtained via fax. The service plan needs to be entered into ISIS and approved by the DHS service worker.

If the client is not applying for the elderly waiver, the team taking part in the emergency staffing develops a temporary contingency service plan with input from the client to deal with the current emergency. All required signatures must be obtained on the service plan before services can be provided. The names of all clients for whom an emergency staffing was held will be placed on the agenda for the next regularly scheduled team staffing. At that time the team will be briefed on the outcome of the emergency staffing, updated on the current status of the client, and will complete and/or edit the formal service plan.

Development of the Service Plan

The CMPFE Coordinator/Facilitator has responsibility and authority to develop and coordinate the implementation of a service plan in conjunction with the interdisciplinary team. Staff from each agency providing services in the service plan is responsible for managing and providing its services to the client.

Instructions for development of the Service Plan can be found in the Assurances.

Copies of the formalized service plan and updates will be given to the client, local DHS office, and to the providers who have an active role in helping clients meet their goals listed in the service plan. Service Plans with the original signatures should be kept in the client file.

Emergency/Contingency Plan

In order to be responsive to health and safety issues of clients in the case management program, case managers need to have a discussion with their clients about emergency situations and backup/contingency plans. Clients and their families need to discuss what they need to do a head of time in order to be prepared for any emergency that may arise. Clients need to know that it is their responsibility to be prepared in the event of an emergency. It is not a CMPFE program responsibility.

Examples of discussions that case managers should have with their client 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 not able to come to your home when they are scheduled.

Individual safety issues should be discussed that are specific to each client's particular needs and living environment.

For program quality assurance purposes, case managers must document in the service plan that individual emergency/contingency plans were discussed with the client. These discussions should be documented under the OUTCOMES section of the care plan under the appropriate category (i.e. Nutrition, Environment, Client Support, etc.) These discussions can also be documented in the client case notes.

Review of a Client Case

In many ways presenting an ongoing client case is similar to presenting a new case at a team meeting. There are two main differences.

- The previous service plan, and when appropriate, the updated comprehensive assessment will be available, and
- Ongoing cases are reviewed more quickly since the information given on a new client is not repeated.

As with presenting a new case, being prepared and organized prior to the team meeting is essential. Prior to the team meeting:

- Review the current service plan with the client to determine if any changes have occurred and if there are any new needs since the last plan was developed.
- If major changes have occurred in the client's situation or if it has been one year since the last comprehensive assessment, a reassessment should be completed.
- If the client is an unreliable historian, check with the involved agencies listed on the client's service plan to see if they are still involved and how often they are providing services.

At the conclusion, a recommendation is made for the next review (in two weeks, three months, six months, etc.). If there are changes to be made in the assignment for case manager, they should be recommended at this time. (In most cases the case manager will remain the same.)

The CMPFE Coordinator/Facilitator will solicit any additional information from other members of the team.

DOCUMENTATION

Documentation and record keeping must be timely and complete, address client needs and outcomes, and monitor progress and client 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 client and cost information as prescribed by the SLCU.

Client Case File

The following information should be included in the case manager's file for each CMPFE client:

- Release of Information form (must be updated annually).
- The FASE Tool (must be completed before the initial comprehensive assessment).
- The comprehensive assessment tool (including all reassessments which must be completed annually).
- The Summary Page (must be completed annually with the reassessment).
- All CMPFE case plans.
- Care Coordination Notes 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.
- Documentation of referral to services, case monitoring, follow-up, evaluation of outcomes of service and other case management activities
- All letters referring to the client.
- All other correspondence related to the client and case management.

Additional information to be included if client has applied for the Elderly Waiver are all Notices of Decision (NOD) and all Levels of Care determinations.

Quality Assurance

Each Area Agency on Aging will provide appropriate quality assurance forms/check sheets to guarantee the Assurances were met regarding the administration of the FASE, referring and completing the Assessment, developing a Service Plan, implementing the Service Plan, and providing on-going Case Management.

Quality Assurance in Case Management for the Frail Elderly Program is the process by which we document that the system is in compliance with state assurances. It is achieved by the CMPFE Coordinator/Facilitator 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 10 client files.

- The components of the client file are present* (Release of Information, FASE, all assessments, all service plans, documentation of quarterly face-to-face visits, etc.).
- Service plans are signed by client, case manager, coordinator/facilitator and DHS service worker in the case of an Elderly Waiver client.
- FASE and assessment completed by qualified staff person.
- Updated assessments completed on an annual basis and in the client file.
- Minimum staffing requirements were met at each interdisciplinary team staffing.

*The order in which components within client files are placed is not stipulated. However, each agency must have the order of client files and the location of all original signatures on the case plan identified in their manual. All client files must be kept a minimum of five years.

Department of Elder Affairs staff will conduct compliance reviews in each county every four years. 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 clients each fiscal year.

Procedure for Potential Conflicts of Interest

The following is a process to delegate case management responsibilities to a team-appointed case manager.

1. An interdisciplinary team meeting will be held on every client who has been referred to case management by the assessor or the assessment agency. (The assessment agency may be the agency that will case manage the client, but not necessarily. New cases will be presented by the assessor, and a case manager will be assigned at the initial meeting.) The interdisciplinary team will decide who has the most contact with the client, and all team providers will agree upon the case manager.
2. Identification of where conflicts do or could exist:
 - Service providers could be territorial when educating the client about service options. In the rural area where services are limited, the provider of a service could be reluctant to inform the client of other service providers.
 - Providers could determine that a client requires nursing home care while the family insists that the client remain at home.
3. Procedures to eliminate or minimize the conflicts:
 - Clients and family members will be encouraged to attend meetings.
 - Staff member will discuss in the staffing which services would be appropriate based on the assessment of the client.

- The client and/or family member will select his or her choice of providers on the service plan.
 - The case manager will go over the service plan with the client before the client signs.
4. A process for conflict resolutions keeping in mind the client's best interest:
- Interdisciplinary team meetings with client and family member participation.
 - Development of service plan to decide which services the client is interested in receiving.
 - Providers suggest services they feel will enable the client to remain in the home.
 - Client is given choice of service providers.
 - When competing services exist within the community that could potentially meet the identified need, all known facts about the services and the service provider agencies will be fairly provided to the client and/or their representative by the case manager. The details presented should include:
 1. Name, address and phone number of potential provider agencies.
 2. Type of service provided.
 3. Cost of service if known.
 4. If Elderly Waiver service plan is being developed, the amount of service (due to cost) the client would be able to receive considering the other waiver services in the service plan and the cost cap.
 - The CMPFE Coordinator/Facilitator will recheck the client's service plan with the case manager in 30 days to make sure everything is in place or if any changes need to be made. Reassessments will be done on a yearly basis or earlier, according to the needs of the client.
5. A process for documenting conflict resolution:
- The client will certify by a signature his or her approval of the service plan.
 - The case manager will affirm by a signature that all details of the service plan were explained to the client.
 - The CMPFE Coordinator/Facilitator will also certify with a signature that the service plan meets the needs of the client and that the client was given the choice of service providers.
6. Complaints from a service provider agency, alleging preference given to a particular agency or agencies, should be made in writing to the CMPFE Coordinator/Facilitator within 30 days of the specific incident (referral) prompting the allegation. The written complaint should contain the following:
- Name of agency and individual filing the complaint.
 - Name of the client.
 - Name of the service in question.
 - Names of all competing service provider agencies who might meet needs

- The approximate date on which the referral for service was made, and
 - The name of the agency who received the referral.
7. Upon receipt of a written complaint, the CMPFE Coordinator/Facilitator and the interdisciplinary team will review the development of the service plan process. If the results of this review show that the above policies were not followed, a new service plan will be developed and the problem corrected, if possible.

The agency who filed the complaint will receive a written response to the complaint within thirty (30) days of the date the complaint was received. The response will explain the outcome of the review process and any action taken.

Grievance Procedure

The grievance procedure may be used by any individuals or institutions that have been denied funding and/or services as requested. The procedure also applies to agencies who believe that they have not been afforded the same opportunity to provide service as another participating agency.

The area agency requires that an individual or agency which has been denied funding and/or services, or who has a question about conflict of interest issues, submit a written grievance to the Director of the Area Agency on Aging within thirty (30) days of notification of the denial. The written grievance will contain the date of denial, party or parties involved, location, and the facts and/or rationale of the grievance. The complainant may also request an interview with the Director of the agency to discuss the grievance.

The Director will have fifteen (15) calendar days in which to make a complete inquiry into the complaint. The Director may conduct the investigation personally or through an appropriate individual or agency for this purpose. This inquiry will include a thorough and documented review of the circumstances under which the denial of funds and/or services occurred.

The Director of the agency will contact the complainant within fifteen (15) days and furnish the complainant with a written summary of the inquiry.

If a satisfactory resolution of the grievance is arrived at, the terms of the grievance will be reduced to writing and signed by both parties and made a part of the grievance file.

If a satisfactory resolution of the grievance is not arrived at, the complainant shall be advised of the Director's recommended disposition of the appeal.

The complainant will have ten (10) days to file a new written appeal to the next level of authority, requesting the previous decision to be reviewed. Each level contacted

will review the appeal, take such action as is deemed appropriate and notify the complainant in writing within fifteen (15) working days after receiving the appeal.

When a satisfactory resolution of the appeal has been achieved, the terms of said resolution must be submitted in writing and signed by both parties and made a part of the grievance file, with a copy of the terms of the resolution provided the complainant.

These procedures will be regarded as minimum standards for furnishing any person an opportunity to be heard on complaints regarding denial of funding and/or services. The complainant reserves the right to withdraw the appeal at any time during the appeal process.

Individual service providers will deal with complaints following their agency policies and procedures.

Appeal Process

A client denied access to the Case Management Program by decision of the interdisciplinary team will have the right to appeal within thirty (30) days of their being notified.

The Area Agency on Aging will meet with the client and/or representative within five (5) working days of notification of appeal. The client has the right to have a family member or other advocate present when meeting with the Area Agency on Aging.

The Area Agency on Aging will review the case within ten (10) working days of the meeting with the client/representative and will notify the client of the decision. The decision of the Area Agency on Aging will be final unless the status of the client changes.

If the client is dissatisfied with the area agency decision, the client can appeal to the Department of Elder Affairs according to the department's rules as defined in 321 IAC 2.7(231).

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
 IH..... Ill and Handicapped Waiver
 IHRC..... In Home Health Related Care Program
 IM..... Income Maintenance
 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