Case Management

Chapter 5 explains the philosophy of case management, Home and Community Services (HCS) and Area Agency on Aging (AAA) case management responsibilities, and the case management tasks required for in-home, residential, nursing facility, and hospital clients.

Ask the Expert

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BACKGROUND

Goals

The primary goals of case management are to assist the client to develop a plan of care to enable them to reside in the setting of their choice and to monitor that plan. Case workers will support the client's independence by coordinating and offering assistance to access needed services. Case workers are custodians of the state's resources and must balance a client's choice with program limits.

Case workers:

- Educate clients, family members, support systems, and other service providers that a comprehensive plan of care is developed within the choices and resources available and that meeting all needs may not be possible.
- Must not view limited choice as a restraint on creative care planning. As a manager of state resources, staff should utilize naturally occurring resources or access non-traditional means to assist a client in meeting their needs and to develop supports based upon realistic expectations and coordinated problem solving.
- Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.
- Support and maximize client independence and self-direction.

Core and Supportive Functions

Core functions may not be waived by the client and include:

- **Assessment.** Perform a face-to-face assessment with the client in the client's residence to determine service needs and program eligibility at least annually.

- **Planning/Plan Monitoring.** Develop a plan of care with each client, authorize services according to that plan, and authorize the client's choice of qualified provider. Monitor, through periodic in-person visits (scheduled and unscheduled) and telephone contacts, to see if the plan is being appropriately implemented and if the services provided are meeting the client's needs.

- **Mandatory Reporting.** Report abuse, abandonment, neglect, or financial exploitation to Adult Protective Services (APS) per Chapter 74.34 RCW. Mandatory reporters are not required by law to report self-neglect by a vulnerable adult.

  Case workers are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults. A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.

See Adult Protective Services policy and procedure and Chapter 74.34 RCW for detailed information about mandated reporting, including consequences of failure to report.

- **Report Suicide Ideation.** If the client has a plan, the means to carry it out, and a time planned, do not leave the client alone. You may withdraw to a safe distance if you fear for your own safety (loaded gun, etc.) and call 911. Contact the Washington State Designated County Crisis Responders, explain what the client has told you, and that you are concerned for the client's safety.

- **Termination Planning.** It is good practice to let all clients know that their services are based on their current needs and can change if their needs change. This is especially true if they are ill with a temporary condition (such as, post-surgical, broken bone). When the CARE assessment determines that a client is no longer eligible: make necessary referrals (if needed) to transition to other services, provide adequate notice via a Planned Action Notice (PAN), and close services in the necessary timeframes.

Note: If a client is receiving a Home and Community Services (HCS) housing resource, you must contact the assigned Housing Program Manager (HPM) prior to inactivating the case. Please involve assign HPM in any case staffing's regarding the client. HCS has services to support housing needs. Please include HPMs if housing is a concern. For more information visit Chapter 6A/HCS Subsidies and GOSH Services.

Supportive functions may be waived by the client and include, but are not limited to:

- **Client Advocacy.** Support client self-advocacy. Intervene with agencies or persons to help clients receive appropriate benefits or services. Clients may also request assistance with advocacy from their case worker even when they are able to advocate for themselves.

- **Assistance.** Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently.
  Assistance can include but is not limited to:
  - Completing a form.
  - Researching a living situation.
  - Assistance with moving arrangements.
  - Arranging transportation.
  - Assisting with Medicaid eligibility review.
  - Other services related to the plan of care.
  - Assistance with locating, hiring, contracting, and terminating providers of their choice.
  - Assistance applying for administrative hearings and access to an administrative hearing coordinator.

- **Referrals**. Making and following up on mandatory referrals as identified in the assessment.

- **Family Support**. Assist the family or others in the client's informal support system to:
  - Make necessary changes in the home environment and/or lifestyle that client has agreed to;
  - Encourage changes in high-risk behaviors or choices that may improve the stability of the plan of care or improve health and psych/social outcomes;
  - Plan a move to or from an in-home setting, residential care, or other setting chosen by the client.
  - Encourage caregiver self-care through support groups, education, and assistance accessing resources.

- **Crisis Intervention**. Assist with short-term crisis intervention in an emergency situation to resolve an immediate problem before a long-term plan is developed or current plan is revised. Crisis intervention may include, but is not limited to:
  - Use of an Exception to Rule (ETR) (see Chapter 3).
  - Arranging for a temporary move to an Adult Family Home or a Nursing Facility.
  - Authorization of Client Training or other waiver or Community First Choice services.
  - Calling 911.

- **Access Resources.** Examples of available resources include discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.

- **Handling Challenging Cases.** Follow the "Challenging Cases Protocol" when the recommended plan of care, appropriate to the client's health, welfare, or safety, cannot be implemented.

Case Management Responsibility Settings and Criteria

Per RCW 74.39A.095, case management responsibilities for long-term care clients are shared by Home and Community Services and the Area Agency on Aging.

Home and Community Services (HCS) Responsibilities

1. New admitted applicants or clients to a nursing facility (NF) who will likely stay in the NF for more than 30 calendar days: Medicaid applicants, Medicaid clients, and dually eligible for Medicare/Medicaid.

2. Long-term Medicaid residents of nursing facilities and those residents who are converting or likely to convert within 180 days to Medicaid (from Medicare or private pay).

3. Newly admitted to or current Medicaid residents in Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facilities, and Adult Residential Care (ARC) facilities.

4. Any adult with prior Adult Protective Services (APS) involvement and in need of ongoing case management and not receiving Core services. See APS policy and procedure for more information on APS.

5. Initial entry into Home and Community Living Administration funded in-home or residential long-term services and supports.

6. Hospital discharge.

7. Private Duty Nursing clients.

Area Agency on Aging (AAA) Responsibilities

1. All clients, aged 18 and older, receiving home and community-based funded services in their home.

2. In-home Medicaid clients who are temporarily in institutional settings. See the Case Transfer Guidelines Section of this chapter for additional information.

3. Based on staff resources, adults aged 60 and older, who reside in the community, are not receiving core long-term services and supports, and are assessed as able to remain in a non-residential setting, and meet one or more of the following:
    a. Require multiple services and/or related activities performed on their behalf;
    b. Are unable to obtain the required services and/or perform the required activities for themselves;
    c. Do not have family or friends who are able and willing to provide adequate assistance;
    d. Meet a-c above and require ongoing case management after an Adult Protective Services (APS) investigation has been completed.

4. If the AAA wants to limit the criteria outlined in 2, it must be approved by the Home and Community Living Administration and included in the contract.

TYPES OF CASE MANAGEMENT

In Home

Home and Community Services (HCS) will:

- Perform an initial assessment.
- Develop the service plan.
- Ensure clients are informed of choices among qualified providers.
- Authorize services.
- Make a telephone monitoring contact with the client if the case is held longer than thirty (30) calendar days. See 'Transferring a Case' for more details.

- Transfer the case to the Area Agency on Aging (AAA). Refer to the Case Transfer Guidelines within this chapter.

Once the AAA receives the case from HCS or another AAA:

1. Case worker will make a **face-to-face visit** in the client's home **within thirty (30) calendar days** of assignment to the Primary Case Manager (PCM) in CARE in the following circumstances (case must be assigned to the PCM within five (5) business days per Case Transfer Guidelines):

    - Client is identified as Targeted Case Management (TCM) by the receiving office or by the transferring office on the CARE Overview screen; or
    - Client has Behavior Point Score (BPS) >6 as documented in CARE; or
    - Client has a documented current pressure ulcer; or
    - The current assessment was performed in a
        - Skilled Nursing Facility, or
        - Hospital, or
        - A different in- home setting than the one they are currently residing in, or
        - Residence screen indicates client has been homeless in the past twelve (12) months; or

    Explicit Terminal Prognosis is documented in CARE or End of Life/hospice is indicated on Case Transfer form or treatment screen

    Supervisor or case worker has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.

2. If a client does not meet the criteria for a 30-day face-to-face visit, the case worker or a case aide must make a **telephone call to the client within thirty (30) calendar days** of initial assignment to the receiving worker and confirm that the client is receiving services as identified in their care plan.

    - The telephone contact must be with the client. A client's representative may be contacted only if the client is unable to communicate. If someone other than the client is contacted, document the reason in a CARE Service Episode Record (SER).
    - If the telephone call results in any concerns that require a face-to-face visit listed in #1 above, the case manager will schedule a face-to-face visit within forty-five (45) days from the date the case was initially assigned to a worker in the receiving agency.

    The telephone or face-to-face (30-day) contact includes sharing and gathering the following information:

    - Case worker/Registered Nurse (RN)/Case Aide introduction to client and reason for the contact.
    - Confirming that the care plan meets the client's identified needs and preferences (such as, personal care, equipment, resource/referrals, follow-up appointments, client's comfort level with the care).

- Determining if there have been any changes in the client's condition, service plan, supports or preferences for case management follow up.
- Advising client/client representative to call the case worker/RN if there are concerns at any time.
- Verifying the client has contact information for the case worker/RN and knows how and when to contact the case worker.
- Document in a CARE Service Episode Record (SER) note to document summary of the discussion/results. In CARE, choose:
    - Contact Code: Telephone Call or Home Visit; **and**
    - Purpose Code: 30 Day Visit.

For lower risk clients, Area Agency on Aging offices wishing to exceed the standard may use the 30-day call to schedule a face-to-face visit within forty-five (45) days from the date the case was initially assigned to a worker in the receiving agency.

Note: If the file has been returned to Home and Community Services per the Case Transfer policy, a new 30-day period begins on the date of the latest electronic transfer to the Area Agency on Aging.

3. One **annual face-to-face assessment** in the client's home must be completed at least every annual cycle. A **Plan Period Tickler** will warn forty (40) days before a Plan Period expires.
    - Significant Change assessments (if they occur) reset the Plan Period annual clock (See Chapter 3/Assessment & Care Planning for discussion of assessment Plan Period and when a Significant Change assessment should be considered temporary).

4. All clients will receive regular monitoring contacts to **monitor the plan of care**, especially any issues that were not resolved at the time of the last face-to-face visit. Clients who meet any of the Targeted Case Management (TCM) criteria will receive more frequent contacts (see TCM section).
    - For Non-Targeted clients, **three monitoring contacts** are required annually in addition to the face-to-face assessment. These contacts can be by phone or in person. The 30-day telephone or face-to-face visit may count as one contact in the first year. Monitoring plan contacts made by Home and Community Services will also count in the first year.

Contacts with the client to assist them with critical needs related to health and safety, maintenance of community living status, or the plan of care will count toward the required annual monitoring contacts. Activity that originates around a supportive function can also be used as a monitoring contact if service plan delivery is discussed.

You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in a CARE Service Episode Record (SER).

Document all contacts you consider as monitoring contacts in a CARE Service Episode Record (SER) using **Purpose Code "Monitor Plan".** This will enable an automated Tickler to notify the case worker if more than four (4) months have passed since the last Monitor Plan SER entry.

Targeted Case Management (TCM)

A client is eligible for Targeted Case Management if they meet at least one of the following criteria:

- Has a potential for abuse and neglect as identified in the assessment on the safety screen or in a CARE Service Episode Record (SER). This includes all clients who have had an Adult Protective Service (APS) referral or open APS case within the past twelve (12) months.
- Lives in an environment that jeopardizes their personal safety, as identified in the assessment on the Safety screen or in a CARE Service Episode Record (SER).
- Is not always able to supervise their paid provider as identified in the assessment on the Cognitive Performance screen and no one is identified on the Cognitive Performance screen as the person responsible for supervision.
- Has thought about suicide in the last thirty (30) days, as indicated on the Suicide screen.
- Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen.

Additional criteria as determined by the case worker and supervisor to address identified concerns
For Targeted Case Management clients, the purpose of these contacts is to monitor issues related to the client's targeted criteria as well as client condition and service plan delivery. Document each discussion with the client in a CARE Service Episode Record (SER).

Examples of Targeted Case Management include:

- Working with the client to find a payee to manage their finances when there is evidence of financial exploitation.
- Helping the client locate housing in a safe neighborhood.
- Encouraging the client to consult a mental health specialist about their suicidal ideation and depression.

Contact requirements include:

- At least one additional face-to-face visit in the client's home within one year from the beginning of Targeted Case Management and each year following. If the 30-day in-person visit occurs during the first year, it may count as an additional face-to-face visit.

- Visits may include Area Agency on Aging nursing assessments and /or collateral professional in-home contacts that have conferred with the case worker and agreed to represent the case worker's concerns and needs while on-site. These in-home contacts report back to the case worker after the on-site visit.

- In addition to the face-to-face requirements, at least four (4) monitoring contacts with the client are required annually.
  - You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in a CARE Service Episode Record (SER).
- Use the Targeted Case Management CARE Service Episode Record (SER) contact code to designate the date TCM began or was terminated. Document the reason(s) the client was:
  - Placed on Targeted Case Management.
  - Terminated from Targeted Case Management.
  - Not placed on Targeted Case Management if they meet targeted criteria (Possible example: Adult Protective Services investigation in last year of an Individual Provider who no longer works for client).
- Use the "Targeted Case Management?" item on the Overview screen to indicate whether the client is currently receiving TCM services.

Guidelines to Support Move from In-Home to Residential Setting

If a client desires to move to a residential facility or nursing facility, follow case management guidelines outlined below. Prior to transferring the case to Home and Community Services, you will need to:

- Inform the client of alternative options to confirm their choice of living arrangement
- Discuss the personal needs allowance (PNA) limits in residential settings and that the client will have a responsibility to pay their provider every month
- Complete the necessary forms and perform another assessment as needed.
- Contact Home and Community Services and review the request for admission, residential setting options, and the most current assessment.
- Verify that the facility has a Medicaid bed available and is contracted to provide for any special needs (such as, dementia).
- Have the client sign an Acknowledgement of Services form (DSHS 14-225), if appropriate.
- Request verbal approval prior to authorization of services in the new setting. Document plan approval in a CARE Service Episode Record (SER) and send documents for signature per Chapter 3/Assessment & Care Planning policy.
- Review the Assessment Details and Service Summary with the provider prior to the client's transition to the residential setting and document in the file.
- Notify financial using the DSHS 14-443 within Barcode and, if applicable, get updated participation amounts from financial. If the client does not enter on the planned date, the participation may need to be adjusted.

- Close all in-home authorizations and open residential authorizations.
- Notify Home and Community Services (HCS) that the client has moved and transfer the case to HCS if the client is expected to stay more than thirty (30) calendar days in the residential or nursing facility.
- If appropriate, ensure current approved Behavioral Health Wraparound Supports (BHWS) Request for Managed Care Organization (MCO) Funding form (DSHS 13-712) is in the client's electronic case record (ECR) file. See Chapter 22a of the LTC Manual for more information regarding BHWS (BHWS funding cannot be authorized in a residential setting

Updating Residential Settings in the CARE Assessment (excluding Nursing Facilities):

Perform either a significant change or interim assessment according to policy.

1. Update the 'Planned living arrangements' dropdown in the Assessment Main screen (When residential is chosen, the Instrumental Activities of Daily Living screens will appropriately be cleared).
2. When the client chooses an Adult Family Home (AFH), the AFH evacuation level must be selected on the Safety screen.
3. Assign treatments to the appropriate Provider Type in the Treatments Screen.
4. Update the Supports Screen assigning appropriate tasks to the residential provider.
5. Change the 'Client chose/planned living situation' setting on the Care Plan screen.

Further information can be found in the Providing Residential Care Case Management and Nursing Facility Case Management sections of this chapter.

Residential

Home and Community Services provides initial and ongoing case management to all Medicaid clients in Adult Family Homes (AFH) and licensed boarding homes who have contracted with Home and Community Living Administration to provide Assisted Living, Enhanced Adult Residential Care, and Adult Residential Care services.

Initial Case Worker Responsibilities

1. Perform an Initial assessment.

2. Complete the:
   - Individual with Complex Behaviors (DSHS 10-234a) for clients with challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).
   - Community Behavioral Health Supports (CBHS) referral form (HCA 13-012)for clients who appear to meet eligibility criteria for supportive supervision and oversight refer to Chapter 22dof the LTC Manual.

- Send the AFH provider the "Case Manager Introduction" letter found in Chapter 8 of the LTC Manual.

Coordinating with the Client and Family

1. Work with the client and the family. If the client does not request the transition to a residential setting (often a member of the client's family will contact the social service specialist about moving a client), determine if the client is also requesting or agreeable to move to a new setting.
    - Explain that the client will have a responsibility to pay participation to their provider every month and will have only a limited amount of money for personal use. Inform the client that failure to make the required payment to their provider may result in a transfer or discharge from the facility.
    - Have the client sign an Acknowledgement of Services form (DSHS 14-225) if appropriate.
    - Have the client sign the Service Summary or give verbal approval prior to authorization of services in the new setting. Document plan approval in a CARE Service Episode Record (SER).

2. Use the AFH/BH Lookup Application to identify facilities with available Medicaid beds (Note: The lookup list does not reflect current Stop Placement actions). Send the list to the client and/or the family so they can visit as many as possible before making a choice. For client transitions to an AFH, if you identify clients with:
    - Dementia or special care needs, they must choose an Adult Family Home with that specialty designation.
    - An Axis I or Axis II DSM IV diagnosis, they must choose an Adult Family Home with the Mental Health Specialty designation.
    - Skilled nursing tasks needs, they must choose an Adult Family Home that has Nurse Delegation training. Skilled nursing may need to be provided by visiting nurses. Not all tasks are subject to nurse delegation, and the client may need to choose an Adult Family Home owned and operated by a Registered Nurse.

Coordinating with the Residential Provider

1. Contact the facility to confirm a Medicaid vacancy. Provide and review assessment details and service summary with the facility to determine if the facility can meet the client's needs. Disclose the rate generated by CARE and discuss possible admission date. Document outcomes in the CARE Service Episode Record (SER).

   NOTE: Case workers must respond to all voicemail and e-mail communications from Adult Family Homes within five (5) business days.

2. Within thirty (30) calendar days of the client's admit or Medicaid conversion (as documented in CARE), assigned staff will visit the facility to meet with the client and facility staff to review and discuss the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) in any of the following circumstances:

- The client was admitted from a state hospital, Department of Corrections, or another specialized institution, such as Hospital Psych Unit, Eval/Treatment center, etc.; or
- Client has Behavior Point Score (BPS) >6 as documented in CARE Web Assessment Summary or Personal Care Results (PCR); or
- Has a potential for abuse and neglect as identified in the assessment on the Legal Issues screen or in the CARE Service Episode Record (SER). This includes all clients who have had an Adult Protective Service (APS) referral in the last twelve months or have an open APS case; or
- Is coded as making Poor Decisions or No/Few Decisions in the assessment on the Cognitive Performance screen and does not have an authorized representative (AREP) or informal decision maker identified in CARE; or
- Has thought about suicide in the last thirty (30) days, as indicated on the Suicide screen; or
- Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen; or
- Client has a documented current pressure ulcer; or
- Explicit Terminal Prognosis is documented in CARE or End of life/hospice is indicated on Case Transfer form or medical screen; or
- Supervisor or case worker has the discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.

Note: For clients converting from private pay to Medicaid, if they have been in a residence more than thirty (30) calendar days prior to conversion, a 30-day visit is not required. The signed Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) may be obtained by mail or fax.

3. If a client does not meet the above criteria for a 30-day face-to-face visit in the facility, have the facility send the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) to the worker. The worker must phone the client and facility staff to review and discuss the NCP or NSA within the same 30-day timeframe.

    - If the telephone call results in any concerns that require a face-to-face visit listed in #2 above, the worker will schedule a face-to-face facility visit within forty-five (45) calendar days of the client's admission, conversion, or transfer to their current residence.

    The 30-day telephone or face-to-face contact includes sharing and gathering the following information:

    - Introduction to client and reason for the contact.
    - Discussing whether the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) is meeting the client's identified needs and preferences and determining their satisfaction with it.

- Determining if there have been any changes in the client's condition or preferences for case management follow up.
- Advising client/client representative to call the worker if there are concerns at any time.
- Verifying the client has contact information and knows how and when to contact the case worker.
- Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the "30 Day Visit" Purpose Code, containing a summary of the discussion/results.

Note: If a signed copy of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) has not been returned within thirty (30) days but has been requested by the case worker, make a report to the Complaint Resolution Unit (CRU) online.

- Include a copy of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA) with signatures of the provider and client in the client's electronic file once received by mail or fax.

4. If items were not taken into account during the development of the Negotiated Care Plan (NCP)/Negotiated Service Agreement (NSA), meet with the provider and attempt to resolve these issues prior to signing the agreement. Formal meetings should occur as appropriate to resolve issues of concern.

Hospital

To learn more about hospital discharge planning, please see Chapter 9/Hospital Assessment.

Nursing Facility Case Management

To learn more about Nursing Facility Case Management, see Chapter 10/Nursing Facility Case Management and Relocation

Joint Case Management

Joint case management may occur when there is a case staffing or when there is shared responsibility for a case.

Case Staffing

When do I hold a case staffing? Hold a case staffing when:

1. Case management needs arise as a result of a current or past Adult Protective Services investigation.

2. Significant complications or confusion exist that may place the client at risk of premature institutionalization, including concerns about the caregiver or environment.

3. There is a need to discuss and transfer case management oversight for complex cases that meet the criteria for targeted case management.

How do I conduct a case staffing?

1. If possible, hold it in the clients' residence or wherever they are receiving care.
2. Always include clients unless they choose not to or an extenuating circumstance prohibits them from participating.
3. As needed, include staff from Home and Community Services, Area Agency on Aging, other agencies, and formal and informal supports.
4. Ensure that clients have completed and signed a consent form authorizing all case staffing participants to discuss their information.
5. Involve your supervisor and/or administrator if there is disagreement among staff on how to resolve an issue.

Shared Cases

A case is "shared" when case workers from multiple offices are part of the client's team. All team members will need to follow CARE guidelines when sharing a case, including:

- Coordinating the assessment responsibilities.
- Using the same "look-back" periods.
- Ensuring that there is one primary case worker per division (The Area Agency on Aging is considered part of Home and Community Services Division).

Shared Case Example:
When a Respite client applies for Core services, the case will be transferred to the Home and Community Services office. However, the Respite worker will need to remain on the team as long as Area Agency on Aging respite services are in place.

For information on sharing cases with Developmental Disabilities Administration (DDA), see the online tutorial.

Non-Core Case Management

If a client is not eligible for Core services, they may qualify for non-core services funded through the Older Americans Act (OAA), Senior Citizens Services Act (SCSA) or through other funding for locally available services. Non-core services could include services such as respite care, nutrition programs, exercise programs, or other locally available services. Clients who may need and be eligible for non-core services should be referred to the local Area Agency on Aging/Information & Assistance office for assistance. The Area Agency on Aging provides case management to clients receiving these services.

Ongoing Case Worker Responsibilities

Visiting and Assessing the Client Annually or Sooner

1. Determine the frequency of contact with each client based on the client's:
   - **Care needs:** Does health status change frequently and/or is the client unstable
   - **Cognition:** Does the client have impaired cognition and/or communication skills?
   - **Emotional**, **psychiatric**, and/or **behavioral** problems.
   - **Support system**: Does the client have a family or social support network?

2. Perform Annual or Significant Change assessments. Obtain and document client consent to services in the CARE Service Episode Record (SER) using the Plan Approval purpose code. Provide the plan of care (assessment details and service summary) to the provider.

Coordinating with and Monitoring Providers

1. Review the NSA at every face-to-face assessment to ensure that the client's needs are met. Reassess and ensure the NSA gets updated and is consistent with the DSHS plan of care.

2. Communicate with the providers. The HCS Regional Administrator and the RCS Regional Administrator may arrange for regularly scheduled meetings between staff to facilitate communication about the coordination of their efforts with providers that are having problems meeting a client's needs.

   These meetings:
   - Provide an opportunity to discuss new homes, new contractors, problem situations and concerns that need to be monitored
   - Should include appropriate HCS, RCS, AAA staff (such as social workers, community nurses, etc.), adult family home licensors, contract monitoring staff, nursing services personnel, and local ombudsman
   - Should explore options which include, but are not limited to, nurse consulting or nursing services intervention, referral to other community resources or services, and use of the discharge resources. See the Nursing Facility Case Management Chapter of the LTC Manual for more details on discharge resources.

3. Review the records kept by the provider to monitor the services provided against the frequency and level of care described in the DSHS Plan of Care/NSA/NCP.

4. Review with each client the frequency and quality of the service the client receives from the provider. If the client is not receiving the services they need or finds the services unsatisfactory, discuss this with the client, their representative, and the provider to attempt to resolve this issue. As needed, consult with the Nursing Care Consultant (NCC), the AAA Nursing service, the

Long-term Care Ombudsman, and Residential Care Services staff. Refer to the Move and Relocation procedures if this intervention is not successful in resolving the issue(s).

5. If needed, document in the SER the services not provided and the reason. Document concerns regarding the quality of the service provided and how the issue was resolved by HCS staff, NCC, or Nursing Services.

6. If the facility fails to develop an NSA, report this to Residential Care Services and document in the SER.

7. Consult with Nursing Services about their visitation schedule.

8. Refer the client for a nursing assessment to determine the appropriateness of Nurse Delegation services if it is determined that the client needs professional assistance with any nursing tasks.

Contacting the Complaint Resolution Unit (CRU)

Make an online report:

- Immediately if there is any indication of abuse, neglect, exploitation, or abandonment of a residential client.
- To enter a complaint if the residential provider does not implement the plan of care or does not achieve the appropriate outcomes.
- To report any issue of concern regarding the quality of life and care for all residents. Provide sufficient information about the issue for RCS staff to initiate an investigation.

Note: APS investigates allegations of mistreatment of a vulnerable adult living in a residential setting, Nursing Facility, or Behavioral Health Center when the alleged perpetrator is not affiliated with the residential setting. The online reporting system may be used to report to APS or CRU. The system will direct the complaint to the appropriate department.

Complaint Resolution Unit (CRU) staff or RCS investigators may contact you for additional information. Document in the SER any activities or actions taken. This information will be available to RCS staff to complete their investigation or to take corrective action.

DOCUMENTATION AND SERVICE EPISODE RECORDS (SERS) IN CARE

The intent of the SER in CARE is to document all contacts and activities related to the client's assessment, service plan, coordination and monitoring of care, and termination of services. Information about the functionality of the SER and a full list of contact and purpose codes can be found in the CARE Web Assessor's Manual

Importance of Documentation

There are a number of reasons to maintain current and accurate documentation in the SER, including:

- Smoother transitions for the client and receiving case workers
- Allows current and future case workers responsible for the client's case to view historic and current interactions with the client and collateral contacts
- Provides a more holistic view of the individual
- Reduces the risk of gaps in service delivery
- Promotes more person-centered case management services for the individual
- Provides a record reflecting that appropriate person-centered case management practices, rules and policies were followed

Documentation Best Practice

- **Be objective and factual:** Avoid subjectivity, opinions and judgements. Document only the facts about what was seen, heard, and/or information that was provided.

- **Be clear and concise:** Do not use abbreviations and acronyms only recognizable to the case worker or other local staff. Only information relevant to the client and situation should be documented.

- **Use readable and professional writing style:** Check for grammar and spelling errors before submitting the SER. Avoid text speak, using all caps, and exclamation marks.

- **Record Action:** Each individual action or decision should be recorded separately.

- **Include individual names:** Use full names and title/role client contacts, vendors, and other client supports. However, APS investigator names should be excluded from SERs. See the APS Restrictions for additional guidance.

- **Enter SERs in a timely manner:** This will promote accuracy and more accurate recollection of conversations and events.

- **Make sure SER entries are for the correct client in CARE:** Once a SER is submitted, it cannot be deleted. If an error is made, append the SER in error and briefly explain the error without using any other client's name. Document SER in the correct client record.

Restrictions

- Do not document the names of other clients in a SER.
- Do not copy and paste emails in SER notes. Instead, summarize the relevant content of the e-mail.
- Adult Protective Services (APS)

- It is important to restrict the information about an APS report in the CARE SER due to confidentiality laws around APS information and risk of disclosure of the confidential APS record.

- In general, do not document information about the APS worker or APS intakes or outcomes in the CARE SER. If this information is needed, it can be found within the APS screen in CARE Web.

- Create a SER that includes any observations that you have based on your own interaction with the client or collateral contacts regarding a situation of concern and any APS report that you made as a mandatory reporter.

- If there was a conversation with an APS worker, you should only document general information. For example, the conversation happened or there was a general update given on the case. Do not include details about the case in the SER.

TRANSFERRING & RETURNING A CASE

Use these protocols when transferring an electronic case record and paper file from one office to another. At any point during a case transfer, the case worker may request a case transfer consultation or case staffing. The case staffing may be done via telephone or in-person.

Determining Who Completes the Annual Assessment

When a client has an upcoming Annual Assessment due within 2 months of the Plan Period End date, the transferring office will be responsible for completing the Annual Assessment prior to transferring to the receiving office.

Example
An assessment with a plan period end date of 10/31 would need to be transferred to the receiving office no later than 08/31. If the case is not transferred by 08/31, the transferring office will be responsible for completing the assessment.

Transfer Protocol

The Assessment and Care Plan section must meet minimum standards outlined in Chapter 3/Assessment & Care Planning.

The transferring case worker is responsible for the electronic case record completeness and accuracy. Prior to transferring a case:

1. When Fast Track Services are authorized, the transferring case worker will verify and document in a SER that at least pages 1 and 2 of the Medicaid application has been received by financial services.

2. Environmental modifications must be arranged and contracted prior to transfer. Completion of the modification and payment of the services may be completed after the transfer of the case. Attach the Barcode Social Service Record (SSR) cover sheet for quotes and receipts related to housing modifications before sending them to HIU.

3. Durable Medical Equipment (DME) must be arranged and ordered prior to transfer. Cases may not be transferred until a DME Exception to Rule (ETR) has been submitted and approved. Attach the Barcode Social Service Record (SSR) cover sheet for quotes and receipts related to housing modifications or DME before sending to HIU. Prior to transfer, if a client has DME needs the transferring case worker should:
    - Ensure DME is obtained by the client; and
    - Confirm that the DME meets the client's identified needs.

4. The transferring case worker must complete the HCS/AAA Case Transfer in Barcode/DMS prior to transferring the case in the Barcode system as required by policy. The Case Transfer is used to ensure all documents required for a particular program have been completed and included in the client's record. It also serves as a means to communicate any special concerns with a case to the receiving office. The financial worker will be able to see the HCS/AAA Case Transfer in the client's ECR and will know that the case was transferred.

5. In Barcode, the transferring office must send all required documents listed on the HCS/AAA Case Transfer to the Hub Imaging Unit (HIU) as "Hot Mail" including:
    - 14-012 DSHS Consent
    - 14-225 Acknowledgement of Services
    - 16-172 Client Rights and Responsibilities
    - Service Summary signed by the client (Including Electronic Signatures)
    - Service Summary signed by the provider(s)
    - RCL Consent Form

    If a client chooses or is required to update their consent form (DSHS 14-012) at any time, the most current signed version replaces all previous forms upon signature. For additional information regarding consent form requirements, please refer to Chapter 3 of the LTC Manual.

    Unless otherwise mutually agreed upon between the transferring office and receiving office, all required documents listed on the HCS/AAA Case Transfer must be visible in the client's Electronic Case Record (ECR) upon transfer.

    Prior to transferring the case, the transferring case worker must have called the client and/or the authorized service providers to verify that all services have been authorized. Use the phone call to notify the client of the imminent transfer and give the client contact information should they have questions/concerns prior to the receiving worker contacting them.

NOTE: The following forms must be re-signed and submitted to DMS when there is a break in service:

- 14-012 DSHS Consent
- 14-225 Acknowledgement of Services
- 16-172 Client Rights and Responsibilities

A break in service occurs when the client going 30 calendar days or longer without receiving services. This includes clients that are in a hospital or skilled nursing facility greater than 30 days.

6. The transferring case worker will verify record completeness using the HCS/AAA Case Transfer before submitting to the supervisor for transfer. Once the "Submit To" supervisor field is enabled, the date sent to the supervisor is populated. The supervisor will receive notification that they have a transfer on their To-Do List. The supervisor will approve for transfer. If the supervisor determines additional items are needed prior to transferring the case, the supervisor will communicate this to the transferring staff from the Case Transfer with a note. The worker will resolve and resubmit to the supervisor for transfer. See Chapter 23a/Social Services Monitoring for supervisory file review requirements.

7. The receiving agency will assign the case to an individual case worker within five (5) business days.

Barcode

DMS is a system that bases all assignments on the current case worker of record. Once a case has been transferred in CARE, and until the receiving office has identified a new primary case worker on the Client Overview screen, DMS creates duplicate document assignments to the default worker at the receiving office and the former case worker to ensure someone takes an action on a document. To alleviate this, the receiving office should assign a case worker as quickly as possible when cases are transferred between offices. However, case transfer policy states that the receiving agency will assign the case to an individual case worker within 5 business days.

Once the HCS/AAA Case Transfer is submitted, the receiving office will verify all required program documents are in the electronic case file and will have 5 days to assign the client to a case worker in CARE. During this time, assignments in Barcode are made to the default worker in both the sending and receiving office according to the matrix until the case is assigned in CARE.

Returning a Case

If the transferred case does not meet the minimum standards identified in Chapter 3, Assessment and Care Planning, or has payment/authorization errors:

1. The receiving agency will notify the transferring agency within 5 business days of receipt of the file.

2. The transferring agency is expected to make necessary corrections to the file documents. During this time, new assignments in Barcode will be made to the office of the case worker assigned in CARE. Necessary changes will be made by the transferring agency within 10 business days from the date notification was received. Unless the transferring agency is notified within the timeframe, the transfer will be deemed complete.

3. Track returned cases, using the form in the following section.

4. The transferring and receiving supervisors or designees are responsible for resolving issues related to case transfers. If any disagreement occurs, it will be addressed through the chain of command established by both the transferring and receiving agencies. Unresolved differences between the HCS regions and AAAs should be referred to the State Unit on Aging Office Chief and Home and Community Services Deputy Director of Field Operations, or their designees, for resolution.

> **Note:** Additional information regarding the case transfer of in-home, Nurse Delegation clients can be found in Chapter 13 of this manual.

Tracking Returned Cases

Use the format listed below to identify trends and patterns in files that are identified as needing correction. It is the responsibility of the receiving agency to document the reasons transferred files do not meet the transfer protocols. Use the forms in discussions between AAA and HCS at local coordination meetings. The identified trends and patterns will be used to determine training needs and to address personnel related issues.

DATE	CLIENT NAME/	AGENCY CASE TRANSFERRED FROM	WORKER CASE TRANSFERRED FROM	REASON RETURNED CODE	COMMENTS

Reason Return Codes
A. Assessment/care plan does not meet minimum standards
B. Provider not qualified
C. Authorization not accurate

Guidelines for Institutional (Hospital, Nursing Facility, or ICF-ID) Settings

The intent of this case transfer policy is to encourage coordinated discharge/treatment planning in the best interest of the client. The AAA case worker, DDA Case Resource Manager, or HCS residential case worker should collaborate with the HCS NFCM to determine if, and when, a case transfer is appropriate for a client who intends to return to a community setting.

In that regard AAA, DDA, and/or HCS staff may:

- Assess a client in the Skilled Nursing Facility (SNF) or hospital;
- Determine NFLOC in the NFCM screen of CARE (DDCS does not have access to this screen. Refer to Chapter 10 for more information on how to complete a NFLOC for DDA clients);
- Attend care conferences at the hospital, SNF, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID);
- Access discharge resources for clients, including MIIE for HCS clients;
- Review charts and/or files for discharge planning purposes.

Timelines

- The client file may remain with AAA/DDCS for thirty (30) calendar days from initial admit to SNF, regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client may be kept longer if a return to the in-home setting is imminent.
- If a hospital stay goes beyond 30 calendar days, the AAA case worker will coordinate with the HCS Social Service Specialist regarding possibility of transfer to HCS (Refer to LTC Manual Chapter 9/Hospital Assessment for additional information).
- AAA/DDA case worker may transfer the client to HCS immediately if the client does not intend to return to the in-home setting.

CHALLENGING CASES PROTOCOL

Introduction

Federal Home and community-based waiver services rules (42 CFR 440.180) and 1915 c waiver rules (42 CFR 441.302(a)) require that the state must assure that, "…necessary safeguards have been taken to protect the health and welfare of the recipients of the services.". If the plan of care cannot assure the health, welfare, and safety of the client due to client environment or resource issues, invoke the "Challenging Cases Protocol".

The purpose of the "Challenging Cases Protocol" is to create statewide consistency addressing challenging situations in which the plan of care for a client or applicant cannot be implemented service termination is not a substitute for standard case management practice. The protocol recognizes the client's preferences of care, services, and life choices. Every effort must be made toward the resolution of issues especially when denial or termination of services is being considered.

HCS and AAA staff will initiate the "Challenging Cases Protocol" when the recommended plan of care, necessary to support the client's health, welfare, or safety, cannot be carried out due to factors including, but not limited to:

1. Client challenges such as:
   - Decision making capability (per RCW 11.130)
   - Refusal of services vital to health, welfare and safety
   - Illegal/criminal activity
   - Behaviors, including self-harm or harm to others (refer to the Challenging Cases Protocol "Imminent Danger" section for further guidance)

2. Physical and social condition of the client's environment:
   - Hazardous conditions for the individual or Agency Provider's Health and Safety (refer to the Challenging Cases Protocol "Hazardous Conditions" section for further guidance):, such as:
     - threatening, uncontrolled, or dangerous animals;
     - illegal drug use or drug manufacturing;
     - poor sanitation or housing structure
     - Presence of hazardous materials in the home, such as exposed sewage
   - A pattern of choosing caregivers that cannot meet their needs.

3. The client or other person(s) in the home are engaged in:

   - illegal activity or other dangerous behaviors toward caregivers, staff, or other residents.
   - discrimination, harassment, or abuse of a caregiver or case worker
   - interference with service delivery or hindering caregiver access to the client
   - interference of assessment and care planning by the case worker

Client safety is a shared responsibility involving the client, their family, friends, neighbors, social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team as the vehicle for community entities to review and make recommendations for a challenging case. Examples of an interdisciplinary/interagency team can include:

- Regional Resource Team
- A-Team
- ad hoc team
- Complex Case Staffing (See Chapter 9: Inpatient Hospital Assessments and Transitions for more information on Complex Case Staffing)

It is important to complete all standard case management activities prior to invoking the steps of the protocol, including targeted case management and an APS referral if you have reason to believe that the client is or has been abused, neglected, abandoned, or financially exploited. If there is an active APS investigation, continue services and case management responsibilities pending the outcome of the APS investigation.

Imminent Danger

Services may be terminated if the "likelihood of serious harm" or "imminent" danger is present to the client or provider.

"Likelihood of serious harm" and "imminent" are defined in RCW 71.05.020:

"Likelihood of serious harm" means (RCW 71.05.020(37):

- A substantial risk that:
    - Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; or
    - Physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
    - Physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
    - The person has threatened the physical safety of another and has a history of one or more violent acts.

Imminent" means "the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote" (RCW 71.05.020 (29)). This includes any situation where a case worker feels that they are in immediate danger due to their surroundings or actions of individuals in their presence. Examples of these scenarios may include a client or individual in the client's home brandishing a weapon and making threats that the individual is clearly capable of carrying out or evidence of a methamphetamine laboratory in the home.

If you receive information that the client or the provider is in imminent danger, or the likelihood of serious harm is present:

1. Determine whether you need to call the police immediately and/or medical assistance.

2. Determine if you have reason to believe that abuse, neglect, abandonment, or financial exploitation of a vulnerable adult is present and an APS referral is warranted.

3. Make a referral to the Local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled or a danger to self or others.

4. If the individual is applying for services or is a services recipient, and:
   - you have determined that the client is capable of understanding the issues impacting their or the provider's health, welfare, and safety; and
   - you have listed the possible consequences of those issues; and
   - you have consulted with your supervisor regarding services termination and your supervisor agrees that you pursue termination of services; then
   - follow the Services Denial procedure.

Hazardous Conditions

Services may be terminated when the client refuses to resolve the hazardous conditions, such as drugs, that may **pose a danger to others.**

1. Determine whether the client is capable of understanding the hazards and consequences and whether a referral for a capacity evaluation is appropriate.
2. Give the client ample opportunity to remove the drugs and/or users in the presence of providers and the social services worker. If the hazard is a methamphetamine lab, neither providers nor the social services worker should go into the residence. Immediately call 911.
3. Discuss with the client the potential of the termination of services due to the presence of hazards.
4. If the client refuses to remove the specific hazard, discuss the case with your supervisor for referral to the interdisciplinary/interagency team.
5. Follow Challenging Cases Protocol.

If the home contains sewage, vermin, lice, or other contaminants to such a degree that **may be harmful** to anyone, determine whether the client understands the danger of such hazards.

1. Make a referral to the local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled, or a danger to self or others.
2. Follow the Targeted Case Management policy.
3. Consider making a referral to Adult Protective Services (APS) if you have reason to believe that the client is experiencing self-neglect and APS services may help them.
4. If the client's situation jeopardizes their health, welfare, or safety, follow the Challenging Cases Protocol.

Refusal to Comply with Mandatory Program Requirements and Service Delivery

Services can be terminated when clients refuse to comply with mandatory program requirements and service delivery provisions. If the client demonstrates a *substantial pattern* of behavior that prevents the determination of eligibility, carrying out the plan of care, or monitoring the services to assure the health, welfare, and safety of the client.

Examples of refusal to comply with the service delivery provisions include, but are not limited to:

- The client is frequently away from their home when the provider arrives (without prior arrangements), so that services cannot be performed.
- The client has prevented or refused multiple providers' attempts to perform vital, authorized services.
- The client, or others in the home, has demonstrated verbal abuse, discrimination, or sexual harassment toward providers on numerous occasions.

If such a pattern of behavior has resulted in resignation of multiple providers:

- Visit the client to discuss the behaviors and inability to deliver services due to the behaviors.
- Refer the client (or others in the home) to other services, such as behavioral health or substance or alcohol abuse treatment services.
- Monitor the client to determine if the client (or others in the home) has stopped the offensive behaviors. A monitoring schedule may be recommended by the interdisciplinary/interagency team; confirm the monitoring schedule with your supervisor.
- Determine whether another provider of another gender is appropriate (e.g., a male client insists on female providers and has demonstrated a substantial pattern of sexual harassment).

If the behavior is directly related to the client's disability, seek appropriate service referrals. Services cannot be terminated or denied under such reasons.

Challenging Cases Protocol Review

If the case worker has determined that the client meets one or more of the Challenging Cases Protocol criteria and has exhausted all standard case management requirements, the case worker will proceed with reviewing and implementing the Challenging Cases Protocol as identified below.

Document all actions, consultations, and statements by the client and/or others in the SER.

- The case worker and supervisor will staff to determine if implementing the Challenging Cases Protocol is appropriate. The supervisor may:
  - Perform a file review.
  - Make further suggestions for approaches or services not yet tried, such as nursing services, intensive or targeted case management, etc.
  - Recommend further monitoring and visits.
  - Recommend contacting other collaterals and/or other entities with shared responsibilities.
- If you and your supervisor feel all options have been exhausted, the supervisor will:

- Instruct you to proceed with the protocol and refer the case to the inter-disciplinary/agency team as needed. (See Interdisciplinary/Interagency Team policy below)

  In rare instances, refer the case directly to the RA/AAA director (or their designee) for a decision to terminate the case (bypassing referral to the interdisciplinary/ interagency team). The supervisor must document the reasons why the case was not referred to the interdisciplinary/interagency team.

- The supervisor reviews the team's recommendations with you and may recommend:
  - Visit the client to discuss the issues and possible consequences
  - The 'team' or relevant members of the team may choose to visit the client to resolve health, welfare, and safety issues
  - If capacity is a concern for decision making, refer to capacity related information in chapter 3.
  - Determine if other services are appropriate, such as a referral to counseling.
  - Determine if other supports are available, such as any informal supports.

Interdisciplinary/Interagency Team

1. When the case worker is instructed to convene a team, current regional teams may be used for the purpose of reviewing a challenging case. This may include Regional Resource Teams or A-Teams. The supervisor must review existing team membership to determine if all disciplines/agencies relevant to the case are represented. If appropriate disciplines/agencies are not represented, the supervisor will identify appropriate members.

2. If the need to convene a team is immediate and other existing teams meeting dates are not convenient or such a team does not exist in the local community, the supervisor may arrange for an *ad hoc* team. The RA, AAA Case Management Director, or their designee may also arrange for an interdisciplinary/ interagency team to be convened.

The case worker will attempt to obtain a signed release of information from the client. If the client refuses, send notice of the challenging case review at the interdisciplinary/interagency team only to those entities with case management responsibility, giving the client's name and other identifying information. If there are team members present not affiliated with the case, the social services worker will discuss the case using the client's initials and not use the client's name.

The interdisciplinary/interagency team is responsible for:

- considering all available assessment information in its deliberations
- identifying the services needed to meet the client's needs
- identifying strategies for resolving obstacles that are preventing the implementation of the plan of care
- estimating the costs for the types and amounts of services identified as necessary to meet the client's needs
- determining whether the individual can be served safely in the community
- developing the plan of care recommendations, including case closure.

Procedure

1. The case worker, along with a supervisor, RA/CMD, and/or designee, will present and facilitate the case at the team meeting. When APS is a part of the interdisciplinary/interagency team, all team members will be required to review and sign the oath of confidentiality on the sign in form notifying attendees that they are required to "keep all shared information confidential (RCW 74.04.060). Participants may take notes but may not place these notes in client files or other official documents or reports." If team members not affiliated with the case are present, only client initials should be used.

2. The team may:
   - decide for the social services worker and/or relevant team members to visit the client to:
     - clarify safety/welfare issues
     - review rights and responsibilities with the client
     - discuss with the client consequences of not accepting services vital to health, welfare and safety
     - involve family and informal supports
   - decide if multiple, frequent visits are necessary
   - develop a monitoring schedule involving the social services worker and/or relevant team members
   - coordinate with other community resources
   - decide to recommend that services be terminated, identifying what other services must remain open or be put into place.

The **social services worker** will document the team's recommendations on the team's documentation form.The **supervisor** will discuss with the case worker whether all, some, or none of the team's recommendations are to be implemented.

Outcome Documentation

The case worker presenting the case is responsible for documenting team recommendations and actions chosen The case worker should include the following information when entering outcome documentation in the SER:

- Team recommendations, including:
  - Team member names, organizations, and contact information
  - Person presenting the case
  - Reason for the referral (what is jeopardizing the client's health, welfare, and safety)
  - Services in place
  - Interventions tried and failed
  - Client needs that are not being met, including:
    - Recommendations for meeting the identified needs
    - Reasons why the needs cannot be met

- If consensus on recommendations cannot be reached, the reasons given and by whom.

- If applicable, any forms used to document a referral to a team or the team's outcome. Forms may include:
  - Team specific form such as:
    - Regional Resource Team Referral Form
    - A-Team Referral Form
  - Interdisciplinary/Interagency Team Documentation Form.

If forms are used, send each team member a copy of the completed form.

Services Denial

If non-compliance or the problems continue, the case worker may, with supervisor approval:

- Contact the client to discuss obstacles to continuing services:
  - Identify a plan to remedy obstacles;
- Inform the client of possible options or denial of services if obstacles are not corrected
  - Identify options for the client;
  - If no options exist or client/representative refuses options offered, then, with your supervisor, refer to RA/AAA Director (or their designee) for a decision to deny services;
- Refer the case directly to the Regional Administrator/AAA Director (or their designee) for a decision to deny services;

The RA (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Office Chief of the decision.

Services Termination

If after completing the Challenging Cases Protocol review, it is determined that services should be terminated, the case worker will:

- The RA (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Office Chief of the decision, prior to the case worker in completing a termination Planned Action Notice.
- Follow client notification of adverse action as Chapter 27/Notices regarding use of the Planned Action Notice (DSHS 14-405).
  - The Action should be Terminated. Do not use Denied.
  - Ten to the end policy does not apply, but no less than ten (10) days notice must be given.
  - Amend the Planned Action Notice to ensure the Effective Date is ten (10) days from the date of the notice.
  - All authorizations and RACs should be ended one day prior to the Effective Date on the Planned Action Notice.

- If the Planned Action Notice is returned as undeliverable, send the PAN/envelope stating "Undeliverable" to HIU for scanning into the electronic client record (ECR).
    - Below is an example reasoning, by choosing "Other" in CARE:

      The Department is terminating your long-term care services after exhausting standard case management activities and the approaches delineated in the Department's Challenging Cases Protocol.

      Following the protocol, any one factor or several factors that jeopardize the health, welfare, and safety of you and/or others can result in termination. Your services are being terminated because…..

      *(**Examples:** You have refused to resolve hazardous conditions that pose a danger to yourself and/or others**;** There is "likelihood of serious harm" or "imminent" danger present to you and/or others**;** You have demonstrated a substantial pattern of behavior that prevents the determination of your eligibility, carrying out your plan of care, or monitoring your services to assure your health, welfare, and safety.)*

      Every effort has been made toward the resolution of these issues, and it has been determined that in accordance with WAC, RCW, and the Department's Challenging Cases Protocol your services will be terminated as of the effective date on this notice.
- The client must be given the opportunity to comply after the written notification is mailed.

If an individual with a history of services termination/denial due to 'challenging cases' issues, reapplies for services:

- Assess whether the issues that caused the termination/denial of services still exist.
- Discuss the case with your supervisor, including the previous reasons for termination/denial.
- Review the following with the client:
    - Reason for the previous termination;
    - Responsibility of the client to notify the provider and/or provider agency (if used) and the social services worker about problems related to the plan of care implementation.
- With supervisor approval, authorize services if the client agrees to follow the plan of care.
- If the client does not agree to resolve issues that caused past services termination, follow the Services Denial procedure.

RESOURCES

Related WACs and RCWs

RCW 74.34	Abuse of Vulnerable Adults
RCW 74.38.010	Legislative recognition—Public policy
RCW 74.38.040	Scope and extent of community-based services program
RCW 74.39.005(7)	Long-term Care Service Options – Purpose (Case Management)

RCW 74.39A.040 (3)(c)	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.39A.090	Discharge planning—Contracts for case management services and reassessment and reauthorization—Assessment of case management roles and quality of in-home care services—Plan of care model language
RCW 74.39A.095	Case management services—Duties of the area agencies on aging—Consumers' plans of care—Notification to consumer directed employer
RCW 70.41.310	Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients
RCW 74.42.057	Notification regarding resident likely to become Medicaid eligible
RCW 74.42.058	Department case management services

Acronyms

AAA Area Agency on Aging	HCLA Home and Community Living Administration
AAG Assistant Attorney General	HCS Home and Community Services
AFH Adult Family Home	ICF-ID Intermediate Care Facilities for Individuals with Intellectual Disabilities
APS Adult Protective Services	LTC Long Term Care
ARC Adult Residential Care	MCO Managed Care Organization
AREP Authorized Representative	NCP Negotiated Care Plan
BH Behavioral Health	NF Nursing Facility
BHWS Behavioral Health Wraparound Services	NSA Negotiated Service Agreement
BPS Behavior Points Score	PAN Planned Action Notice
CA Case Aide	PASRR Pre-Admission Screening and Residential Review
CBHS Community Behavioral Health Supports	PBS Public Benefit Specialist
CDE Consumer Directed Employer	PCM Primary Case Manager
CDWA Consumer Direct Care Network Washington	PCR Personal Care Results
CM Case Manager	PCRC Personal Care Results Comparison
CNC Community Nurse Consultant	PNA Personal Needs Allowance
CPS Child Protective Services	RA Regional Administrator
CRU Complaint Resolution Unit	RCS Residential Care Services
DMHP Designated Mental Health Professional	RN Registered Nurse
DMS Document Management System	SER Service Episode Record
DOC Department of Corrections	SNF Skilled Nursing Facility
DSHS Department of Social and Health Services	SSS Social Service Specialist
EARC Enhanced Residential Care	TCM Targeted Case Management
ESH Eastern State Hospital	WSH Western State Hospital

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2020	Beth Adams	Moved to new template and edits to improve grammar and aesthetics,	
2/2021	Rachelle Ames	Repaired broken links, added form links and replaced the term "placement" with more person-centered language	
2/2021	Rachelle Ames	Updated "Social Worker" terminology to "Social Service Specialist"	
2/2021	Victoria Nuesca	Updated language related to MCO and Behavioral Health Personal Care	
2/2021	Rachelle Ames	Replaced "placement" language with person-centered language	
2/2021	Rachelle Ames	Added guidance about SER documentation	
5/2022	Kellie Nelson	Updated required documents/process for conversion to CDE	
2/2023	Sun-Young Pak	• Replaced the "APS Chapter" with "Adult Protective Services policy and procedure" • Updated language related to "Mandatory Reporting" • Replaced "local Designated Mental Health Professional (DMHP)" with "local County Designated Crisis Responders" • Updated the outdated CARE screens names	
8/2023	Natalie Lehl	• Fixed broken links	
6/2024	Natalie Lehl	• Updated the "Transfer Protocol" section. • Updated case management "Guidelines to Support Move from In-Home to Residential Setting". • Clarified Termination Planning section: for a client receiving an ALTSA housing resource, the assigned HPM must be contacted prior to inactivating a case.	
10/2024	Natalie Lehl	• Example added to Transferring & Returning a Case Guidelines • Clarification on consent forms • Fixed broken link to Chapter 13	
03/2025	Natalie Lehl	• Added SER Policy Language	
07/2025	Natalie Lehl	• Updated formatting, grammar, and placement of information throughout chapter • Replaced ALTSA with HCLA • Replaced DDA with DDCS • Added clarifying language to Targeted Case Management • Included Agency and AFH contact guidelines for staff response time	
10/2025	Natalie Lehl	• Updated mandatory reporting requirements	

		• Added additional DME policy that must be completed prior to case transfers • Updated Chapters 9a and 9b to reflect merge • Added Complex Case Staffing to sample team list for Challenging Cases Protocol	
04/2026	Natalie Lehl	• Updated language and links related to housing and chapter 6. • Challenging Cases Protocol: Updated RCW links and definitions. Conflicting information clarified and duplicative language removed. • Added additional policy around APS documentation in SERs. • Updated Chapter links and title for Chapter 9. • Replaced outdated BHPC form with current CBHS form	
07/2026	Natalie Lehl	• Updated Challenging Cases Protocol • Replaced case manager and social service specialist with case worker • Formatting changes • Added BHWS/MCO policy	

APPENDIX

For Word version or other languages, visit Electronic DSHS Forms.

DSHS 05-246 **Notice of Action Exception to the Rule** (Excluding AFH)

DSHS 10-234 **Individuals with Challenging Support Issues**

- For any clients entering a residential facility who have challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).

Community Behavioral Health Supports (CBHS) referral form

DSHS 14-012 **Consent for Services**

DSHS 14-225 **Acknowledgment of Services**

DSHS 14-300 **PASRR Level One**

DSHS 14-405 Planned Action Notice (in CARE)

DSHS 14-443 **Financial/Social Service Communication**
For communication with the financial worker regarding the status of the client