MANAGING THE CASE LOAD

The adult services worker must monitor his/her case load to ensure timely contacts with the client for reviews and that provider payments are authorized. MiAIMS provides easy access to much of the information needed to effectively manage the case load. Adult services workers and supervisors have the ability to access information on the status of contacts, reviews, payments, and provider management.

Six Month Review

ACP cases must be reviewed every six months. A face-to-face contact is required with the client and should include the provider.

Note: Adult services workers must have a face-to-face contact with the client as often as needed, but at least every six months. If the contact with the client is at a place outside of the facility, then the facility provider must also be contacted. The adult services worker must update MiAIMS screens and review dates for any information that has changed since the last review.

Requirements for the review contact must include a review of the current comprehensive assessment and plan of care.

Prior to the scheduled visit, the adult services worker reviews the existing plan of care in MiAIMS. It may be helpful to print all or part of the plan to take on the home visit. Appropriate questions to be discussed with the client, provider, and collateral sources are topics such as community services or sheltered workshops. Continuation of any services, progress toward stated goals, and necessary modifications need to be addressed during this review process including:

- Follow-up with collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Review the Bureau of Community and Health Systems (BCHS) forms at the Adult Foster Care/ Home for the Aged (AFC/HA) home. Some of the BCHS specific numbered forms are ***required*** for use by the facility. However, there are some forms the AFC home may develop an approved equivalent form in lieu of the

BCHS form. See also **ASM-060, BCHS Rules for Records and Forms.**

Resident Funds Record Part I and II (**BCAL 2318 and 2319 REQUIRED forms**)-AFC homes often will not take overall responsibility for resident funds, but they must document at minimum the intake of monies for the monthly payment of the resident as well as any petty cash the client has been given while living at the facility. The AFC must document the credit and debit of payments each month per licensing rules and use the required BCAL form.

Note: The adult services worker examines these facility forms to protect the client's rights for an accurate accounting of monies received and expended on their behalf. When a client is totally dependent on Medicaid to pay for their living arrangements, the AFC provider must make sure the client retains the allotted personal care money per month for personal spending money; see **ASM-077, ACP SSI/SDA Provider Rates,** for the designated amounts due to the client.

- **Assessment Plan for AFC Residents** (**BCAL 3265 or approved equivalent**)-This specific numbered form is not required by BCAL for the AFC to have in the resident file. The adult services worker must sign the BCAL form or the facility form when the resident is on the ACP program.

- **Resident Care Agreement** (**BCAL 3266 REQUIRED FORM**)-The facility Resident Care Agreement must be completed and available for the adult services worker to review and sign as the responsible agency. Information contained on this form indicates any specialized help and what the facility will or will not provide that client while living at that facility.

- **Medication Record** (**BCAL 3267 or approved** equivalent)-The facility ***must*** document medication distribution. The adult services worker must examine the client's medication record to ensure that the provider/staff are documenting distribution of medications. This form also will list the current medications the resident is taking so the adult services worker can indicate any additions, deletions, or changes since the last review.

- **Weight record** (**BCAL 3485 or approved** equivalent)-The facility ***must*** maintain continuous weight record of the

residents. It is important to review the weight record as an indication of the client's health status. Substantial changes in weight not ordered by a physician may indicate a problem and should be monitored. As sustained weight loss may suggest inadequate food intake or an undiagnosed medical condition. Unplanned weight increases should also be evaluated by a physician. An adult services worker must initial and date the weight log at each review.

The following list of BCHS numbered forms are not used frequently, but are necessary to be present in a client file for certain circumstances or incidents in an AFC facility. These reports documenting special information are:

- **AFC Incident/Accident Report (BCAL 4607) REQUIRED-only this form can be used by the licensed facility)**.
- **Resident Health Care Appraisal (BCAL 3947 REQUIRED-only this form can be used by the licensed facility).**
- **Appointment of Designated Representative (BCAL 3268 and BCAL 3268-I or APPROVED equivalent).**

A copy of **AFC Incident/Accident Report** (**BCAL 4607**) that involves incidents or accidents of an ACP resident is to be sent to the MDHHS. If the report suggests abuse, neglect, or exploitation then an APS referral must be made.

Home for the Aged

The BCHS forms listed in the case management sections for review are ***not*** used in **Home for the Aged (HA)** facilities. HA facility forms are described in **ASM-060, BCHS Rules for Records and Forms**.

CASE DOCUMENTATION

All reviews include:

A review of all MiAIMS screens and update the information as needed.

- Update the review dates on the appropriate screen.

- Select the contact type and enter the purpose or nature of the contact.
- Record details of the contact in the narrative field.
- Record the summary of case progress in the plan of care.
- Update the payment authorization dates.

Note: In ACP cases, state funds can be used to pay the personal care supplement while waiting for the DHS-54A certification date. When the certification date is entered in MiAIMS, a transfer to Title XIX Federal funding occurs as indicated below:

- If there is a physician certification date listed on the Medical tab in MiAIMS, then the funding source is Title XIX.
- If there is no physician certification date, the adult services worker must obtain a Medical Needs Statement (**DHS-54A**) from the resident's doctor as soon as possible.

After receiving the physician certification, enter the 54A signature date in the Medical module. End date any current payment authorizations that have been paid out of state funds.

Enter a new payment authorization for the facility using the signature date of the DHS-54A as the effective start date. This action will trigger the switch to Federal Title XIX funds.

Note: A new authorization is entered to prevent any overlap of payments.

- Send a copy of the plan of care and signature page to the home provider within **five business** days of the home call to meet BCHS requirements.

The review process is an excellent opportunity to give feedback to the provider regarding resident care, record management and licensing compliance.

Positive observance should be awarded verbally to the home provider. Any areas of concern should also be brought to the provider's attention so they can be corrected to avoid any potentially serious incidents.

If providers are not complying with licensing rules, the adult services worker is to notify the licensing consultant. It is important to maintain regular contact with the licensing consultant assigned for the county.

If there is any suspected abuse, neglect or exploitation of an adult in the licensed facility, a referral to **Adult Protective Services (Centralized Intake number 1-855-444-3911**) must be made as well as reporting a complaint to BCHS. When a referral is received, the adult protective services worker will investigate an assigned referral in conjunction with the licensing consultant if possible.

Note: Adult services worker must still follow APS standard of promptness (SOP) of a face to face contact within 72 hours which may require going out without the licensing consultant.

Any new, relevant data the adult services worker obtains concerning the resident should also be shared with the provider. The adult services worker must maintain a good working relationship with the home provider/owner and the licensing consultant to provide the best overall service to the resident.

DHS-1212 NEGATIVE ACTION LETTER

During case management, an adult services worker may have a need to suspend or terminate personal care supplement payments on an active case. A **DHS-1212, Advance Negative Action Notice,** must be sent to the client.

The DHS-1212, Advance Negative Action Notice, is used and generated in MiAIMS when there is a suspension or termination of ACP services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- **Suspended** - payments stopped but the case will remain open.
- **Terminated**- case closure.

The client may appeal the negative action by requesting an administrative hearing. A **DHS-0092**, **Request for Hearing,** form is generated with a negative action notice in MiAIMS and must be mailed with the negative action notice. For more information on hearing procedures; see the **Bridges Administrative Manual (BAM) 600, Hearings** for more information.

The negative action letter effective date must be 10 business days after the date the adult services worker typed the letter and the

notice must be placed in the department mail the same day the negative action notice is generated.

If the adult services worker has not been contacted for a hearing on the action, then the specialist will complete the action on the date that was stated in the DHS-1212 letter.

If the specialist is made aware of a hearing request prior to the negative action date, the case remains open and payments continue to the license facility as long as the client resides in the facility until the hearing.

Note: When the local office receives a hearing request as a result of negative action, all attempts to resolve the issue at the local level must take place; **see BAM-600, Hearings, Local Office Review, pages 16-19**.

The ACP program payment will cease immediately when the negative action involves an unlicensed facility. Title XIX is only allowed to be paid to current, licensed facilities.

The ten business day effective date is not required if the notice is sent due to:

- Client death.
- Licensee death.
- Client moved.
- Client request to stop services.

Note: When the client leaves the facility, end date the authorization the day **before** the client left the facility. Medicaid pays a facility for the day in to the facility, not the day out of the facility.

Legal Base

Administrative Rule 400.901 and 902 (Hearings and Appeals).