

INTAKE AND PRIORITIZATION:

The following information addresses the provider agency responsibilities as they pertain to the intake and prioritization processes.

INTAKE:

A. Entrance to Community Care Service System:

Individuals seeking services may enter the community care service system by direct contact with an access point.

B. Intake Process:

1. **Process Commencement:** The intake process begins when an individual contacts the Elder Helpline or other access point seeking assistance.
2. **Necessary Information:** Essential information about the nature of the person's physical, mental and functional abilities/concerns/limitations/problems, as well as general background information, is obtained during the intake process to assist in screening for eligibility and appropriate service referrals.

C. The Prioritization Assessment Form (701A):

1. **DOEA Form 701A:** The Prioritization Assessment Instrument is used to collect common information about applicants/clients applying for services funded by the Department of Elder Affairs.
 - a. It is also used to prioritize persons so that those in greatest need and with the least assistance available will receive services first.
 - b. This form is used over the phone or in person.
 - c. Call the client within three business days after receiving a referral to complete a Prioritization Assessment Form (DOEA Form 701A).
 - d. If the applicant can be served, the Assessment Instrument (DOEA Form 701B) will be completed within fourteen business days after receiving the referral.
 - e. If the applicant cannot be served, he/she is placed on the Assessed Priority Consumer List (APCL).

2. **Staff Completing the 701A:** Staff who has received training and certification may complete the 701A.
3. **Procedure for Completion of Form:** The procedure for completing the Prioritization Assessment Form is described in the Assessment Instructions (DOEA Form 701D).

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APCL MAINTENANCE AND PRIORITIZING ENROLLMENT OF NEW CONSUMERS:

- A. Trained and certified staff conducts screening and assessment activities of potential consumers as the first step to enrollment on the APCL. The AAA ensures the APCL is maintained in the Client Information and Registration Tracking (CIRTS) System when enrollment in a program for services funded by the department is not available. Staff must inform potential consumers or referring parties about the assessed priority consumer lists and provide suggestions regarding other agencies or sources of assistance, including Medicaid, Food Stamps, and private pay options. Staff must also provide consumers contact information and encourage them to call for re-screening if their situations change.

Staff enters information for consumers waiting for DOEA-funded services in the CIRTS enrollment screen with the program status of APCL. The priority ranking score is automatically generated in CIRTS for these individuals. Only one APCL is maintained for each DOEA-funded program in each planning and service area (PSA.) The AAA must ensure that persons placed on the APCL are re-screened at regular intervals to determine if their situations have changed.

B. CONSUMER ENROLLMENT ON AN APCL

1. New consumers not enrolled on an APCL and not enrolled in a DOEA-funded program
 - a. Individuals enrolled on an APCL will be screened using Form 701A.
 - b. Individuals may be enrolled on more than one APCL after consideration of consumer need, program eligibility and targeting requirements.
2. Consumers receiving case management and dually enrolled (CIRTS Enrollment Screen program status codes set to "APCL" and "ACTV") in the following programs: ADI, CCE, CS, HCE, LSP, OAA, and ADA/ALE Medicaid Waivers.
 - a. Consumers, regardless of priority ranking score, will be assessed by the case manager annually using Form 701B.
 - b. Case managers have the responsibility to conduct semi-annual care plan reviews and annual reassessments. If case management is provided under CS or LSP, then the requirements are the same as those for other DOEA-funded case managed consumers. If case management is not provided, then OAA requirements apply.

- c. If there is a significant change between annual assessments, an “update” type assessment will reflect a new priority ranking score on the APCL.
 3. Consumers with a CIRTS Enrollment Screen program status code set to “APCL” and not enrolled or receiving services in any DOEA-funded program.
 - a. Consumers with a priority ranking score of 3, 4, 5, and 6 are re-screened every six months using Form 701A.
 - b. Consumers with a priority ranking score of 1 or 2 are re-screened annually using Form 701A.
 4. Consumers receiving one or more OAA registered services and having CIRTS Enrollment Screen program status codes set to “ACTV” for OAA and “APCL” for any DOEA-funded program.
 - a. Consumers, regardless of priority ranking score, will be reassessed annually using Form 701B, Assessment Type “O.” As noted, this also applies to CS and LSP if the providers operate under OAA requirements.
 - b. Consumers who are enrolled in OAA, CS or LSP for Congregate Meals or Nutrition Counseling and who are also on the APCL for any DOEA-funded program must be re-screened annually using Form 701A or using Form 701B, Assessment Type “O,” in order to generate a priority ranking score for the APCL.
 - c. If there is a significant change between annual assessments, an “update” type assessment will reflect a new priority ranking score on the APCL.
 5. Consumers screened using Form 701A and received a priority ranking score of 3, 4 or 5 with a CIRTS Enrollment Screen program status code set to “APCL” and subsequently assessed using Form 701B and receive a new priority ranking score of 1 or 2.
 - a. ADI, CCE and HCE applicants are returned to the APCL to allow for prioritization of other consumers on the APCL with priority ranking scores of 3, 4, or 5.

- b. ADA/ALE potential clients not placed on **APPL** status are returned to the APCL to allow for prioritization of other consumers on the APCL with priority scores of 3, 4 or 5. However, ADA/ALE Medicaid Waiver applicants (program code in CIRTS is set to **APPL**) who receive a lower priority ranking score on a 701B continue through the Medicaid waiver application process. The lower priority ranking score on a 701B does not disqualify **applicants** for the Medicaid waiver programs.
 - c. The Notice of Instruction (NOI) #061705-1-I-SBCS dated June 17, 2005 provides detail regarding the use of the CIRTS program status code of APPL.
6. When a consumer is no longer waiting for services, the program status code must be appropriately modified to termination. Termination from the APCL occurs if the person is no longer interested in waiting for services, is no longer able to receive services, begins receiving services, or begins the eligibility process.

Consumer enrollment in DOEA-funded programs is based on available funding, specific program eligibility, targeting and prioritization criteria as stated in law, rule and DOEA contracts.

C. Consumer Enrollment in DOEA-funded Programs to Receive Services

1. OAA: OAA targeting and program eligibility requirements apply for consumers enrolled in OAA Title IIIB (supportive services), Title IIIC (nutrition services), Title IIID (preventive health services), and Title IIIE (caregiver services).
2. CCE: Pursuant to Section 430.205(5), Florida Statutes, Adult Protective Services referrals in need of immediate services to prevent further harm will be given primary consideration for receiving services in the CCE program. APS high-risk clients (Priority 7) must receive case management and crisis-resolving services within 72 hours of the APS referral per DOEA policy.
3. ADI, CCE, CS, HCE, LSP and ADA/ALE Medicaid Waivers: Approval to begin the eligibility process for ADI, CCE, CS, HCE, LSP and ADA/ALE Medicaid Waivers is determined by the availability of funds and the priority ranking of individuals. The order of priority (except for CCE APS high risk referrals) is as follows:
 - a. Individuals designated as Imminent Risk (Priority 6) of being placed in a nursing home (including individuals designated as Aging Out and non-Aging Out individuals);
 - b. Individuals designated as Aging Out (regardless of priority ranking score); and

- c. Individuals with the highest priority score starting with individuals with a priority ranking score of 5.

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PURPOSE:

A. CLIENT ASSESSMENT PURPOSE:

1. **Areas of Need:** A comprehensive assessment of the client's condition and changes in that condition revealed during assessment and/or reassessment shall identify areas of need where services and/or informal networks should be developed;
2. **Planning and Budgeting:** Assessment information evolves into the development of profiles on client impairments and service needs, which are useful in planning and budgeting for those needs.

B. ASSESSMENT FORMS:

1. Assessment forms are used to conduct client assessments for all DOEA programs. The assessment forms are listed below:
 - a. **Prioritization Assessment Form (DOEA Form 701A)**
 - b. **Assessment Instrument (DOEA Form 701B)**
 - c. **Congregate Meals Assessment (DOEA Form 701C)**
2. **Assessment Instructions (DOEA Form 701D):** Specific and detailed instructions for completing the assessment forms are included in the Assessment Instructions (DOEA Form 701D).
3. **Development of Care Plan:** The case manager utilizes the information gathered through the assessment in the development of a client centered care plan. The final page of the Assessment Instrument (DOEA Form 701B) is a summary of all assessment information. The page notes: client problems, barriers to meeting these needs, resources available, and the gaps that exist in meeting the client's needs. These gaps become the needed services on the client's care plan.

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CRITERIA FOR ADMINISTRATION OF THE CLIENT ASSESSMENT:

A. Annual Assessment Requirement:

Case managers shall complete annual client assessments for the following programs:

1. **ADI:** Alzheimer's Disease Initiative.
2. **CCE:** Community Care for the Elderly.
3. **CS:** Contracted Services.
4. **HCE:** Home Care for the Elderly.
5. **LSP:** Local Services Program
6. **OAA:** Older Americans Act registered services. (701B form with "O" items/sections completed)

Reassessments: After the initial assessment, annual assessments are referred to as reassessments.

- B. Client Not Capable of Providing Information:** If a client is unable to provide information for the assessment due to illness or impairment, the case manager must attempt to obtain the information from the spouse, family, caregiver or other source.
- C. Reassessment Face-to-Face Requirement:** Reassessments must be administered face-to-face with the client on an annual basis using a **new** Assessment Instrument (701B).
- D. Sharing of Completed Assessments:** All DOEA program agencies shall accept assessments completed by other agency staff who have been trained and certified to complete the assessment forms.
- E. Updates to Completed Assessments:** The following criteria apply regarding updates:
1. **Assessment Forms Received from Another Agency:** Assessment forms administered by a trained/certified assessor working for another agency shall be reviewed for accuracy when received to ensure the information is correct in describing the client's current situation. Updates shall be made as necessary.

2. **Update Requirements:** The update does not require completion of a new assessment; however, the update does require a review of the client's condition/situation to determine changes.
3. **Face-to-Face Requirement:** The case manager will conduct a face-to-face interview with the client to determine the necessary revisions to the assessment.
4. **Changes in Client Condition:** If the client's condition changes during the year and this significantly affects the client's functional status, the case manager shall review the impact of this change and update the form.
 - a. Only areas of the assessment with significant changes need to be updated.
 - b. The case manager shall make appropriate notations in the case record and the care plan will be revised accordingly.
 - c. A case manager may choose to update the assessment form at any time conditions change that affect the client's functional status.
5. **Significant Changes:** Examples of significant changes which may affect the client's condition include the following:
 - a. Changes in health status such as an accident or illness;
 - b. Change in living situation;
 - c. Changes in the caregiver relationship;
 - d. Loss, damage, or deterioration of the home living environment;
 - e. Loss of spouse, family member, or close friend; or
 - f. Loss in income.

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F. Assessment Training and Certification: The following procedures shall be followed in regards to training and certification:

1. **Training/Certification:** Staff must have received training and certification on completing the assessment forms from a planning and service area assessment training team prior to conducting client assessments.
2. **Interim Arrangement:** An interim arrangement may be made for new employees who have not yet obtained certification, which requires a certified worker to review and approve the assessment as documented by the reviewer's signature.

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CONDUCTING THE INTERVIEW:

INTERVIEWING TECHNIQUES:

A. Establishing Rapport:

1. **Interview Relationship:** The case manager must make every effort to establish a good interviewing relationship and environment by providing warmth, genuineness, and empathy.
2. **Respect and Dignity:** The case manager must treat the applicant/client with dignity and respect.
3. **“Hints”:** The case manager should refer to “Developing Rapport” in the Assessment Instructions (DOEA Form 701D).

B. Applicant/Client Involvement:

1. **Privacy:** In most cases the applicant should be interviewed alone.
2. **Involvement of Others:** A family member or caregiver may need to be present to provide the assessment information if the applicant/client is confused, very ill, or otherwise unable to provide the necessary information. However, the case manager must try to involve the client as much as possible in the interview.

C. Statement of Interview Intent:

The case manager will state that the intent of the interview is to obtain specific information in order to:

1. Determine what type of assistance the person may need; and
2. Ensure that all eligibility criteria are met.

D. Confidentiality:

The case manager will inform the client that the data collected will be kept confidential; however, with his/her written consent, there may be situations when information will need to be shared with another agency in order to obtain services that will be of assistance. (Refer to Section 5 of this chapter—Case Record for more information on confidentiality).

E. Case Manager Instructions for Interviewing and Conducting Assessments:

Instructions for interviewing and conducting the assessment are included in DOEA Form 701D. Case managers shall follow these instructions.

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ASSESSMENT SCORES:

Two scores are produced when the completed Assessment Instrument is entered into the Client Information and Registration Tracking System (CIRTS).

A. Risk Score:

This score indicates the likelihood that the individual will go into a nursing home.

1. There are questions within the Assessment Instrument, which add value to the risk score, measuring the client's frailty.
2. The risk score can change after the client begins to receive services due to changes in the client's medical and physiological condition. Nevertheless, as frailty normally increases with age, the risk score tends to increase over time.
3. This score has values that range from 0-100.

B. Priority Score:

This score indicates the client's need for services.

1. Both the client's frailty and the resources available to meet his/her needs are calculated.
2. Greater frailty adds to the score, while the available resources subtract from the score.
3. The priority score tends to decrease as the client receives services.
4. This score is indicated as part of a range, with the lowest value being Level 1.

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ASSESSMENT INSTRUCTIONS - DOEA Form 701D (Instructions for Forms 701A, 701B, 701C):

Instructions for completion of the DOEA forms 701A, 701B and 701C assessment instruments are included in DOEA Form 701D. These forms are incorporated by reference in Rule Chapter 58A-1, Administration of Administration on Aging Programs, F.A.C.

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SECTION 4: CARE PLANNING AND SERVICE ARRANGEMENT:

DEFINITION AND PURPOSE OF THE CARE PLAN:

A. CASE MANAGER:

The case manager uses the care plan for the following tasks:

1. **Information Organization:** To organize service information related to client problems/gaps; and
2. **Documentation:** To document the plan of action to address client problems and needs through the development of service solutions that meet the client's needs.

B. CARE PLAN INCLUSIONS: The care plan should prescribe the following services:

1. **DOEA Funded:** Services provided through DOEA funded programs; and
2. **Non-DOEA Funded:** Services funded outside of DOEA or informal services provided by the caregiver, family or friends.

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DEVELOPMENT OF THE CARE PLAN:

A. General: The care plan development is:

1. **Mutual Endeavor:** A mutual endeavor between the case manager, the client, and the caregiver and other family members; and
2. **Roles:** Specifies the roles and contributions of family members.

B. Client or Caregiver/Case Manager Expectations: The following applies to the client/caregiver and case manager:

1. **Written Consent:** The client, or caregiver if the client is unable, must be involved in the care plan development and must provide written consent to the plan;
2. **Expectations:** In order to avoid possible false expectations on the part of the client, caregiver and family members, the case manager shall explain, during the initial interview, that services will be planned, and provided as feasible, in keeping with the care plan goals;

C. Time Frame: The case manager must complete the care plan within 14 business days after completion of the client assessment. The client shall receive a copy of the care plan.

D. Care Plan Consultation: The case manager may consult with individuals, such as the client's physician, nurse, hospital discharge planner, or other specialized medical staff, as possible, to ensure appropriate care planning.

E. Confidentiality: Every caution shall be taken to protect client confidentiality.

1. **Necessary Information:** Only necessary information (e.g., medical history for health services) must be communicated to agencies involved in the care plan. All HIPAA regulations (the federal Health Insurance Portability and Accountability Act of 1996) will be followed at all times.
2. **Client Consent:** The client must provide individual informed client consent before any case information is shared with agencies.

- F. Client-Centered Care Planning:** Case managers shall perform the following client-centered tasks regarding care planning:
- 1. Case Manager Task:** Case managers shall concentrate on assisting clients to identify:
 - a. What the client identifies as problems;
 - b. What solutions are available to alleviate the problems; and
 - c. Whether the solutions are possible or feasible.
 - 2. Commitment:** The client's commitment to the plan is crucial as well as the commitment of the family, caregiver, or other informal providers.
 - 3. Case Manager Role:** The case manager should use communication skills to enable the client to perform the following care planning tasks (or the caregiver in the absence of client capability):
 - a. Understand goals;
 - b. Appraise resources; and
 - c. Decide on a course of action.
 - 4. Case Manager Identification of Goals:** In some instances, case managers may identify additional goals that they should discuss with the client and, if agreeable, add to the care plan.
- G. Consideration of Most Appropriate Resources:** In completing the care plan, the case manager shall consider the most appropriate resources to provide the services outlined in the care plan. The client must be given the opportunity to participate in the selection of service providers.
- 1. Non-DOEA Services:** Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.
 - a. Service Development:** These services can and should be developed to effectively address client needs as an alternative to purchased services from providers of DOEA funded services.

- b. **Preservation of Funds:** Case managers shall emphasize using informal resources whenever possible to preserve program funds for clients with the most critical needs.
 - c. **Other Resources:** The case manager and client shall consider informal resources, such as faith-based organizations and civic groups in the development of the care plan.
 - d. **Examples:**
 - i. A concerned friend or family member can sometimes arrange to provide homemaker or personal care assistance.
 - ii. A faith-based organization can sometimes provide meals or transportation services.
2. **DOEA Funded Services:** Other services come from the service providers in the local community care service system, which are funded through the department.
3. **Resource Directory:** The case manager should have access to a local community care service system resource directory to assist in selecting and arranging for services.
4. **Client Refusal:** If a client refuses a service(s) recommended by the case manager, the case manager shall document the refusal in the case narrative notes in the client's case file. The case manager may periodically make the suggestion of adding the needed service.

CARE PLAN FORMAT: Refer to Attachment 5 of this chapter for instructions on development of the care plan.

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REVIEW AND EVALUATION OF SERVICES:

- A. 14-Day Follow-Up Contact:** The case manager must telephone or visit the client within 14 business days following the ordering of services to determine the following:
- 1. Service Satisfaction:** Is the client satisfied with the services? If not, why?
 - 2. Quality of Service:** Is the client satisfied with the quality of the services performed? If not, why?
 - 3. Interviewer:** The individual conducting the interview is:
 - a.** Not required to observe the service being performed; but is
 - b.** Encouraged to observe services being performed and conduct discussions with the service worker if there is any indication that this action would be beneficial in determining the quality of services (e.g., the client expresses dissatisfaction with the way the service is performed).
- B. Quality Assurance (QA) Interviews:** Quality assurance interviews should rate the following subject areas at a minimum:
- a. Rapport:** Service worker's rapport with the client. Does the service worker communicate effectively with the client (including no language barriers)? Does the service worker communicate effectively with the client (including no language barriers)?
 - b. Service Worker Attitude:** Service worker's attitude towards job performance. How does the service worker approach the job? Is he/she positive, negative, enthusiastic? Other observations.
 - c. Service Worker Compliance:** Service worker's compliance with assigned duties. Are all services being completed as assigned?
 - d. Service Worker Dependability:** Service worker's dependability regarding the work schedule. Does the service worker arrive timely, arrive when expected by the client, stay as long as planned in the care plan?
 - e. Client Evaluation:** Client's evaluation and assessment of the service provided. Is the client satisfied with the services received?
 - f. QA Interview Format:** Agencies may devise their own formats for the quality assurance interview.

REVIEW AND UPDATE OF CARE PLAN:

A. Care Plan Review:

Case manager responsibilities are as follows:

1. **Semiannual Review:** The case manager shall conduct a care plan review and home visit at least semiannually and more frequently, if necessary, depending upon the changes in the client's condition.
 - a. **Definition of Semiannual:** Semiannual is defined as the end of the month, which falls 180 days after the initial service delivery.
 - b. **Example:** If the initial service date is July 23, 2007, then the case manager must complete the semiannual review by January 31, 2008.
2. **Review Schedule:** The case manager shall establish a care plan review schedule for home visits and face-to-face contact with each client based on this standard.
3. **Continuity of Services/Changes in Client Status:** The case manager will monitor for continuity of services and changes in the client's functional status which warrant the following changes in the recommended care plan:
 - a. Increase in services;
 - b. Decrease in services; and
 - c. Any other changes.
4. **Review Parameters:** The review is not a complete reassessment but a review of problems/gaps and changes in the client's functional status that warrant modification of the care plan.
5. **Review Date:** The review date will be posted on the care plan form along with the case manager's initials.

- B. Care Plan Update To Case Narrative:** The case manager's responsibilities for case narrative are as follows:

1. **Address Goals:** Address each problem/gap listed on the care plan in the case narrative after the semiannual visit.
 2. **Progress/Barriers:** The case narrative shall describe progress or barriers encountered.
 3. **Instructions:** Refer to section 5 of this chapter, Case Record, for information on case notes.
- C. Review Outline:** The care plan review will comply with the following guidelines:
1. **Review Date:** The case manager shall visit the client at least semiannually and review the care plan.
 2. **Service Needs:** The case manager and client will discuss the following:
 - a. Continuation of current services in relation to the client's identified needs; and/or
 - b. Need for additional services due to changes in condition; and/or
 - c. Acknowledgement of improvements and the corresponding changes in or termination of specific services.
 3. **Plan for Services:** The case manager will perform the following tasks regarding client services:
 - a. Review services provided;
 - b. Discuss any changes that need to be made with the client/client's representative, a spouse or caregiver; and
 - c. Revise the care plan as needed.

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CASE CLOSURE/SERVICE TERMINATION:

CASE CLOSURE PROCEDURES:

A. Procedures:

Procedures shall be developed to discontinue services to clients when their condition has either improved or declined sufficiently that services are no longer effective or appropriate.

B. Case Closure:

An individual's case may be closed for services for any of the following reasons:

1. **Change in Condition:** The client's condition has declined to the extent that he/she can no longer be safely maintained in the home.
 - a. **Hospitalization:** In the case of hospitalization, the case manager shall maintain contact with the client and hospital social services worker to assist in planning for the client's discharge.
 - b. **Other Placements:** If the client is discharged to a location other than home (i.e. nursing home, assisted living facility, adult family care home or other placement), the case manager shall maintain contact with the client for a three-month period or until such time it is evident that return to the home is no longer possible. Follow-up with the placement facility staff may be completed by correspondence or telephone.
2. **Move Out of County/Service Area:** The case manager shall arrange to transfer client records upon request and communicate with service providers in the client's new area.
3. **Client Death:** The case manager shall close a case upon the death of a client.
4. **Client Ineligibility:** The case manager shall close cases when clients become technically or financially ineligible for services.
5. **Services No Longer Needed:** The case manager shall close cases when services are no longer needed such as the following:
 - a. **Improved Condition:** The client's functional status has improved so that services are no longer required.

- b. **Other Sources Available:** The client's family or other persons are available to assist the client.
- c. **Transfer to Other Program:** The client is transferred to another program.
- d. **Client Request:** The client requests that services be terminated.

C. Responsibilities In Case Closures:

- 1. **Case Manager:** The case manager shall record a brief explanation of the termination reason and the effective date in the case record.
- 2. **Case Management Agency:** The case management agency shall develop and implement the following:
 - a. **Written Notification:** To provide advance written notification to clients when terminating services; and
 - b. **Grievance Rights:** To provide information to clients regarding their right to appeal the decision with the **exception** of the following situations:
 - i. The client has moved out of the service area;
 - ii. The client requested termination;
 - iii. The client has been placed in an assisted living facility or nursing home; or
 - iv. The client has died.
 - c. **Notification Timeframe:** The timeframe for notification shall be established in conjunction with the case management agency's grievance procedures.