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CHAPTER 41

CASE MANAGEMENT FOR ADULT SERVICES

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CHAPTER 41

CASE MANAGEMENT FOR ADULT SERVICES

41.00 PROGRAM AUTHORITY

Federal: 45 CFR 228

State: RCW 78.08.043, 78.08.045, 74.38.01, 74.30.040 parts (1) and (5), 74.09.530, 74.34.070, 74.42.610, 18.51.310

WAC 388-15-010, 388-15-140, 388-15-580, 388-15-620(1)(f)

41.10 POLICY

A. Introduction

1. This chapter covers policies and procedures which apply to CSO clients who need case management.

2. Responsibility for case management is divided between the CSO System and the Aging Network (Area Agency on Aging, their contractor or designee), according to criteria based on:

   a. The client's age,

   b. The client's living situation; residential or nonresidential.

B. Background

The Department of Social and Health Services' Long-Term Care Policy promotes the utilization of in-home and nonmedical residential care as preferred alternatives to nursing home placement for elderly and disabled adults. Successful implementation of this policy requires that a variety of services and support systems be provided or coordinated on behalf of individuals in need. The crucial element necessary to accomplish such coordination is effective and efficient case management.

These policies and procedures address only those clients who need case management. The CSO System serves many functionally impaired adults who need assistance and services but do not need intensive case management. While these clients will not receive ongoing case management, they may receive all of the other services for which they are eligible. CSO staff maintain their responsibilities related to

delivering these services. These responsibilities may include performing one or more case management functions. However, a client must receive all of the case management core functions listed in Section 41.12 B. 1. to be considered a case management client.

41.11 Purpose of Service

These services and activities are designed to achieve and maintain the maximum level of health and functional independence of which the elderly or disabled adult is capable.

41.12 Service Description

A. Case Management Definition

1. Case management assists elderly and/or disabled adults to obtain and effectively use necessary support services.

2. Case management includes:

   a. Core functions, which are provided to all case management clients;

   b. Supportive functions, which are provided only when needed. (See Section 41.12 B. below.)

3. The case manager maintains ongoing contact with the elderly or disabled adult to enable a prompt response to changes in his/her condition.

4. Case management is provided only until the person's situation has stabilized or a family member or friend is both able and willing to assume case management responsibilities.

B. Case Management Functions

1. Case Management Core Functions

   All core functions are provided to each case management client. Core functions include:

   a. Comprehensive assessment;

   b. Service plan development;

   c. Service plan implementation;

   d. Service plan review;

e. Termination planning;

f. Record maintenance.

2. Case Management Supportive Functions

Supportive functions are provided to case management clients only as needed. They include:

a. Client advocacy;

b. Assistance;

c. Consultation;

d. Networking;

e. Family support;

f. Crisis intervention.

41.13 General Policies Related to This Service

A. Division of Case Management Responsibility

Implementation of the department's case management policy requires a sharing and coordination of case management responsibility between the CSO System and the Aging Network.

1. The Comprehensive Assessment function is performed by CSO System or Aging Network staff, depending on who was initially contacted by the client or referral source. Therefore, the CSO System may perform a comprehensive assessment for a client who will eventually receive case management from the Aging Network and vice versa.

2. If the client is age sixty or older, the Service Plan Development function is performed by the CSO System and/or Aging Network according to the Case Management Implementation Plan developed jointly by the Area Agency on Aging and the Regional Office.

3. The determination of whether the CSO System or Aging Network will be responsible for ongoing case management is made during service plan development, using the criteria listed in 41.13 A. 5. below.

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4. Ongoing case management includes:

   a. Service Plan Implementation;

   b. Service Plan Review;

   c. Termination Planning;

   d. Record Maintenance.

5. In the absence of exceptional circumstances, the division of responsibility for ongoing case management is as follows:

   a. COPES clients

      (1) COPES clients age sixty or over residing in the community receive case management from the Aging Network.

      (2) COPES clients under age sixty residing in the community receive case management from the CSO System.

      (3) COPES clients age eighteen or over and in residential care receive case management from the CSO System while in residential care. Case management responsibility is transferred to the Aging Network when a COPES client age sixty or over leaves residential care and will remain a COPES client or meets other case management target population criteria.

   b. Non-COPES Community Clients

      (1) Non-COPES clients age sixty or over who reside in the community and meet the target population criteria receive case management from the Aging Network.

      (2) Non-COPES clients age eighteen through fifty-nine who reside in the community and meet the target population criteria receive case management from the CSO System.

   c. Non-COPES residential care clients age eighteen or over who meet the target population criteria receive case management from the CSO System while in residential care. Case management responsibility is transferred to the Aging Network when a non-COPES client age sixty or over leaves residential care if the client meets the target population criteria for community adults.

B. Principles of Case Management Performance

Case management is provided to target population adults consistent with the following principles:

1. The client's right to self-determination (right to refuse services, right to participate in case management activities) shall be respected.

2. The client's right to confidentiality shall be respected.

3. Case management staff shall endeavor to establish and maintain a positive working relationship with the client, including overcoming the initial resistance exhibited by clients who are fearful, suspicious, hostile, etc. A positive relationship is required for the effective performance of case management functions.

4. Qualified staff shall perform case management functions.

5. Case management staff shall receive ongoing training and supervision.

C. Legal Limitations on Disclosure of Information

Legal limitations exist on a case manager's disclosure of information about his/her client. The law treats all communication received from the client as confidential, whether verbal or written, including records derived from those communications.

The case manager may disclose those communications to anyone with his/her client's prior, informed consent. Without that prior, informed consent, except for disclosures to auditors and researchers in defined circumstances, the case manager may only make disclosures of information for purposes directly connected with the administration of the program under which the client is applying for or receiving benefits. In short, so long as the disclosure is for the purpose of providing services, it would be appropriate.

Disclosure of information to others does not, by itself, abrogate a client's expectation of privacy as protected by the law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. The case manager is responsible for impressing this upon the service providers with whom he/she works.

The fact that disclosure to another service provider has been made does not, in and of itself, permit that provider access to all the records of information the case manager may have. Disclosure beyond what the case manager initially volunteers is at the discretion of the case manager, absent the written authorization of the client.

In conclusion, the disclosure of information required for a coordinated assessment of a client and for the coordinated delivery and monitoring of services to that client by a case manager and the service providers he/she contacts is permitted by law. That group must maintain confidentiality. Disclosure to individuals outside that group is not permissible without consent.

41.14 Priorities Related to this Service

Prior to October 1, 1985, priorities will be those in the Case Management Implementation Plan. Following October 1, 1985, case management clients will be served in the following priority order:

Case Management Target Population

A. COPES clients who reside in an Adult Family Home or Congregate Care Facility.

B. Adults age eighteen through fifty-nine residing in the community who are assessed as able to remain in a nonresidential setting and who:

1. Require multiple services and/or activities performed on their behalf; AND

2. Are unable to obtain the required services and/or perform the required activities for themselves; AND

3. Do not have family or friends who are able and willing to help them obtain all the required services or perform all the required activities; AND

4. Will be authorized for chore services or adult protective services.

C. Adults in Medicaid-funded Nursing Home beds who:

1. Are no longer eligible for Medicaid-funded Nursing Home care due to changes in financial status or level of nursing needs; or

2. Continue to be eligible for nursing home care, but prefer and can be appropriately served through COPES or other alternative services; or

3. Are Medicaid-funded and require case management because of decertification or closure of the Nursing Home.

D. Adults residing in the community, Congregate Care Facilities or Adult Family Homes who are assessed as needing a Nursing Home placement for six months or less. The adult being placed may be Medicaid-funded, state-funded, or private pay.

E. Adults in state-funded Congregate Care Facility or Adult Family Home beds who are assessed as able to leave residential care.

F. Adults residing in the community who are assessed as needing placement in a Congregate Care Facility or Adult Family Home but able to move back to the community within six months. The adult must receive some state funding for his/her residential care.

41.15 Eligibility

A. Persons who meet the target population criteria listed in Section 41.14 are eligible for case management services.

B. For eligibility requirements for specific services which might be required by case management clients, see the following:

1. Chore Services, Chapter 42;

2. Adult Protective Services, Chapter 44;

3. COPES, Nursing Homes, Congregate Care, and Adult Family Homes, Chapter 46;

4. General service eligibility, Chapter 03.

41.20 PROGRAM STANDARDS

41.21 Program Expectations/Response Time

A. Screening

1. Adults who apply to or are referred to the CSO for case management, residential placement services, chore services, or adult protective services are screened to determine the need for case management.

2. Screening for case management is performed using the target population criteria in Section 41.14.

3. Case management screening by telephone is completed within one working day after receipt of a referral.

4. Case management screening requiring a home visit is completed within three working days after receipt of a referral.

B. Comprehensive Assessment

1. A comprehensive assessment is provided for those adults screened by CSO staff who appear to meet the case management target population criteria listed in Section 41.14.

2. A comprehensive assessment is provided for target population adults in residential care (see Section 41.14).

3. A comprehensive assessment completed by the CSO System or Aging Network shall be accepted by the other agency.

4. A comprehensive assessment is initiated within five working days following screening unless a different response time has been requested by the person completing the screening.

C. Service Plan Development

1. CSO System staff have responsibility for coordinating development of the case management service plan when they complete the comprehensive assessment.

2. The service plan is developed according to the Case Management Implementation Plan and completed:

   a. Within ten working days following completion of assessment for plans which do not involve a case staffing;

   b. Within ten working days following completion of assessment for plans involving telephone case staffing;

   c. Within twenty working days following completion of assessment for plans involving in-person case staffing.

3. The assignment of ongoing case management responsibility takes place during service plan development. In the absence of exceptional circumstances, the division of responsibility for ongoing case management is as described in Section 41.13 A. 4.

4. The case manager who completed the comprehensive assessment and coordinated service plan development writes the proposed service plan and delivers it to the designated ongoing case manager within five working days after the proposed service plan is developed.

5. The ongoing case manager discusses the proposed service plan with the client or his/her designated representative within five working days after the plan is developed (or received from the Aging Network).

6. If the plan is not agreed to, the ongoing case manager initiates development of a revised plan. All parties involved in developing the initial service plan are involved in the development of a revised service plan.

7. The service plan becomes final when signed by the client or his/her representative. If it is not appropriate to obtain such a signature, the reason(s) must be documented on the Case Management Service Plan (DSHS 14-192D).

D. Service Plan Implementation

1. The following service plan implementation activities are performed as appropriate:

   a. Counseling.

   b. Authorization of services.

   c. Referral for services.

   d. Case coordination.

   e. Case management supportive functions:

      (1) Client Advocacy

      (2) Assistance

      (3) Consultation

      (4) Networking

      (5) Family Support

      (6) Crisis Intervention

   f. Case monitoring.

2. The ongoing case manager follows up with the client or his/her representative within ten working days of any referral to services to determine if the referral was successful. The referral process may have been initiated by the client, informal support system, or staff.

3. The ongoing case manager maintains regular contact with the client. Frequency of contact is based on the client's need and progress in implementing the service plan.

4. The ongoing case manager ensures that the client or his/her representative understands how to make telephone contact to get routine assistance.

5. The case manager ensures that an emergency protocol is established for the protection of the client in the event of accident, sudden change in functional status, or loss of support system.

E. Service Plan Review

1. All service plan reviews are conducted in person with the client or his/her representative, using the Comprehensive Adult Reassessment form (DSHS 14-192B).

2. Service plan review dates are determined by the case manager based on the client's situation, with the following minimum standards:

   a. Initial review within thirty days after service plan agreed to by client;

   b. Second review no more than sixty days after the first;

   c. Third review no more than nine months after the second;

   d. Subsequent reviews at least annually.

F. Termination Planning

1. Nursing Home Clients

   a. The case manager terminates case management when a service plan review indicates that no other level of care will be appropriate to meet the client's needs.

   b. Case management is terminated if the client is still in the facility after six months unless the appropriate case management supervisor authorizes a continuance. Such authorization is documented in the client's case record.

2. Congregate Care Facility/Adult Family Home Clients, Non-COPES

   a. The case manager terminates case management when a service plan review indicates that no other level of care will be appropriate to meet the client's needs.

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b. Case management is terminated if the client is still in the facility after six months unless the appropriate case management supervisor authorizes a continuance. Such authorization is documented in the client's case record.

3. Community Clients, Non-COPES

a. The case manager terminates case management when the client's situation has stabilized and formal and informal support systems are operating adequately to meet the client's needs.

b. Case management is terminated after one year unless the appropriate case management supervisor authorizes a continuance. Such authorization is documented in the client's case record.

4. COPES Clients

a. COPES clients continue to receive case management for the duration of the COPES authorization.

b. At the expiration of the COPES authorization, they are screened to determine if they meet other case management target population criteria and, if so, case management is continued.

5. Documentation of Reason(s) for Termination

Whenever case management is being terminated, the reason(s) for termination are clearly documented on the Case Management Service Plan form, DSHS 14-192D.

6. Notification of Termination

When case management is terminated, staff notifies the client and/or his/her representative and all individuals and agencies continuing to provide services, as appropriate.

7. Follow-Up After Termination of Case Management

Clients continuing to receive CSO services are screened to determine the need for case management at regular program reviews.

G. Record Maintenance

The case manager establishes and maintains a documentation file on each client according to agency policy. The file includes but is not limited to the following information:

1. A face sheet containing personal and demographic information on the client and his/her informal support system (DSHS 14-139).

2. A current Comprehensive Adult Assessment (DSHS 14-192), including the Case Management Supplement (DSHS 14-192C), and the Case Management Service Plan (DSHS 14-192D); and the Comprehensive Adult Reassessment (DSHS 14-192B) forms completed during service plan reviews.

3. A narrative record of client contacts, including problems encountered and service plan modifications developed in response.

4. Such other documentation as may be necessary to systematic case management and service plan continuity.

H. Case Management System Coordination

It is recommended that case managers from the CSO System and the Aging Network meet monthly to discuss referrals, changes in policies or procedures, common problems and case management techniques.

41.22 Appropriate Program/Service Outcomes

A. Client remains in his/her home and resides in a safe and healthy environment.

B. Client remains in own home rather than moving to a more restrictive environment.

C. Client moves from Nursing Home to a less restrictive environment.

D. COPES client resides in own home, Congregate Care Facility, or Adult Family Home, rather than Nursing Home.

E. Client moves from Congregate Care Facility or Adult Family Home to nonresidential care.

F. Client moves to a different Nursing Home because of decertification or closure of the Nursing Home.

41.30 SERVICE PROCEDURES

41.31 Screening

A. The following persons are screened to determine their need for case management.

1. All adults applying or referred for:

   a. Case management;

   b. Residential placement services;

   c. Chore services.

2. All persons receiving adult protective services.

B. Screening is performed using the target population criteria listed in Section 41.14.

C. Screening includes direct telephone or in-person contact with the client. Collateral contacts may also be made.

D. Adults who appear to meet the case management target population criteria are referred for a comprehensive assessment.

E. Adults who do not meet the case management target population criteria but appear to require other services are referred for appropriate services.

F. If requested, the referral source shall be notified of case disposition following the screening.

41.32 Comprehensive Assessment

A. The purpose of the comprehensive assessment is to determine the client's need for case management and/or other services by documenting his/her functional assets, deficits and needs in the following psychosocial and health areas:

1. Physical health (health problems, current diagnosis, medications, treatments).

2. Mental health/emotional status.

3. Cognitive functioning.

4. Behavior problems.

5. Social relationships.

6. Ability to perform activities of daily living.

7. Economic status.

8. Environmental situation.

9. Other needs identified by the client.

B. The comprehensive assessment is provided for those adults who appear to meet the case management target population criteria listed in Section 41.14.

C. The Comprehensive Adult Assessment form (CAA, DSHS 14-192), including the Case Management Supplement (DSHS 14-192C), is used for the comprehensive assessment.

D. The comprehensive assessment is always performed in person at the client's current place of residence. Collateral contacts may be made in writing, by telephone or in person.

E. The comprehensive assessment is performed by staff of the agency (CSO System or Aging Network) which performed the case management screening.

F. A comprehensive assessment completed by the CSO System or Aging Network shall be accepted by the other agency.

G. It may become evident during the comprehensive assessment that the client does not meet the case management target population criteria as indicated by the screening. When this occurs, the client shall be referred directly to appropriate services by the agency which did the comprehensive assessment. No ongoing case manager will be assigned.

41.33 Service Plan Development

A. Process

1. CSO staff are responsible for coordinating development of the case management service plan when CSO staff have performed the assessment. The following activities are included:

   a. Ensure that case management service plans for adults age sixty or over are developed according to the Case Management Implementation Plan. Aging Network staff are not involved if the adult is moving from one residential setting to another. Ideally, the service plans are jointly developed

by CSO System and Aging Network case management staff, in conjunction with other appropriate parties, and the service plan is developed during an in-person case staffing.

b. When warranted by client need, ensure that case management service plans developed by the CSO System with no Aging Network involvement are developed through case staffing with other appropriate parties listed in c. below, according to the Case Management Implementation Plan.

c. Include appropriate participants in case staffing based on assessment of client need:

(1) The client and/or his/her representative.

(2) DSHS Community Nurse.

(3) DSHS Nursing Care Consultant.

(4) Professional staff from Developmental Disabilities.

(5) Professional staff from Mental Health.

(6) Professional staff from Alcohol and Substance Abuse.

(7) Health care providers or staff from other community agencies.

(8) Significant others in the client's informal support system.

d. When case staffing is warranted, prepare for case staffing by completing the Problems/Unmet Needs section of the CAA Case Management Service Plan form (DSHS 14-192D), and compiling other information pertinent to the development of the service plan.

e. When case staffing is warranted, initiate telephone or in-person case staffing, according to Case Management Implementation Plan.

f. Complete development of the service plan within time specified in Section 41.22.

g. If necessary, implement a temporary service plan appropriate to client health and safety while a longer term plan is under development.

h. Ensure client confidentiality consistent with state law and department policy.

2. The decision regarding the assignment of ongoing case management responsibility is made during service plan development using criteria stated in Section 41.13 A., Division of Case Management Responsibility. It will be necessary to allow exceptions for unique circumnstances with respect to the assignment of ongoing case management responsibility. The following are examples of such exceptional circumstances:

   a. An older person known to the Aging Network case management staff enters a hospital for surgery and is thereafter discharged to a nursing home for a temporary recovery period prior to returning home. Despite the residential care setting, this person may benefit from case management by the Aging Network.

   b. A man, age sixty, and his wife, age fifty-five, have been receiving CSO services for a number of years. The wife has been placed in a Congregate Care Facility and receives case management from the CSO System. The husband, while capable of living at home, has recently been assessed as needing case management. Despite his community-based care setting, he may benefit from case management services provided by the same person who assists his wife.

3. Such details of case staffing as timing, location, and prior exchange of information may be determined locally by written agreement between the DSHS Regional Administrator and the local Area Agency on Aging Director.

4. It may become evident during the case staffing that the client does not meet the case management target population criteria as indicated by the screening. When this occurs, the client is referred directly to appropriate services by the agency which completed the comprehensive assessment. No ongoing case manager will be assigned.

B. <u>Service Plan Content</u>

1. The case management service plan includes the following:

   a. Problems/needs identifed.

   b. Services/activities needed to address problems/needs, including details such as frequency, days of the week, time of day, etc.

   c. Activities that staff will perform in working with the client and name of responsible staff person.

   d. Responsibilities the client will assume.

e. Responsibilities the client's family or others in the client's informal support system will assume.

f. Timetable for referral of the client to needed services or for initiation of needed activities.

g. Name of the agency and person responsible for ongoing case management.

h. Date when the service plan will be reviewed in person with the client and/or his/her representative.

2. A case management service plan for a community client (one who is not in or entering residential care) describes the services and activities that will be provided to maintain the client in the community.

3. A case management service plan for a client who is in residential care, or who is entering residential care for a short-term placement, describes the services and activities that will be provided to enable the client to move to a nonresidential or less restrictive residential care setting.

C. Service Plan Documentation

1. The service plan is documented on the Case Management Service Plan form, DSHS 14-192D(X).

2. The Individual Service Plan (ISP) portion of the DSHS 2-305(X), Service Episode Record, may cross-reference the DSHS 14-192D(X) to avoid duplicate recording.

3. The case manager who completed the assessment and coordinated service plan development is responsible for writing the service plan and delivering it to the designated ongoing case manager according to timelines in Section 41.21.

D. Client Agreement Regarding the Service Plan

1. The ongoing case manager discusses the proposed service plan with the client and/or his/her representative prior to implementation. Should the plan not be agreed to, following such discussion, development of a revised plan is initiated by the ongoing case manager.

2. All parties who were involved in developing the initial service plan are involved in the development of a revised service plan.

3. The service plan becomes final when signed by the client and/or his/her representative. If it is not appropriate to obtain such a signature, the reason(s) must be documented on the CAA Case Management Service Plan form, DSHS 14-192D(X).

E. Distribution of the Service Plan

The ongoing case manager distributes copies of the final service plan to those involved in implementing the plan and to others, as appropriate, within five working days after the service plan is agreed to by the client and/or his/her representative.

41.34 Service Plan Implementation

A. Activities

1. Counseling

Provide counseling to the client and/or his/her representative to encourage cooperation in implementing the service plan or to resolve problems interfering with the client's functioning. Counseling will be provided at the most appropriate location for the client.

2. Authorize Services

Authorize services included in the service plan for which own agency has authority.

3. Refer for Services

Ensure that the client is successfully referred to all resources listed in the service plan.

a. Provide information and support to the client to enable him/her to self-refer if this is within the client's capability.

b. Provide information and support to persons in the client's informal support system to enable them to make the necessary referrals if the client is unable to self-refer.

c. Contact resources and make referrals for the client if neither of the above are possible.

d. Follow-up with the client and/or his/her representative within ten working days to determine if referrals were successful, whether the referral process was initiated by the client, informal support system, or staff. Should the original referrals prove unsuccessful, the service plan is

revised and renegotiated to identify substitute resources and referrals. The case manager consults with those parties involved in the original service plan development regarding any substantial changes in the plan.

4. Case Coordination

Maintain contact with resources involved in implementing portions of the service plan to ensure coordinated service delivery, share new information, and work out any coordination problems which may arise.

5. Case Management Supportive Functions

Be prepared to perform or arrange for the performance of one or more of the following case management supportive functions:

a. Client Advocacy

Intervene with agencies or persons to help individual clients receive appropriate benefits or services.

b. Assistance

Help the client obtain a needed service or accomplish a necessary task (complete a form, find a living situation, help with moving, provide transportation or escort, etc.).

c. Consultation

Consult with service providers and professionals to utilize their expertise on the client's behalf.

d. Networking

Develop a series of linkages between formal and informal support systems for the purpose of creating an effective continuum of care.

e. Family Support

Help the family or others in the client's informal support system deal with stress arising from the client's impairments, make necessary changes in the home environment and life style, plan a move to or from residential care, etc.

f. Crisis Intervention

Provide short-term intervention in an emergency situation to resolve the immediate problem before a long-term service plan can be developed.

6. Case Monitoring

Maintain regular contact with the client to carry out the service plan (see B.).

B. Regular Contact with the Client

1. Frequency of contact is based on the client's need and progress in implementing the service plan. Since case management clients are frail, vulnerable, and usually have multiple impairments, it is anticipated that contacts will occur with definite regularity.

2. The case manager ensures that the client and/or his/her representative understands how to make telephonoe contact to secure routine assistance.

3. The case manager ensures that an emergency protocol is established for the protection of the client in the event of accident, sudden change in functional status, or loss of support system.

C. Documentation

Ongoing case management services and other CSO services are documented on the DSHS 14-154, Social Service Authorization. Changes are documented on the DSHS 14-159, Change of Service Authorization.

41.35 Service Plan Review

A. Method of Service Plan Review

Service plan reviews are always conducted in person at the client's place of residence or temporary residence. Collateral contacts may be made in writing, by telephone, or in person.

B. Content/Documentation of Service Plan Reviews

An in-person service plan review consists of:

1. Determining whether there has been a change in the client's condition or situation. The Comprehensive Adult Reassessment form (DSHS 14-192B) is used to document this portion of the service

plan review, as per form instructions. The Evaluation (EVAL) section of the Service Episode Record (SER), DSHS 2-305(X) may refer to the DSHS 14-192B to avoid duplicate recording.

2. Determining whether the case management service plan needs to be revised. If so, revisions are documented on the CAA Case Management Service Plan, DSHS 14-192D, as per form instructions. The Individual Service Plan (ISP) section of the Service Episode Record (SER), DSHS 2-305(X), may refer to the DSHS 14-192D, to avoid duplicate recording.

3. For COPES clients, changes in the COPES service plan are documented on the COPES Individual Plan of Care, DSHS 14-225. Information is conveyed from Aging Network Case Managers to the CSO using procedures covered by local agreement. In every case, the DSHS 14-225 may only be signed by the authorizing service worker.

C. Distribution of Service Plan Revisions/COPES Review Documents

1. Service plan revisions are sent to all affected agencies and/or individuals as appropriate.

2. Documentation of each COPES review done by an Aging Network Case Manager is sent to the appropriate CSO within five working days of completion of the review, for inclusion in the CSO case record.

D. Division of Responsibility

1. Case management staff are responsible for reviewing the service plans of clients for whom they have ongoing case management responsibility.

2. An initial review may indicate that the service plan must be revised and the revision will likely result in a residential client becoming a community client or vice versa. When this occurs for a client age sixty or over, the agency which performed the service plan review (CSO or Aging Network) contacts the other agency to develop a revised service plan.

E. Review Dates

1. The review date schedule for all case management clients is described in Section 41.21, Program Expectations/Response Time.

2. In addition to service plan reviews conducted at the intervals described in Section 41.21, the case manager conducts an in-person service plan review whenever he/she determines or learns of a change in the client's condition or situation which might require a service plan revision.

3. Planned review dates are documented on the Case Management Service Plan, DSHS 14-192D.

41.36 Termination

Clients are terminated from case management services according to the criteria listed in Section 41.21 F. Termination is documented on the DSHS 14-159, Change of Service Authorization.

41.80 SSPS CASE MANAGEMENT CODES (See SSPS Manual)

A. Code 4605 is used for Comprehensive Adult Assessment or Review, for case management as well as for assessments for other purposes.

B. Code 4105 is used for both COPES and non-COPES Ongoing Case Management Services. This begins after assessment and service plan development are completed. This code is used only when the designated case manager is CSO staff.

C. Other adult service codes may be used as appropriate.

41.97 INTERFACE WITH OTHER DSHS SERVICES

In implementing the service plan, the CSO case manager may coordinate with other CSO services and other parts of DSHS.

A. Division of Developmental Disabilities

DDD professional staff will be included in service plan development for all DDD clients. Determination of the ongoing case manager will be made during service plan development on a case-by-case basis.

B. Division of Mental Health

Mental health professional staff will be included in service plan development for all mental health clients. Determination of the ongoing case manager will be made during service plan development on a case-by-case basis.

C. Bureau of Nursing Home Affairs

The Nursing Care Consultant (NCC) refers clients to the CSO for case management when:

1. The client is determined to be not in need of nursing care;

2. The client continues to be in need of nursing care, but is anticipated to be ready to leave the nursing home within six months.

A copy of the most recent Client Profile, DSHS 13-336(X), is sent along with the referral. Information already on the DSHS 13-336(X) need not be copied onto the DSHS 14-192(X) if the DSHS 13-336(X) is included in the assessment documentation.

D. Other CSO Services

1. Financial services to apply for financial grants or determine financial eligibility for services.

2. Chore services to provide meals, household work, twenty-four hour supervision, etc., to maintain a person in his/her own home.

3. COPES services for an in-home alternative to nursing home care.

4. Adult Protective Services for investigation of any suspected or alleged abuse.

5. Community nurses or nursing care consultants regarding nursing care needs.

6. Residential services workers for placement in Adult Family Home, Congregate Care Facilities, or Nursing Homes.

41.98 INTERFACE WITH NON-DSHS SERVICES

A. The CSO and the Aging Network work together to coordinate delivery of case management and other services to persons in the case management target population, Section 41.14.

B. Such conflicts of opinion and professional judgment as may arise during the course of service plan development shall be resolved at the direct service level whenever possible. Should CSO System and AGing Network case management staff be unable to resolve a particular issue through direct negotation, that issue shall be referred to the respective supervisors and, if necessary, to the respective administrators for a decision.

C. The service worker may also confer or coordinate with:

1. Federal agencies such as the Social Security Administration or the Veterans' Administration concerning financial entitlements.

2. County-designated mental health professionals and mental health clinics regarding mental health services and/or institutional commitment.

3. County health services for community health nurses, sanitation and rodent control, etc.

4. Local home health agencies for in-home nursing care.

5. Local legal services, local Bar Associations, or the Foundation for the Handicapped, etc., for legal services to establish guardianship or for help with other legal problems regarding the protection of the client and/or his/her resources, such as landlord-tenant problems, foreclosure, etc.

6. Advocacy groups representing APS clients, e.g., The Trouble Shooters, the Foundation for the Handicapped, and local Councils on Aging.

7. Senior Citizens Centers for personal social experiences, and local senior programs such as meal service, health clinics, respite, and transportation.

8. Other community resources for services essential to the protective service plan, such as resumption of utilities, daily telephone check-in, etc.

41.99 REQUIRED FORMS AND INSTRUCTIONS

A. See Chapter 46, Residential Services for Adults, for instructions on these forms:

DSHS 14-192(X)	Comprehensive Adult Assessment
DSHS 14-192B(X)	Comprehensive Adult Reassessment

B. See Chapter 99, General Forms, for instructions on these forms:

DSHS 2-305(X)	Service Episode Record
DSHS 14-139(X)	Social Services Eligibility Document and Face Sheet
DSHS 14-192C(X)	Comprehensive Adult Assessment Case Management Supplement
DSHS 14-192D(X)	Case Management Service Plan