Table of Contents

15.01.03 - RULES GOVERNING CARE COORDINATION FOR THE ELDERLY

IDAPA 15
TITLE 01
CHAPTER 03

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IDAHO OFFICE ON AGING

000. AUTHORITY.
The Idaho Senior Services Act, Chapter 50, Title 67, Idaho Code, provides for "in-home services, designed to permit older people to remain independent and be able to avoid institutionalization and that these services be provided in a coordinated manner and be readily available when needed and accessible to all older people;" and authorizes the Idaho Commission on Aging (IOOA) to promulgate rules under the Act. (7-1-96)

001. TITLE AND SCOPE.
These rules governing the operation of Care Coordination Services are promulgated by the Idaho Commission on Aging pursuant to Chapter 52, Title 67, Idaho Code. (7-1-96)

002. -- 009. (RESERVED).

010. DEFINITIONS.
For the purposes of these rules: (7-1-96)

01. AAA. Area Agency on Aging. (7-1-96)

02. Active Cases. Those cases that require in-home services within the quarter following the Eligibility Evaluation. (7-1-96)

03. Activities of Daily Living (ADLS). Eating, dressing, bathing, toileting and transferring. (7-1-96)

04. Care Coordination (CC). A program designed to locate, mobilize, and coordinate a variety of in-home care and other services required by individuals at high risk of placement in a long-term care facility. (7-1-96)

05. Care Coordinators. Client advocates, service brokers, and managers of service units. It is not the function of the Care Coordinator to provide "hands on" care, be a companion to, or directly supervise services provided the client. (7-1-96)

06. Client. The recipient and or legal representative, as defined below. (7-1-96)

07. Diminished Capacity. The inability of an individual to accomplish daily activities without personal assistance, standby assistance, supervision, or cues. (7-1-96)

08. Fiscal Effectiveness. A financial record of the cost of all formal services provided to insure maintenance of the individual in their home is more cost effective than placement in long term care. (7-1-96)

09. Formal Supports. Those supports and services which are paid for by public funds. (7-1-96)

10. ICOA. Idaho Commission on Aging. (7-1-96)

11. Informal Supports. Those supports and services provided by friends, volunteers, relatives, and others, for which there is no fee. (7-1-96)

12. Instrumental Activities of Daily Living (IADLS). Preparing meals, shopping for personal items, managing money, using the telephone (accessing emergency services), and housework. (7-1-96)

13. Legal Representative. A term that includes appropriate Power of Attorney, Conservator, Legal Guardian, or other court appointed entity who has the legal authority to speak for the client. (7-1-96)

14. Program Director. An employee of the AAA who meets the Staff Qualifications stated in Subsection 051.01.a. and is responsible for the actions, training, and accomplishments of the Care Coordinators and

the administration and reporting requirements of the CC program. Program Directors may also expect to function as Care Coordinators. (7-1-96)

011. POLICY.
CC is a part of a continuum of community-based care designed to provide assistance needed to compensate for individual functional limitations. CC is one method employed by the AAA to comply with the Older Americans Act mandate for coordination of community based services. The CC program is a service provided by the AAA for those services funded by Older Americans Act and State Senior Services Act Funds. Through research, development, and coordination of services, the AAAs will assist individuals to live independently in a home environment. (7-1-96)

012. ELIGIBILITY.
Eligibility is based on the individual's ability to perform activities of daily living (ADLS) and instrumental activities of daily living (IADLS). Client must be at least sixty (60) years of age and a resident of Idaho. (7-1-96)

013. PURPOSE OF SERVICE.
CC activities enhance client autonomy, consider client preferences, and promote efficient use of available resources. CC is an outcome based program. The end result will be more efficient use of available services and personnel and improved reporting procedures that will confirm AAA services are provided to those most in need and at highest risk of nursing home placement. CC is a short-term administrative service employed to initiate and coordinate in-home care. Once services have been put in place only minimal contact with the client is required. Follow-up by telephone will meet most needs with the exception of reevaluations or a marked change in client status. (7-1-96)

01. Single Point of Entry. To establish a centralized "single point of entry" for AAA services and referrals to other required community based services. (7-1-96)

02. Avoid Institutionalization. To avoid costly, premature, or inappropriate institutionalization of Idaho's senior citizens. (7-1-96)

03. In-home Services. To determine appropriate use, avoid duplication, ensure cost containment and fiscal effectiveness of in-home services required by seniors in maintaining their independence, family units, dignity, productivity, and respect utilizing formal and informal supports and AAA services. (7-1-96)

014. PAYMENT FOR SERVICES.
Care Coordination services may be provided at the request of an individual or their legal representative even though the individual does not meet eligibility requirements. In those cases a fee for services will be imposed based on actual cost of services. Funds realized from payment for services must be reinvested in the Care Coordination Program. (7-1-96)

015. -- 025. (RESERVED).

026. PRIORITIES RELATED TO CARE COORDINATION.
Recipients of Care Coordination must display a diminished capacity to accomplish ADLS and/or IADLS and will be assigned a Priority Grade as a result of the Eligibility Evaluation. Services will be provided based on the Priority Grade assigned. When two (2) or more individuals are assigned the same Priority Grade it is the responsibility of the CC Program Director to determine and document "client most in need." (7-1-96)

027. SERVICE FUNCTIONS.
Care Coordination provides responsible utilization of available informal (unpaid) resources before arranging for formal (paid) services. The Care Coordinator and client will work together in determining the frequency, duration, and need of in home services. Services will be arranged subsequent to approval by the client or legal representative. Services provided will be recorded and monitored to insure fiscal effectiveness and compliance with the Care Plan. (7-1-96)

01. Eligibility Evaluation. An evaluation of individual's capabilities and financial status, as well as the informal and formal supports (both potential and in place). The Eligibility Evaluation, reevaluation, and referrals will be accomplished using forms provided by the ICOA. (7-1-96)

02. Care Plan. A written plan of care that specifies client needs, goals and how they might best be met, client share of cost (if appropriate), and service hours authorized. The Care Plan must be presented to and approved by the individual prior to implementation of services. Other funding sources may require approval of the Care Plan by the attending physician. (7-1-96)

03. Service Arrangement. In-home services must be arranged and authorized by the Care Coordinator according to the Care Plan, as agreed to by the client. Care Coordinators are agents of the client and the AAA in negotiating, arranging, and monitoring services and for insuring the financial feasibility of the Care Plan. (7-1-96)

04. Follow-up. The frequency of on-going contact with the client is maintained and justified in the Care Plan. The Care Coordinator and service provider will maintain communications to insure: (7-1-96)

a. Duplication of services is avoided; (7-1-96)

b. Clients are notified of discontinuance or suspension of services; (7-1-96)

c. Clients are notified of modification of the Care Plan. (7-1-96)

05. Reevaluation. A standardized reevaluation of the client's status and need will be conducted as established in the Care Plan, or a minimum of once a year, or when significant changes occur in the client status. The client and legal representative, if appropriate, must be present during the reevaluation. (7-1-96)

028. OTHER SUPPORTIVE SERVICES.

01. Necessary Services. Care Coordinators may assist the client in obtaining benefits, services, medically related devices, assistive technology, necessary home modifications, or other services required to fulfill unmet needs. (7-1-96)

02. Social-Emotional Support. The Care Coordinator links the clients and their families with supports available to facilitate life adjustments and bolster informal supports. (7-1-96)

03. Unmet Needs. Care Coordinators identify and document unmet client needs to assist the AAA in future planning. (7-1-96)

04. Other Informal Resources. In all cases, available informal resources must be explored prior to the utilization of formal resources. This includes third party reimbursement, public funds, and other available formal and informal community programs. (7-1-96)

05. Care Coordination Responsibilities. CC is responsible for linking clients to services required to maintain clients in their homes. Once services and referrals have been established, follow-up is not necessary unless the client requests assistance with additional problems; a service provider, legal representative, or other, indicates there is a change in circumstances; or additional problems are identified. (7-1-96)

029. TARGET POPULATION.

The target population includes, but is not limited to the following: (7-1-96)

01. Clients with Physician's Written Order. The client with a physician's written order authorizing twenty-four (24) hour care placement, providing the Care Plan is approved in writing by the physician. (7-1-96)

02. ADL or IADL Clients. Those clients unable to accomplish one (1) or more ADL or IADL's without personal assistance, standby assistance, supervision, or cues. (7-1-96)

03. Special Needs Clients. The presence of multiple, complex, and diverse service needs. (7-1-96)

04. Currently Institutionalized Clients. The currently institutionalized client who, with physician approved supportive services and Care Plan, will be able to maintain their independence in their own home. (7-1-96)

030. STRUCTURE AND ROLES.
CC is the centralized evaluator and arranger of services and provides those activities outlined previously under Service Functions. AAAs will be the provider for CC services. The AAA is responsible for the implementation of these rules. (7-1-96)

031. -- 050. (RESERVED).

051. STANDARDS OF PERFORMANCE.

01. AAAs Must Assure CC Meets the Requirements for Service Neutrality. An agency providing CC cannot be a direct provider of other in-home services without proper written justification and approval of the Director ICOA. (7-1-96)

02. Implementation of Care Plan. Care Coordinators will work with service providers toward implementation of the Care Plan, and to avoid duplication of evaluations, assessments, and services when possible. (7-1-96)

03. Eligibility Evaluations. Eligibility Evaluations provide information necessary to determine eligibility for any AAA services. The client's written permission must be obtained prior to sharing information obtained with any other agency or the initiation of any services not provided by the AAA. (7-1-96)

052. STAFF QUALIFICATIONS.
CC staff will meet the following standards: (7-1-96)

01. Qualified Staff. Care Coordinators are paraprofessionals who have a high school diploma or GED and a minimum of five years working directly with aged and or disabled populations in a provider or service capacity, or an individual with a Degree and two (2) years experience working with disabled and or aged population. Program Directors are required to meet the minimum qualifications outlined above and have a minimum of two (2) years supervisory experience. (7-1-96)

02. Minimum Qualifications. CC staff must receive a minimum of ten (10) hours in-service training per year. Orientation of newly appointed Care Coordinators, addressing community resources and program eligibility, is the responsibility of the Program Director and must be accomplished prior to client contact. (7-1-96)

053. CLIENT RIGHTS.
The client retains the right to receive or refuse services. Every client will read or be informed of the Client Rights and Responsibilities prior to the completion of the Eligibility Evaluation. Every client must sign an ICOA consent form prior to the initiation of services. (7-1-96)

054. CARE PLAN.
The Care Plan must be accomplished on an ICOA form, in ink. (7-1-96)

055. REVIEW OF CARE PLAN.
All Care Plans will be reviewed at least once each year. The review must be accomplished in the presence of the client. If there are no changes in the Care Plan, it may be re-authorized. Re-authorization implies the client is in agreement and in continued need of services as outlined in the Care Plan. Re-authorization requires the completion of the ICOA Care Coordination Re-evaluation form, the signatures of the client and the Care Coordinator, and the date. (7-1-96)

056. MONITORING.
Monitoring is quality control and quality assurance. From a quality control perspective the Care Coordinator determines if services are being provided as outlined in the Care Plan and if the client is satisfied with the care. Through quality assurance the Care Coordinator determines if the services meet the goals established in the Care Plan. Monitoring of care includes a review of the client record to determine if changes in service have been authorized, if the Care Plan continues to be cost and client effective, provider observations and information relative to informal caregivers, additional actions required by the Care Coordinator, reevaluations, amended Care Plan, and contacts with the client. All contacts with or on behalf of the client will be documented, signed, and dated in the

client's case record. In all instances the AAA is responsible for monitoring CC activities from a quality control and quality assurance perspective. Case files will be maintained for three years after termination of services. (7-1-96)

057. PROVIDER NOTIFICATION.
Contracted services must be approved, suspended, or terminated in writing by the CC Program Director, AAA Director, or Care Coordinator. Verbal approval for emergency service activities will be followed by written authorization, including any special instructions. (7-1-96)

058. TERMINATION.

01. Documentation. Documentation of notice of termination must be duplicated in the case record, signed, and dated by the Care Coordinator. (7-1-96)

02. Appeals Process. The client must be provided information on the appeals process specific to any service funding source. (7-1-96)

03. AAA Services. AAA services authorized by the CC Program may be discontinued by the Care Coordinator for any of the reasons listed below, or at the discretion of the Program Director or AAA Director. (7-1-96)

04. Conditions of Termination. Services may be terminated for any of the following reasons: (7-1-96)

a. Services proved ineffective, insufficient, or inappropriate to meet client needs; (7-1-96)

b. Other resources were utilized; (7-1-96)

c. Client withdrew from the program or moved; (7-1-96)

d. Family or other support to client increased; (7-1-96)

e. Client placed in an institution or long term care; (7-1-96)

f. Client died (if obituary in case file, no notification of termination required); (7-1-96)

g. Client's functioning improved; (7-1-96)

h. Client refused service; (7-1-96)

i. Client's home is hazardous to the service provider, requires approval of AAA Director; (7-1-96)

j. Client's home is not reasonably accessible to the service provider; (7-1-96)

k. Client's behavior is a threat to the safety of the service provider, requires approval of AAA Director; (7-1-96)

l. Client verbally abuses or sexually harasses service provider; (7-1-96)

m. Client refuses to pay fee determined for service; (7-1-96)

n. Service provider is not available in locale. (7-1-96)

o. Services are no longer cost effective. (7-1-96)

05. Notification of Termination and Right to Appeal. Client will be informed in writing of the reasons for agency-initiated service termination and the right to appeal at least two (2) weeks prior to termination. Exceptions to the two (2) week advance notification of termination must be justified and approved in writing by the AAA Director. Appeal actions are the responsibility of the AAA. The client will be referred to other services as appropriate.

(7-1-96)

059. MEDICAL EMERGENCY.
The primary physician must be notified immediately regarding all known medical emergencies. Written verification will follow within two (2) working days. Emergency follow-up or notification activities will be recorded in the case record. (7-1-96)

060. CASE RECORD.
There will be a individual case record for each CC client and may be reviewed by the client at any time. The case record will contain the following information: (7-1-96)

01. ICOA. A completed ICOA Eligibility Evaluation. (7-1-96)

02. Cost Comparison Worksheet. A current cost comparison worksheet. (7-1-96)

03. Care Plan. A standardized Care Plan. (7-1-96)

04. Written Record. A written record of all activities accomplished with, for, or on behalf of the client, maintained by the Care Coordinator. (7-1-96)

a. Entries will be dated and signed by the Care Coordinator. (7-1-96)

b. Entries will be maintained in chronological order. (7-1-96)

c. Entries will be made in ink. (7-1-96)

d. Statements included in the case record that relate to the client will reflect who made the statement and when the statement was made. (7-1-96)

05. Documentation of Guardianship, Conservatorship, or Power of Attorney or Legal Representative. (7-1-96)

06. Signed Release of Information. (7-1-96)

061. -- 075. (RESERVED).

076. WAIVERS.
Agencies seeking a "Waiver" to contract out CC must make a formal written request to the Director, ICOA. The waiver request will include clear and specific information, and documentation demonstrating the desired service will be provided in a more appropriate, effective, and fiscally responsible manner by the contracting agency. (7-1-96)

077. -- 999. (RESERVED).