Case Management Standards & Certification Procedures

Older Americans Act & Choices for Care Programs

Revised January 1, 2017

State of Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
Adult Services Division
280 State Drive, HC2 South
Waterbury, VT 05671-2070

http://www.dail.vermont.gov
Telephone: (802) 241-0294
Fax: (802) 241-0385

Available in alternative format by request.

Table of Contents

I. INTRODUCTION

The Adult Services Division (ASD) within the Department of Disabilities, Aging and Independent Living (DAIL) recognizes that quality case management is a critical part of our long-term services and supports system and is crucial to the fulfillment of DAIL's mission. The mission of DAIL is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

In order to ensure the statewide quality of case management services offered under Older Americans Act (OAA) programs and Choices for Care (CFC), ASD has instituted Case Management Standards and Certification Procedures. The purpose of this document is to establish minimum case management performance standards and to provide guidance for case management agencies and individual case managers. These standards and certification procedures apply to case management services offered under OAA programs and CFC. The Choices for Care Program Manual and Regulations provide more detailed policies and procedures specific to CFC.

DAIL authority to establish service standards and to certify providers of case management services under OAA programs and CFC is established in Vermont state statute, the Center for Medicare and Medicaid Services (CMS) approved Global Commitment to Health 1115 Waiver, and the Older Americans Act.

II. DEFINITIONS

A. **Case Management:** Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

B. **Conflict of Interest:** Conflict of interest is a situation in which someone in a position of trust has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially or effectively. A conflict of interest exists even if no unethical or improper act results from it. A conflict of interest can create an appearance of impropriety that can undermine confidence in the person, profession or system. Each provider of case management services must maintain a conflict of interest policy that is in line with the standards set by the Centers for Medicare and Medicaid (CMS). See Appendix A for a link to the CMS regulations.

C. **Home and Community-Based Services (HCBS):** HCBS services are person-centered services provided to an individual in their own home or in the home of another person. HCBS services assist individuals to maintain as much independence, community participation, freedom of choice and control over their lives as possible, while preventing the need to live in a licensed facility. The Centers for Medicare and Medicaid Services (CMS) regulates Medicaid funded HCBS services with regards to person-centered planning and settings characteristics.

D. **Modifications:** "Modifications" are any individual-specific exception to the person-centered planning process as required by the federal home and community-based services (HCBS) regulations. Modifications must be documented and include specific elements identified in Section IV. M.

E. **Person Centered Planning:** Person-centered planning is a process for supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that honor the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. The Centers for Medicare and Medicaid Services (CMS) regulates person-centered planning for HCBS services covered under Vermont's Choices for Care program and other similar HCBS long-term services and supports programs. See Appendix A for a link to the CMS regulations.

F. **Quality Management:** Quality Management is a set of integrated tools and practices used by an organization to maximize its effectiveness, efficiency and performance. Quality management efforts strive to answer three questions: 1) how much are we doing, 2) how well are we doing it, and 3) is anyone better off. Vermont Act 124 and

the Vermont Government Accountability Office provides specific guidance regarding outcomes and performance measures according to the Results Based Accountability framework.

G. **Self-Neglect:** Self-neglect is an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision (National Adult Protective Services Association).

III. AGENCY CASE MANAGEMENT STANDARDS

All agency policies governing case management activities under OAA and CFC programs listed in the section must be reviewed and approved by ASD. Changes made to the approved policies must be reviewed and approved by ASD prior to implementation.

Case management agencies are expected to be knowledgeable of and in compliance with all relevant state and federal laws and requirements. Case management agencies shall also ensure the requisite case management agency policies are in place, the case management agency is responsible to ensure that all case managers providing services under OAA and CFC programs comply with the ASD Case Management Standards & Certification Procedures and related case management agency policies.

Case management agencies shall have the following written policies and protocols:

A. **After Hour Coverage**: The protocol shall at a minimum ensure that people are able to leave a message with the agency when it is closed.

B. **Consumer Complaint and Grievance Policy**: The policies and procedures shall outline how the case management agency will respond to consumer complaints and grievances. The policies shall address how consumers are informed about agency policies, including the complaint and grievance policy, and will explain how the process works.

C. **Information and Referral Policy**: The policy shall state that the case management agency will accept and respond to requests for information and/or assistance from individuals, caregivers and other third parties.

D. **Mandated Reporting of Abuse, Neglect, and Exploitation Policy**: The policy shall address how the case management agency will respond in cases of suspected abuse, neglect, and/or exploitation of vulnerable adults. The policy must be consistent with the requirements of Vermont statute 33 V.S.A. § 6903 and DAIL policies. ASD shall coordinate review and approval of this policy with Vermont Adult Protective Services, at the Department's Division of Licensing & Protection.

E. **Self-Neglect Policy**: The policy shall define how the agency will serve adults identified as self-neglect. This may include a referral to the AAA (for adults age 60 and older) or the local Designated Agency (DA) for adult mental health services (for adults under the age of 60). In the case of CFC referrals, the case management agency selected by the person shall be responsible for serving the person identified as self-neglecting.

F. **Maximum Caseload Policy**: The policy shall state the maximum caseload size for case managers, the prioritization process for people accessing case management services, and the management of waiting lists for people who cannot be served at any given time.

G. **Case Management Supervision Policy**: The policy shall address how supervision is provided including accessibility of supervisors, review of client records, on-going feedback between the supervisor and case manager and timely performance evaluations of case managers.

H. **Orientation Training Policy**: The policy shall outline the orientation training for new case management staff.

I. **Training Policy**: The policy shall outline ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

J. **Quality Management Policy**: The policy shall outline the case management agency's ongoing Quality Management plan regarding case management services. (Refer to Section II. Definitions for a definition of Quality Management).

K. **Conflict of Interest Policy**: At a minimum, the policy shall: (Refer to Section II. Definitions for a definition of Conflict of Interest).
   1. Define conflict of interest,
   2. Describe the agency's process for preventing conflict of interest,
   3. Describe how case managers report potential conflicts of interest immediately with their supervisor,
   4. Describe the agency's process for correcting conflict of interest when it occurs.
   5. Describe that the case manager developing the person-centered plan shall not be any of the following:
      a. Related by blood or marriage to the individual or to the paid caregivers of the individual
      b. Financially responsible for the individual
      c. Empowered to make financial or health-related decision on behalf of the individual
      d. Holding financial interest in an entity that is paid to provide care for the individual
      e. Other limitations as set by CMS and in line with federal rules.

L. **Client Record Policy**: The policy shall include:
   1. The procedure governing their use, storage and removal.
   2. The conditions for release of information contained in the record.
   3. The requirements of authorization in writing by the person or legal representative for release of information.
   4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of 3 years and the maintenance of all financial records for a period of 7 years.
   5. Compliance with the Health Insurance Portability and Accountability Act.

M. **Background Check Policy**: The policy shall outline the background checks required in order for a person to be employed as a case manager. The policy must be

consistent with the DAIL Background Check Policy.

N. **Emergency Management Plan**: The agency shall have a plan describing how it will identify the critical functions and services it performs that must continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the agency will collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the agency will:

1. Identify persons who might require specific assistance during an emergency; and

2. Provide information and encourage people to develop a personal emergency preparedness plan. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service

   and/or personal harm. Involvement and consideration of family caregivers, as well as other natural supports must be part of the process.

O. **Agency Confidentiality Policy**: The agency shall have a policy that is no less stringent than the Agency of Human Service Consumer Information and Privacy Rule.

P. **Smoking Policy**: Agency shall have a smoking policy that at a minimum prevents staff from smoking in the presence of people receiving services.

Q. **Limited English Proficiency Policy**: Agency shall have a policy that describes how people with limited English proficiency will be assured meaningful access to services provided by the agency. The policy must comply with federal regulations.

IV. INDIVIDUAL CASE MANAGER STANDARDS

A. The case manager must be knowledgeable of and comply with all agency policies and standards.

B. A case manager shall be knowledgeable about the full range of services available to individuals in their region and shall ensure that individuals are informed of available resources and services. The case manager will make any needed referrals.

C. A case manager shall provide service in an efficient, effective and collaborative manner to avoid duplication of services, unnecessary costs, and administrative tasks.

D. A case manager shall respond to requests for information and/or assistance from individuals in a timely manner.

E. A case manager shall inform all individuals of the agency's grievance procedures.

F. To the extent possible, a case manager shall ensure the person receives person-centered services in the least restrictive and most appropriate setting in accordance with his or her needs and preferences, as required by the U.S. Supreme Court Olmstead decision. (See Appendix A.)

G. A case manager shall recognize self-neglect behaviors and offer intervention, when such behaviors jeopardize the person's wellbeing. For people not enrolled in Choices for Care, a referral shall be made to the AAA (for adults age 60 and older) or the regional Designated Agency for adult mental health (for adults under age 60).

H. A case manager shall respect the person's rights, strengths, values and preferences, encouraging the individual to create, direct and participate in their individualized written person-centered plan to the fullest extent possible.

   1. The person may involve a caregiver or a legal representative in decision making. A legal representative may be a legal guardian appointed by probate or family court with specific duties outlined in the court order, an attorney or power of attorney.

   2. People have the right to make their own decisions and decide who they want to be involved in decision making. In the event that a person has a guardian or agent, the case manager will involve him/her in accordance with that individual's legal responsibility. When a person does not appear to have the capacity to make decisions and there is no legal guardian or agent the case manager shall refer to the agency policy on self-neglect.

   3. The case manager will provide a person-centered process that is timely and occurs at times/locations of convenience to the individual.

4. Person-centered planning must reflect a process that the setting in which the individual resides is chosen by the individual.

5. A case manager shall ensure that a person has the right to receive services under conditions of acceptable risk. "Acceptable risk" is the level of risk an individual and/or his/her guardian, if there is one, is willing to accept after the informed consent process. A case manager may work with the individual and the service provider to develop a Negotiated Risk Agreement when necessary.

I. Assessment: A case manager, with input and participation by the person and his/her support network, shall assess the individual's strengths and needs using the assessment tool(s) approved by ASD.

1. A case manager shall update the assessment at least annually, or at any time there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed.

2. A case manager shall make every effort to assure the completeness and accuracy of the initial assessment and any subsequent reassessments.

3. Assessments need to be completed in compliance with Choices for Care and other program protocol.

J. Goals: When a person requires case management assistance for complex issues the case manager along with the individual and his or her support network shall identify person-centered goals.

K. Planning: Using the information from assessments and in consideration of the individual's person-centered goals, the case manager shall discuss all available options with the individual and his or her support network; and, agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific service or support to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the person. The initial goal and strategy identification shall be completed within 60 days of completion of the assessment.

L. Monitoring and reviewing: A case manager shall monitor the delivery of formal and informal services and supports to ensure that services are being provided as planned, to ensure that the person's identified needs are being met, and goals are being pursued. Monitoring shall include regular contact with the individual, caregivers, and service providers. The individuals' goals and strategies shall be updated to reflect the annual reassessment or more frequently if there is a significant change in the person's life that would alter the amount and type of formal and informal services and supports needed. For more specific guidelines, refer to program and agency requirements.

M. Documentation: A case manager shall maintain current, complete and accurate paper or electronic files for each person including but not limited to:

1. A written release of information or documentation of why a written release of information could not be obtained.

2. The appropriate assessment form designated by DAIL.

3. Person-centered plan which is driven by the individual. The plan must:
   a. Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports the individual's strengths and preferences.
   b. Reflect the setting in which the individual resides is chosen by the individual.
   c. Reflect clinical and support needs as identified through an assessment of functional needs.
   d. Reflect individually identified goals and desired outcomes.
   e. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of paid services.
   f. Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
   g. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
   h. Identify the individual and/or entity responsible for monitoring the plan.
   i. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
   j. Be distributed to the individual and other people involved in the plan.
   k. Include those services, the purchase or control of which the individual elects to self-direct.
   l. Prevent the provision of unnecessary or inappropriate services and supports.

4. Modifications, or exceptions, to the CMS required HCBS person-centered planning process must be documented and include the following: (see definition of Modifications)
   a. Identify a specific and individualized assessed need for modification

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan
c. Document less intrusive methods of meeting the need that have been tried but did not work
d. Include a clear description of the condition that is directly proportionate to the specific assessed need
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
g. Include informed consent of the individual or their legal representative
h. Include an assurance that interventions and supports will cause no harm to the individual.

5. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.

6. Other correspondence received or sent which is relevant to individual.

7. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.

8. Guardianship/ Power of Attorney and other advanced directives must be documented in the assessment.

9. If the case manager is taking direction from a legal representative, there must be a copy of the legal documentation maintained in the individual's case management record. (e.g. Guardianship or Power of Attorney documents.)

10. Documentation of Negotiated Risk Agreement (if applicable).

11. Documentation of required reporting of suspected abuse, neglect and exploitation.

V. CERTIFICATION PROCESS

A. A case management agency is deemed certified for one to three years by the ASD when the following components have been met:

1. An Area Agency on Aging have a current approved area plan on file with the ASD or a Home Health Agency has received designation to provide Medicare home health services in the State of Vermont by Division of Licensing and Protection (DLP) through the designation or survey process.

2. ASD has completed a certification review.

3. The agency has demonstrated compliance with all requirements found in the Case Management Standards or has shown progress that is acceptable to ASD towards resolving unmet case management standards at time of initial certification or re-certification.

B. The ASD certification process includes:

1. Verification that an Area Agency on Aging has a current approved area plan on file with ASD or verification that a Home Health Agencies has received designation to provide Medicare home health services in the State of Vermont, by Division of Licensing and Protection (DLP) through the designation or survey process.

2. Approval of the policies required in the Case Management Standards.

   a. Policies shall be submitted to ASD in a manner which allows ASD to maintain an electronic file for each agency.

   b. Policies which have been approved as part of the AAA Area Plan process or as part of the Home Health Agency designation do not have to be resubmitted at the time of the initial or recertification process. (See Appendix D for a list of those policies which are included in the Agency on Aging Area Plan or Home Health designation process.)

   c. Policies relating to case management services which have been updated or altered since the previous certification review must be submitted to ASD for approval prior to the certification review process.

3. Review of complaints received and documented at ASD during the past year.

4. Consultation with the following community partners regarding the quality of case management services provided by the agency, as needed:
   - Adult Day providers
   - Waiver Team Members
   - Public Guardians

- Field Directors

5. An on-site review at the case management agency.

    a. Each agency will be notified of the review within one (1) week of the pending on- site visit. ASD reserves the right to make unannounced agency site visits with the intention to conduct a targeted review.

    b. The on-site portion of the review will last for three (3) days but may be extended at the discretion of ASD. It will include:
        - A review of individual CFC and/or OAA case management files.
        - Home-based interviews with individuals who receive case management services through CFC or OAA programs. Interviews may also include family members, surrogates and/or caregivers.
        - Individual interviews with case management staff.
        - Interviews with the Agency Director, Long Term Care Director, and/or Case Management Supervisor(s) to discuss the quality of case management services, the implementation of policies and procedures, and program understanding within the agency.
        - An exit interview with the agency director and others the director may choose to invite. This interview will summarize the preliminary findings of the review.

    c. The review sample will be limited to 4 to 6 individuals participating in High/Highest Needs CFC and/or OAA programs. The sample selection will be announced during day one of the review and may be expanded at the discretion of ASD. Records of other recipients of services may be reviewed as required.

    d. The discovery period of the review process will last no more than fourteen (14) consecutive days. This timeframe may be extended by mutual agreement between ASD and the agency.

    e. A written report addressing the results of the Certification Review will be available to the agency within thirty (30) days from the end of the review process.
        - The written report will consist of a brief letter which states the date of the review under discussion and the Review Grid completed by the DAIL reviewer at the time of the review.
        - A brief statement of particular areas of strength of the agency.
        - A statement of whether all of the Standards were met or not. If any area was not met, the letter will refer the reader to the Review Grid.
        - Any corrective action plan required from the agency must be received by ASD within 15 days from the date the agency received the ASD written report of the results of the quality review.

6. The final review report will have one of the following recommendations.

    a. Three-year certification: No corrective actions or recommendations.

    b. Two-year certification: Granted at the discretion of ASD if the agency's corrective action will bring an unmet standard into full compliance within a month of submittal to ASD.

    c. One-year certification: Granted at the discretion of ASD if the agency's corrective action plan will bring an unmet standard into full compliance after follow-up review visit(s).

    d. Suspension of certification: Granted at the discretion of ASD pending corrective action plan acceptance and follow- up review.

7. Certified Case Management agencies will be listed on the DAIL website. A redacted copy of the certification documents will be available to the public upon request.

8. The following documents will be used as technical references during the Certification Review process:
    a. Case Management Standards & Certification Procedures for Older Americans Act Programs and Choices for Care

    b. Case Manager Training Process

    c. Choices for Care High / Highest Needs Program Manual

    d. Older Americans Act and Accompanying Regulations

VI. APPEALS

The decision to suspend certification or to decertify may be appealed to the Commissioner of the Department of Disabilities, Aging and Independent Living.

1. The agency shall file for an appeal within 10 working days of a notice of suspension or decertification.

2. The Commissioner shall hear the appeal within 45 days of notice from the agency.

3. The Commissioner shall issue her or his decision in writing within 30 days of the hearing.

4. The agency's certification shall remain in place during the appeal process.

5. These deadlines may be increased if agreed to by both DAIL and the case management agency.

APPENDIX A

State and Federal Statutory Authority

I. **State Statute**: The Department of Disabilities, Aging and Independent Living has statutory authority to manage programs and protect the interests of older Vermonters and Vermonters with disabilities within Title 3, Chapter 53, Subchapter 004, Section 3885a of Vermont State Statutes.

The Commissioner has the authority to determine the policies and to exercise the powers and perform the duties required for the effective administration of the Department within Title 3, Chapter 53, Subchapter 003, Section 3052 of Vermont State Statues.

II. **Choices for Care**: Choices for Care is managed under Vermont's Global Commitment to Health 1115 Waiver. The Centers for Medicare and Medicaid Services (CMS) sets parameters for operations and quality management in the Code of Federal Regulations (State Assurances), Vermont's Special Terms and Conditions and Comprehensive Quality Strategy.

III. **Home and Community-Based Services (HCBS) Medicaid Regulations** – New HCBS Federal regulations (2014) set forth new requirements for HCBS settings standards and person-centered planning for people receiving services in home-based settings. The regulations are intended to enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

IV. **Older Americans Act**: The Older Americans Act (OAA) requires the State to be responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all state activities under the Act. Vermont is also responsible for setting specific objectives for each area for all services under the Act. 42 U.S.C.§3025 (a)(1)(c).

Vermont uses Title III-E funds to support case management activities. Vermont is required to establish standards and mechanisms designed to assure the quality of services, and to establish quality standards and mechanisms and accountability. 42 U.S.C.§3030s-1(e)(l).

OAA regulations require Vermont to develop policies governing all aspects of programs operated under Title III and to be responsible for the enforcement for these policies. (45C.F.R.§§1321.11 and 1321.17).

V. **Olmstead Decision**: On June 22, 1999, the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate;

(2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.