Case Management Functions and Staff Qualifications

Goals of Case Management

The primary goal of case management is to enable vulnerable adults to reside in the setting of their choice with long term services and supports that maximize independence, dignity, and quality of life. Case managers assist clients in developing a safe plan of care to achieve this goal, arrange for and coordinate related services, and provide ongoing monitoring of the care plan. Case managers are also custodians of state resources and must balance client choice with program limits.

Case managers:

- Assess the client's functional and cognitive needs.
- Support/maximize client independence and self-direction.
- Create and monitor care plans, coordinate with agency and Individual Providers to provide in-home services.
- 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.
- Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.

Required Functions of Case Management

- **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 or when there is a serious change in client condition. Both assessments and reassessments are completed using the state's Comprehensive Assessment Reporting Evaluation (CARE) tool.
- **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 telephone contacts or home visits, to see if the plan is being appropriately implemented and if the services provided are meeting the client's needs.
- **Terminate unqualified providers**. Individual Providers may be deemed unqualified due to lack of compliance with background check, training, or certification rules or due to character, competency, and suitability review outcomes.
- **Contracting Individual Providers (IPs).** Clients may select individuals to provide services in their care plan. Case managers or case aides will ensure qualifications are met related to criminal background checks, training requirements, and home care aid certification requirements, and execute contracts in the statewide Agency Contracts Database.
- **Mandatory Reporting:** Report abuse, abandonment, neglect, self-neglect, or financial exploitation to Adult Protective Services (APS) per Chapter 74.34 RCW.
- **Report Suicide Ideation:** According to policy.

- **Service Termination Planning.** Services are based on the client's current needs and level of services can change if needs change. This is especially true if the client has a temporary condition (e.g. post-surgical, broken bone). When the CARE assessment determines that a client is no longer eligible for a particular service, case managers make necessary referrals (if needed) to transition the client to other services, provide adequate notice, via a Planned Action Notice (PAN) and close services in the necessary timeframes.

Nurse Consulting Services. Nurses educate clients, providers, and case managers about health-related assessment topics to enhance the development and implementation of the client's plan of care. Referrals should be considered when clients meet the criteria as shown in the CARE tool. Agencies will deliver nursing services as defined in Chapter 24 Nursing Services of the Long-Term Care Program Manual.
The Nursing Service Program will maintain compliance with RCW 74.34, RCW 74.39, RCW 74.39A, and all applicable regulations in WAC 388-71 and WAC 388-106.

Additional Supportive functions may be required. These 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.
- **Assistance.** Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently.
- **Referrals**. Making and following up on referrals to healthcare providers, including mental health and other services 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 clients have 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 residential care, etc.
    - Encourage caregiver self-care through support groups, education, and assistance accessing resources.
- **Crisis Intervention**. Provide short-term crisis intervention in an emergency situation to resolve the immediate problem before a long-term plan is developed or current plan is revised.
- **Access Resources.** Examples of available resources include discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.

Case Management Responsibilities. Per RCW 74.39A.095, case management responsibilities for long-term care clients are shared by DSHS Home and Community Services and the Area Agency on Aging for King County. This includes case management for all clients, age 18 and older receiving ALTSA-funded community-based services in their home and in-home Medicaid clients who are temporarily in institutional settings. For more detailed information on requirements of case management, see the:
Home and Community Services Information for Professionals Procedure and Reference Materials, found at https://www.dshs.wa.gov/altsa/home-and-community-services-information-professionals, specifically:

- Long Term Care Manual:
    - Chapter 3: Assessment and Care Planning
    - Chapter 5: Case Management
    - Chapter 7: CORE LTC Programs
    - Chapter 7A: In-Home Provider Requirements
    - Chapter 24: Nursing Services
    - Chapter 27: New Freedom
- Assessor's Manual

Staffing of case management programs must include roles for program management, supervision, case management, and nursing staff. Some case management programs also have specialized roles for administrative hearing coordination and case aides to support other case management duties. Case Managers, Case Aides, and Nurses are considered "Case Handling" staff. Case Handling Staffing ratios must meet state minimum standards set by ALTSA. It is estimated these will be between 70 and 75 clients per Case Handling FTE for SFY16.

Case Manager Qualifications
Case managers will meet at least the following minimum education and experience requirements:

1. Bachelor's degree (Master's preferred) in social services, psychology, or related field and three years of social service experience involving interviewing, counseling, or crisis intervention; or
2. An exception can be requested if it has been demonstrated that applicants cannot be located who meet the education and experience requirements above and one or more of the following two conditions exist:
    a. Bilingual or bicultural staff are necessary to assure access to limited-English speaking or culturally isolated populations; and/or
    b. The client populations are geographically isolated.

Case Management Supervisor Qualifications
Case Manager Supervisors must have a Bachelor's degree in Social Services, Human Services, Business, or Public Administration or a relevant field (Masters preferred) and three years of experience in human services or contract administration, service delivery, community organizing, including one year of supervisory or lead experience (or a combination of education, training and experience). Experience may be paid or volunteer.

Case Aide Qualifications
Case Aides must have at least two years of college level courses in social work or a related field and one year of experience providing direct human services. Experience may be paid or volunteer.

Program Manager Qualifications
A Case Management Program Manager must have a B.A. in a relevant field and two years of administrative experience (one year of supervisory experience may be substituted for one year of administrative experience).

Nurse Qualifications
A Case Management Program Nurse must have a current registered nurse (R.N) credential from the Washington State Department of Health. A nurse must also have a BS in Nursing; and two years of clinical nursing experience with elderly and/or adults with disabilities; or three years of clinical nursing experience.