CASE MANAGEMENT IN COLORADO: ESTABLISHMENT OF STATE PRACTICE

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FINAL REPORT

Case Management in Colorado: Establishment of State Practice

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ABSTRACT

This project, conducted by the Colorado Department of Social Services with assistance from Colorado State University, was designed to enhance long term care development through the establishment of a case management system for the newly formed Single Entry Point system in the state.

The major activity of the project was a statewide comparative study of case management, as practiced by administrators and case managers in the three public systems which provide long term care for adults and have similar models of case management. These agencies included social services, developmental disabilities and mental health. The survey focused on obtaining responses from case managers and administrators of agencies providing case management. Major questions addressed the characteristics of case managers, their educational background and experience, job responsibilities, salaries, caseloads, and populations served. In addition, the functions of case management across systems, supervision and training received, and major issues and concerns relative to the process of case management were addressed. Information obtained from the survey was used to design a new case management system for long term care clients in social services.

In addition to the survey, analyses of state practice and development in case management were conducted and informal interviews were held with related officials in state government and private agencies.

As a result of project activities, standards and state rules for the case management program were developed. The Single Entry Point system for long term care was implemented at seven sites in 1993, and training was conducted for case managers and supervisors of the program. A procedures manual for case managers was produced which formed the basis of the statewide training.

EXECUTIVE SUMMARY

Background:

Colorado has been in the process of developing a new long term care system for publicly funded clients for a number of years. In 1991, legislation was passed to implement a single entry point system to improve access to services through case management, the consolidation of programs and the use of a uniform assessment instrument. This action by the legislature followed the work of an interim sub-committee on long term care which addressed the status of case management in the State. As a result of this work, it was recommended that more information was needed on how the various service systems were utilizing case management, and the practices and models in place. It was felt that this information was needed prior to making any system changes or, in the case of social services, the development of a new model for long term care programs.

The major issues and problems concerning case management which existed in Colorado at the time of this project were: the lack of statewide information on case management practice across programs; the lack of a common operational definition of what constitutes the roles and functions of case managers; insufficient funding for case management and the lack of training in case management methods.

As operated by the public human services systems, case management had evolved in the State as a response to problems unique to each system. In social services, case management was first introduced in adult programs with the Home and Community Based Services waiver program, but was limited to clients of this program. For the developmental disabilities system, case management had formed the basis of its community based programs since they began, while the mental health system had more recently been using a variety of case management models as well as training programs for its staff.

Objectives:

The major objective of this project was to design and implement the case management component of the single entry point system in long term care in the Department of Social Services. It was determined that it was important that there be a clear operational definition of case management, consistent performance standards and quality training for case managers. In order to achieve these objectives it was necessary to collect and analyze information about how the current system was operating through a statewide survey of case managers working in the existing

programs. In addition, information about the development of case management in other states and privately through the national organizations was collected.

Methods:

The methods used in this project consisted of a mail survey of case managers in the social services, developmental disabilities and mental health systems and administrators of the local participating agencies. Over five hundred survey instruments were mailed to agencies, 369 responses were received, with a response rate of 65%. Data was analyzed by graduate students at Colorado State University. Consultation was obtained on the instrument design from the Long Term Care Centers at the University of Minnesota and Brandeis University.

Findings and Recommendations:

In comparing case management in the three service systems, it was found that there were differences in the functions performed by case managers and their job responsibilities but little variance in the problems and issues which case managers had with their jobs. Most case managers were white females with college degrees, few had advanced degrees. While all the case managers assumed job responsibilities which were not case management related, this was most prevalent in the mental health system. The developmental disabilities system had the smallest caseloads and earned the lowest salaries, social services were paid the highest salaries. For all the systems, the multi-problem dually diagnosed client took the most case management time. Paperwork was a consistent problem in terms of time spent on various tasks for all of the case managers. At the time of the study there was very little activity in terms of computerization of case management in any of those surveyed, and what was occurring took place in such areas as accounting or billing. Each system identified its training needs. The highest ranked content areas by system included: social services-assessment, mental health-counseling, developmental disabilities-mental health problems.

The following are recommendations derived from the information collected from the project and the implementation of the case management component of the single entry point system. More attention needs to be paid to the concerns of case managers, agencies need to consider hiring case aides or using volunteers to relieve case managers of the non-case management functions. Agencies should consider developing triage systems to alleviate the stress caused by handling large caseloads. High quality training and good supervision are needed in assuring quality case management. Comprehensive evaluations need to be conducted on the case

management process and outcome measures need to be incorporated into the design. Interagency relationships need to be strengthened and quality assurance mechanisms should by integrated into the work performance of case managers.

DISSEMINATION

The dissemination of information collected as a result of this project was ongoing during the grant period. Information was continuously shared with staff of the Department of Social Services involved in single entry point development and the long term care programs. More formal presentations were made to the state Mental Health Conference, the Case Managers Association, and the Adult Supervisors. Material from the survey was used as a component of the case management training for the Single Entry Point agencies.

The products of the project, the State Rules and the Procedures Manual were used in statewide training of the single entry point case managers and dispersed widely to all of the case managers in the system.

FINAL REPORT

Introduction:

The purpose of this project was to develop a case management system which would operate for the public long term care programs in Colorado through the newly formed Single Entry Point agencies. In order to develop a comprehensive system of case management which built on work already completed in the State in long term care, it was necessary to study how the system was operating prior to the establishment of the Single Entry Point system. The strengths and weaknesses of case management as currently managed were studied through a survey of those practicing in the three major service systems: social services, developmental disabilities and mental health. In order to systematically collect a wide range of information across the programs, a mail survey was selected as the primary method of data collection. This information was supplemented with on-site interviews of case managers and analyses of other state efforts and policies relative to case management development.

This report summarizes the work of the project, the results of the survey and the consequent system development activities in Colorado. At the time of the beginning of the project the Single Entry Point system was in the design phase. By the time the project had ended the system had been implemented in seven sites statewide. Case management formed the framework of the Single Entry Point system and, as such, needed the most study prior to finalizing the design selected. The initial proposal for this project was in response to a legislative sub-committee on case management which was part of an overall effort of a special session of the legislature on long term care. This sub-committee found that very little was known about case management in the State, and recommended more research on the subject in such areas as descriptions of the models used by service systems, how they compared and the strengths and weaknesses of each model. Additionally, there were very few training programs for case managers, and the schools offering education in human services were not providing case management curricula.

Legislation for the Single Entry Point system was passed in 1991 in order to improve access to long term care through case management, the consolidation of service programs and the use of a uniform assessment instrument. The objective of the Single Entry Point system was to integrate the existing publicly funded long term care programs, through case management agencies operating in local areas of the State, which would provide information and referral, intake, assessment, reassessment, monitoring and local resource development. The use of cost effective services and the appropriate utilization of services for both public and private persons were also objectives of the system.

This project was the result of a cooperative effort of staff of the Long Term Care Systems Development unit, responsible for the Single Entry Point system in the Colorado Department of Social Services, and Paul Bell, Professor of Psychology at Colorado State University. Dr. Bell and his staff provided assistance with the project design and conducted the analysis of the data from the case management survey.

Background:

In order to develop a comprehensive informational base on case management in the State, it was decided to include in the survey the three service systems which were most likely to provide services for the long term care client-social services, developmental disabilities and mental health. The following information describes the status of the three delivery systems as they were operating at the time of the survey relative to case management. Changes in the social services system as a result of the activities of this project and other efforts at the state level are included in the section of the report on conclusions and recommendations.

Social Services:

Within the adult programs in social services offering long term care services, case management, as a formal process, was first introduced into their operations with the Home and Community Based Services Medicaid waiver programs in 1983. At this time, the other adult programs operating in the system were staffed by caseworkers, offering casework services through county departments of social services. For the Home and Community Based Services case management programs, the traditional model of case management was utilized with staff providing assessment, program eligibility, monitoring and reassessment through case management agencies.

In 1988, the Colorado Department of Social Services developed a comprehensive plan to provide direction for long term care systems development in the State which included a framework for reorganizing the existing long term care programs into single entry points in local communities. Based on a case management model of service delivery, this system would offer information and referral, assessment, care planning, reassessment, monitoring, and resource development for long term care clients. The intent at this point was to provide services for those in community based programs as well as selective services for nursing home residents. Concurrent with these activities, the Colorado Legislature created a Long Term Care Task Force to study various issues in Colorado, including case management. A special advisory group was formed to study case management in the three delivery systems - mental health,

developmental disabilities and social services. There were two major outcomes relative to this project: a finding that not enough was known about the operation of case management in these systems, and a recommendation to pursue long term care legislation to establish a single access system. Legislation, Senate Bill 9, was introduced by the Task Force and passed in the 1990 session. This Bill mandated the development of a uniform assessment instrument to be used by all long term care programs and the study of a single entry point system. The intent at this point was to consolidate all of the long term care programs and to offer services for private pay clients two years after the system was operationalized.

The passage of legislation to actually implement the Single Entry Point system has been the most important event in the evolution of case management in the State. This legislation, House Bill 1287, was passed in the 1991 session and directed the Department of Social Services to establish the system in geographic regions around the State. Local County Commissioners were to establish districts and select agencies to administer the program. Existing funds from the Home Care Allowance program, Adult Foster Care and the Home and Community Based Services administrative dollars were to be consolidated to finance and increase the Medicaid matching funds for support. In addition a Long Term Care Advisory Committee was formed which included persons with expertise in case management. In 1993, the first seven single entry point agencies became operational, including nearly fifty percent of the long term care population in public programs. Designed as a phased in approach of implementation, all of the State was to be covered by single entry point agencies by 1995.

Developmental Disabilities:

Case management was instituted in the developmental disabilities service system as a response to deinstitutionalization, with the purpose of facilitating access to community services and resources for developmentally disabled persons who had previously been in institutional placements.

In the developmental disabilities system in Colorado, the Colorado Division for Developmental Disabilities has responsibility for services and supports to individuals with developmental disabilities, and has overall responsibility for services provided by the 20 local agencies or Community Centered Boards (CCB's) and through three Regional Centers providing institutional care. The CCB's function as single entry points for access to services and eligibility

determination; they are also the locus of case management services for individuals with developmental disabilities.

In 1982, a community based committee which included the Division, the CCB's and the Regional Centers developed a manual for case managers which included specific policies and procedures for all of the operating case management programs in the system. The major functions of case management were defined and included: intake, the development of the Individual Habilitation Plan (IHP), the development of the Individual Program Plan (IPP), monitoring and review, transfer or termination and continuing contact. Each person would have a case manager assigned and supervised through the CCB.

Four levels of service delivery are available for persons with developmental disabilities, including: the 20 CCB's, the Regional Centers, certain agencies which target services for the DD, and generic community agencies, such as community mental health centers and county departments of social services which provide needed services.

More recently the Division, in its five year plan, speaks of changing the focus of case management in response to complaints of consumers that case managers had too much power and persons did not want to be viewed as "cases" needing to be "managed".

Mental Health:

For the Mental Health system the development of the Community Support System, in response to deinstitutionalization in the 1970's, prompted interest in case management. Case management was viewed as a way to assist individuals in maximizing their use of existing resources which enable them to remain safely and independently in communities. In many ways, case management has functioned as a mechanism to assure the responsiveness of the service system to the needs of mentally ill persons who are dependent on the system. An additional reason for the support of case management in mental health has been the need to maximize resources due to scarce public dollars for the development of new resources; case management has been thought of as a cost containment measure, in that through it persons receive appropriate services and remain in community settings.

In general, the objectives of case management as provided in the mental health system focus on the following: reduction in the use of inpatient care when not appropriate, assistance to individuals in functioning independently, improving

the continuity of care and empowering client access to services. While the functions of case management are fairly consistently defined among the service delivery agencies, the actual models of delivery vary among the Community Mental Health Centers and from state to state.

The Colorado Mental Health system has utilized case management in a variety of ways. In 1987, the Division of Mental Health funded Dr. Paul Bell to conduct a study of case management as practiced in the sixteen Community Mental Health Centers across the State in order to understand the range of models in place. Findings of this study indicated that "the major trend was the absence of uniformity across Centers rather than common themes." Both the staffing patterns, in terms of the roles of case managers in the Centers and the models of case management used, varied considerably. Three broadly defined models of case management were identified in the system at that time: Centers which had separate case management units; a clinical model, where case managers also function as therapists; and, an intermediate model which functioned somewhat in between the other two, where therapists did provide case management. The study found that the only significant difference between the models was that those with separate units tended to provide more non-traditional services than the intermediate and clinical models, which were more traditional in their approaches. However, no outcome studies were done to actually evaluate the differences in models.

In the early 1990's, the Division adopted rules and regulations which specifically addressed standards and policies for case management and began to address case management in training provided for staff. More recently, the five year plan for community mental health in the State described case management as the " hub of the wheel" in providing services for seriously mentally ill persons. In this system, case management was being provided to individuals by a single case manager, a team of case managers or by a primary therapist. The coordination of services with other providers and interagency consultation were described as important components of this system.

Methods:

The methodologies used to obtain the necessary information from which to design the case management component of the Single Entry Point system in Colorado consisted of a mail survey of administrators and case managers statewide, consultation with staff and policy makers, use of a community advisory group to develop the case management standards, and ongoing reviews of activities being conducted in case

management development in other states and national organizations. Consultations were also held with staff of the Long Term Care Centers funded by the Administration on Aging at the University of Minnesota and Brandeis University.

Survey Methodology: In consultation with Colorado State University and the Geriatric Long Term Care Centers, a two part survey instrument was developed (see Appendix A). Part 1 of the instrument was designed for the agency administrator and Part 2 was for case managers or caseworkers in the long term care programs. This instrument was pre-tested with case managers in three agencies which were centrally located near the Denver area.

Administrators from the three systems were consulted regarding sampling strategies and assisted in gaining cooperation from the local agencies. No comprehensive lists existed in any of the systems of the case managers and each system required different strategies for contacting local agencies and selecting the respondents. As a result, different sampling strategies had to be developed for the service systems, placing limitations on the comparison of the data across the three systems. In smaller agencies in social services all case managers or caseworkers serving adults, age 18+, were asked to respond. The administrators with the agency with the most knowledge about case management were self selected from each agency. Larger agencies were asked to select 25% of the eligible workers to participate, using a random number selection process. Not all of the potential respondent agencies completed the survey, so the geographic distribution of respondents was not even across the State. The following chart illustrates the response rates for the case managers surveyed in each of the service systems. There was a 65% response rate for the case managers responding from all of the systems.

	Response Rates for Case Mangers		
	Number Mailed	Number Returned	% Completed
SS	220	161	73%
DD	120	60	50%
MH	225	148	66%

SECTION A: CHARACTERISTICS OF THE AGENCIES SURVEYED

The administrators of the agencies surveyed in the three service systems were included in the study in order to obtain descriptions of how they functioned in terms of the operation of case management. Information requested included general descriptions of the agencies, case management practices and the role of the agency in providing training for the case managers.

The agencies included which served developmentally disabled and mentally ill persons provided services for only these populations, while respondents from the social services agencies stated that they also saw as their function the promotion of public health and provided case management as a separate function to various populations. Of the three, social services agencies had been in operation for the longest time and had offered case management for the longest period of time. As for case management, nearly all reported that they had written standards for case management practice, with mental health having the highest percentage (93%), followed by developmental disabilities (87%) and social services (71%). All developmental disabilities agencies reported that they had formal policies and procedures regarding case management while nearly three fourths of the respondents from the other two systems reported having formal policies. Approximately one fourth of the mental health and developmental disabilities respondents reported that they had waiting lists at their agencies for case management services, while 9% of the social service respondents reported waiting lists.

Respondents were asked about their policies regarding case management training at the various agencies surveyed. Table 1 illustrates the role of the agencies from the three systems in supporting training for their staff. Both the mental health and developmental disabilities agencies reported more supportive activities related to staff training. In the case of mental health, all of the agencies reported that they sponsored training on case management and that the state agency also provided training for their staff. In the case of social services, less than one third (31%) reported that the agency provided any training on case management. Very few agencies from the three systems (2-7%) reported that staff were responsible for identifying and paying for their training.

Table 1

Agency Policies for Training			
	SS	DD	MH
Budgeted To Purchase Training	46%	87%	36%
Sponsors Training on CM	31%	87%	100%
State Provides Training on CM	76%	80%	100%
Staff Responsible to Identify and Pay for Own Training	2%	7%	7%

SECTION B: DESCRIPTION OF THE SERVICE SYSTEMS

The following section describes the characteristics of the respondents, case managers or caseworkers in adult programs in the three service systems included in the survey-social services, mental health and developmental disabilities-and their job responsibilities as case managers. Prior to this survey, little information was available in the State concerning the characteristics of persons providing case management in these systems. In order to develop case management standards which address staff qualifications and functions it was necessary to obtain baseline information about the existing staff configurations. Questions were asked which addressed their background, language abilities and job responsibilities.

The Social Services System

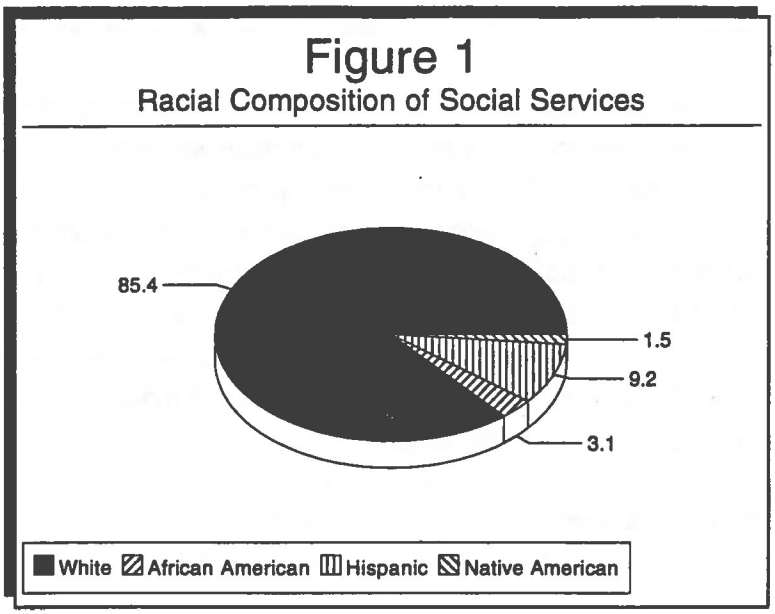
Staff:

The mean age for both case managers and caseworkers in the social service programs responding to the survey was 42.5 years, with an age range from 20 years to 65 years. As would be anticipated, most of the workers were female (81%).

Table 2

Characteristics of the Social Services Staff		
• MEAN AGE	=	43 years
• AGE RANGE	=	20 - 65 years
• SEX - MALE	=	19%
• SEX - FEMALE	=	81%

The majority of the staff surveyed were white (85%). Approximately 9% of the staff were Hispanic; African American workers comprised 3% of the workforce, while 6 % were Native Americans. Client specific data from a new Integrated Long Term Care Database developed by the Colorado Department of Social Services revealed a somewhat different racial/ethnic composition of clients served in the programs receiving most of the case management services. Approximately 66% of the clients were white, and 6% were African American. The most significant difference between the racial composition of the populations served and the race of the case managers, however, occurred with the Hispanic population as one-quarter (25%) of the clients were Hispanic, while only 9% of the staff in social services were Hispanic.



Education:

Because very few formalized educational programs have existed in Colorado which address the process and functions of case management, both at the graduate and undergraduate level, we were interested in the educational backgrounds of those currently providing case management in the system. This information was used in the development of educational criteria for the case management standards as well as in the design of training.

In social services, nearly all of the sample had at least a four year college degree (88%). Of these, 71% had a Bachelor's degree, 18% had Master's degrees and .8% had a Ph.D. A very small number (6%) had only a high school education. For those individuals with a college degree, most had concentrated in sociology, psychology or education. For those with a Master's degree, most of the degrees were in social work or counseling.

Table 3

Educational Background of Case Managers in Social Services	
High School Graduate	1.5%
Some College	7.7%
4-Year College	70.8%
Master's Degree	17.7%
Ph.D. Degree	0.8%

In addition to questions which addressed academic background of those surveyed, we asked whether or not staff had any professional licenses related to their work as case managers. For those in social services, most (87%) did not, although 3% mentioned licenses in the education area, 6% were licensed as registered nurses (RNs) and 2% were licensed social workers. The relatively small number who were licensed as social workers was somewhat surprising, given that these were individuals employed in social service agencies.

Approximately 17% of the social services staff spoke a language other than English, with Spanish the most frequently mentioned language (12%), followed by French and German. Additionally, about 2% of the sample could use sign language.

Job Responsibilities:

One intent of this study was to provide data and information on the functions of case management as practiced, prior to establishing a new system of case management within the social service system. At the time of the study, only one-fourth of the social services staff related that their job titles were "case manager". Their titles included student case manager, case manager assistant, director of case management, and case management associate. Most of the staff surveyed in the social service agencies (70%) were referred to as caseworkers or social workers, a small number (3%) identified themselves as nurses.

Table 4

Job Titles of Case Managers		
• Case Manager	=	25%
• Nurse	=	3%
• Case/Social Worker	=	70%
• Other	=	2%

In surveying how long persons had been in their current positions, the caseworkers/social workers had worked in their agencies twice as long as the case managers had, from an average of 7 years for caseworkers to 3 years as case managers. This difference was probably due to the more recent development of the Home and Community Based Services Medicaid waiver program within the social service system within the last ten years; this program has used case managers rather than caseworkers as the key staff persons.

In addition to the length of time employed, the job experience relative to case management was of interest to us. Caseworkers/social workers had twice as much work experience in their fields as the case managers, from 10 years for case workers to 5 years for the case managers. In their current positions they also had been on the job for longer periods of time, for an average of 6 years for the caseworkers to 3 years for case managers.

Aside from their job responsibilities as caseworkers or case managers, nearly a half (45%) of the sample had other job responsibilities in their respective agencies. These individuals spent nearly a quarter (25%) of their time completing tasks not identified as casework or case management. The most frequently mentioned other job responsibilities included supervisory work, public relations, clerical/front desk jobs, program evaluation, and program coordination.

Within the social services system, nearly three quarters (75%) of the surveyed staff (71%) worked full time, although it is important to note that nearly one quarter were part-time workers. In addition, a very small number of the respondents either worked under a contract, as student interns, or on an "as needed basis."

For all social services staff surveyed, the average full time gross monthly salaries reported by those surveyed ranged from $2049 to $3100.

Over half of the surveyed staff persons functioned in their agencies as members of teams (59%), although it is important to note that 42% of the staff did not operate in a team environment. For those who were members of teams, the teams were focused on joint decision making regarding cases, adult/child protection issues, and home health cases.

The Developmental Disabilities Service System

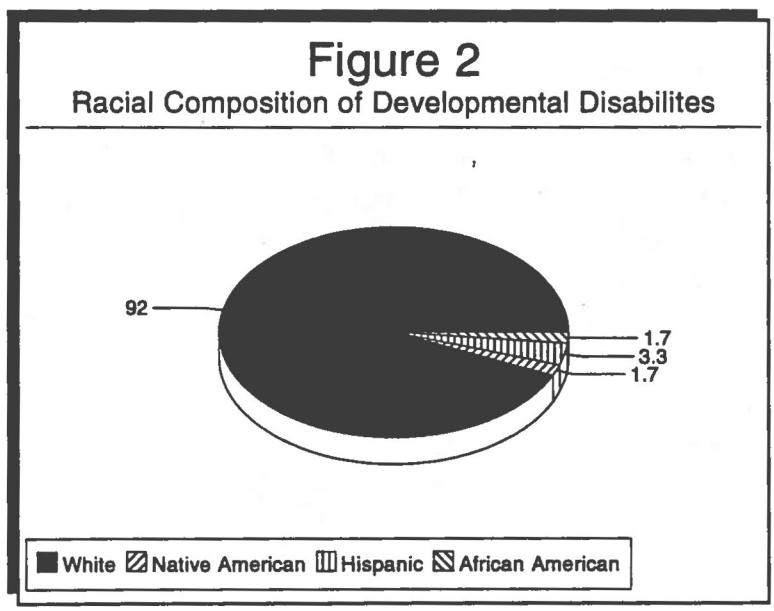
Staff:

At the mean age of 37 years, case managers in the developmental disabilities system were somewhat younger than their counterparts in the other service systems, their ages ranged from 23 to 59 years. Most of the staff were female (82%).

Table 5

Characteristics of the Staff in Developmental Disabilities		
• MEAN AGE	=	37 years
• AGE RANGE	=	23 - 59 years
• SEX - MALE	=	18%
• SEX - FEMALE	=	82%

Nearly all of the staff surveyed were white (92%). Of those whose race was identified as other than white, 3% were Hispanic, 2% were African American, and 2% were Native American.



Education:

Most (95%) of the case managers surveyed from the developmental disabilities system had at least four year college degrees; of these, 70% had bachelor's degrees and 25% had Master's degrees; there were no Ph.D.s in this group of case managers. Those persons with college degrees usually had majored in psychology, followed by social work or sociology. Master's degrees were most often in social work, counseling and education. Only 10% of the staff had professional licenses and most often these were in education. Of the one-fifth of the responding staff who also spoke a language other than English, most spoke Spanish (17%).

Table 6

Educational Background of Case Managers in the Developmental Disabilities System	
High School/GED	0.0%
Some College	5.0%
4-Year College	70.0%
Master's Degree	25.0%
Ph.D. Degree	0.0%

Job responsibilities:

Reflecting the established position of case management in the developmental disabilities system, most persons performing case management functions in the participating agencies had job titles of case managers (95%); the remaining were either caseworkers or social workers. Those identified as case managers had been at their agencies for an average of four years; their total experience as case managers was about five years. The small number of persons called caseworkers had been in their agencies for 5 years and had been on their jobs as caseworkers for about 6 years.

Forty-two percent (42%) of the developmental disabilities staff indicated that they had job responsibilities in their agencies other than case management and that they spent, on an average, about 14% of their time on these other tasks. Most of the tasks involved supervision and liaison work with other agencies or work related to participation on teams. The gross monthly salary for case managers surveyed in the developmental disabilities system ranged from a minimum of $1608 per month to a maximum of $2500. Most workers (92%) were employed on a full time basis.

Interdisciplinary teams are widely used in this delivery system to make decisions and this was reflected in the data, as nearly all (98%) of the respondents indicated that they were members of a team.

The Mental Health System

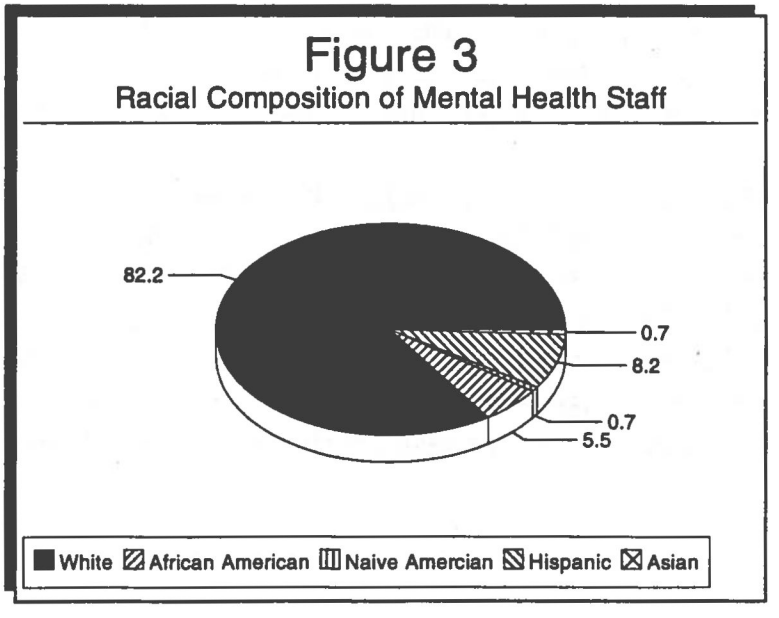
Staff:

In the mental health system, the mean age of the responding individuals who performed case management functions was 41 years; however, the age range of these persons was very wide--from 23 years old to 77 years. The mental health sample had somewhat more male case managers than the other systems (35%), although females were in the majority at 64%.

Table 7

Characteristics of Mental Health Staff		
• MEAN AGE	=	41 years
• AGE RANGE	=	23 - 77 years
• SEX - MALE	=	64%
• SEX - FEMALE	=	35%

As with the other delivery systems, most case managers were white (82%), however, in mental health 8 % of the staff were Hispanic, 5.5% were African American and 0.7% were Native Americans.



Education:

Most (93%) of the surveyed respondents in mental health agencies had at least a four year college degree, 55% of these persons had Master's degrees, and over one third (36%) had bachelor's degrees, while 2% had Ph.D.s. The college degrees were most often in social work or psychology and those with Master's degrees were in social work, counseling or psychology. A considerable number (12%) of the respondents had professional licenses in social work, either an ACSW or a LCSW and about 4% were Rns. Nearly 20% of the staff spoke a language other than English, most of these persons spoke Spanish (14%).

Table 8

Educational Background of Case Managers in Mental Health	
High School Graduate/GED	0.7
Some College	4.1%
4-Year College	36.3%
Master's Degree	54.8%
Ph.D. Degree	2.1%

Job Responsibilities:

As would be anticipated, over half of the mental health staff surveyed (63%) had job titles as mental health workers. However, nearly one third of the these persons were referred to as case managers as they functioned in their jobs. Most (88%) were employed on a full-time basis. The average full-time gross salary for these respondents ranged from $1754 to $3093 per month.

On an average, these case managers had worked at their current agencies for over three years and had somewhat more experience functioning as case managers (7.7 years) than those in the other systems. When asked if they performed tasks other than case management, nearly all (89%) reported that they did. On an average, these workers spent about half their time doing other tasks, most often tasks related to supervision, administration or coordination. In addition, over half of the tasks performed involved work as therapists.

Summary:

Although comparisons of the characteristics of persons providing case management in the three systems is somewhat limited because of the differences in sampling strategies, the data suggest distinctions between the systems on a number of factors. The case managers in the developmental disabilities system were somewhat younger than in social services and mental health agencies. In a profession dominated by female staff, the mental health agencies had more male staff. All staff were predominately white. Social service agencies had a larger percentage of Hispanic and Native American staff, while mental health had overall the highest percentage of minority staff and developmental disabilities, the lowest percentage of minority personnel.

Although the majority of all staff surveyed were well educated with at least college degrees, the mental health staff were the most well educated, primarily because of the large number of persons with advanced degrees. Salaries of those surveyed were highest for case managers in the social services agencies and lowest for those in the developmental disabilities system.

At the time of the survey, the developmental disabilities system appeared to have acknowledged the role of case managers in a more consistent, formal and well defined manner than the other service systems. This can most likely be explained by the fact that this system has been based on a case management model since its inception. Considerably more staff have the job title of case manager, and most of the staff surveyed in this system worked full time as case managers. While all of the case management staff had some job responsibilities in their agencies which did not fall within the usual definition of case management, in the developmental disabilities system fewer of the staff than in the other systems had responsibilities other than case management. In fact, twice as many mental health staff, who identified themselves as case managers, reported that they had other job responsibilities than case management than did staff surveyed from developmental disabilities and social services. Respondents reported that they spent nearly half of their time on "other" tasks while case managers from the other service systems reported that they spent from 25% to 14% of their time on other tasks. There were not notable differences in the amount of time that case managers had been on their jobs in the agencies, however, persons surveyed from the mental health system had been employed for the longest time.

Table 9

Educational Background in the Three (3) Service Systems (%)					
	H.S./GED	Some College	4-Year Degree	Masters Degree	Ph.D.
SS	1.5%	7.7%	70.8%	17.7%	.8%
DD	.0%	5.0%	70.0%	25.0%	.0%
MH	.7%	4.1%	36.3%	54.8%	2.1%

Table 10

Salaries of the Case Managers		
	Average Full Time Monthly Salary	Maximum
SS	$2049	$3100
DD	$1608	$2500
MH	$1754	$3093

SECTION C: CASE ASSIGNMENT

The number of clients carried by a case manager at any point in time is usually referred to as a caseload. The size of a caseload is generally assumed to play an important role in the quality of case management services provided, the smaller the caseload, the higher the quality of care. Within social service systems, many states have been wrestling with the question of whether or not to set specific standards regarding caseload size and if they do, what the standard should be. A brief telephone survey of selected states and national organizations which focus on long term care issues revealed that it is difficult to get a national perspective on caseload size, primarily because each state includes different functions in their definitions of case management. However, it was reported that, in general, most of the Medicaid waiver programs have caseloads of 70 to 90 cases, while the state funded home care programs have higher caseloads. (LTC Center,University of Minnesota). Some states such as Oregon set caseload standards by program areas; for example, in-home services have a standard of 69 cases per worker, while residential care programs have a standard of 100. Most Social Health Maintenance Organizations set standards of around 70 cases

per staff member. A number of variables determine how individual states decide on caseload standards, including: the method in place for reimbursement of case management, the composition of caseloads and the case mix, the functions of the case manager, if and how paraprofessional staff are used in the case management system, and the funding available for case management.

In Colorado, the caseload size was originally established at 45 cases for many of the adult programs in social services, and more recently, at 55 cases for the Single Entry Point case management agencies. As with the national scene, the waiver programs have had lower caseloads than the state funded Home Care Allowance program which, in some areas, has had caseloads of over 100 cases. Within the service system for those with developmental disabilities, caseload size varied from one Community Centered Board to another. The average caseload is reported to be around 70, with a range from 50 to 150 cases. There are no specific caseload standards currently in place in the DD system.

Table 11

Average number of clients in caseloads/1992		
SS/Case Manager	=	40
SS/Caseworker	=	42
DD	=	56
MH	=	26

To clarify the issue of caseload size and the populations served by each of the service systems, we asked respondents the average number of clients which they had in their caseloads in the previous year (see Table 11). In addition, questions were asked which addressed the specific populations served, the source of funding for their care and which of the population groups in their caseloads consumed the most case management time. In order to diminish the negative effects of large caseloads, a number of states have been experimenting with triaging case assignments, so that there is a planned distribution of cases among staff based on specific criteria, one of which is the amount of case management needed by the populations served. Table 12 illustrates the distribution of caseloads across diagnostic categories for the service systems surveyed.

Table 12

Distribution of Caseloads Across Diagnostic Categories by Age Groups						
Age	System	Physically Disabled	Mentally Ill	Develop-mentally Disabled	Dually Diagnosed	Traumatic Brain Injured
65+	SS	87%	2%	1%	9%	1%
	DD	13%	5%	67%	13%	2%
	MH	23%	68%	1%	6%	2%
18-64	SS	52%	25%	10%	8%	5%
	DD	9%	3%	72%	15%	1%
	MH	4%	71%	5%	18%	2%
0-17	SS	45%	3%	27%	23%	2%
	DD	17%	2%	77%	2%	2%
	MH	3%	85%	5%	7%	0%

Social Services

For respondents of the survey, case managers in the current social services system reported an average caseload size of 40 clients, for caseworkers, the size was slightly higher at 42 persons.

Staff reported that their caseloads were comprised primarily of older persons (age 65+) who were physically disabled. For clients who were ages 18 to 64, social service staff were also seeing persons who were physically disabled (52%) and individuals who were mentally ill (25%). The clients who were children, ages 0 to 17 years, were primarily physically disabled (45%), followed by those who were developmentally disabled (27%) or dually diagnosed (23%), (defined as persons with more that one official diagnosis).

Respondents of the survey were asked to identify which population groups took the most time in the provision of case management. Within the social services system, the elderly took the most case management time (55%), followed by the physically disabled (24%), children (20%), and the dually diagnosed (13%). Lower users of case management among the populations served by social services staff were developmentally disabled clients, persons with traumatic brain injuries, and mentally ill persons.

Clients seen in the social service system were supported by a range of various public programs. Information provided by both caseworkers and case managers regarding the source of public support for their clients revealed that the Home Care Allowance program was the most frequent source of funding at 71%, followed by Supplemental Security Income (SSI) (63%), Home & Community Based Services (HCBS) (55%), Medicare (53%), Medicaid (47%), and Social Security Disability Income (SSDI) (44%).

Developmental Disabilities

Respondents from the developmental disabilities system indicated that they were carrying the highest caseloads among the three systems, with staff reporting an average number of 56 clients per caseload. Although all clients in this system are developmentally disabled, other disabilities also appeared. For persons who are elderly (ages 65+) in the system, 67% were classified as developmentally disabled, while 13% were physically disabled and 13% were dually diagnosed. Among adults, 72% were identified as developmentally disabled, however, 15% of this group were also dually diagnosed individuals. For children, over three fourths (77%) were developmentally disabled, and 17% were physically disabled. Physical disabilities and/or dual diagnoses occurred in as much as 25% of the caseloads. Persons seen by the respondents in this system tended to receive public assistance from SSI (88%), Medicaid (82%), HCBS (78%), and Medicare (75%).

Case managers responding to this survey indicated that the most case management time was spent with their developmentally disabled clients but that those clients who were also dually diagnosed used a good deal of case management time, followed by persons who were mentally ill. Those individuals classified as lower users of case management time included the elderly, the traumatic brain injured, and children. Interestingly, the elderly, who comprised a fairly large percentage of the caseloads, were perceived to not drive as much case management time as the other groups.

Mental Health

The problem of caseload size in the mental health system has not received as much attention as other issues. This is most likely due to the fact that the functions of case management are usually performed by a variety of staff persons and many staff carry mixed caseloads of persons needing case management and those who do not. For example, a therapist might provide case management for some clients but only therapy for others. In this study, respondents from mental health agencies reported average

caseloads of 28.5 persons, smaller than those reported by the other systems (see Table 11).

Persons identified as providing case management in the mental health agencies were seeing mostly mentally ill persons in all of the age categories, as would be expected. Physically disabled older persons (23%) and dually diagnosed persons from ages 18 to 64 (18%) were additional categories represented as being seen with relatively high frequency.

Staff reported that aside from the mentally ill clients, dually diagnosed clients drove the most case management time. The elderly were low users of case management time as were children. Both of these groups, however, were being seen in significant numbers within the system.

Most persons in the mental health system who were receiving case management were receiving assistance from Medicaid (77%), followed by SSI (69%), SSDI (67%), and Medicare (62%). Of note is the fact that it was reported that over 7% of the clients were receiving the Home Care Allowance and 19% were in Adult Foster Care, programs operated by the social services system.

Summary:

The variances between the surveyed systems in terms of caseload size were not great, except in the case of the developmental disabilities agencies where, on the average, caseloads were much smaller. From the information collected regarding the populations served, it appeared that case managers in all the systems were seeing multi-problem individuals and that persons with dual diagnoses were the most problematic for all. While the elderly comprise the largest number of clients in the social service system, they were being seen in both developmental disabilities and mental health programs, but were perceived by all of the case managers as not being heavy or demanding users of case management.

SECTION D: CASE MANAGEMENT/CASEWORK ACTIVITIES

Because case management practices differed among the service systems and even within systems by the agencies providing case management, we felt information regarding job functions could best be defined by the case managers surveyed. The questions asked of the respondents in this section addressed the case management tasks performed during an average week and other job responsibilities related to case management. In addition, those tasks which were the most time consuming for the case managers in arranging services for clients were identified.

Social Services

Respondents were asked the average amount of time which they spent on the various functions generally assumed to be part of the case management process. The total number of hours which social service staff estimated that they spent on case management or casework tasks was 35.16 hours per week. Of the total hours spent, monitoring and follow up activities, which included ongoing client and service provider contact to check on client progress, and whether services were received, consumed the most time at 5.65 hours per week. These activities were followed by reassessments and assessments, each of which took about five hours per week, and case planning and service arrangement, both estimated to take approximately four hours. Three hours were spent on eligibility determination and intake. The least amount of time (1.09 hours) was spent on resource development, defined in the survey as the actual development of new resources for individuals when services were not available.

Table 13

Case Management Activities in Social Services		
TASKS	#hrs/wk	%/time
Case Finding	1.17	3.3
Intake	2.81	8.0
Assessment	4.68	13.3
Elig. Determination	2.95	8.4
Case Planning	3.77	10.7
Service Arrangement	3.94	11.2
Monitoring/Follow-up	5.65	16.1
Reassessment	4.85	12.8
Resource Development	1.09	3.1
Other Client Interventions	1.92	5.4
Other Tasks	2.33	6.6
TOTAL	35.16	

Social service staff were also asked to identify any other interventions performed on the behalf of clients. Nearly one fourth of the respondents reported client counseling as an intervention, other frequently mentioned activities were family contacts and family education. Other tasks completed regularly as part of their jobs included

attending meetings (26%), crisis interventions (8%) and typing reports (3%). Respondents were asked about the time which they spent in a week on other job responsibilities. Overall, staff spent the most time on additional client contacts (9 hours), completing forms and paperwork (9 hours).

In addition to the performance of case management, we asked respondents to rank the tasks performed in terms of those activities which were the most time consuming for them in arranging services for clients or consumers.

Table 14

Activities that are the most Time Consuming in Arranging Services			
	SS	DD	MH
Telephone Contact	4.5	5.0	6.0
Case Conferences/Meetings	3.0	8.2	6.3
Contacts/Clients/Families	4.5	5.2	5.8
Paperwork	8.5	8.4	8.2
Travel/Home Visits	5.1	4.7	4.1
Client Preferences	4.6	3.7	5.1
Vendor Limitations	5.1	6.1	5.3
Service Monitoring	5.9	7.0	6.0
Physician Contacts	3.6	2.6	4.4
Family Problems	4.8	5.9	5.2
1 = least time consuming . . . . 10 = most time consuming			

For staff from all of the participating agencies, paperwork clearly drove the most time. For social services, monitoring of services, working with providers and home visits, including the travel time, took considerable time. The least amount of time was spent on meetings, case conferences and physician contacts.

Developmental Disabilities

Case managers in the developmental disabilities system reported that they performed about 42 hours of case management in an average week. Of these hours, the most time was spent on monitoring and follow up (9.2 hours), case planning (6.38), and service arrangement. The least amount of time was spent on case finding, intake and

assessment. Other reported client interventions included counseling, direct client contacts, phone calls and family education efforts. Tasks regularly completed as part of case management jobs included attendance at meetings and crisis interventions.

Table 15

Case Management Activities in Development Disabilities		
TASKS	**#hrs/wk**	**%/time**
Case Finding	**.89**	**2.1**
Intake	**2.02**	**4.8**
Assessment	**2.09**	**5.0**
Elig. Determination	**1.58**	**3.7**
Case Planning	**6.38**	**15.1**
Service Arrangement	**5.25**	**12.5**
Monitoring/Follow-up	**9.20**	**21.7**
Reassessment	**3.73**	**8.9**
Resource Development	**2.38**	**5.7**
Other Client Interventions	**2.78**	**6.6**
Other Tasks	**5.74**	**13.7**
TOTAL	**42.04**	

As illustrated in Table 14, the three most time consuming tasks for developmental disabilities staff included paperwork, case conferences or meetings,and monitoring services provided to clients. The least time consuming tasks were physician contacts and attending to client preferences. Other time consuming activities for staff included working with dually diagnosed persons, transportation for clients, and scheduling activities.

Mental Health

As indicated in Table 16, staff performing case management functions in the mental health system spent, on an average, over 29 hours per week on case management. Of these hours, most (10.94) were spent on tasks identified as "other" client interventions and "other" tasks, which included counseling, therapy and crisis intervention. Very little time was spent on those tasks traditionally thought of as part of the case management process. Of the more traditional tasks, monitoring and follow up took the

most time, about 3 hours per week, followed by case planning (2.3 hours), assessment (1.96 hours) and reassessment (1.83 hours). As with the other systems, case finding took the least amount of time. Other tasks identified by the respondents as being a regular part of their case management jobs were crisis intervention, attending meetings, direct supervision, and serving on committees.

Table 16

Case Management Activities in Mental Health		
TASKS	#hrs/wk	%/time
Case Finding	.48	1.6
Intake	1.20	4.1
Assessment	1.96	6.7
Elig. Determination	.88	3.0
Case Planning	2.30	7.8
Service Arrangement	1.31	4.5
Monitoring/Follow-up	3.35	11.4
Reassessment	1.83	6.2
Resource Development	.73	2.5
Other Client Interventions	10.94	37.3
Other Tasks	4.36	14.9
TOTAL	29.34	

Mental health staff reported that they spent about 22 hours per week on additional job responsibilities related to case management. Of these, the most time (8 hours) was spent on client contacts, followed by paperwork (6 hours), and crisis management (2 hours).

Arranging for services for clients is often a time consuming task for case managers. To address this issue, we asked respondents to rank a series of possible activities according to the amount of time it took to perform them. For mental health staff, the most time consuming activities were paperwork, case conferences or meetings, and monitoring services provided to clients. The least time consuming activities were travel to make home visits, and physician contacts.

Summary:

In order to develop a quality case management system which is responsive to the needs of long term care clients, it was important to understand the systems in place in the State. The job functions of the case managers operating in the three systems differed in terms of the kinds of tasks performed and the amount of time spent on them. For example, in social service and developmental disabilities agencies, the case managers spent most of their time on monitoring cases and follow up, while in mental health the most time was spent on client interventions such as providing therapy, counseling and crisis intervention. In this respect, the role or functions performed by the mental health case manager differed markedly from the other systems. In terms of the amount of time spent by the case managers on tasks related to arranging services, paperwork drove the most time across all three systems.

SECTION E: SUPERVISION OF CASE MANAGERS

The type and quality of supervision provided to case managers is an important factor in assuring a quality case management system. Case managers usually had not received any formal education in case management concerning skills needed to perform their jobs, and case management training was in the beginning stages in the State. Because case management, as defined, varied from agency to agency in terms of job descriptions and the qualifications of professional staff performing the tasks associated with case management, we were interested in the supervision provided for case managers. Questions in this section of the survey addressed the characteristics of individuals who were serving as supervisors in terms of their job titles and educational backgrounds, as well as the levels of supervision which they provided for the case managers. Tables 17 and 18 illustrate the job titles of supervisors and their educational levels by service system.

Table 17

Job Titles of Supervisors			
	SS	DD	MH
Director	36.2%	93.3%	61.6%
Program Manager	1.5%	3.3%	9.6%
Supervisor	50.0%		18.5%
Administrator	1.5%		2.7%
Other	1.5%		1.4%

Table 18

Education of Supervisors			
	SS	DD	MH
Bachelors	28%	25%	4%
Masters/SW	15%	15%	35%
Masters/Other	14%	8%	28%
Ph.D.			10%
Nursing	7%		8%
Don't Know	19%	2%	9%
Other	11%	27%	5%

The various roles and functions of supervisors in the case management systems varied by service system as illustrated by Table 19.

Table 19

Supervisory Tasks										
	Chart/Record Reviews		Home Visits		Training		Individual Problem Solving		Consult Policies & Procedures	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
SS	68%	32%	15%	85%	47%	52%	71%	28%	94%	6%
DD	25%	75%	7%	93%	50%	50%	77%	23%	92%	8%
MH	77%	23%	15%	84%	66%	34%	84%	16%	94%	6%

Social Services

The job title identified by the social service staff for their supervisors in half the cases was "supervisor" in the agencies surveyed; however, over one-third (36%) of the supervisors also served as "directors" in their agencies indicating that they were not "full-time" supervisors. This category included such job titles as case management

director, director of support services, program director, executive director of the agency, public health director, and nursing director.

Over one-fourth (28%) of the supervisors had advanced degrees at the Masters level, half of which were in social work; one quarter of the supervisors had bachelor degrees. About 7% had nursing degrees.

Social services staff met with their supervisors most often on an as needed basis (36%) or on a once a week basis (25%). However, about 9% met only on a monthly basis, while 12% met more than once a week.

The role of supervisor varied considerably in terms of the tasks performed. The most frequently performed task was consultation on polices and procedures (94%) followed by individual problem solving (72%), and record reviews (68%). About half the supervisors provided training and half did not. Very few (15%) made home visits as part of the supervisory process.

Developmental Disabilities

Nearly all (93%) of the supervisors in the developmental disabilities system had job titles of "director", usually as director of programs, service coordination or case management. In this system, one-fourth of the supervisors had bachelor's degrees and nearly a quarter of the supervisors (23%) had masters degrees, most of which were in social work.

About a third of the case managers met with their supervisors on an as-needed basis, while a third also met once a week or more often. Twenty percent of the staff reported that they met once a month and ten percent every two weeks.

The major supervisory tasks in this system included consultation on policies and procedures and individual case problem solving. As with social services, half the case managers reported that their supervisors provided training and half did not. Very few of the supervisors went on home visits (7%) and only one-fourth performed chart reviews as part of supervision.

Mental Health

In contrast to social services, supervisors of the case managers in the surveyed mental health agencies were most often directors of some kind in their agencies (62%), usually director of professional services, extended care, service coordination or

nursing. Nearly one-fifth of these individuals were called supervisors and about 10% were program managers.

In mental health nearly three quarters of the supervisors had advanced degrees (73%) and 10% of these were Ph.D.s. About eight percent had nursing degrees.

Over half of the respondents met with their supervisors on a weekly basis, about 14% met more than once a week and 16% met on an as-needed basis.

Supervisors most often provided consultation regarding agency or program policies and procedures, followed by individual problem solving and record reviews. About 66% provided training, although over one third did not. Most of the supervisors did not make home visits with the case managers.

SECTION F: STAFF DEVELOPMENT

In both the development of new case management programs and the improvement of existing programs, staff development is an important consideration. In Colorado, very little skill development training for case managers had been offered in the social services and mental health systems up to the time of the survey. Social services personnel most often received training in the mechanics of program operation such as rules, procedures and how to complete forms. It was felt that it would by useful to collect information on staff development from the case managers which could be utilized in designing future training sessions and in the development of standards for case managers. Information collected by the survey focused on the initial training provided to case managers by their agencies, routine on-going training provided internally, outside training attended, current training needs and the format preferred for training offerings in the future.

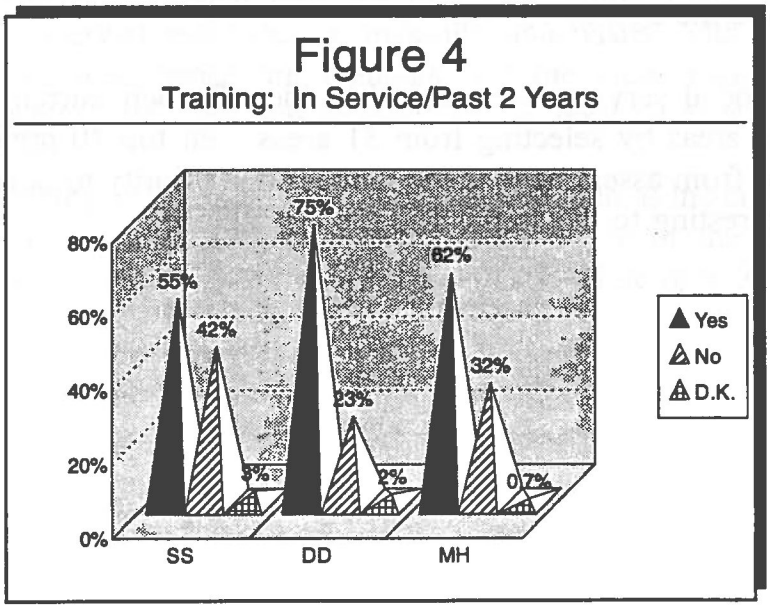
Because case managers were not likely to have received formal training or education in how to be a case manager, we were interested in the role and responsibilities of the agency hiring case managers in the development of their staff. Respondents were asked in what content areas they had received training or instruction relative to case management as preparation for their roles as case managers. The following chart illustrates the preparation received.

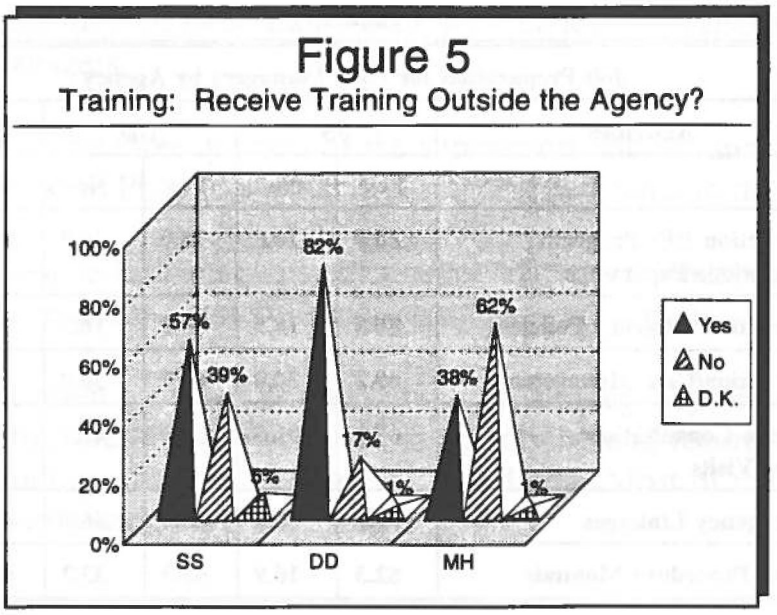
Table 20

Job Preparation for Case Managers by Agency						
Activities	SS		DD		MH	
	Yes	No	Yes	No	Yes	No
Instruction RE: Program Regulations/Paperwork	86.9	10.8	75.0	16.7	90.4	9.6
Instruction - Agency Policies	80.8	18.5	80.0	16.7	93.8	6.2
Instruction/Case Management	69.2	30.0	66.7	30.0	69.2	30.8
Provide Consultation/ Home Visits	67.7	31.5	55.0	41.7	78.1	21.9
Interagency Linkages	39.2	60.0	40.0	56.7	45.9	54.0
Use of Procedure Manuals	82.3	16.9	63.3	33.3	69.9	30.1

Workers in the three systems received considerable preparation specific to agency policies and procedures, program regulations, use of procedure manuals, with somewhat less preparation is the areas of case management or casework skills. Much less attention was directed to external relations with other agencies or programs.

Figures 4 and 5 identify the percentage of persons in the three systems who received training from the agency in which they worked and from sources outside the agency over the previous two years.





Social Services

Over half (55%) of the social services staff had received in-service training sessions relative to case management within the previous two years. A slightly higher percentage (57%) had also participated in training or educational activities offered outside their agencies during this time period. It is important to keep in mind that a considerable number of persons also reported no training activities, either in house (42%) or outside the agency (39%).

Persons from social services were asked to identify their current training needs in various content areas by selecting from 31 areas their top 10 preferences. Subjects selected ranged from assessment as the number one priority to developing case plans as the least interesting to the staff. The top ten included:

Table 21

Content Areas Preferred by Social Services Staff	
1.	Assessment
2.	Abuse/Neglect
3.	Community Resources/Find, Develop
4.	Legal Issues
5.	Alzheimer's Disease
6.	Medical Terminology
7.	Common Diseases of Special Populations
8.	Program Eligibility
9.	Aging Process
10.	Developing Case Plans

The type of format for future training preferred by social services staff was computer assisted training in five day sessions, offered in the Denver area.

Mental Health

Nearly all the mental health staff reported that they had received training or instruction on the regulatory aspects of their jobs and in agency policies and procedures; over three-fourths had received assistance in making home visits, with somewhat fewer reporting assistance with procedure manuals and the case management process. Training on interagency linkages was received by the least number of persons.

Participation in training sessions offered by the agency such as in-service sessions and training attended externally were addressed. Over 60 % of the respondents had received in-service training during the prior two years, while only 30% had received outside training.

For those in the mental health system participating in the survey, counseling skills were identified as their preferred need for training. The top ten subject areas selected from a total of 31 possible areas of interest for training were as follows:

Table 22

Content Areas Preferred by Mental Health Staff	
1.	Counseling
2.	Working with Difficult Clients
3.	Community Resources
4.	Mental Health Problems
5.	Legal Issues
6.	Interviewing Skills
7.	Resolving Quality of Care Issues
8.	Assessment
9.	Abuse/Neglect
10.	Group Facilitation/Coordination

Mental health staff also preferred computer assisted training as a format, five day sessions, and that they be held in Denver or offered regionally.

Developmental Disabilities

Most case managers received training on agency policies and program regulations; somewhat fewer were instructed in case management activities, use of procedural manuals and home visits. Less than half (40%) received preparation in interagency linkages. Three-quarters of the case managers had received in-service training offered through their agencies. Nearly all (82%) of the staff had received training from sources outside the agency.

When asked to select their preferred topics for future training, case management staff selected mental health problems as their first preference. The following ten topics were selected by the staff.

Table 23

Content Areas Preferred by Developmental Disabilities	
1.	Mental Health Problems
2.	Aging Process
3.	Working with Difficult Clients
4.	Legal Issues
5.	Community Resources
6.	Abuse/Neglect
7.	Assessment
8.	Working with Families of Clients
9.	Alzheimer Disease
10.	Counseling Skills

Staff preferred computer assisted training, offered in five day sessions in Denver.

SECTION G: AUTOMATION

This section of the survey addressed the issue of the use of computers in the delivery of case management services. At the time of the survey a number of software programs had been developed nationally to computerize case management, but none were in use in the three service systems in Colorado at the time of the study. Because all of the systems were in the process of change regarding automation with the goal of making the operations of case management programs more efficient, questions were included which addressed where agencies were currently in their use of automation and whether or not the respondents felt automation of specific tasks would be useful to them in their daily work. Although the respondents to these questions often did not answer all of the questions in a consistent manner, the data, although limited, did suggest certain levels of knowledge regarding this issue which could be used in planning system changes regarding automation.

Table 24

Automation of Case Management Tasks by System						
	SS		DD		MH	
	Yes	No	Yes	No	Yes	No
Intake	1.5	79.2		71.7	2.1	74.7
Assessment		88.5		76.7	1.4	87.7
Eligibility	.8	63.1		75.0	.7	80.8
Case Planning	.8	88.5		80.0	1.4	88.4
Service Management	1.5	85.4		76.7	.7	87.0
Monitoring	.8	79.2		78.3	.7	82.2
Reassessment	.8	80.0		76.7	.7	86.3
Client Tracking	4.6	52.3	3.3	43.3	4.1	54.1
Resource Development	2.3	76.9	1.7	73.3	1.4	79.5
Billing	10.8	42.3	10.1	63.3	19.2	11.6

Staff from all three systems identified the billing process as most likely to be automated in the agencies surveyed, followed by client tracking. Interestingly, these functions were usually performed by persons not identified as case managers, such as financial or accounting staff.

It was evident that very little automation was occurring in the systems, with the developmental disabilities agencies reporting that they were less likely to have automation than the other two. Most of the respondents felt that automation would be useful in certain areas, such as with billing, client tracking and eligibility, areas most likely to already be automated. Case management respondents did not view computerization as having the potential to ease case management functions such as assessment, intake or client monitoring.

SECTION H: ISSUES AND CONCERNS

Case management, although accepted as a key component of the delivery systems, had been a fluid, ever changing process in the State over the previous five years. At the time of the survey all three systems were in the process of making significant changes in how they used case management in the delivery of services and how staff could best be utilized and trained to increase the capacity of case management to assure quality service delivery and provide cost containment of scarce resources.

At the end of the survey all of the respondents were asked a series of open-ended questions concerning what they liked about their jobs, what the major frustrations with their case management position were, how their effectiveness as professionals could be improved, and their opinion regarding the service systems in which they worked.

The intent of this section of the survey was to provide the Department with information which could be used in the development of standards for case management for the new Single Entry Point system in social services and strategies to improve the effectiveness of case management.

Social Services

When asked what they liked the most about their jobs, over half (53%) of the respondents from the social services agencies identified that contact with clients was the most satisfying aspect of their jobs; one-quarter mentioned that the feeling of helping others provided their job satisfaction. The contacts with peers and co-workers also provided positive experiences for those completing the survey (12%).

The major frustrations with these positions centered on the lack of resources and services in their communities for clients, and the frustrations resulting from this (38%), followed by too much paperwork (28%), as well as the constant changes in program rules and regulations (12%).

Over half (55%) of the social services staff felt that improved training and continuing education would improve their effectiveness on the job. About 12% of these respondents mentioned a range of factors categorized as "other" responses, including such factors as time management, ways to make information about what other agencies are doing accessible, the development of credentials for case managers by the State, and issues related to the generalists vs specialists roles for case managers. The third highest category of responses included reducing caseloads, developing ways to reduce paperwork, and better communication between the State and local staff.

When asked their opinions regarding the system in which they worked, approximately 13% of the responses were positive regarding the social services system, stating that it was a "good" system and worked as well as could be expected. The remainder of the responses were more negative and focused on suggestions to improve the system, such as reducing paperwork, more stability in the programs, better coordination among agencies, increase in salaries, better public support and awareness, and to have fewer rules and regulations.

Mental Health

The staff surveyed which provided case management in the mental health system identified three major aspects of their jobs which they liked the best: contact with consumers (51%), feeling of helping others (20%), and the contact they had with their co-workers and peers. Other areas mentioned less frequently included working with health care professionals, the opportunity provided by their jobs to use their counseling skills, problem solving, the combination of working with people and doing paperwork.

In contrast to the social services respondents, these individuals identified their major job related frustrations as too much paperwork (38%), followed by the lack of resources and services for clients (28%), and the fact that they had too much to do and not enough time to spend with clients. Additional concerns were: the fact that case management with mentally ill persons took a great deal of time, the lack of knowledge related to case management, feelings of isolation from other case managers in other agencies, the productivity requirements for case managers and the reimbursement policies.

In responding to the question of how their effectiveness as professionals could be improved, the majority of the respondents stressed that they needed improved training and continuing education for case managers (64%), more and improved supervision, (11%) and that ways to reduce paperwork needed to be created (8%). Other suggestions included: more case aides, need for a medications nurse, having more emergency resources available, and a reduction in workloads.

Of the three service systems surveyed, the mental health respondents felt the most positive about the system in which they worked, but did feel that paperwork needed to be simplified and reduced and that the system would function better with more public dollars. Other suggestions mentioned for system improvements included the need to develop more residential services, improved vocational programs, more coverage by nurses when appropriate, a system which moved faster, more time to spend with non-crisis situations and improvement in the internal environment of agencies. Of interest is the fact that several of the case managers mentioned that it would be helpful to create a network of case managers across the state for mutual support.

Developmental Disabilities

As with their counterparts in mental health and social services, case managers in developmental disabilities received their job satisfaction from the contact they had

with clients (50%) and from the feeling of helping others (27%). About 20% of the respondents mentioned the diversity of job tasks as positive aspects of their jobs. The major frustrations with their jobs were paperwork (45%), lack of resources for clients (32%), and the large caseloads they were required to handle (23%).

Staff from the developmental disabilities system also felt that more and better training and continuing education would improve their effectiveness (50%), as well as the reduction in caseload size. Over one quarter of those responding in this system felt that they worked in a good system which worked as well as could be expected, given all the external limitations which existed. As with the mental health system, respondents also felt that the infusion of more public dollars into the system would improve service delivery.

In conclusion, although each of the systems involved in the survey were very different in their structure, focus and in the emphasis they placed on case management, all staff shared common rewards, concerns and frustrations with their jobs. The case managers reported a strong sense of purpose and mission in working with people and in receiving great personal satisfaction from helping others. Additionally, they had very positive reasons for liking their jobs. The frustrations of the case managers, probably common to all human services staff, centered also on clients and the inability of case managers to find the services needed in their communities. In addition, respondents complained about not having enough time to spend with their clients because of the amount of paperwork which needed to be completed. The latter problem is evidence of a central conflict for case managers who are often caught in a "tug of war" between the clients they serve and the multiple requirements of the bureaucracies they are employed by.

SECTION I: OUTCOMES/SYSTEM CHANGES

Long term care service delivery with its problems of accessibility, cost and fragmentation of services, has provided fertile ground for the development of case management. Case management has historically been defined by the service system in which it is operated in terms of the functions performed by the case managers, and the goal or outcomes anticipated as a result of the intervention. As a result, case management is often difficult to define by the systems which utilize and operate case management programs, and case managers, especially in social programs, lack the professional identification present in related professions such as social work and nursing. In Colorado, each of the three systems included in the survey used case management in a different way to achieve what appeared to be the common goals of improving access to services and brokering services for clients.

This project focused on making system changes in the long term care programs offered through the Colorado Department of Social Services by establishing a quality case management program as the basis for a new single entry point system. Information collected and activities conducted during a two and a half year period formed the basis of changes in policies and procedures regarding case management. The system changes which have occurred regarding case management are as follows:

Standards and procedures for how case management would operate in the State were developed (Appendix C). This effort was accomplished with the assistance of an advisory committee composed of persons from community agencies and consumers.

Definition of the case management model which would operate the long term care programs out of the Single Entry Point agencies.

Establishment of a training program for case managers and administrators in the Single Entry Point agencies. This training was built into the Single Entry Point rules for the program which require agencies to have training plans and to offer training on a regular basis for their case management staff. In addition, the rules commit the State to offer training for the first three years of operation. During the period of this project, statewide training and instruction were provided in three day sessions which addressed how to operate a Single Entry Point agency in terms of rules, policies and procedures. The second phase of the training component focused on skill development for case managers. Using the survey findings, this phase began with a two day session on assessment.

Although the survey findings indicated very little interest or activity in the area of using computers to carry out the case management process, the State initiated a demonstration project in two of the Single Entry Point sites after the end of this project. Computers are being used to enter data from the assessment instrument and send the data to the Peer Review Organization for eligibility review. In addition, the other forms used in the case management process have been computerized.

SECTION J: RECOMMENDATIONS

As a result of this study and the actions taken in implementing case management in the Single Entry Point system, a number of recommendations can be made for future actions and improvements in the system.

Policy makers need to listen to case managers in developing long term care systems. As key persons in the operation of programs who are clear about their mission and responsibilities to clients, these individuals are often working in situations which produce excessive stress and conflict. This conflict is generated by the systems which operate long term care programs with scarce resources, over-regulation and excessive paperwork. Although usually approached as insurmountable problems by administrators, issues need to be addressed from a problem solving approach and the case managers should participate in such discussions. Agencies should consider hiring case aides and additional clerical staff to assist case managers in providing supportive services in such areas as paperwork, follow-through on obtaining documentation from clients, phone calls, etc. Volunteers should also be considered for some of these tasks when there is a staff person available to provide volunteer supervision.

Programs should be reviewed to assure that all paperwork required is necessary and not redundant.

Agencies should consider developing a triage system to reduce the time pressures and frustrations of large caseloads. Similar to a case mix process, clients could be assigned, depending on the level of case management required, so that the clients who place heavy demands on the system are dispersed among case managers.

High quality training needs to be provided for case managers and their supervisors which addresses the content areas identified in the survey. The focus of the training needs to be on skill development, rather than program compliance and regulation as the sole concern.

The supervision of case managers needs to upgraded; most supervisors have not had training or education in case management. It would also be beneficial to provide training which focuses on the process of supervision and how best to develop the skills necessary to provide quality supervision.

Comprehensive evaluations of the case management process and the performance of case managers need to be conducted on a regular basis. It is particularly necessary that outcome measures be developed for case management.

All human services systems providing case management relative to long term care should establish working relationships with each other in order to clarify case management roles and responsibilities, provide training and cooperate on individual case conferences.

Case management needs to have built-in measures to assure quality services for clients. This evaluation information needs to be available to the case managers to improve job performance.

APPENDIX A: SURVEY INSTRUMENTS

Case Management Survey

Part I: Administrator

Name:	
Title:	
Agency:	
Address:	
Telephone:	

1. What is the major function of your agency? _____
_____
_____

2. How long has it been in operation? ____ Years____ Months

3. How long has the agency been providing case management services? ____ Years____ Months

4. How many clients did your agency serve in the last fiscal year? _____

5. What is the total number of FTEs employed by your agency? _____

6. How many of the staff perform case management functions? _____

7. Do you have written standards for case management practice? ___ Yes ___ No

8. Do you have formal policies and procedures for case management at your agency? ___ Yes ___ No

9. Does the agency provide case management for private pay clients? ___ Yes ___ No
If yes, check all that apply.
____ On a sliding fee scale basis ____ Full pay
____ Through contracts with private entities
____ Other, specify _____
_____
_____

10. What are the reimbursement sources for the case management services provided at your agency? (Check all that apply.)

____ Medicaid
____ Medicare
____ Private insurance
____ Title III, Older Americans Act
____ Other, specify _____

____ Contracts with private entities
____ State funds
____ Private dollars
____ Grants

_____

11. Does your agency have a waiting list for case management services? ___ Yes ___ No
If yes, on the average, how long do persons wait? _____

12. Which of the following describes the policies of your agency regarding training? (Check all that apply.)

____ Dollars are budgeted to purchase training for staff
____ The agency sponsors training on case management
____ The state provides training on case management
____ Staff are responsible for identifying and paying for their own training
____ Other, please describe _____

_____

_____

(Skip the following question if a Community Mental Health Center.)

13. In addition to services purchased for clients, does your agency hire, manage, or operate any service delivery programs? (i.e., homemaker services, transportation, counseling, etc.) If yes, please list the services. ___ Yes ___ No

_____

_____

_____

_____

_____

Case Management Survey

Part II: Case Manager/Caseworker

Your Name (Optional):	
Agency Name:	
Program Name:	
Agency Address:	
Telephone:	

A. DEMOGRAPHIC INFORMATION

This section asks a series of questions which will help us describe individuals who perform case management.

A.1. What is your current job title? _____

A.2. Your age: _____

A.3. Your gender: ___ Male ___ Female

A.4. Your race or ethnic origin:
___ White, non Hispanic ___ Black
___ Hispanic ___ Asian
___ Native American
___ Other, specify: _____

A.5. What level of education have you completed?
___ High school or GED
___ Some college
___ College degree, type of degree: _____, discipline_____
___ Masters degree, type of degree: _____, discipline_____
___ Other, specify:_____
_____

A.6. Do you have a professional license? ___ Yes ___ No
If yes, please identify the type of license:_____

A.7. Do you speak any language other than English? ___ Yes ___ No
If Yes, please list the language:_____

A.8. How long have you performed case management functions at this agency?

Years _____ Months _____

A.9. How many years of experience do you have working in case management including your current position?

Years _____ Months _____

A.10. Aside from your responsibiliites in case management, do you have any other job responsibilities in this agency? ___ Yes ___ No

If yes, please describe the responsibilities _____

_____

_____

In your judgement, what percent of your time is spent on other tasks? _____%

A.11. What is your current gross monthly salary (excluding benefits)? $_____/Month

A.12. What is your job status as a case manager in this agency?

___ Full time ___ Part time ___ Contractual

___ Other, specify:_____

B. CASE ASSIGNMENT

B.1. What was the average number of individuals in your case management caseload during the past year? _____

B.2. At the present time, how many of the individuals in your caseload are in the following population groups?

Age Categories	Physically Disabled	Mentally Ill	Developmentally Disabled	*Dually Diagnosed	Traumatic Brain Injured
Ages 65+ (elderly)					
Ages 18-64					
Ages 0-17 (children)					

* More than one official diagnosis.

B.3. Please estimate how many of the individuals in your caseload receive assistance from the following programs. (Check all that apply.)

___ HCBS-EBD Medicaid waiver program
___ HCBS-DD Medicaid waiver program
___ HCBS-PLWA Medicaid waiver program
___ Older Americans Act programs
___ Social Security Disability Insurance (SSDI)
___ Medicaid/General Fund
___ Medicare
___ Home Care Allowance (HCA)
___ Adult Foster Care
___ Supplemental Security Income (SSI)
___ Other, specify _____

_____

B.4 How much case management time do each of the following population groups consume? Please <u>estimate</u> the time spent in terms of high, medium and low amounts of time.

Elderly (65+)	[_] High	[_] Medium	[_] Low	[_] N/A
Physically disabled (ages 18 to 64)	[_] High	[_] Medium	[_] Low	[_] N/A
Mentally ill	[_] High	[_] Medium	[_] Low	[_] N/A
Developmentally disabled	[_] High	[_] Medium	[_] Low	[_] N/A
Traumatic brain injured	[_] High	[_] Medium	[_] Low	[_] N/A
Dually diagnosed	[_] High	[_] Medium	[_] Low	[_] N/A
Persons Living With AIDS	[_] High	[_] Medium	[_] Low	[_] N/A
Children under age 18	[_] High	[_] Medium	[_] Low	[_] N/A
Other, specify:	[_] High	[_] Medium	[_] Low	[_] N/A

_____

_____

B.5 Are you a member of an interdisciplinary team which makes joint decisions concerning clients? ___ Yes ___ No

If yes, please describe _____

_____

B.6. Who supervises your work in case management? Please identify the job title and academic/professional background of the supervisor.

Job Title: _____
Background: _____

B.7 How often do you meet with your supervisor on a scheduled basis?

___ More than once a week
___ Once a week
___ Every two weeks
___ Once a month
___ Every two months
___ As needed
___ Other, specify_____

_____

B.8 Which of the following activities are completed by your supervisor? (Check all that apply.)

___ Chart/record reviews
___ Home visits to clients
___ Training
___ Individual problem solving
___ Consultation regarding policies/procedures
___ Other, specify _____

_____

C. CASE MANAGEMENT/CASEWORK ACTIVITIES

C.1. The following is a list of the tasks often performed by persons who do case management. Please estimate on the average the number of hours each week you spend doing each of these tasks. The total at the bottom should be the number of hours you spend doing case management each week (include time with supervision, paperwork, etc.) If you do not perform the task, mark NA.

	Task	Hours
A.	Case finding: locating and contacting potential clients for services, usually via outreach	_____
B.	Intake: receiving information about a new referral and follow up	_____
C.	Assessment: contacting the applicant, assessing client functioning and the need for services	_____
D.	Eligibility determination: deciding whether a client meets the financial and program requirements to receive services or benefits.	_____
E.	Case planning: developing a written plan which documents the need for services	_____
F.	Service arrangement: implementing the service plan to set up services	_____
G.	Monitoring and follow up: ongoing client and service provider contact to check on client progress and whether services are received	_____

H. Reassessment: contact with the client and providers to routinely reassess need for services and revise the care plan when needed. _____

I. Resource development: actual development of new resources for individuals when services are not available. _____

J. Other client interventions: (counseling, therapy, etc.) _____
Please specify: _____
_____
_____

K. Please describe any other tasks that are regularly done as part of your job, (i.e., meetings, family work, crisis work, etc.) _____ _____
_____
_____

L. What is the <u>total</u> number of hours you spend on case management in an average week? _____

C.2. Please <u>estimate</u> the number of hours of your time that you spend on other job responsibilities related to case management in an <u>average</u> week:

		Hours
A.	Client contacts (phone and face to face contacts in office, and in client's living environment)	_____
B.	Contacts with family members or other informal caregivers	_____
C.	Completion of forms or paperwork required by programs	_____
D.	Meetings on behalf of clients	_____
E.	Crisis Management	_____
F.	Other contacts, specify_____ _____ _____	_____
	TOTAL	_____

C.3. What, in your experience, is the most time-consuming activity in arranging services for clients? (Please rank the items from 1 = most time-consuming, to 10 = least time-consuming.)

___ Difficulty making telephone contact with providers
___ Case conferences or meetings about clients
___ Difficulty making contact with client or family members
___ Paperwork - completing forms
___ Travel time for home visits
___ Client preferences (e.g. unrealistic demands or expectations about how services should be provided)
___ Vendor or service provider limitations (e.g., no providers available, poor quality of services)
___ Monitoring services provided to clients
___ Physician contacts
___ Family problems/issues
___ Other, specify _____

C.4. Which of the following tasks are automated (computers used to assist with completing tasks) at your agency? How useful is the automation?

Tasks	Automated		Not Useful	Useful	Very Useful
	Yes	No			
Intake					
Assessment					
Eligibility Determination					
Case Planning					
Service Arrangement					
Monitoring					
Reassessment					
Client Tracking					
Resource Development					
Billing					
Other, specify					

D. STAFF DEVELOPMENT

D.1. When you were hired at this agency, what was involved in training you to perform case management functions? (Check all that apply.)

___ Instruction on program regulations and paperwork.
___ Instruction on agency policies and procedures.
___ Instruction on the case management or caseworker process, including assessment and care planning.
___ Observation and consultation with supervisor or experienced staff in making home visits, after assignment of caseload.
___ Training on interagency linkages.
___ Use of procedure manuals, and other written communications.
___ Other, specify _____

D.2. Did you participate in routine in-service training sessions related to case management in the past two years (internal to the agency or your work unit)? ___ Yes ___ No
If yes, please identify the training and who provided it.

Content of Training	Sponsor of Training

D.3. Did you participate in educational or training activities offered outside your agency relative to your case management job in the past two years? ___ Yes ___ No

Content of Training	Sponsor of Training

D.4. Which of the following subject areas for training would be most helpful to you now? (Please select the top ten, and rank from 1 = the most helpful through 10 = the least helpful.)

___ Abuse and neglect
___ Aging process
___ AIDS
___ Alzheimer's disease
___ Assessment
___ Client rights
___ Common diseases of special population groups
___ Community resources (find, develop)
___ Counseling skills
___ Cultural differences
___ Developmental disabilities
___ Developing case plans
___ Documentation
___ Financial eligibility
___ Financial management
___ Group facilitation/ coordination
___ Interviewing skills
___ Legal issues
___ Medical terminology
___ Medications
___ Mental health problems
___ Monitoring for quality assurance
___ Program eligibility
___ Program requirements
___ Rehabilitation services
___ Residential services
___ Resolving quality of care issues
___ Traumatic brain injuries
___ Working with difficult clients
___ Working with families of clients
___ Working with special populations
___ Other _____

_____

D.5. What do you prefer in terms of format, time frame, and location for training sessions? (Rank the following choices in each column from 1 = the most preferred, to 5 = the least preferred.)

Format	**Time Frame**	**Location**
___ Lecture	___ 1-2 hour sessions	___ In own agency
___ Audio/visual	___ 1 day workshop	___ In own area
___ Workshop	___ 2-3 day workshop	___ Regional
___ Computer assisted	___ 5 day workshop	___ Denver
___ Other	___ Other	___ Other_____

E. ISSUES AND CONCERNS

E.1. What do you like best about your job?_____

_____

_____

_____

_____

E.2. What are the major frustrations with your position as they relate to case management functions?

E.3. How could your effectiveness as a professional be improved? (i.e., training, support, supervision, etc.)

E.4. In general, what do you think about the service system in which you work? (i.e., what parts could be improved? Who needs to make the changes? etc.)

APPENDIX B: PROGRAM OPERATIONS

PART TWO
PROGRAM OPERATIONS

OVERVIEW OF THE SINGLE ENTRY POINT PROGRAM:

The purpose of the Single Entry Point program is to provide access to long term care services offered through the following publicly funded long term care programs operated by the Colorado Department of Social Services: the Home and Community Based Services programs, the Home Care Allowance program, Adult Foster Care and, when appropriate, nursing facilities. In addition, the Single Entry Point agency will serve persons who can pay privately for case management and long term care services. The functions performed by the Single Entry Point agency are based on a case management model of service delivery. Case management is provided by the Single Entry Point agency in compliance with the standards for case management established by the Department.

CASE MANAGEMENT IS DEFINED AS:

The determination of a person's eligibility for services, assessment of functioning and need for services, the development and implementation of a care plan, coordination and monitoring of service delivery, evaluation of service effectiveness and reassessment of the client.

RESPONSIBILITIES OF THE CASE MANAGER:

The case management functions in the Single Entry Point agency, which the case managers are responsible for, include: assessing potential clients, developing care plans, providing ongoing case management, monitoring service provisions, conducting reassessments, developing resources for clients needing services not available and closing cases when appropriate (Volume 8, Section 023.42).

TIME FRAMES FOR COMPLETING CASE MANAGEMENT TASKS:

The time frames for completing the specific case management tasks are found in the Single Entry Point rules (Volume 8, Section 023.42) as follows:

1. The case manager contacts the client at least quarterly. If the client's condition or the program criteria require it, the client is contacted more frequently.

2. The case manager has face-to-face contact with the client at least every six months, or more frequently, if the program or the condition of the client warrants it.

3. The case manager reassesses the client at least every six months, or more frequently, if the condition of the client changes or if the specific program requires it.

4. The case manager uses the client uniform assessment instrument (ULTC-100) to update the information collected during the assessment and reassessment of the client.

5. The case manager is responsible for monitoring the services provided to the client and the contract between the client and the service provider when this is required by the program. In monitoring, the case manager should monitor for the quality of care provided, client satisfaction and for the health and safety of the client.

CASE MANAGEMENT SERVICE FUNCTIONS:

The Single Entry Point agency is responsible for the performance of the following functions in accordance with the standards established by the Department for each of the functions, described in more detail below (Volume 8, Section 023.2):

INFORMATION AND REFERRAL (I&R):

1. Single Entry Point staff provide information and referral for anyone who contacts the agency for assistance or information. This function serves as the initial point of contact between the agency and persons who call or walk into the agency for assistance.

2. At the time when the Single Entry Point staff person makes this contact, the Information and Referral Tally Sheet is completed. The information collected on this form is not client specific. It addresses the range of Information and Referral activities occurring in the Single Entry Point agency during the period for which the form is completed.

3. The Information and Referral Tally Sheet is completed by Single Entry Point staff on a weekly basis. The type of service requested is identified. For each service identified, the person completing this form then completes three categories of information: 1) whether information was requested regarding a service; 2) if the person was referred to another agency or program for the service; and 3) if the service is not available in the Single Entry Point agency district.

4. Staff also record at the bottom of the form the total number of telephone calls received during this period and the number of persons who are referred to the Single Entry Point for an intake interview. This form and instructions can be found in Appendices 1 and 2.

5. Information collected regarding Information and Referral activities can provide the Single Entry Point agency and the Department with data about the kinds of requests received by the agency, referral patterns and the availability or lack of community resources for long term care.

6. If the individual contacting the agency is requesting long term care services, the Single Entry Point staff informs the person that the next step in the process for them to receive services is to have a Single Entry Point intake worker perform an intake interview.

7. Long term care services are defined as diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services provided in institutional and non-institutional settings, including the home, for persons who have chronic functional impairments.

INTAKE:

1. The intake interview is conducted by the Single Entry Point staff person responsible for the Intake function, most often by telephone.

2. The long term care Single Entry Point agency Intake Form is used to record the information collected during the intake contact with the applicant or someone acting on their behalf. This form collects information which the intake worker uses in making a recommendation to the client or the person acting on his/her behalf for further activity (assessment, referrals). A copy of the form and instructions for completing it are included in Appendices 3 and 4.

3. The completed Intake Form is kept at the Single Entry Point agency, usually in the client's case record.

4. The Intake form collects data pertaining to: client demographic information, referral source and type, living situation, contact information, presenting problem, diagnosis, discharge information, assistance indicated, potential funding sources and financial eligibility, potential program status, the intake worker's recommendation and reasons for the recommendation and the client's acceptance of this recommendation.

5. The Intake worker verifies the individual's current financial eligibility status from the County Department of Social Services to determine if the person is currently receiving public benefits or has been determined as

eligible for benefits. If the person has not been receiving benefits, or his/her eligibility for benefits has not been determined, the individual is referred to the County Department of Social Services where the person resides, within one working day after the initial contact with the individual.

6. When necessary, the Single Entry Point staff assists the applicant in completing the financial eligibility forms and attachments for the County Department of Social Services. However, the County Department of Social Services where the person resides is responsible for the actual determination of financial eligibility.

7. At the end of the Intake interview, the Single Entry Point staff person makes a recommendation as to whether or not the individual should have a comprehensive assessment by a case manager. In order to make this recommendation for an assessment, the staff person must have positive (yes) answers to the following questions:

   a. Is the person/family member requesting long term care services?

   b. Is the person potentially program eligible for any of the public long term care programs (i.e. Medicaid nursing facility, Home and Community Based Services for the Elderly, Blind and Disabled [HCBS-EBD] and for Persons Living with AIDS [HCBS-PLWA], Home Care Allowance and Adult Foster Care)? In addition, the Area Agency on Aging can contract with the Single Entry Point to provide case management for persons who need this service.

   c. Is the person potentially eligible from a financial perspective for the publicly funded long term care services?

   d. If the individual is not financially eligible, does he/she have private resources to pay for long term care services?

   e. Does the person accept the Intake worker's recommendation for an assessment?

ASSESSMENT:

Following the Intake worker's recommendation for a comprehensive assessment and the client's agreement to have one, the Single Entry Point case manager conducts a face to face assessment where the person is currently living, using the Uniform Long Term Care Client Assessment Instrument (ULTC-100) to evaluate the client. This form and the instructions for completing it can be found in Appendices 5 and 6.

1. The ULTC-100 must be used for persons eligible to receive services through the following programs:

a. Medicaid funded nursing facility care

b. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD)

c. Home and Community Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA)

d. Home Care Allowance

e. Adult Foster Care

f. In-home services under the Older Americans Act when the person needs case management

g. The Program for All-Inclusive Care of the Elderly (PACE)

2. When an individual who can pay privately for an assessment and long term care services through resources other than public dollars, requests these services and agrees to have an assessment, the Single Entry Point case manager completes the ULTC-100 for the person.

3. In completing the ULTC-100, the case manager completes a series of activities which include, but are not limited to, the following tasks:

a. Obtain any necessary diagnostic information from the client's physician and the physician's signature.

b. Determine the client's functional abilities by observing and interviewing the individual in their residential setting.

c. Assess the ability and appropriateness of the informal support system (family, neighbor, friends) to care for the individual.

d. Determine the client's service needs.

e. Assess the feasibility of deinstitutionalization when the client is a resident of a nursing facility.

f. Review residential placement options with the client and family and the funding sources for the placement when it appears that out-of-home placement is a possibility.

g. In accordance with program rules, determine the client's eligibility for publicly funded long term care programs.

h. Discuss and document the client's preference for services and document this on the ULTC-100.

i. Provide assistance when the client cannot complete the necessary application forms for the state administrated programs.

j. If required for entrance into a program, submit documentation to the Peer Review Organization for certification of program eligibility.

k. Refer client to alternative services when he/she is not eligibile for the long term care programs administered through the Single Entry Point agency.

TIME FRAMES FOR COMPLETING THE ASSESSMENT PROCESS:

1. When the Single Entry Point staff determines that an assessment is needed, a case manager is assigned to the client within one working day from the initial contact with the individual.

2. The case manager makes the initial contact with the client within one working day from the date when the case was assigned to schedule an assessment.

3. When a person is being discharged from a hospital or a nursing facility and is accessing Medicaid, the assessment is completed within two working days after the initial contact is made with the client or the person acting on their behalf.

4. For those persons who are not being discharged from a hospital or a nursing facility, the assessment is started within five working days from the date the case is assigned. It is completed within ten working days from the date it was assigned.

5. If, through the administration of the ULTC-100, the individual is determined to need long term care services, either as a client of the publicly funded programs or as a private pay client, a care plan is developed for the person before services are actually arranged.

CARE PLAN:

The purpose of the Care Plan is to document the service needs of the client and to provide the case manager with a framework for planning for the care of the client following the assessment. The Care Plan also provides an opportunity for the client, family and the case manager to work together in planning for the care of the client

(Vol 8, Sec.023.23). A copy of the care plan form and instructions appear in Appendices 7 and 8. A copy of the Care Plan is placed in the client file. In the case of the Home and Community Based Service programs, a copy of the Care Plan is submitted for prior authorization to Blue Cross and Blue Shield.

1. The case manager completes the Care Plan within fifteen working days after it is determined that the individual is eligible for any of the publicly funded long term care programs.

2. The case manager completes the Long Term Care Plan, which includes the following information:

   a. Demographic information about the client, medicaid eligiblity information, the dates covered by the Plan, the termination date and reasons for termination and the date the Plan was revised.

   b. Areas of concern identified in the assessment process which are likely to indicate the need for services.

   c. Service plan: this section of the Plan includes the categories of services which the client may need,-- supportive services, Medicaid State Plan services and services offered through the Single Entry Point agency. Also included is whether or not the service is needed or if the client is already receiving the service, the name of the provider, the funding source for the service, the frequency at which the service will be needed and the specific functions of the service which the client needs.

   d. The last section of the Plan is a statement to be signed by the client and the case manager stating that the client has been informed of a choice of providers and that he/she understands that he/she can change providers. In addition, the client signs a statement that he/she chooses services offered either in the community or in a nursing facility.

   e. An additional page has been added to the Plan which includes a summary of the revisions made to the Plan. This section is only used when revising the form during a reassessment. This page also includes a section which identifies the client's unmet needs: whether or not the need was critical to the health or safety of the client and the reason(s) why the need could not be met. The client does not sign this section. It is kept in the case record.

3. Following the completion of the Care Plan, the case manager arranges for services, coordinates services as necessary and formalizes any provider agreements according to program rules.

4. As part of the care planning process, Single Entry Point staff complete the necessary forms which are required for the program(s) the client will receive, authorizes services (including cost containment requirements) and determines client co-payments.

5. The complaint procedures are explained to the client. (See Part I of the Procedures Manual.)

6. The case manager uses the informal network of service providers, i.e. family member, friends and neighbors, whenever appropriate, to meet the service needs of the client before purchasing services.

7. When the quality of service is comparable, the case manager encourages the client to select the lowest cost service provider when public dollars are being used.

ON-GOING CASE MANAGEMENT:

The goals of on-going case management are to: monitor the quality of services received by the clients, identify any changes in the needs of clients, identify and resolve any problems with service delivery and make changes in service plans as appropriate (Volume 8, Section 023.24).

1. Quality of care: in assuring that clients receive quality care, the case manager monitors for the following factors:

   a. The appropriateness and the quality of the services provided.

   b. The amount of care received.

   c. The timeliness of service delivery.

   d. Client satisfaction with the services and the provider.

2. The tasks associated with on-going case management include the following:

   a. Review the client's care plan and service agreements as needed and/or as specified by program regulations.

   b. Contact the client and the service providers involved in a case at least quarterly, unless program rules are different. If the client's condition changes, contact the client more frequently as needed.

c. When complaints are raised by the client regarding services, contact the service providers and any collateral persons to assist in resolving the issues raised.

d. Make informal assessments of client functioning, the effectiveness of services, and their cost-effectiveness.

e. Make appropriate referrals to enforcement agencies and community resources when indicated.

f. Report any information regarding overpayment, incorrect payments or the misuse of public assistance or Medicaid benefits to the appropriate agency and cooperate in the recovery process (Volume 3, Section 3.810).

REASSESSMENT:

The reassessment of the client occurs six months following the initial assessment or the previous assessment. However, a reassessment occurs more frequently if the client's condition changes or if a program requires more frequent reassessments (Volume 8, Section 023.25). Reassessments are not conducted by Single Entry Point staff for nursing facility residents. The nursing facility staff conducts the reassessments.

The assessment instrument, the ULTC-100, is used to update the information collected during the previous assessment.

The reassessment process includes the following activities:

1. Obtain the diagnosis and signature from the client's physician at least annually or more frequently if there is a change in the client's condition or if the program rules specify that it be completed more often.

2. Assess the functional status of the client, using the ULTC-100 and review the Care Plan.

3. Review the service agreements and provider contracts or agreements.

4. Evaluate the effectiveness and appropriateness of the services delivered and the quality of care received.

5. Verify financial Medicaid eligibility and other program eligibility.

6. If necessary, renegotiate the care plan and service agreements.

7. Inform the physician of changes in the client's need for services.

8. Submit the appropriate documentation to the Peer Review Organization for certification of continued program eligibility if the program requires this for a continued stay review (CSR).

9. Refer the client to the appropriate community resources and develop resources for the client if they are not available in the community.

10. Submit documentation for the authorization of services when the program requires this.

DISCONTINUATION:

Clients can be discontinued from programs operated by the Single Entry Point agency or from the Single Entry Point itself for a variety of reasons, i.e., no longer eligible, move, death, nursing home placement, etc. When the case manager decides that a case is to be discontinued, the name of the client needs to be added to the **Client Discontinuation Form,** which is submitted monthly to the Department and the Colorado Foundation for Medical Care. This form identifies the clients discontinued in that month, their social security number, the date the discontinuation is effective and the reason for being discontinued. This form and the instructions appear in Appendices 9 and 10.

RELATIONSHIP WITH HOSPITALS:

1. It is the responsibility of the Single Entry Point agency to develop working relationships with hospital discharge planners in their district. Hospital discharge planners are responsible for completing the ULTC-100 for persons being discharged from hospitals to nursing homes. For discharges to the community, the hospital worker begins the assessment and the case manager completes it. In addition, they are a referral source for the long term care services administered by the Single Entry Point agency.

2. Some suggested ways of working together include: regular meetings with the discharge planners to discuss Single Entry Point issues, having discharge planners serve on advisory committees and work groups, establishing cooperative agreements, providing joint training sessions, etc.

3. In the case of discharges from hospitals of persons who are accessing Medicaid, the discharge planner must begin the discharge process. The Single Entry Point must complete the assesssment two working days after the initial contact with the patient or the person acting on their behalf. In this situation, it is important that the discharge planner work closely with the Single Entry Point case manager in the planning and selection of long term care options for clients.

APPENDIX C: SINGLE ENTRY POINT RULES

8.020 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long term care single entry point system consists of single entry point agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long term care to access appropriate long term care services. During the phased implementation of the single entry point system, persons in need of long term care services who reside in an area in which a single entry point agency has not yet been selected and/or has not yet become operational, shall access these services in accordance with state rules for each publicly funded long term care program. Once the single entry point agency becomes operational, applicants and recipients of publicly funded long term care programs shall access these services through the single entry point agency.

Legal Authority

Pursuant to C.R.S. 26-4-522, the state department is authorized to establish a statewide single entry point system, to be implemented in four stages:

A. Provision of a final plan and adoption of rules for the implementation of the single entry point system;

B. Designation of single entry point districts;

C. Initial implementation of single entry point agencies for districts that wish to participate in the single entry point system prior to final implementation; and

D. Final implementation of single entry point agencies for any remaining districts.

8.020.1 DEFINITIONS

A. Agency applicant means a legal entity seeking designation as the provider of single entry point agency functions within a single entry point district.

B. Assessment means a comprehensive face-to-face interview with the client and appropriate collaterals (such as family members, friends and/or caregivers) and an evaluation by the case manager, with supporting diagnostic information from the client's physician, to determine the client's level of functioning, service needs, available resources, and potential funding resources.

8.020.1 DEFINITIONS (continued)

Added eff. 1/1/92

C. Care planning means the process of identifying with the client and appropriate collaterals, goals and client choices for the care needed, services needed, appropriate service providers, and client co-payment, based on the client assessment and knowledge of the client and of community resources.

D. Case management as defined in CRS 26-4-507(2)(b).

E. Corrective action plan means a plan which includes the specific actions the agency shall take to correct non-compliance with standards, and which stipulates the date by which each action shall be completed.

F. Failure to satisfy the scope of work means incorrect or improper activities or inactions by the single entry point agency in terms of its contract with the state department.

G. Financial eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.

H. Intake/screening/referral means the initial contact with individuals by the single entry point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.

I. On-going case management means the evaluation of the effectiveness and appropriateness of services, on an on-going basis, through contacts with the client, appropriate collaterals, and service providers.

J. Private pay client means an individual for whom reimbursement for case management services is received from sources other than a state administered program, including the individual's own financial resources.

Rev. eff. 12/1/92

K. Program means a publicly funded program including, but not limited to, Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Medicaid nursing facility care, Program for All-inclusive Care of the Elderly (PACE), and case management services funded through the Older Americans Act (Title III-B).

8.020.1 DEFINITIONS (continued)

L. Reassessment means a comprehensive face-to-face interview with the client and appropriate collaterals and an evaluation by the case manager, with supporting diagnostic information from the client's physician, to determine the client's level of functioning, service needs, available resources, and potential funding resources.

M. Resource development as defined in CRS 26-4-507(2)(i).

N. Single entry point as defined in CRS 26-4-507(2)(k).

O. Single entry point district means two or more contiguous counties, or a single county, that have been designated as a geographic region in which one agency serves as the single entry point for persons in need of long term care services.

P. Single entry point agency means the organization selected to provide case management functions for persons in need of long term care services within a single entry point district.

Q. State designated agency as defined in CRS 26-1-103(7).

8.020.2 SINGLE ENTRY POINT CLIENTS

Added eff. 1/1/92

Persons shall access the above listed long term care programs through the single entry point agency that serves the single entry point district in which they reside.

.21 Client characteristics. An individual who desires access to long term care services shall meet the following criteria:

A. The individual shall require skilled, maintenance and/or supportive services; and

B. The individual has functional impairment in areas of mobility, confusion, bowel or bladder function, activities of daily living, and/or instrumental activities of daily living, necessitating long term care services provided in a nursing facility, a residential alternative, or the individual's home; and

C. If the individual has a primary diagnosis of developmental disability or mental illness, the individual's needs are primarily for long term care services, in accordance with specific program eligibility criteria; and

D. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental; or

E. The individual has long term care needs and has resources to pay for services without public assistance.

Rev. .22 eff. 12/1/92

Clients of publicly funded programs. Single entry point agencies shall provide services to clients of publicly funded long term care programs including, but not limited to, Medicaid nursing facility care, Program for All-inclusive Care of the Elderly (PACE), Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home Care Allowance, Adult Foster Care, long term home health care accessed through one of these services, and Older American's Act case management services.

Add .23 eff. 1/1/92

Program-specific eligibility criteria. Authorization to receive services through a publicly funded program shall be in accordance with the program's eligibility criteria.

8.021 IMPLEMENTATION OF THE SINGLE ENTRY POINT SYSTEM

The single entry point system shall be implemented in the following phases:

A. The designation of single entry point districts throughout the state, to be completed no later than May 31, 1992;

B. The participation of single entry point districts through the recommendation of single entry point agencies by July 1, 1992 (phase 1 agency selection), or by July 1, 1993 (phase 2 agency selection), or by April 30, 1994 (phase 3 agency selection); and

C. The full operation of all single entry point agencies no later than July 1, 1995.

8.021.1 SINGLE ENTRY POINT DISTRICT DESIGNATION

.11 Designation process

A. No later than January 10, 1992, the state department shall provide information on the district designation process to the county commissioners of the state.

B. No later than March 31, 1992, the county commissioners of each county shall submit to the state department their recommendation for the designation of their county as a single entry point district or as one county in a multi-county district.

1. When a proposed district includes more than one county, the combined boards of county commissioners shall submit their recommendation to the state department.

2. The letter of recommendation submitted by the county commissioners shall include the following information:

   a. The geographic boundaries of the proposed single entry point district;

   b. The organizational structure, operational methods and decision-making process of the board(s) of county commissioners;

8.021.1 SINGLE ENTRY POINT DISTRICT DESIGNATION (continued)

.11 Designation process (continued)

c. Assurances that the proposed district meets all criteria set forth in state department rules for single entry point district designation;

d. The designation of a contact person for the proposed district; and

e. A resolution supporting the recommendation, passed by the county commissioners of each county in the proposed district.

C. No later than April 30, 1992, the state department shall approve the recommendation of a proposed district's county commissioners, provided the proposed district meets the single entry point district designation criteria set forth in state rules.

D. In the event some county commissioners do not make a recommendation for district designation by March 31, 1992, the state department shall designate districts by May 31, 1992, in accordance with the district designation criteria.

.12 District designation criteria

Single entry point districts shall meet the following criteria:

A. All counties shall be included in the single entry point system. In the event a county is not included in a proposed district, a proposed district contiguous to this county may be approved contingent upon the inclusion of the county.

B. Counties composing a multi-county district shall be contiguous.

C. A single county may be designated a district provided the county serves a monthly average of 200 or more clients from the following community-based programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), and/or Older American's Act case management services.

D. Multi-county districts shall not be required to serve a minimum number of clients.

8.021.1 SINGLE ENTRY POINT DISTRICT DESIGNATION (continued)

.12 District designation criteria (continued)

E. Each district shall have at least one full-time case manager employed by the single entry point agency that serves the district.

F. Each district shall assure adequate staffing by the district's single entry point agency to provide coverage for all case management functions and administrative support, in accordance with state department rules (Volume 8.023).

.13 Changes in district designation

A. The county commissioners from one or more counties in a district may request that their county join a neighboring district provided the following criteria are met:

1. The county commissioners assure that both districts involved will continue to meet the district designation criteria; and

2. The change in district designation is supported by the county commissioners of the counties in both districts involved in the change.

B. The county commissioners shall notify the state department six months prior to the proposed change in district designation.

C. The state department shall approve the proposed change in district designation provided each district continues to meet district designation criteria.

D. Any change in district designation shall require amendments to the single entry point agency contract for each district involved.

E. In the event an approved change in district designation results in the termination of a single entry point agency contract, an alternate agency shall be selected in accordance with the state department's rules for single entry point agency termination or non-renewal of contract.

8.021.1 SINGLE ENTRY POINT DISTRICT DESIGNATION (continued)

.13 Changes in district designation (continued)

F. Single entry point districts may transfer parts of a county to another district, provided all of the following criteria are met:

1. The county commissioners of both districts and the state department shall approve of the transfer.

2. The transfer shall occur at contract renewal time.

3. Both districts shall continue to meet district designation criteria.

4. Reimbursement for single entry point functions shall be negotiated between both districts and the state department.

8.021.2 SINGLE ENTRY POINT AGENCY SELECTION

Each single entry point district may submit its recommendation for a single entry point agency at one of the three agency selection phases.

A. The district's recommendation for a single entry point agency shall be approved by the state department provided the proposed single entry point agency meets all agency selection criteria.

B. The state department shall contract with approved single entry point agencies.

1. The term of contract with a single entry point agency shall be five years.

2. Each single entry point agency shall be monitored by the state department and/or its designee and shall be certified annually, based on its compliance with performance standards.

3. Contracts may be renewed if the agency is in compliance with all performance standards.

4. In the event of a change in the district designation, the contract with the single entry point agency serving the district may be amended or terminated.

.21 Phase 1 agency selection. No later than July 1, 1992, any district that wishes to participate during Phase 1 should submit its recommendation for a single entry point agency to the state department.

A. No later than September 30, 1992, the state department shall approve or deny the district's recommendation.

B. If the district's recommendation is approved, the designated single entry point agency shall be operational on July 1, 1993.

C. In the event the district's recommendation is denied, the district may submit an alternate recommendation to the state department by July 1, 1993 for Phase 2 agency selection.

8.021.2 SINGLE ENTRY POINT AGENCY SELECTION (continued)

.22 Phase 2 agency selection. No later than July 1, 1993, any district that wishes to participate during Phase 2 should submit its recommendation for a single entry point agency to the state department.

A. No later than September 30, 1993, the state department shall approve or deny the district's recommendation.

B. If the district's recommendation is approved, the designated single entry point agency shall be operational on July 1, 1994.

C. In the event the district's recommendation is denied, the district may submit an alternate recommendation to the state department by April 30, 1994 for Phase 3 agency selection.

.23 Phase 3 agency selection. No later than April 30, 1994, any remaining district shall submit its recommendation for a single entry point agency to the state department.

A. No later than September 30, 1994, the state department shall approve or deny the district's recommendation.

B. If the district's recommendation is approved, the designated single entry point agency shall be operational on July 1, 1995.

C. In the event the district's recommendation is denied, the state department shall select a single entry point agency in accordance with state department rules.

.24 Single entry point agency selection by the state department. After April 30, 1994, if no agency has been recommended by a single entry point district, the state department shall select a single entry point agency to serve the district by conducting a request for proposal (RFP) process, or by conducting a sole source procurement, or by other means, in accordance with state department rules.

.25 Agency termination or non-renewal of contract. The contract with a single entry point agency may be terminated or not renewed by either party for various reasons including, but not limited to, failure to achieve or maintain financial viability and non-compliance with performance standards adopted by the state department. In the event the contract with a single entry point agency is terminated or not renewed, the following process shall apply:

A. The single entry point agency shall notify the state department sixty (60) days prior to terminating its contract.

8.021.2 SINGLE ENTRY POINT AGENCY SELECTION (continued)

8.021.25 Agency termination or non-renewal of contract (continued)

B. In the event the state department is terminating the contract, the state department shall notify the single entry point agency and the district's contact person sixty (60) days prior to the termination.

C. The county commissioners for the district shall recommend a new single entry point agency within ninety (90) days after notification.

D. Extensions may be granted if the district has not recommended a new single entry point agency within ninety (90) days.

E. The state department shall approve the district's recommendation, provided the proposed single entry point agency meets all criteria for agency selection.

F. The county commissioners of the district, upon approval by the state department, shall make arrangements to provide case management services to clients within the district during the interim period between the termination of the single entry point agency's contract and the selection of an alternate agency.

.26 Emergency termination of agency contract. A sixty (60) day notification of termination of the single entry point agency contract may not be feasible, for example, in situations where the state department terminates an agency's contract due to deficiencies which threaten to harm the health and safety of clients, or situations where the agency experiences unforeseen financial hardship resulting in the immediate closure of the business. The following procedures shall apply for the emergency termination of an agency's contract:

A. The county commissioners of the district, upon approval by the state department, shall make arrangements to provide case management services to clients within the district between the termination of the single entry point agency's contract and the selection of an alternate agency.

B. In the event of suspected abuse, neglect or exploitation, clients shall be referred to the Protective Services section of the county department of social services of each client's county of residence.

C. The selection of a permanent single entry point agency shall follow procedures for agency termination.

8.021.3 SINGLE ENTRY POINT AGENCY SELECTION CRITERIA

.31 General provisions. An agency applicant seeking designation as the single entry point agency for a district shall provide sufficient documentation to the county commissioners of the district to demonstrate its ability to comply with all agency selection criteria including fiscal management, organizational capability, program capability, and community orientation and cooperation.

A. An agency applicant's office need not be located within the district at the time of application.

B. An agency applicant that has been approved as the single entry point agency for a district must establish an agency office within the district.

.32 Organizational structure. An agency applicant for single entry point agency may be an existing or newly created organization or sub-unit of an existing organization.

A. The agency applicant may be a private, not-for-profit organization, a private, for-profit organization, a governmental agency, or a quasi-governmental agency.

B. The agency applicant is not required to have been a case management agency for a Home and Community-Based Services (HCBS) program.

.33 Satellite offices. The single entry point agency may establish or sub-contract with one or more organizations as free-standing local satellite offices of the single entry point agency, in order to facilitate the delivery of single entry point functions throughout the geographic area served by the agency. Each satellite office shall serve the full range of single entry point agency clients.

.34 Application process. The agency applicant shall submit sufficient copies of the following information to the contact person for the district, and, if the agency applicant becomes the district's recommendation for single entry point agency, the district shall submit this information to the state department:

A. Business plan, including the following:

1. Proposed budget, including salaries, benefits, rent, operating costs, travel costs, liability insurance and expected revenues;

2. Resumes of current staff;

8.021.3 SINGLE ENTRY POINT AGENCY SELECTION CRITERIA (continued

.34 Application process (continued)

3. Statement of other obligations which may impact the agency applicant's capabilities; and

4. If the agency applicant is an existing organization, financial statements and an independent audit report for the previous year.

B. Description of organizational structure, including:

1. Description of the agency applicant's legal identity with supporting documentation, such as articles of incorporation, mission statement, by-laws, and intergovernmental agreements, if applicable;

2. Governing board structure and membership;

3. Relationship to county commissioners of the district;

4. Organizational chart, including the number of persons and number of full-time equivalents (FTEs) in each position.

5. Description of proposed staffing pattern, including job descriptions;

6. Description of telephone system, including provisions for off-hours and weekend message/referral service.

C. A three-year service plan for the implementation and operation of the proposed single entry point agency, including the following information, as well as a discussion of the agency applicant's ability to comply with all selection criteria.

1. Identification of specific goals and measurable objectives;

2. Description of the agency applicant's plan to overcome any geographic barriers within the district, including distance from the agency office, to provide timely assessment and case management services to clients;

3. Description of the agency applicant's plan to monitor the quality of care provided to clients;

4. Description of the agency applicant's plan to provide services to private pay clients within two years of agency start-up; and

8.021.3 SINGLE ENTRY POINT AGENCY SELECTION CRITERIA (continued)

.34 Application process (continued)

5. Description of the agency applicant's plan to involve long term care consumers in the planning and evaluation functions of the agency.

D. Evidence of agreements to cooperate with key organizations within the district including, but not limited to, county departments of social services, area agencies on aging, county public health agencies, home health agencies, assisted living facilities, nursing facilities, hospitals, mental health centers, independent living centers, community centered boards for the developmentally disabled, and local social security administration offices.

.35 Fiscal management. The agency applicant shall provide the following assurances with supporting documentation:

A. The agency applicant is capable of efficiently managing financial resources;

B. The agency applicant is capable of managing funds from multiple funding sources including:

1. Compliance with, or knowledge of, governmental fund accounting, cost (or grant) accounting, reporting requirements, internal controls, and cash management;

2. Availability of an accounting system for the handling of multiple funding sources; and

3. Capability of timely reporting of monthly accounting, financial and program management information to the state department, by computer diskette or by modem.

.36 Organizational capability. The agency applicant shall assure its ability to comply with all administrative standards set forth in the state department's rules for single entry point agency functions and shall make the following assurances:

A. Personnel policies and procedures for the recruitment, hiring, evaluation and termination of employees and volunteers shall include the following:

8.021.3 SINGLE ENTRY POINT AGENCY SELECTION CRITERIA (continued)

Add .36 eff. 1/1/92

Organizational capability (continued)

1. An affirmative action plan;

2. Requirements that reference checks and background investigations be conducted on all employees and volunteers and documented in personnel files;

3. A training plan for case managers and other key staff members;

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4. Requirements that reasonable accommodations shall be made for an employee who has a disability; and

Add eff. 1/1/92

5. Job descriptions for each position.

B. Clients, service providers and others may access the single entry point agency office during normal business hours.

1. The agency office shall be staffed to operate at least forty (40) hours per week, during normal business hours, Monday through Friday, excluding holidays; and

2. The agency office shall be accessible to persons who are disabled.

C. The agency applicant's policies and procedures shall provide for a telephone system and trained staff to ensure timely response to telephone calls, after hours messages/referrals, access to telecommunications devices and/or interpreters for the hearing and vocal impaired, and access to foreign language interpreters as needed.

D. The agency applicant's liability insurance shall meet the state department's minimum requirements for contractors.

E. All clients of the single entry point agency shall be informed of feasible long term care alternatives.

1. The client and/or the client's legal representative shall participate in the development of a plan of care, including the choice of type of service provider and the choice of provider.

8.021.3 SINGLE ENTRY POINT AGENCY SELECTION CRITERIA (continued)

.36 Organizational capability (continued)

2. If the agency applicant plans to provide any direct service in addition to specified single entry point functions, the agency applicant shall comply with state department rules concerning the provision of direct services by single entry point agencies.

F. The agency applicant shall have access to compatible computer hardware and appropriate software to access the state department's computer system.

.37 Program capability. The agency applicant shall assure that all functions of the single entry point agency shall meet the state department's performance standards, using the agency applicant's designated staff resources and experience, including the following assurances:

A. The ability of key management staff to effectively administer the single entry point agency;

B. The agency applicant's knowledge and understanding of long term care issues including program eligibility, financial eligibility, continuum of care, and the integration of formal and informal community and client resources.

.38 Community orientation and cooperation. The agency applicant shall assure its capability to respond to local needs and shall demonstrate support from the county commissioners of the district through the provision of a letter of endorsement from the board of county commissioners from each county in the district.

8.022 FINANCING OF THE SINGLE ENTRY POINT SYSTEM

Single entry point agencies shall be established as administrative units for the purpose of providing case management services.

8.022.1 FUNDING SOURCES

In accordance with state and federal rules and regulations, public funds shall be utilized to finance the single entry point system including, but not limited to, funds from the following sources:

A. Funds for case management services provided through the Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program;

B. Funds for case management services provided through the Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA) program; and

C. Funds for casework services for Adult Foster Care and Home Care Allowance clients from the state's general fund; and

D. Older American's Act funds for case management services.

E. In addition to the above listed funding sources, reimbursement for single entry point agency functions may be available from other sources.

8.022.2 REIMBURSEMENT METHODOLOGY

Reimbursement for single entry point functions shall be determined by the number of counties included in a district and by the number of clients served, subject to the availability of funds.

A. A single entry point agency that serves a multi-county district shall annually receive a base amount for each county included in the district, plus an amount for each client served, to be determined annually by the state department.

B. A single entry point agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each client served each year.

C. The amount for each client shall be based on the number of clients served from one or more of the following programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), and Older American's Act case management services.

8.022.3 COST ALLOCATION

State and federal funds shall be allocated to each single entry point district at the beginning of each state fiscal year (July 1 - June 30), based on the above single entry point reimbursement methodology.

A. The state department shall divide each single entry point district's allocated amount into equal monthly payments and shall make monthly payments to each single entry point agency at the beginning of each month for the respective month's expenditures.

B. At year end, each single entry point agency's allowable costs shall be reconciled with the agency's allocation. Reimbursement for allowable expenditures shall be made to the extent of the district's allocation. In the event a district's allocation is greater than its allowable expenditures, the district shall remit any overpayment.

C. Allowable agency expenditures are those which the state department deems allowed or required, in accordance with the following federal rules: CFR Title 45, Part 74, Appendix C; Office of Management and Budget Circular A-87, January 1981; and U.S. Department of Health and Welfare, December 1976, Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government (OASC-10). This rule does not include later amendments to or editions of the incorporated material. Copies are available for public inspection during regular business hours, and may be obtained at cost or examined from the Director of the Division of Accounting and Purchasing, Colorado Department of Social Services, 1575 Sherman Street, Denver, CO.

D. Single entry point agencies may be audited by representatives of the state department and independent audit firms, in accordance with state and federal rules.

E. Pre-audits made in the state department may result in reducing the single entry point agency's reimbursement by the amount of any incorrect payments. Post audits made by the field audit staff verify the correctness of payments and may result in additional adjustments in reimbursement.

F. Single entry point agencies shall maintain documentation to support the actual costs of operation. Quarterly reports submitted to the state department shall document time expended by employees on specified programs, in accordance with a state prescribed time analysis method.

8.022.4 PRIVATE PAY CLIENTS

Single entry point agencies shall provide case management services to private pay clients within two years from agency start-up.

A. The single entry point agency must serve private pay clients who are able to make payment in full on a fee-for-service basis and may serve private pay clients on a sliding fee basis.

B. If the single entry point agency chooses to serve private pay clients on a sliding fee basis, the single entry point agency shall be responsible for obtaining supplemental funds to cover the cost of case management services for these clients.

C. The single entry point agency shall establish separate accounting cost centers for the reporting of private pay clients as separate and distinct from clients of publicly funded programs.

D. The services provided to private pay clients shall be subject to the same standards as apply to clients who are recipients or applicants for state administered programs, including the collection of comparable client specific data.

8.023 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.023.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY

Add eff. 1/1/92

The single entry point agency shall be required by federal or state statute, or by mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the agency, to comply with the following standards:

Rev. eff. 12/1/92

A. The single entry point agency shall serve persons in need of long term care services, regardless of impairment or disability, in accordance with program criteria, except that persons in need of specialized assistance such as services for developmental disablilities or mental illnes may be referred by a single entry point agency to programs under the Department of Institutions;

Add eff. 1/1/92

B. The single entry point agency shall have the capacity to accept multiple funding source public dollars;

C. The single entry point agency shall have the capacity to file for and receive payment from private insurance carriers, and charge and collect fees for services from clients;

D. The single entry point agency shall have the capacity to contract with individuals, with for-profit entities, and with not-for-profit entities to provide some or all single entry point functions;

E. The single entry point agency shall have the capacity to receive funds from public or private foundations and corporations; and

F. The single entry point agency shall be required to publicly disclose all sources and amounts of revenue.

.11 Community advisory committee. The single entry point agency shall establish a community advisory committee for the purpose of providing public input and guidance for single entry point agency operation.

A. The membership of the community advisory committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, long term care service providers, long term care ombudsman, human service agencies, county government officials, and long term care consumers.

B. The community advisory committee shall provide public input and guidance to the single entry point agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall single entry point agency operations, service quality, client satisfaction, and other related professional problems or issues.

8.023.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY (continued)

.12 Personnel system. The single entry point agency shall have a system for recruiting, hiring, evaluating, and terminating employees.

A. Single entry point agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

B. The single entry point agency shall maintain written job descriptions for all positions.

.13 Accounting system. The single entry point agency shall comply with all rules and regulations for accounting practices set forth by the state department.

A. In addition, the single entry point agency shall assure the following:

1. Funds are used solely for authorized purposes;

2. All financial documents are filed in a systematic manner to facilitate audits;

3. All prior years' expenditure documents are maintained for use in the budgeting process and for audits; and

4. Records and source documents are made available to the state department, its representative, or an independent auditor for inspection, audit, or reproduction during normal business hours.

B. The single entry point agency shall be audited annually and shall submit the final report of the audit to the state depart-ment within six months after the end of the state's fiscal year. The single entry point agency shall assure timely and appropriate resolution of audit findings and recommendations.

.14 Liability insurance coverage. The single entry point agency shall maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the state department's minimum requirements for contract agencies.

.15 Information management. The single entry point agency shall be responsible for the collection and reporting of summary and client specific data pertaining to information and referral services provided by the agency, program eligibility determination, financial eligibility determination, care planning, service authorization, resource development, and fiscal accountability.

8.023.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY (continued)

.15 Information management (continued)

A. The single entry point agency shall have access to computer hardware and software, compatible with the state department's computer systems and with sufficient capacity, to access the state department's computer systems.

B. The single entry point agency shall have adequate staff support to maintain a computerized information system in accordance with the state department's requirements.

.16 Recordkeeping. The single entry point agency shall maintain client records in accordance with program requirements, including the documentation of all case activities, the monitoring of service delivery, and service effectiveness. If applicable, the client's legal representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.

.17 Confidentiality of information. The single entry point agency shall protect the confidentiality of all applicant and recipient records in accordance with the confidentiality of information section of staff manual Volume 7 (Section 7.000.92) and state statute (CRS 26-1-114 as amended). Fiscal data, budgets, financial statements and reports which do not identify clients by name or number are open records.

.18 Client rights. The single entry point agency shall assure the protection of the client's rights as defined by the state department under applicable programs.

A. The single entry point agency shall assure that the following rights are preserved for all clients of the single entry point agency, whether the client is a recipient of a state administered program or a private pay client:

1. The client and/or the client's legal representative is fully informed of the client's rights and responsibilities;

2. The client and/or the client's legal representative participates in the development and approval of the client's plan of care;

3. The client and/or the client's legal representative selects service providers from among available and appropriate providers in the client's single entry point district;

8.023.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY (continued)

.18 Client rights (continued)

4. The client and/or the client's legal representative has access to a uniform complaint system provided for all clients of the single entry point agency; and

5. The client and/or the client's legal representative has access to a uniform appeal process for all applicants and recipients of publicly funded programs when benefits or services are denied or reduced and the issue is appealable.

B. At least annually, the single entry point agency shall survey a random sample of clients to determine their level of satisfaction with services provided by the agency.

1. The random sample of clients shall constitute ten (10) clients or ten percent (10%) of the single entry point agency's average monthly caseload, whichever is higher.

2. If the single entry point agency's average monthly caseload is less than ten (10) clients, all clients shall be included in the survey.

3. The client satisfaction survey shall conform to guidelines provided by the state department.

4. The results of the client satisfaction survey shall be made available to the state department and shall be utilized for the single entry point agency's quality assurance and resource development efforts.

C. The single entry point agency shall assure that consumer training and information regarding long term care services are available for all clients at the local level.

.19 Access. There shall be no physical barriers which prohibit client participation in accordance with the American Disabilities Act.

A. The single entry point agency shall not require clients to come to the agency's office in order to receive assessments or case management services.

B. The single entry point agency shall comply with anti-discriminatory provisions, as defined by federal and state department rules.

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

The functions to be performed by a single entry point agency shall be based on a case management model of service delivery.

A. The single entry point agency shall provide case management services in compliance with standards established by the state department.

B. The single entry point agency shall provide sufficient staff to meet all performance standards. In the event a single entry point agency sub-contracts with an individual or entity to provide some or all service functions of the single entry point agency, the sub-contractor shall serve the full range of single entry point programs.

C. Protective services. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

.21 Intake/screening/referral

A. The intake/screening/referral function of a single entry point agency shall include, but not be limited to, the following activities:

1. The provision of information and referral to other agencies as needed;

2. The completion of a long term care screen and program targeting form;

3. The determination of the appropriateness of a referral for a comprehensive long term care client assessment;

4. The identification of potential payment source(s), including the availability of private funding resources; and

5. If the payment source is public assistance, the verification of financial eligibility for public assistance.

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.21 Intake/screening/referral (continued)

a. Single entry point agency staff shall verify the individual's current financial eligibility status, or refer the client to the county department of social services of the client's county of residence for application, within one working day after initial contact with the individual.

b. Single entry point agency staff shall assist the individual in completing financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides.

c. The county department of social services for the county in which the individual resides shall determine the individual's financial eligibility. Other arrangements for determining financial eligibility may be made by agreement between the single entry point agency and the individual's county of residence, subject to approval by the state department.

B. If the single entry point agency staff has determined that a comprehensive long term care client assessment is needed, a case manager shall be assigned, within one working day from the initial contact with the individual, to conduct the assessment.

C. On a monthly basis, the single entry point agency shall submit to the state department summary data on client intakes, clients not assessed, and services requested but not available, using a state-prescribed form.

.22 Assessment

A. The case manager shall complete the Uniform Long Term Care Client Assessment Instrument in accordance with instructions provided by the state department.

1. A Uniform Long Term Care Client Assessment Instrument shall be completed for individuals eligible to receive services through the following programs:

a. Medicaid nursing facility care;

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.22 Assessment (continued)

Added eff. 1/1/92

b. Home and Community-Based Services for the Elderly, Blind, and Disabled (HCBS-EBD);

c. Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA);

d. Home Care Allowance;

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e. Adult Foster Care;

f. In-home services provided by the Older American's Act when the individual is in need of case management services; and

Added eff. 12/1/92

g. Program for All-inclusive Care of the Elderly.

Added eff. 1/1/92

2. The Uniform Long Term Care Client Assessment Instrument shall be completed for a client in need of Medicaid Home Health services if the client is accessing home health services through one of the above listed programs.

3. The Uniform Long Term Care Client Assessment Instrument shall be completed for clients who are able to pay for case management services through resources other than public assistance.

B. The case manager shall begin the assessment and complete the assessment within time frames specified by the state department.

1. The case manager shall initially contact the client within one working day from the date of assignment to complete an assessment.

2. For an individual who is not being discharged from a hospital or nursing facility, the face-to-face client assessment shall begin within five working days from the date of assignment to complete an assessment and shall be completed within ten (10) working days from the date of assignment.

3. For an individual who is being discharged from a hospital, or who is a resident of a nursing facility and is accessing Medicaid as the payment source, the client assessment shall be completed within two working days after the initial contact with the individual, the individual's representative, or facility staff.

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.22 Assessment (continued)

a. A hospital discharge planner may complete the assessment for an individual who is being discharged from a hospital. The single entry point agency must ensure the assessment is conducted in accordance with these state department rules.

b. Program eligibility and service authorization shall comply with program rules.

C. The case manager shall complete the following activities for a comprehensive client assessment:

1. Obtain diagnostic information from the client's physician;

2. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in his or her residential setting;

3. Determine the ability and appropriateness of the client's caregiver, family, and other collaterals, to provide the client assistance in activities of daily living;

4. Determine the client's service needs, including the client's need for durable medical equipment and/or home modifications;

5. If the client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

6. If an out-of-home placement is required, review placement options based on the client's needs, the potential funding sources, and the availability of resources within the district including, but not limited to, the client's home, an adult foster care home, an alternative care facility, a nursing facility, or another residential alternative;

7. Ascertain the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state department rules;

8. Determine and document client preferences in program selection;

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.22 Assessment (continued)

9. Assist the client in the completion of applications for state administered programs, if appropriate;

10. Submit appropriate documentation to the Peer Review Organization (PRO) for certification of program eligibility, if required for entrance into a program; and

11. Refer the client to alternative services, if the client does not meet the eligibility requirements for a long term care program administered by the state department.

.23 Care planning

A. The case manager shall develop the care plan after completing the client assessment and prior to the arrangement for services. The case manager shall complete the care plan (including all required paperwork) within fifteen (15) working days after determination of program eligibility.

B. Care planning shall include, but not be limited to, the following tasks:

1. The identification and documentation of care plan goals and client choices;

2. The identification and documentation of services needed, including type of service, specific functions to be performed, frequency of service, type of provider, and services needed but not available;

3. The determination of client co-payment and documentation of client choices, in accordance with program requirements;

4. The formalization of the care plan agreement, including appropriate signatures, in accordance with program requirements;

5. The authorization for services, in accordance with program directives, including cost containment requirements;

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.23 Care planning (continued)

6. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision, and formalizing provider agreements in accordance with program rules;

7. The completion of program requirements for authorization of services;

8. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;

9. The explanation of complaint procedures to the client.

C. Prudent purchase of services:

1. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

2. When services are available to the client at no cost from family, friends, volunteers, or others, these services shall be utilized before the purchase of services, providing these services adequately meet the client's needs.

3. When public dollars must be used to purchase services, the case manager shall encourage the client to select the lowest cost provider of service where quality of service is comparable.

.24 On-going case management

A. The major goals of on-going case management shall be:

1. To monitor the quality of care provided to clients;

2. To identify changes in the client's needs which may require a full reassessment or a change in the plan of care;

3. To identify and resolve any problems with service delivery; and

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.24 On-going case management (continued)

4. To make changes in service plans as appropriate to client needs.

B. The case manager shall assure quality of care by monitoring the appropriateness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, and the safety of the client, and by taking corrective actions as needed.

C. On-going case management shall include, but not be limited to, the following tasks:

1. Review of the client's care plan and service agreements;

2. Contact with the client concerning the client's satisfaction with services provided;

3. Contact with service providers concerning service coordination, effectiveness and appropriateness, as well as concerning any complaints raised by the client or others;

4. Contact with appropriate collaterals in the event any issues or complaints have been presented by the client or others;

5. Conflict resolution and/or crisis intervention, as needed;

6. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

7. Notification of appropriate enforcement agencies, as needed; and

8. Referral to community resources as needed.

D. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or misutilization of any public assistance or Medicaid benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with state department rules (Volume 3, Section 3.810).

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.24 On-going case management (continued)

E. The case manager shall contact the client and each service provider at least quarterly, or more frequently as determined by the client's needs or as required by the program.

.25 Reassessment

A. The case manager shall complete a reassessment of a client within six months of the initial client assessment or the previous reassessment. A reassessment shall be completed in less than six months if the client's condition changes or if required by program criteria.

B. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the Uniform Long Term Care Client Assessment Instrument.

C. Reassessment shall include, but not be limited to, the following activities:

1. Obtain diagnoses and signature from the client's physician at least annually, or sooner if the client's condition changes or if required by program criteria;

2. Assess client's functional status;

3. Review care plan, service agreements, and provider contracts or agreements;

4. Evaluate service effectiveness, quality of care, and appropriateness of services;

5. Verify continuing Medicaid eligibility, other financial and program eligibility;

6. Renegotiate care plan and service agreements;

7. Inform the client's physician of any changes in the client's needs;

8. Submit appropriate documentation to the Peer Review Organization (PRO) for certification of continued program eligibility, if required by the program for a continued stay review;

8.023.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY (continued)

.25 Reassessment (continued)

9. Refer client to community resources as needed and develop resources for the client if the resource is not available within the client's community; and

10. Submit appropriate documentation for authorization of services, in accordance with program requirements.

D. The single entry point agency shall not be responsible for reassessments of residents of nursing facilities. Reassessment of a nursing facility resident shall be conducted by the facility's staff.

8.023.3 INTERCOUNTY AND INTERDISTRICT TRANSFER PROCEDURES

.31 Intercounty transfers. Single entry point agencies shall complete the following procedures to transfer clients to another county within the same single entry point district:

A. Notify the income maintenance technician of the client's plans to relocate to another county and the date of transfer, and instruct the technician to follow the procedures for intercounty transfers (Volume 3.140.3).

B. If the client's current service providers do not provide services in the area where the client is relocating, make arrangements in consultation with the client for new service providers.

C. If the client is moving from one county to another county to enter an Alternative Care Facility, forward copies of the following client records to the Alternative Care Facility, prior to the client's admission to the facility:

1. Uniform Client Assessment Instrument (ULTC-100), certified by the Peer Review Organization (PRO);

2. Client Payment Form for Alternative Care Facility clients; and

3. Verification of Medicaid eligibility status.

D. Notify the Peer Review Organization (PRO), if the client is a recipient of a program requiring PRO-certification, and the state department of the transfer within thirty (30) calendar days, using a state-prescribed form.

.32 Interdistrict transfers. Single entry point agencies shall complete the following procedure in the event a client transfers from one single entry point district to another single entry point district:

A. The transferring single entry point agency shall contact the receiving single entry point agency by telephone and give notification that the client is planning to transfer, negotiate a transfer date, and provide information.

8.023.3 INTERCOUNTY AND INTERDISTRICT TRANSFER PROCEDURES (continued)

.32 Interdistrict transfers (continued)

B. If the transfer is from one county to another county, the transferring single entry point agency shall notify the income maintenance technician of the client's plan to transfer and the transfer date, and instruct the technician to follow procedures for intercounty transfers (Volume 3.140.3). The receiving single entry point agency shall coordinate the transfer with the income maintenance technician of the new county.

C. The transferring single entry point agency shall forward copies of the client's case records, including forms required by the publicly funded program, to the receiving single entry point agency prior to the relocation, if possible, or in no case later than five (5) working days after the client's relocation.

D. If the client is moving from one single entry point district to another single entry point district to enter an Alternative Care Facility, the transferring single entry point agency shall forward copies of client records to the Alternative Care Facility, prior to the client's admission to the facility, in accordance with the procedures for intercounty transfers.

E. The receiving single entry point agency shall begin a face-to-face assessment with the client within five (5) working days after notification of the client's relocation and complete the assessment within ten (10) working days after notification of the client's relocation, in accordance with assessment procedures for single entry point agency clients.

F. The receiving single entry point agency shall review the care plan and change or coordinate services and providers as necessary.

G. If indicated by changes in the care plan, the receiving single entry point agency shall revise the care plan and service authorization forms as required by the publicly funded program.

H. Within thirty (30) calendar days of the client's relocation, the receiving single entry point agency shall forward to the state department, or its designee, revised forms as required by the publicly funded program.

I. Within thirty (30) calendar days of the client's relocation, the transferring single entry point agency shall notify the Peer Review Organization (PRO), if the client is a recipient of a program requiring PRO certification, and the state department, using a state-prescribed form.

8.023.4 STAFFING OF A SINGLE ENTRY POINT AGENCY

.41 Staffing patterns. The single entry point agency shall provide staff for the following functions: receptionist/clerical, administrative/ supervisory, case management, and medical consulting services.

A. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, assisting single entry point agency staff with clerical duties, and entering data into an information management system.

B. The administrative/supervisory function of the single entry point agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, resource development, marketing, liaison with the state department, and, as needed, provide case management services in lieu of the case manager.

C. The case manager function shall include, but not be limited to, all of the case management functions previously defined for single entry point case management services, as well as resource development, and attendance at staff development and training sessions.

D. The medical consultant services functions shall include, but not be limited to, access to a licensed medical professional (such as a physician or a registered nurse) who shall provide consultation to single entry point agency staff regarding medical and diagnostic concerns.

.42 Qualifications of staff. The single entry point agency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

A. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).

B. An individual who is employed as a caseworker or case manager at the time the single entry point agency becomes operational who does not meet the minimum educational requirement may qualify as a single entry point agency case manager under the following conditions:

8.023.4 STAFFING OF A SINGLE ENTRY POINT AGENCY (continued)

.42 Qualifications of staff (continued)

1. The determination as to the qualification as a case manager shall be made jointly by the single entry point agency and the state department;

2. Experience as a caseworker or case manager with the long term care client population, in a private or public social services agency may substitute for the required education on a year for year basis; and

3. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

C. The case manager shall be required to demonstrate competency in all of the following areas:

1. Knowledge of and ability to relate to populations served by the single entry point agency;

2. Client interviewing and assessment skills;

3. Knowledge of the policies and procedures regarding public assistance programs;

4. Ability to develop care plans;

5. Knowledge of long term care community resources; and

6. Negotiating skills.

D. The single entry point agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of long term care.

.43 Functions of the case manager. The single entry point agency's case manager(s) shall be responsible for all case management services provided by the single entry point agency including: information and referral, intake/screening/referral, assessment of clients, development of care plans, on-going case management, monitoring of clients, reassessments, resource development for individual clients, and case closure.

A. The case manager shall contact the client at least quarterly, or more frequently if warranted by the client's condition or if required by program criteria.

8.023.4 STAFFING OF A SINGLE ENTRY POINT AGENCY (continued)

.43 Functions of the case manager (continued)

B. The case manager shall have a face-to-face contact with the client at least every six months, or more frequently if warranted by the client's condition or if required by program criteria.

C. The case manager shall reassess the client at least every six months, or more frequently if warranted by the client's condition or if required by program criteria, and shall update the information on the client's Uniform Long Term Care Client Assessment Instrument as needed.

D. The case manager shall monitor the services provided to the client, and shall monitor the contract between the client and the provider when required by the publicly funded program.

1. The case manager shall monitor the quality of care provided, and

2. The case manager shall monitor the health and safety of the client.

E. The following criteria may be used by the case manager to determine the client's level of need for case management services:

1. Availability of family support,

2. Overall level of functioning,

3. Mental status or cognitive functioning,

4. Duration of disabilities,

5. Whether the client is in a crisis or acute situation,

6. The client's perception of need and dependency on services, and

7. The client's move to a new housing alternative, if applicable.

.44 Training of single entry point agency staff. Single entry point agency staff, including supervisors, shall attend training sessions provided by the state department for single entry point agencies.

8.023.4 STAFFING OF A SINGLE ENTRY POINT AGENCY (continued)

.44 Training of single entry point agency staff (continued)

A. Prior to agency start-up, the single entry point agency staff shall receive training provided by the state department, which will include, but not be limited to, the following content areas:

1. Background information on the development and implementation of the single entry point system;

2. Mission, goals and objectives of the single entry point system;

3. Regulatory requirements and changes or modifications in federal and state programs;

4. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

5. Federal and state requirements for the single entry point agency.

B. For the first three years of agency operation, the state department will provide in-service and skill development training for single entry point agency staff on an annual basis. Thereafter, the single entry point agency will be responsible for in-service and staff development training.

8.023.5 RESOURCE DEVELOPMENT

.51 Resource development committee. The single entry point agency shall assume a leadership role in facilitating the development of local resources to meet the long term care needs of individuals who reside within the single entry point district served by the single entry point agency.

A. Within 90 days of the effective date of the initial contract, the single entry point agency's community advisory committee shall appoint a resource development committee.

B. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: area agencies on aging, county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards for the developmentally disabled, vocational rehabilitation agencies, and long term care consumers.

C. In coordination with the resource development efforts of the area agency(ies) on aging that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

1. The resource development plan shall include:

a. An analysis of the long term care resources available within the single entry point district;

b. Gaps in long term care resources within the single entry point district;

c. Strategies for developing needed resources; and

d. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support, and a time frame for accomplishing stated objectives.

2. The data generated by the single entry point agency's information and referral, intake/screening/referral, client assessment, documentation of unmet client needs, resource development for individual clients, and data available through the state department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

8.023.5 RESOURCE DEVELOPMENT (continued)

.51 Resource development committee (continued)

Added eff. 1/1/92

D. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the state department.

Rev. .52 eff. 12/1/92

Certification of service providers. The single entry point agency shall be responsible for the certification of adult foster care facilities within the single entry point district, in accordance with state department rules for adult foster care (Staff Manual, Volume 7, Sections 7.102.10 - 7.102.80).

8.023.6 PROVISION OF DIRECT SERVICES

Add .61 eff. 1/1/92

Waiver criteria. The single entry point agency may be granted a waiver by the state department as a provider of direct services provided the agency complies with the following criteria:

A. The single entry point agency shall document at least one of the following in a formal letter of application for the waiver:

1. The service is not otherwise available within the single entry point district or within a sub-region of the district; and/or

2. The service can be provided more cost effectively by the single entry point agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

B. The single entry point agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report to the state department which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

C. The single entry point agency shall assure the state department that efforts have been made, and will continue to be made, to develop the needed service within the single entry point district or within the sub-region of the district, as a service external to the single entry point agency. The single entry point agency shall submit an annual progress report to the state department on the development of the needed service within the district.

8.023.6 PROVISION OF DIRECT SERVICES (continued)

.61 Waiver criteria (continued)

D. The direct service provider entity and the single entry point agency shall be administratively separate.

E. In the event other service providers are available within the district or sub-region of the district, the single entry point agency case manager shall document in the client's case record that the client has been offered a choice of providers.

8.024 ACCOUNTABILITY MECHANISMS FOR SINGLE ENTRY POINT AGENCIES

8.024.1 PERFORMANCE BASED CONTRACT

A single entry point agency shall be bound to the terms of the contract between the agency and the state department, including quality assurance standards and compliance with the state department's rules for single entry point agencies and for publicly funded programs.

8.024.2 CERTIFICATION OF SINGLE ENTRY POINT AGENCIES

A single entry point agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the state department's rules and in the contract between the agency and the state department.

A. Certification as a single entry point agency shall be based on an evaluation of the agency's performance in the following areas:

1. The quality of the services provided by the agency;

2. The agency's compliance with program requirements, including compliance with case management standards adopted by the state department;

3. The agency's performance of administrative functions, including reasonable costs per client, timely responses, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring;

4. Whether targeted populations are being identified and served; and

5. Financial accountability.

B. The state department or its designee shall conduct reviews of the single entry point agency.

C. No later than thirty (30) days following the review, the state department shall notify the single entry point agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

8.024.2 CERTIFICATION OF SINGLE ENTRY POINT AGENCIES (continued)

.21 Provisional approval of certification. In the event a single entry point agency does not meet all of the quality assurance standards established by the state department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of clients.

A. The agency will receive notification of the deficiencies and a request to submit a corrective action plan to be approved by the state department.

B. The state department shall provide technical assistance to facilitate corrective action.

.22 Denial of certification. In the event certification as a single entry point agency is denied, the procedure for single entry point agency termination or non-renewal of contract shall apply (Section 8.021.25).

8.024.3 ENFORCEMENT ACTIVITIES

In the event the single entry point agency fails to satisfy the scope of work as defined in the contract between the agency and the state department, the state department reserves the right to take remedial action.

.31 Remedial actions. Based on the severity of the agency's failure to satisfy the scope of work, the state department may take one or more of the following remedial actions:

A. Withhold payment to the contractor. In the event the single entry point agency is not in compliance with state department standards, funds may be withheld until the necessary services or corrections in performance have been completed.

B. Deny payment or recover reimbursement. In the event tasks were not performed, or not performed in a timely manner, payment for these tasks may be denied or reimbursement for these tasks may be recovered.

C. Removal from work. The state department may request that the single entry point agency remove from work an employee or agent of the single entry point agency whom the state department justifies as being incompetent, careless, insubordinate, or otherwise unacceptable, or whose continued employment is contrary to the public interest or the best interest of clients or of the state department.

8.024.3 ENFORCEMENT ACTIVITIES (continued)

.31 Remedial actions (continued)

Added eff. 1/1/92

D. Fiscal sanctions. In the event the single entry point agency fails to adhere to all applicable federal and state regulations, the state department may impose monetary fines on the single entry point agency.

E. Termination of contract. The state department may terminate the contract with the single entry point agency for any of the following reasons: default by the single entry point agency, insolvency or bankruptcy on the part of the single entry point agency, unavailability of funds, denial of certification, or for the convenience of the state department.

F. Revocation of certification. The state department may revoke certification of the single entry point agency when the agency fails to meet the terms of the contract.

8.024.4 APPEAL PROCESS

The contract with the single entry point agency shall not be subject to arbitration. Any dispute concerning performance of the contract shall be decided by the Manager for Health and Medical Services, Colorado Department of Social Services.

A. The Manager for Health and Medical Services shall send a certified letter with the written decision to the single entry point agency.

B. The decision of the Manager for Health and Medical Services shall be final and conclusive unless the single entry point agency files a written appeal of the decision with the Executive Director, Colorado Department of Social Services, within thirty (30) days from the date the single entry point agency received the written decision.

Added eff. 12/1/92

C. If the dispute involved the provision of direct services as provided for under 8.023.6, the appeal process will follow Section 26-1-106(2), C.R.S.

10.235 DIRECT PROVISION OF SERVICES (continued)

Rev. eff. 2/1/91

B. The services which are directly related to an area agency's administrative functions include:

- advocacy
- coordination
- program development
- information and referral
- outreach
- needs assessment
- long term care ombudsman
- training
- case management

Added eff. 2/1/91

C. Except for those services described above or where waiver is granted by the state department, area agencies shall award funds by a grant or contract to community services provider agencies and organizations.

Rev. eff. 2/1/91

D. Direct Provision of Services - Waiver Required

In order to provide and prior to providing direct services other than those exempt from the waiver listed in Sec. 10.235 B, an area agency shall request a waiver from the state agency in the four year plan and whenever the area agency is applying for a waiver in order to provide a service not previously approved by the state department.

Rev. eff. 10/1/85

E. Waiver Application Requirements

The waiver application shall set forth documentation that direct service provision is necessary to assure an adequate supply of services, or that services of comparable quality can be provided more economically by the area agency than by any agency that has applied to provide the services. The waiver application shall include documentation of (a) adequate notice, (b) effort to develop service provider, and (c) either: (1) documentation of a lack of applicants; or, (2) documentation of the area agency's greater efficiency and effectiveness in providing the services than any applicant.

Rev. eff. 2/1/91

1. Adequate Notice:

a. The area agency shall document that potential service providers in the PSA were given adequate notice regarding the availability of funds and the grant application process.

Rev. eff. 10/1/85

b. The notice shall include a description of the services to be provided, population to be served and estimated amount of funding available.

10.235 DIRECT PROVISION OF SERVICES (continued)

Rev. eff. 2/1/91

2. Efforts to Develop Service Provider:

The area agency shall develop and implement a plan to assist potential direct service providing entities to develop their capacity to effectively and efficiently provide services under the four year plan.

3. Lack of Applications to Provide Service:

In the event that no applications to provide services are received by the area agency following the adequate notice requirements outlined in Sec. 10.235 E.1. above, the area agency shall state in its waiver application that no applications were received.

4. Efficiency and Effectiveness:

a. In the event that applications are received from potential service providers, the area agency may document in its waiver application that direct provision of the service by the area agency will be more efficient and effective.

b. The determination that a service may be provided more efficiently and effectively by the area agency than by applicant service providers shall be made by an impartial review committee or the local advisory council, and shall be based upon pre-established and pre-published measurable criteria, uniformly applied to all applicants and to the area agency.

Added eff. 1/1/92

F. Relationship to Single Entry Point Agency:

1. An Area Agency utilizing OAA funds to provide case management services and which is not designated as the Single Entry Point Agency for long term care services shall contract with the Single Entry Point Agency(ies) in its Single Entry Point District(s).

2. The Area Agency(ies) within a Single Entry Point District shall participate on the Single Entry Point Community Advisory Committee and the Single Entry Point Resource Development Committee.