Case Manager Training

Assuring quality in home and community-based services

CASE STUDY #1

EPISODE 1

Jane is a Supervisor at Jefferson County Area Agency on Aging (JCAAA), a case management agency providing oversight to HCBS and other home care services. Prior to her promotion Jane spent five years as an HCBS case manager working primarily with the elderly.

For the last week Jane has been providing training to Ruby, who recently joined the agency as a new Case Manager. Ruby has ten years of experience as a personal care attendant and one year of experience as a case manager, all in another state. Since she is new to this state and to this job, she has been listening closely as Jane explains the role of a case manager at JCAAA and how that relates to the six HCBS Assurances.

Today Jane feels that Ruby is ready to start working in the field and she comes to Ruby's office to start the process.

Jane: Good morning! I see you're finishing-up the orientation materials on the Federal Assurances. Any questions on the Assurances, or your roles and responsibilities related to quality?

Ruby: No, I think it makes sense. I mean, it makes sense *on paper*. I still need to see how it all plays out in real life.

Jane: Well that's good timing. We just got a new referral and I thought we'd get you started. Here's the file on Mr. Richard Kaye, an elderly gentleman who needs supports to continue living at home. Why don't you review the file and we'll talk later about scheduling your first meeting with Mr. Kaye and his family?

Ruby: Sounds great.

Ruby begins to read about Mr. Kaye.

Case Background

Mr. Kaye is an 83 year-old who has been living independently with his wife in the home they've shared for 50 years. Mr. Kaye has been in failing health over the last five years due primarily to gradual memory loss and complications from his diabetes. He has had several falls in the last three months, one of which was serious enough to send him to the hospital. Over time Mr. Kaye's son Rob, who lives nearby, has noticed his father declining. Several weeks ago he discussed this observation with his mother, but she minimized the symptoms and assured her son that she was perfectly able to care for Mr. Kaye at home. Rob raised the possibility of getting some kind of in-home assistance, but Mrs. Kaye declined.

Last week Mrs. Kaye died very suddenly of a heart attack. As the family arrived in town for the funeral several of Rob's siblings stayed with Mr. Kaye. During that time they observed problems Mr. Kaye was having remembering to take his medications and maintaining his balance. One day he would have taken his morning insulin twice if the family had not been there to intercede.

The children realized that it was unlikely Mr. Kaye could continue to live alone. They planned a conversation with Mr. Kaye during a visit with Mr. Kaye's primary care physician. As expected, Mr. Kaye was strongly opposed to leaving his home and told his children he thought he would decline more quickly if they put him in a place "full of strangers". After some negotiation it was decided that Rob would move in with Mr. Kaye at least for the short term and Rob's son, a local college student, would stop in during the day while Rob was at work. The Dr wrote a prescription for physical therapy and Mr. Kaye agreed (reluctantly) to have physical therapy twice a week.

Things went well for the first month. Mr. Kaye seemed to be adjusting to Mrs. Kaye's death and with the help from his family he was managing. But there were signs of potential problems. Mr. Kaye would often forget to use the walker that the physical therapist left, his grandson stopped in less and less often during the day, and Rob was often pressured to work overtime.

Six weeks after the family's support plan was put in place Mr. Kaye took a bad fall in the bathroom just after noon and remained on the floor until Rob's son came to visit at 4:30. Mr Kaye hit his head on the tile floor and could feel that his head was bleeding but lacked the strength to get up.

Mr. Kaye was taken to the hospital where Rob joined him. Mr. Kaye was lucky; although his head wound required stitches he did not break any bones. But Mr. Kaye was also dehydrated and his blood sugar level was dangerously low, probably because he had forgotten to eat his morning snack and his lunch. Mr. K aye was admitted to the hospital until he could be stabilized.

At another family meeting it was acknowledged that this plan was not working. Rob was exhausted, his son was too busy at school to stop in regularly, and Mr. Kaye's balance and memory problems were worsening. All agreed that Mr. Kaye could not be left alone all day and that Rob needed more support. The family was ready to work with the hospital social worker on a different plan for their father's discharge.

Notes on Key Points of Case Study

CASE STUDY #1

EPISODE 2

Jane: Hi Ruby – did you get a chance to read Richard Kaye's background?

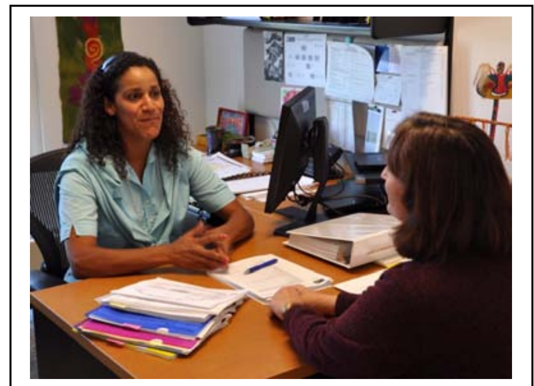
Ruby: Yeah. Sounds like Mr. Kaye is a good candidate for the HCBS Waiver. I'm anxious to get to work and see what we can do to help, but I'm a little confused about my role.

Jane: How so?

Ruby: Well, according to the file Mr. Kaye already has a Level of Care (LOC) assessment. I thought that was part of my job – I always did LOC's at my last job?

Jane: No wonder you're confused. Remember when we were talking about the HCBS waiver program, and how every state applies to CMS for permission to operate a waiver?

Ruby: Yes…



Jane: Well, although states have to make an Assurance to CMS that they'll use an LOC process, each state can design that process differently. Some things are standard, like each state has to assure that participants meet institutional level of care criteria, but states can make their own decisions about who will conduct the LOC and how.

In this state, our Medicaid Agency contracts with a private agency to do all LOC determinations, so we don't receive a referral until the LOC is completed.

Ruby: So, is the level of care requirement different here too? I mean, at my last job a person was eligible for home based services only if they needed help with certain activities of daily living and therefore would be eligible for nursing home level of care.

Jane: That's what LOC determination means throughout the HCBS waiver program: HCBS is an alternative to nursing home care. But each state defines nursing home level of care a bit differently. I'll get you the criteria we use in this state so you can be familiar with them.

Ruby: OK. So the only thing that is really different is that I won't have any responsibilities toward the LOC process?

Jane: Well, not so fast! It's true that you won't be involved in the initial LOC. But remember, another part of the CMS Assurance is that LOC determinations must be revisited at least once a year – more frequently if a person's status changes. You're still responsible for keeping an eye on each person you work with, and if there is a change, or if a year has passed and no reassessment has been done, you make the referral.

Ruby: I suppose that means more forms to fill out? I mean, if I make a referral for a reassessment?

Jane: Yes, but remember what I've been telling you about the paperwork. All of this paper serves a purpose. First, it helps our state provide evidence to CMS that we're complying with the Assurances. In fact, we get reviewed regularly by the state -and that audit includes a review of our records. But more important to our participants, the data we collect helps our agency, our state and CMS figure out what works and what doesn't work in HCBS services. We've learned a lot through all that paperwork!

Ruby: I'm beginning to get that picture. Well, I think I'm ready to get out there and get started. So, what's the next step, do I set up a meeting with Mr. Kaye and his family?

Jane: First let's review our protocol for service planning, and then we can talk about your visit with Mr. Kaye.

Ruby: Sounds great.

CASE STUDY #1

EPISODE 2

PROCESS QUESTIONS

1. Even if Mr. Kaye had not met the institutional level of care criteria he could still receive HCBS waiver services but would be placed on a waiting list.

   True or False?

2. What are some of the level of care criteria in our state?

3. Although another agency conducts the actual level of care assessment, name three things the state might look for in Ruby's participant records to indicate compliance with this Assurance?

4. Name one possible performance measure for this Assurance:

CASE STUDY #1

EPISODE 3a

Ruby contacted Mr. Kaye and his son Rob to set up a time to begin the service plan prior to Mr. Kaye's hospital discharge. She asked Rob who else was involved in his father's care to make sure she invited everybody involved to participate. Rob gave her the phone number of the hospital social worker who was helping with Mr. Kaye's discharge.

Later that week Ruby sat down with Mr. Kaye, Rob, Rob's son, and the social worker. Ruby was very attentive to Mr. Kaye as she moved the conversation through the agency's needs assessment protocol. She paused often to confirm that the discussion was in line with Mr. Kaye's needs and wishes. After a lengthy conversation the group agreed that Mr. Kaye's needs included:

1) Help with dressing, breakfast and lunch preparation, and bathing 3 times a week
2) Preparation and monitoring of medications
3) Improved strength and balance to prevent falls

In response to the needs identified, Ruby included the following HCBS supports in Mr. Kaye's plan:

(1) A personal care attendant for 2 hours a day Monday thru Saturday in the morning to assist with meal preparation, dressing, and bathing.
(2) Weekly RN visit to prepare Mr. Kaye's medications and monitor his blood sugar;
(3) Physical therapy to maintain the progress he made while in the hospital.

She provided the family with a list of available agencies in the area. The family chose Home Caregivers based on a neighbor's recommendation. Ruby also discussed a back-up plan with the family and they identified a second care worker to fill in when needed. Ruby knew from prior conversations that Mr. Kaye wanted to remain at home so she made a note of that in the file and did not waste his time discussing other options.

The group also discussed a number of services and supports to be provided by the family and other community partners outside of the HCBS program, like Meals on Wheels, but since those were not HCBS services Ruby did not include them in the plan.

She sent the draft plan to Jane for her review.

CASE STUDY #1

EPISODE 3a

Reflection Exercise

Think about how Ruby did in her drafting her first plan. What feedback do you think Ruby received from Jane? What did she do well, and what could she have done better?

Did Well	Could Be Improved

CASE STUDY #1

EPISODE 3b

After reviewing Mr. Kaye's service plan, Jane met with Ruby.

Jane: Hi Ruby. I just finished reading your draft service plan for Mr. Kaye and your notes from the meeting. Do you have time for a little feedback?

Ruby: Of course! I'm anxious to hear what you think.

Jane: Overall Ruby you did really well. I mean it. I was impressed with several of your notes and the way you focused on Mr. Kaye and his wishes. You also included all of the appropriate people in the meeting, scheduled the meeting when everyone could attend, and provided detailed documentation on the needs assessment form. I was impressed that you remembered to include a back-up plan and to offer the family a choice of providers.

Ruby: Thanks --- and you're right. Mr. Kaye is so quiet it took some effort to be sure he was really participating.

Jane: That was great. But I also noted a few things missing from his plan. First, you didn't note the frequency or duration of his physical therapy. You also mention in your notes that Mr. Kaye will be enrolled in Meals on Wheels, but you didn't include any non-HCBS supports in his plan.

Ruby: Woops – I forgot that one. I guess because it doesn't make a lot of sense to me to include things we have nothing to do with.

Jane: Well if you mean things that the waiver isn't paying for, that's true. But remember that the needs assessment must identify *all* of the services and supports the participant will need in order to meet his goals and remain safely at home. Without including non-HCBS services the plan may not demonstrate that all of Mr. Kaye's needs are being adequately addressed.

I also noted that you didn't get a letter signed by Mr. Kaye confirming that you discussed all care options and that he prefers in home care?

Ruby: Well, we already had notes in the file from the referral. I didn't want to waste his time talking about things I thought were already decided.

Jane: Yes, but think of this from the perspective of quality control and the Assurances. We need to be sure that Mr. Kaye is aware of all of his choices so that his choice of home care is an informed choice. You need to be sure he understands all of his options – that's part of the Assurances.

Ruby: hmm.. yes, I can see where its important to make sure he knows his options. I should have talked to him about that.

AND, I bet the next thing you're going to tell me is that we can only *demonstrate* that we've met the Assurance by *good documentation* – meaning I should also have gotten that letter signed!

Jane: (laughing) hey - I think you're catching on!!

Ruby: Sounds like I'm going back to Mr. Kaye's house to tie up the lose ends.

Jane: Thanks, Ruby. And remember, this was a great first effort – I think you're going to be a wonderful case manager.

CASE STUDY #1

EPISODE 3b

Reflection Exercise

Look back at the chart you created in Exercise 3a. Compare your responses to the feedback Ruby received from Jane. Here are some of our thoughts on what Ruby did well and what could be improved.

Did Well	Could Be Improved
▪ Invited everyone identified by Mr. Kaye and the family to attend the meeting ▪ Scheduled the meeting when all could attend ▪ Worked with Mr. Kaye to complete his needs assessment protocol ▪ Identified services to meet each need ▪ Included a back-up plan (a second care worker) ▪ Offered Mr. Kaye and his family a choice of providers	▪ Did not document the frequency or duration of physical therapy ▪ Did not include non-HCBS services and supports (ex: Meals on Wheels). ▪ Did not discuss options other than HCBS; did not ask Mr. Kaye to sign documentation to confirm his preference to receive services at home.

Is there anything you would add to each list? Anything you would take off?

CASE STUDY #1

EPISODE 4a

Three Months Later

Since the plan was completed and approved Mr. Kaye has done well in spite of his increasingly failing memory. The nutrition specialist from meals on wheels was able to recommend a special diabetic menu that his family and care attendants have followed faithfully. As a result, the nurse noted that Mr. Kaye's blood sugar was far more stable.

In addition, the two months of in-home physical therapy strengthened Mr. Kaye's legs such that his falling was all but eliminated. At the end of seven weeks the physician recommended that the physical therapy be discontinued. The physician urged the family to continue to help Mr. Kaye. with exercise and walking.

But two weeks ago Ruby got a call from Mr. Kaye's son Rob. Mr. Kaye has been falling again and recently spent several hours in the emergency room. Rob asked that Ruby increase the number of hours that a personal care attendant could be in the home.

Ruby was really busy when the call came in but did quickly make arrangements to increase personal attendant hours. She didn't have a chance to meet with the Mr. Kaye or the family before making the new arrangements or to return Rob's calls the following week.

After three unreturned calls Rob asked to speak with Jane to express his frustration. According to Rob, the family had specifically asked that the attendant come in the afternoon when Mr. Kaye seemed more disoriented. The family had also expressed Mr. Kaye's preference for a male attendant but was sent a female. Mr. Kaye is not comfortable working with a woman.

The next day Jane and Ruby were scheduled to meet and Jane promised Rob they would discuss his father at that meeting.

Jane: Hi Ruby. Come on in, its good to see you.

Ruby: Yes, – seems I'm always on the run!

Jane: I know it's been a busy time -- But Ruby, we need to talk. While you were out yesterday I had a call from Rob Kaye about his father.

Ruby: Oh? I think all things considered Mr. Kaye is doing well. He needs some additional help which we hadn't planned, but Home Caregivers has a wonderful care attendant who can go to Mr. Kaye's later in the morning.

Jane: Rob was feeling we ignored the wishes of the family. He specifically asked for a worker to come in the afternoon, but we sent someone who comes in the morning. He also said you didn't pay attention to his preference for man rather than a woman.

Ruby: Oh my. Yes, I do remember that Rob mentioned preferring afternoons.   And I don't think I carried that message to the provider agency. I feel awful about that – I'll change the arrangements as soon as I can. And I'll ask the provider if they might have a male worker to assign to Mr. Kaye.

Jane: Well, that's just one issue. After Rob called I followed up by looking at Mr. Kaye's service plan. I wanted to see if the time of day and gender preference had been documented. What I found really concerns me --- not just because you didn't specify time or gender, but because there was no mention that you had re-evaluated his needs based on Rob's call or that the plan had been updated at all.

Ruby: Oh I know. I haven't had a chance to meet with Mr. Kaye and his family or change the plan.

CASE STUDY #1

EPISODE 4a

Process Questions

Reflection: Before we go on, can you name at least three ways in which Ruby's actions were problematic?

1.

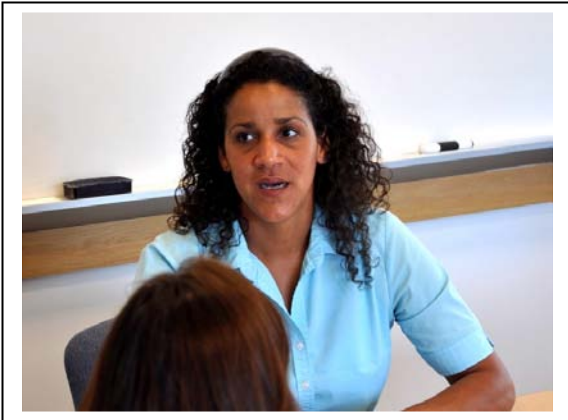
2.

3.

Let's see what Jane has to say.

CASE STUDY #1

EPISODE 4b



Jane: Ruby, that's not an acceptable practice. The services you're arranging must always be consistent with the current service plan. Do you remember why?

Ruby: Well, I remember that an updated service plan is one part of the six federal HCBS Assurances. But since personal care attendant was already in his plan, I thought it was ok to increase his hours.

Jane: I'm not picking on you Ruby. I think you've done great work with Mr. Kaye and I can't help but notice the compassion you bring to your work. But this is *serious*.

Ruby: I do care -- I think that's kind of what went wrong here. I was busy last week and didn't want Mr. Kaye to wait for additional hours until I could meet with him and update his plan. I thought I'd catch up with the paperwork later.

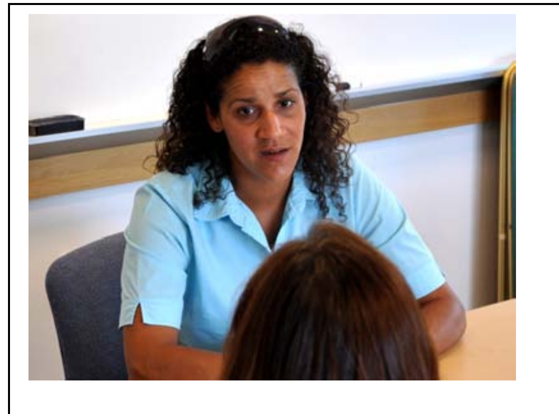
Jane: I know Ruby – I know you wanted to get Mr. Kaye what he needed. But in your rush to provide service you forgot two of the most basic ways we assure quality. First, you didn't really listen to Mr. Kaye and the family; and second, you were operating outside of an approved service plan. I know you intended to update the plan, but it's been over two weeks. Operating this way puts you, this agency, and the people you serve at risk.

And Ruby, a service plan is more than "paperwork" – it's how our participants communicate *what services* they need, *when* and *how*. Implementing and tracking the plan is how we learn what works in keeping our participants safe at home. It also allows

our providers to get paid for their services – any service provided must be identified in the service plan or there is the possibility the provider won't get paid.

Ruby: Oh no. I wouldn't want that to happen. I promise I will meet with Rob and Mr. Kaye today. I'll get the plan updated. I'll make this right -- I'm really sorry.

Jane: There are other potential consequences of poor documentation. If Rob hadn't called me yesterday you wouldn't be updating the plan today. And do you know what is happening on Monday?



Ruby: No.

Jane: On Monday the state will be here to review our files. If the state finds that we're not following the requirements of the Assurances that can jeopardize our contract with them. And if the data the state submits to CMS does not show evidence of how the Assurances are being met, it threatens the entire waiver.

Ruby: I know you're right. On the one hand I'm acting like providing services is more important than doing the paperwork, while on the other hand I really *do know* that only by doing the paperwork will the state and CMS know that we are providing quality services – and let us keep providing them – and let me keep this job!

Jane: I know it's hard when you're busy. But Ruby just come and ask me for help if you need it. It's important to have a service plan that is based on the individual's wishes and needs and that remains up to date.

Ruby: I promise it won't happen again.

CASE STUDY #1

EPISODE 4b

Process Questions

Now that you have heard Jane's feedback, compare Jane's response to the list you made after Episode 4a.

In what ways did your list match Jane's feedback?

In what ways did it differ?

In your group create a final list.

CASE STUDY #1

EPISODE 5a

Things have been going well for both Ruby and Mr. Kaye. Ruby updated Mr. Kaye's service plan and has been monitoring the plan closely. She makes sure that any service Mr. Kaye receives is tied to a goal in the service plan and that all services are well documented.

Ruby checks in with Mr. Kaye and Rob regularly to make sure the plan is working and that Mr. Kaye is getting what he needs. Things have been going smoothly.

Unfortunately, Ruby has just received notification from Home Caregivers, (HC), that Mr. Kaye's favorite home care assistant is leaving for another job. HC has assigned a new care assistant to Mr. Kaye and assures Ruby that George, the new worker, is qualified for the role. But Ruby knows that changing a care assistant can be hard for the elderly, especially when the former relationship was so compatible.

George's first day at work coincides with Ruby's next visit with Mr. Kaye so she is available to help in George's orientation. She listens as Rob and Mr. Kaye explain to George the daily assistance Mr. Kaye needs and his preferences for when and how he receives each service. Ruby provides a copy of the relevant section of the Service Plan and describes each task in detail. Ruby notes with concern that George asks no questions, does not take notes, and does not interact directly with Mr. Kaye. When she asks George questions about his prior experience he's vague.

Ruby makes a note to come back later in the week to observe George at work. She also will call Home Caregivers and inquire into George's prior experience.

In Ruby's next visit with Mr. Kaye she observes similar behavior: George rarely interacts with Mr. Kaye and Mr. Kaye is unusually quiet. Dirty dishes are piling up in the sink and the house seems disorderly. When 2:00 comes and passes, Ruby reminds George that Mr. Kaye likes his afternoon snack at 2:00. George is pleasant enough when he comes into the kitchen to fix a snack, but doesn't seem to know where to start. Ruby observes

George in the kitchen and notes that he doesn't wash his hands before he begins. She politely reminds him to wash. When George is out of the room Ruby asks Mr. Kaye if has been getting his snacks this week; Mr. Kaye says he doesn't remember.

Ruby's level of discomfort is rising. Although George is trying, he doesn't seem to have adequate training or experience for the job. She never heard back from HC about George's prior experience. She drives back to the office thinking about what she should do next.

CASE STUDY #1

EPISODE 5a

PROCESS QUESTION

What would you do if you were Ruby?

A. Nothing yet. The family hasn't complained and certifying that direct care workers are qualified is the responsibility of the provider agency. It's only been a week and he wouldn't be working at Home Caregivers if he weren't qualified.

B. Take no action now, but plan to come back and observe again next week.

C. Talk to her supervisor

D. Check in with Home Caregivers to alert them to the potential problems and confirm George's qualifications and training record.

CASE STUDY #1

EPISODE 5b

Ruby decides to choose action D. She decides to call Bill, her contact at Home Caregivers. She will also talk to her supervisor.

Ruby: Hi Bill. I just came back from a visit with George and Mr. Kaye. Do you have a minute to talk?

Bill: Of course. How do you like George? Are things working out?

Ruby: He seems like a really nice kid – quiet, but pleasant. But he also seems really inexperienced. I know it's just his first week, but I see some red flags. I was wondering if you had a chance to check into his background?

Bill: I got your message last week and did go up and get his file. But I'm sorry to say I haven't had a lot of time to look at it (Bill finds a file in his desk drawer and opens it)

Bill: (talking kind of to himself and flipping through papers)… Now what did I find…. Oh I remember. According to George's record, he has six months of experience in another state, and he completed our state Certification Training program last month.

Ruby: Did he take the training here?

Bill: No, we aren't offering the course anymore. Looks like he took it over in Dover County. Although… (looking through papers)… I don't see the certificate in here.

Ruby: Is that unusual, should the certificate be there?

Bill: Absolutely – we always ask for a training record.

Ruby: Would you mind following-up with George and letting me know what you find? And the sooner the better – I really am concerned.

Bill: (A little short, exasperated) I'm sure there's nothing to worry about – we only hire qualified staff. But I'll find George today and get back to you.

Ruby: thanks, Bill

When Ruby returns to her office the next day Bill has already left a message. According to his message, Bill called the Dover County training program and asked for a faxed copy of George's training records. According to the records, George did enroll in their training program about 8 months ago, but he left after taking only one module and did not earn a certificate. Without that certificate George doesn't meet state qualifications and should not have been hired.

Bill apologized for the oversight and assured Ruby that allowing George to begin work before he provided proof of certification was against Home Caregiver's personnel policies. He promised to look into the breach. He also let Ruby know that George had been removed from Mr. Kaye's care and a direct care supervisor was taking over until Ruby and Bill could discuss options.

Ruby went into Jane's office and explained the whole situation, looking for Jane's guidance on how to proceed.

Ruby: To tell you the truth, I was worried that I'd overstepped my role by asking Bill about George's records. But now I'm glad I did.

Jane: Ruby you did just what we need you to do! Your job is to make sure our participant's get the competent, quality services they need. I know it's uncomfortable to question somebody's competence, but you didn't back down from the challenge. I'm proud of you!!

Ruby: So, my question now, is should I talk to Rob and Mr. Kaye about finding another provider? Can Home Caregivers be trusted?

Jane: (looking pensive) Well, through the years Home Caregivers has been one of our best providers, so I do tend to see this as an isolated incident. (Then more decisive) But I think we should do a few things….

CASE STUDY #1

EPISODE 5b

PROCESS QUESTION

Can you guess what Jane is going to suggest?

What might you suggest to Ruby?

CASE STUDY #1

EPISODE 6

Today Ruby is stopping by to visit with Mr K and his latest caregiver, Beverly. Bev has been on the job for 3 months and is doing well. When Ruby gets to the house Mr. Kaye is taking a nap so she sits down to review Mr. Kaye's plan with Bev. At one point in the conversation Bev makes a remark that raises a concern for Ruby:

Bev: "I like working with Mr. Kaye and Rob. Rob is so great to work with, I'm happy he lives so nearby. He's not like his sister Sally; I don't trust her *at all*. She treats her dad so badly."

Ruby (with concern): What do you mean?

Bev: "Don't worry – its not like she beats him or anything. But I'm pretty sure she is stealing from him and it makes me so mad --- he's such a sweet guy."

Bev: "One day while I was visiting Mr. Kaye Sally came by with a friend who has a notary license. They practically forced him to sign a power of attorney giving Sally control over Mr. Kaye's checking account. They wanted me to sign as a witness but I refused – told them I wasn't allowed to."

Ruby: "So without a witness they couldn't implement the agreement?"

Bev: "That's what I was *hoping*. But no, somehow they got the bank to accept it. I bet they just forged a signature".

Ruby: "How do you know that?"

Bev: "Because the next week the bank statement came in the mail. Mr. Kaye has a lot of limitations but on most days his thinking is OK. When he opened the statement he showed it to me and asked me to help him remember what some of the checks were for; he was concerned about his balance. And sure enough, there were a bunch of checks written by Sally."

Ruby: “Could they have been checks to pay for Mr. Kaye’s expenses?”

Bev: No way. Sally lives all the way down in Medford and the checks were for things like a new stereo and lunch out at the Medford Mall.

Ruby: “Did Mr. Kaye talk to Sally or Rob?”

Bev: “Oh sure – he called Sally while I was there. I could hear her yelling at him and telling him it was none of his business. And Sally’s no fool: the checking account statements don’t come to the house anymore. I bet she had the address changed. All Mr. Kaye has is his social security checks – makes me furious that Sally is taking his money”

Ruby: “Bev, did you report this to your supervisor or to Adult Protective Services?”

Bev: “No way. I’ve learned the hard way never to get involved in family politics”

Ruby: “Bev, you have no choice. It’s the law: you’re a mandated reporter in this state. In fact, you were required to report this within 24 hours.”

Bev: “I know I’m a mandatory reporter. But like I told you – they never beat him or abuse him or anything.”

Ruby: “That may be, but forcing him to sign a power of attorney and then taking his money against his will is exploitation. Exploitation is a critical incident – you have to report exploitation just as you would if he were being abused”

Bev: “Oh no – I told you, I never get in the middle of family squabbles”

CASE STUDY #1

EPISODE 6

PROCESS QUESTIONS

1. What should Ruby do if Bev refuses to report the incident? What would you do?

   a. Since Ruby didn't witness the interaction, all she can do is encourage Bev to make a report. She should try to be more persuasive.

   b. Ruby should wait a few days to give Bev a chance to report, but if she doesn't, Ruby should make the report herself.

   c. If Bev won't file a report, Ruby should do it immediately.

2. Often situations are not as clear as the example with Ruby and Bev. Have you ever experienced a time when a situation looked like it *might* require reporting, but you weren't really sure? Talk in your group about experiences you have had and what you did. What types of situations are most challenging?

3. Provide three examples of how case managers can use the planning process to prevent future instances of abuse, neglect or exploitation.

Assurance #6
Administrative Authority

PROCESS QUESTIONS

1. Using the flip chart paper, draw a diagram of the organizational structure for your waiver. At the top, show the Medicaid Agency. At the bottom, show your case management agency. Identify organizational layers in between, including:

- Unit within Medicaid agency if within an umbrella agency
- The state Operating Agency if other than Medicaid.
- Any regional/sub-state entities for the HCBS waiver.

2. Are the following statements True or False?

    a. The state Medicaid agency pays for services under the HCBS waiver but otherwise delegates all responsibility and oversight for waiver operations to other agencies or entities

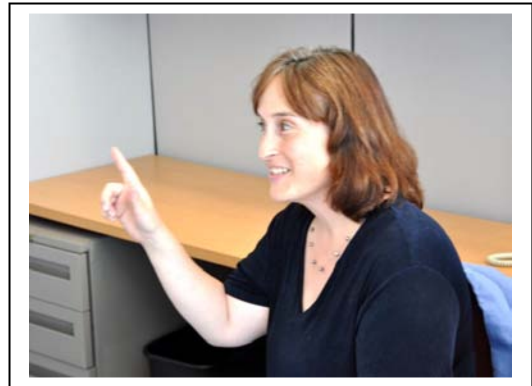
    b. As long as the waiver program is administered within state government, the Medicaid agency is assumed to have sufficient oversight.

    c. Rules governing the operation of the HCBS waiver must be promulgated through the Medicaid Agency.

CASE STUDY #1

EPISODE 7: Finale

Let's take ***one last look*** at our case study. At this point, Ruby has been on the job for over a year. She's learned a lot about the six Assurances and takes her role in meeting each Assurance seriously. Generally she is feeling much more comfortable in her role and really enjoys her work. But this has been a tense week: the state has been on-site all week conducting an audit. Ruby knows that the audit includes a review of case records as well as interviews with participants and their families. She also knows that the state was meeting with Jane and other administrators late yesterday afternoon to summarize their findings. She is anxious this morning to hear the results.



Jane has called Ruby into her office. She wants to share with Ruby the results of the recent state audit.

Jane: Hi Ruby. Thanks for stopping by. I wanted to give you some good news!

Ruby: Sounds like we did OK in the audit?

Jane: (Handing Ruby the report) Yes! Overall we did *very* well. As I told you, the purpose of the audit is to determine if we're meeting the six Assurances and fulfilling the terms of our contract. Take a look at the report. For each Assurance the report describes the federal requirements and how the state measures our performance on each requirement. As you can see, data from our participant records was a major source of information for the audit.

Ruby: I can see that – and it looks like we did great!

Jane: Yes. I especially wanted to thank *you* because in the state's random review of participant files they chose several of the people you work with. And they were very impressed --- they specifically praised your service plans and the way you document both the services needed and the way those services were provided. Your paperwork made it very clear that the services were eligible for reimbursement. They also noted the thoroughness of the plans and the inclusion of non-Medicaid and informal supports. You were one of our stars!

Ruby: Thanks. I appreciate the good feedback. I got off to a rocky start with Mr. Kaye, but I really have been working hard since then to make sure everything is in place.

Jane: And it shows. Thanks to Case Managers like you we did very, very well.

Ruby: I have to admit that when you first talked to me about documentation I had a bad attitude. I was thinking "nobody is going to come here and look at all of these details – it's impossible". But it was clear you meant business, so I did change my ways!

Jane: Absolutely. There's no guesswork involved: the state Medicaid Agency is *required* to provide oversight of the HCBS waiver, so they *will* come and they *will* take a good long look at our records. They even survey our participants and their families to find out if they're satisfied with our work.

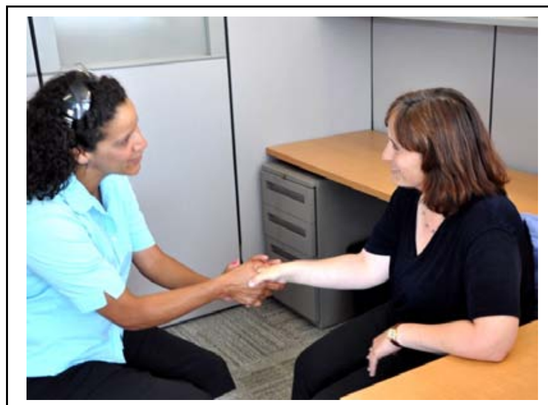
Ruby: Right. Now I understand that we *need* to do all that paperwork so the agency gets credit in an audit.

Jane: (laughing) Well, wait a minute! That's not the whole story. Documentation is not *just* about "getting credit". It is also about good service. Documentation helps you think about what you're doing and check to see if you've thought of everything. It also helps other providers and workers understand what is happening with a participant.

Ruby: Yes, I've really seen how that works. Its true that the better I get at making notes the better able I am to keep up with my participant's needs. But right now I am just enjoying this audit report. Luckily for us, we did great!

Jane: Yes, we did very well. But there's no "luck" here. We did great because case managers like you not only delivered great services but also documented what you do.

Ruby: That's great news for our participants – and also good news for me. I really like my job and I know we only get the chance to continue if we keep our records up to date.

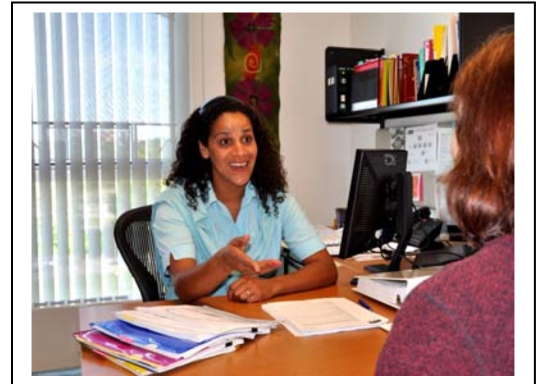


Jane: Thanks, Ruby for all of your hard work. You've made a real difference in the lives of your participants, and that's what this is all about.

Case Manager Training

Assuring quality in home and community-based services

CASE STUDY #2



EPISODE 1

Jane is a supervisor at Jefferson County Community Resource Group (JCCRG), a support coordination agency providing coordination and oversight of HCBS and other home care services. Prior to her promotion Jane spent five years as an HCBS support coordinator working primarily with people with developmental disabilities.

For the last week Jane has been providing training to Ruby, who recently joined the agency as a new support coordinator. Ruby has ten years of experience as a personal care attendant and one year of experience as a support coordinator, all in another state. Since she is new to this state and to this job, she has been listening closely as Jane explains the role of a support coordinator at JCCRG and how that relates to the six HCBS Assurances.

Today Jane feels that Ruby is ready to start working in the field and she comes to Ruby's office to start the process.

Jane: Good morning! I see you're finishing-up the orientation materials on the Federal Assurances. Any questions on the Assurances, or your roles and responsibilities related to quality?

Ruby: No, I think it makes sense. I mean, it makes sense *on paper*. I still need to see how it all plays out in real life.

Jane: Well that's good timing. Here's the file on Mr. Sam Wilson – he prefers to be called "Sam" -- a young man who needs support to continue to live at home with his aging parents. His father, has been his primary caregiver, but was recently hospitalized. Why don't you review the file and we'll talk later about scheduling your first meeting with Sam and his family?

Ruby: Sounds great.

Ruby begins to read about Sam.

Case Background

Sam is a 36 year old man with Down's syndrome, a seizure disorder and complications from diabetes. He has lived with his parents since birth. Both of Sam's parents are now in their seventies. Things have gone fairly well for Sam with help from his father, in particular. Sam's father has helped Sam over the years with daily living activities (meals, medications, laundry, and transportation), and more recently he has monitored Sam's diabetes. Sam's Mom is less able to help him due to her own health issues.

A week ago, Sam's father was hospitalized unexpectedly with a heart ailment. Sam and his mother coped with the help of neighbors for five days before being advised that her husband's condition was chronic and would restrict his ability to serve as Sam's primary caregiver going forward. Not knowing where to turn for help, the hospital's social worker advised Sam's Mom to contact the Regional Department of Developmental Services (DDS) office to find out what services may be available to assist in this emergency.

Sam's Mom was grateful when DDS responded quickly to her call. Within a few days, a support coordinator came to the home to meet with Sam and his Mom. Sam talked about the critical role his Dad played in his life and his fear and anxiety about the future. He would like to live more independently and his Mom believes this might be in his best interest since they can no longer help him the way they did in the past. But the immediate priority is to get Sam the supports he needs at home. His mother expressed concern about Sam's dependence on others to get through the day, take his medications and do household chores.

The support coordinator reassured Sam and his Mom that services were available to help Sam through this transition and beyond. He described the types of support services that were available through Medicaid's home and community based waiver program for people with intellectual disabilities as one possibility. Under the waiver, someone could help Sam with his daily activities as his Dad had once done. The waiver could also support Sam outside the home in getting around the community, finding work, and connecting with his church community. Relieved, Sam indicated that he would like to talk to someone about the waiver and how he could get services.

The support coordinator arranged to have someone from the DDS assessing unit come within the week to do a level of care assessment with Sam. The task was made easier since Sam already was on Medicaid for his health insurance. The assessor reviewed with Sam and his Mom his medical and physical status and his functional abilities. Given Sam's medical history, his intellectual disability and his need for assistance doing many of the basic activities of daily living, the assessor confirmed that he met the state's level of care criteria that would make him eligible for the HCBS waiver program. The assessor would review the case with her supervisor to get final approval. The assessor was also

pleased to report that the legislature recently authorized funds for additional openings under the HCBS DDS waiver. Sam and his Mom were told to expect a call from the Jefferson County Resource Group who would be given the referral once the level of care was approved.

Notes on Key Points of Case Study

CASE STUDY #2

EPISODE 2

Jane: Hi Ruby – did you get a chance to read Sam's background?

Ruby: Yeah. Sounds like Sam is a good candidate for the HCBS Waiver. I'm anxious to get to work and see what we can do to help, but I'm a little confused about my role.

Jane: How so?

Ruby: Well, according to the file Sam already has a level of care assessment. I thought that was part of my job – I always did level of cares at my last job?

Jane: No wonder you're confused. Remember when we were talking about the HCBS waiver program, and how every state applies to CMS for permission to operate a waiver?

Ruby: Yes…

Jane: Well, although states have to make an Assurance to CMS that they'll use an LOC process, each state can design that process differently. Some things are standard, like each state has to assure that participants meet institutional level of care criteria, but states can make their own decisions about who will conduct the LOC and how.

In this state, our Medicaid Agency delegates responsibility to the Department for Developmental Services, or DDS, to do all level of care determinations for the DDS waiver program, so we don't receive a referral until the level of care is completed.

Ruby: So, is the level of care requirement different here too? I mean, at my last job a person with intellectual disabilities was eligible for home based services only if they would be eligible for ICF-MR level of care.

Jane: That's what LOC determination means throughout the HCBS waiver program: HCBS is an alternative to nursing home care. But each state defines nursing home level of care a bit differently. I'll get you the criteria we use in this state so you can be familiar with them.

Ruby: OK. So the only thing that is really different is that I won't have any responsibilities toward the LOC process?

Jane: Well, not so fast! It's true that you won't be involved in the initial LOC. But remember, another part of the CMS Assurance is that LOC determinations must be revisited at least once a year – more frequently if a person's status changes. You're still responsible for keeping an eye on each person you work with, and if there is a change, or if a year has passed and no reassessment has been done, you make the referral.

Ruby: I suppose that means more forms to fill out? I mean, if I make a referral for a reassessment?

Jane: Yes, but remember what I've been telling you about the paperwork. All of this paper serves a purpose. First, it helps our state provide evidence to CMS that we're meeting the Assurances. In fact, we get audited regularly by the state to make sure our participants' records include a current level of care determination and any status change redeterminations. But more important to our participants, the data we collect helps our agency, our state and CMS figure out what works and what doesn't work in HCBS services. We've learned a lot through all that paperwork!

Ruby: I'm beginning to get that picture. Well, I think I'm ready to get out there and get started. So, what's the next step, do I set up a meeting with Sam and his family?

Jane: First let's review our protocol for service planning, and then we can talk about your visit with Sam.

Ruby: Sounds great

CASE STUDY #2

EPISODE 2

PROCESS QUESTIONS

1. Even if Sam had not met the institutional level of care criteria he could still receive HCBS waiver services but would be placed on a waiting list.

   True or False?

2. What are some of the level of care criteria in our state?

3. Although another agency conducts the actual level of care assessment, name three things the state might look for in Ruby's participant records to indicate compliance with this Assurance?

4. Name one possible performance measure for this Assurance:

CASE STUDY #2

EPISODE 3a

Ruby contacted Sam and his mother to set up a time to begin the service planning process. She asked them who helps Sam and who is important in his life to make sure she invited everybody involved to participate. Sam gave her the phone number of his best friend Ed who takes him to church each Sunday. Sam's Dad was now home from the hospital and very much wanted to be part of any planning process as well. Ruby scheduled a time to go to the home when everyone identified was available to meet.

Later that week Ruby sat down with Sam, his mom, his dad and his friend Ed. Ruby talked with Sam, his parents and his friend and identified the support he needed, how often and from whom. This covered the help he needed at home and in the community; his longer term goals for living on his own and working; and his need for help monitoring his health and medical conditions. She was very attentive to Sam as she moved the conversation through the agency's needs assessment protocol. She paused often to confirm that the discussion was in line with Sam's needs and wishes. Sam repeated that his goal was to someday live on his own and to get a job where he could be part of a team. After a lengthy conversation everyone agreed that Sam's needs included:

1) Help with bathing and dressing in the morning
2) Skills training for meal/snack preparation and other independent living skills
3) Monitoring of seizure medications and blood levels
4) Job training

In response to the needs identified, Ruby included the following HCBS supports in Sam's plan:

1) A direct support staff for 2 hours a day Monday thru Saturday to assist with dressing and bathing and one hour in the afternoon to provide skills training in IADLs as Sam prepares to live more independently
2) Monthly RN visit to check Sam's seizure activity log, his medications, and check his insulin log
3) Supported employment position
4) Community integration training once a week

She provided the family with a list of available agencies in the area. The family chose Horizons Unlimited based on a neighbor's recommendation. Ruby also discussed a back-up plan with the family and they identified a second support person to fill in when needed. Ruby knew from prior conversations that Sam wanted to live at home so she made a note of that in the file and did not waste his time discussing other options, such as living in an ICF-MR.

The group also discussed a number of services and supports to be provided by the family and other community partners outside of the HCBS program, (e.g. Community Education walking program) but since those were not HCBS services Ruby did not include them in the plan.

She sent the draft plan to Jane for her review.

CASE STUDY #2

EPISODE 3a

Reflection Exercise

Think about how Ruby did in her drafting her first plan. What feedback do you think Ruby received from Jane? What did she do well, and what could she have done better?

Did Well	Could Be Improved

CASE STUDY #2

EPISODE 3b

Jane: Hi Ruby. I just finished reading your draft service plan for Sam and your notes from the meeting. Do you have time for a little feedback?

Ruby: Of course! I'm anxious to hear what you think.

Jane: Overall Ruby you did really well. I mean it. I was impressed with several of your notes and the way you focused on Sam and his needs and preferences. You also included all of the appropriate people in the meeting, scheduled the meeting when everyone could attend, and provided detailed documentation on the needs assessment form. I was impressed that you remembered to include a back-up plan and to offer the family a choice of providers.

Ruby: Thanks --- and you're right. Sam is so quiet it took some effort to be sure he was really participating.

Jane: That was great. But I also noted a few things missing from his plan. First, you didn't note the frequency or duration of his supported employment. You also did not include any mention of the support that the family and his friend were going to provide. You also mention in your notes that Sam will be enrolled in the Community Education walking program, but you didn't include any non-HCBS supports in his plan.

Ruby: Woops – I forgot that one. I guess because it doesn't make a lot of sense to me to include things we have nothing to do with.

Jane: Well if you mean things that the waiver isn't paying for and we don't monitor, that's true. But remember that the needs assessment must identify *all* of the services and supports the participant will need in order to meet his goals and remain safely at home. Without including non HCBS services the plan may not demonstrate that all of Sam's needs are being adequately addressed.

I also noted that you didn't get a letter signed by Sam confirming that you discussed all care options and that he prefers in home care?

Ruby: Well, we already had notes in the file from the referral. I didn't want to waste his time talking about things I thought were already decided.

Jane: Yes, but think of this from the perspective of quality control and the Assurances. We need to be sure that Sam is aware of all of his choices so that his choice of home care is an informed choice. You need to be sure he understands all of his options – that's part of the Assurances.

Ruby: hmm.. yes, I can see where it's important to make sure he knows his options. I should have talked to him about that.

AND, I bet the next thing you're going to tell me is that we can only *demonstrate* our compliance with the Assurance by *good documentation* – meaning I should also have gotten that letter signed!

Jane: (laughing) hey - I think you're catching on!!

Ruby: Sounds like I'm going back to Sam's to tie up the loose ends.

Jane: Thanks, Ruby. And remember, this was a great first effort – I think you're going to be a wonderful support coordinator.

CASE STUDY #2

EPISODE 3b

Reflection Exercise

Look back at the chart you created in Exercise 3a. Compare your responses to the feedback Ruby received from Jane. Here are some of our thoughts on what Ruby did well and what could be improved.

Did Well	Could Be Improved
▪ Invited everyone identified by the family to attend the meeting ▪ Scheduled the meeting when all could attend ▪ Worked with Sam to complete the needs assessment protocol ▪ Identified services to meet each need ▪ Included a back-up plan (a second support person) ▪ Offered Sam and his family a choice of providers	▪ Did not document the frequency or duration of supported employment. ▪ Did not include support provided by parents and friend, Ed. ▪ Did not include non-HCBS services and supports (ex. Community Education walking program). ▪ Did not discuss options other than HCBS; did not ask Sam to sign documentation to confirm his preference to receive services at home, rather than at a facility.

Is there anything you would add to this list? Anything you would remove?

CASE STUDY #2

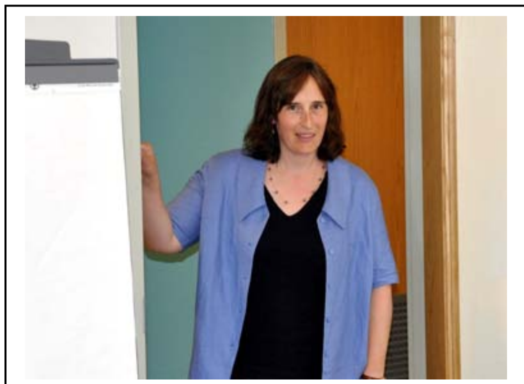
EPISODE 4a

Three Months Later

Since the plan was completed and approved, Sam has done well. But two weeks ago Ruby got a call from Sam's mother. Sam has needed more help in the afternoon when he gets home from his job. Sam's mother asked that Ruby increase the number of hours that a direct support worker could be in the home. Ruby was really busy when the call came in but did quickly submit a request to the state for an increase in direct support hours. She didn't have a chance to meet with Sam or the family before making the new arrangements or to return Sam's mother's calls the following week.

After three unreturned calls Sam's mom asked to speak with Jane to express her frustration. She said the family had specifically asked that the worker come in the afternoon when Sam seemed more agitated and restless. The family had also expressed Sam's preference for a male worker but was sent a female. Sam is not comfortable with a woman helping him.

The next day Jane and Ruby were scheduled to meet and Jane promised Sam's mother they would discuss her son's situation at that meeting.



Jane: Hi Ruby. Come on in. It's good to see you.

Ruby: Yes, – seems I'm always on the run!

Jane: I know it's been a busy time -- But Ruby, we need to talk. While you were out yesterday I had a call from Sam's mother.

Ruby: Oh? I think all things considered Sam is doing well. He needs some additional helpwhich we hadn't planned, but Horizons Unlimited has a wonderful support person who can go to Sam's later in the morning.

Jane: Sam's mom was feeling we ignored the wishes of the family. She specifically asked for a support person to come in the afternoon, but we sent someone who comes in the morning. She also said you didn't pay attention to Sam's preference for a man to help him.

Ruby: Oh my. Yes, I do remember she mentioned preferring afternoons. And I don't think I carried that message to the provider agency. I feel awful about that – I'll change the arrangements as soon as I can. And I'll ask the provider if they might have a male support person to assign to Sam.

Jane: Well, that's just one issue. After she called I followed up by looking at Sam's service plan. I wanted to see if the time of day and gender preference had been documented. What I found really concerns me --- not just because you didn't specify time or gender, but because there was no mention that you had re-evaluated his needs based on his mom's call or that the plan had been updated at all.

Ruby: Oh I know. I haven't had a chance to meet with Sam and his family or change the plan.

CASE STUDY #2

EPISODE 4a

Process Questions

Reflection: Before we go on, can you name at least three ways in which Ruby's actions were problematic?

1.

2.

3.

Let's see what Jane has to say.

CASE STUDY #2

EPISODE 4b

Jane: Ruby, that's not an acceptable practice. The services you're arranging must always be consistent with the current service plan. Do you remember why?

Ruby: Well, I remember that an updated service plan is one part of the six federal HCBS Assurances. But since direct support was already in his plan, I thought it was ok to increase his hours.

Jane: I'm not picking on you Ruby. I think you've done great work for Sam and I can't help but notice the compassion you bring to your work. But this is *serious*.

Ruby: I do care -- I think that's kind of what went wrong here. I was busy last week and didn't want Sam to wait for additional hours until I could meet with him to re-evaluate and update his plan. I thought I'd catch up with the paperwork later.

Jane: I know Ruby – I know you wanted to get Sam what he needed. But in your rush to provide service you forgot two of the most basic ways we assure quality. First, you didn't really listen to Sam and his family; and second, you were operating outside of an approved service plan. I know you intended to update the plan, but it's been over two weeks. Operating this way puts you, this agency, and the people you serve at risk.

And Ruby, a service plan is more than "paperwork" – it's how our participants communicate *what services* they need, *when* and *how*. Implementing and tracking the plan is how we learn what works in keeping our participants safe at home. It also allows our providers to get paid for their services – any service provided must be identified in the service plan or there is the possibility the provider won't get paid.

Ruby: Oh no. I wouldn't want that to happen. I promise I will meet with Sam and his mom today. I'll get the plan updated. I'll make this right -- I'm really sorry.

Jane: If Sam's mother hadn't called me yesterday you wouldn't be updating the plan today. And do you know what is happening on Monday?

Ruby: No.

Jane: On Monday the state will be here to review our files. If the state finds that we're not following the requirements of the Assurances that can jeopardize our contract with them. And if the data the state submits to CMS does not show evidence of how the Assurances are being met, it threatens the entire waiver.

Ruby: I know you're right. On the one hand I'm acting like providing services is more important than doing the paperwork, while on the other hand I really *do know* that only by doing the paperwork will the state and CMS know that we are providing quality services – and let us keep providing them – and let me keep this job!

Jane: I know it's hard when you're busy. But Ruby just come and ask me for help if you need it. It's important to have a service plan that is based on the individual's wishes and needs and that remains up to date.

Ruby: I promise it won't happen again.

CASE STUDY #2

EPISODE 4b

Process Questions

Now that you have heard Jane's feedback, compare Jane's response to the list you made after Episode 4a.

In what ways did your list match Jane's feedback?

In what ways did it differ?

CASE STUDY #2

EPISODE 5a

Things have been going well for both Ruby and Sam. Ruby updated Sam's service plan and has been monitoring the plan closely. She makes sure that any service Sam receives is tied to a goal in the service plan and that all services are well documented. Ruby checks in with Sam and his mother regularly to make sure the plan is working and that Sam is getting what he needs. Things have been going smoothly.

Unfortunately, Ruby has just received notification from Horizons Unlimited, (HU), that Sam's favorite support person is leaving for another job. HU has assigned a new support person to Sam and assures Ruby that George, the new person, is qualified for the role. But Ruby knows that changing a direct support worker can be hard, especially when the former relationship was so compatible.

George's first day at work coincides with Ruby's next visit with Sam so she is available to help in George's orientation. She listens as Sam's mother explains to George the daily assistance Sam needs and his preferences for when and how he receives each service.

Ruby provides a copy of the relevant section of the Service Plan and describes each task in detail. Ruby notes with concern that George asks no questions, does not take notes, and does not interact directly with Sam. When she asks George questions about his prior experience he's vague.

Ruby makes a note to come back later in the week to observe George at work. She also will call Horizons Unlimited and inquire into George's prior experience.

In Ruby's next visit with Sam she observes similar behavior: George rarely interacts with Sam and Sam is unusually quiet. Sam's area seems disorderly. As part of the service plan, George is supposed to provide skills training to Sam on meal/snack preparation. When it comes time for an afternoon snack, to make sure Sam's blood sugar remains stable, George prepares a sandwich for Sam but does not explain what he is doing or ask Sam to participate or help. Ruby notices that George does not wash his hands. She

politely reminds him to wash. When George is out of the room Ruby asks Sam if he has been getting his snacks this week; Sam says he doesn't remember.

Ruby's level of discomfort is rising. Although George is trying, he doesn't seem to have adequate training or experience for the job. She never heard back from HU about George's prior experience. She drives back to the office thinking about what she should do next.

CASE STUDY #2

EPISODE 5a

PROCESS QUESTION

What would you do if you were Ruby?

A. Nothing yet. The family hasn't complained and certifying that direct care workers are qualified is the responsibility of the provider agency. It's only been a week and he wouldn't be working at HU if he weren't qualified.

B. Take no action now, but plan to come back and observe again next week.

C. Talk to her supervisor

D. Check in with HU to alert them to the potential problems and confirm George's qualifications and training record.

CASE STUDY #2

EPISODE 5b

In this case, Ruby chose action D. She decides to call Bill, her contact at Horizons Unlimited. She will also talk to her supervisor.

Ruby: Hi Bill. I just came back from a visit with George and Sam. Do you have a minute to talk?

Bill: Of course. How do you like George? Are things working out?

Ruby: He seems like a really nice kid – quiet, but pleasant. But he also seems really inexperienced. I know it's just his first week, but I see some red flags. I was wondering if you had a chance to check into his background?

Bill: I got your message last week and did go up and get his file. But I'm sorry to say I haven't had a lot of time to look at it (Bill finds a file in his desk drawer and opens it)

Bill: (talking kind of to himself and flipping through papers)… Now what did I find…. Oh I remember. According to George's record, he has six months of experience in another state, and he completed our state Certification Training program last month.

Ruby: Did he take the training here?

Bill: No, we aren't offering the course anymore. Looks like he took it over in Dover County. Although… (looking through papers)… I don't see the certificate in here.

Ruby: Is that unusual, should the certificate be there?

Bill: Absolutely – we always ask for a training record.

Ruby: Would you mind following-up with George and letting me know what you find? And the sooner the better – I really am concerned.

Bill: (A little short, exasperated) I'm sure there's nothing to worry about – we only hire qualified staff. But I'll find George today and get back to you.

Ruby: thanks, Bill

When Ruby returns to her office the next day Bill has already left a message. According to his message, Bill called the Dover County training program and asked for a faxed copy of George's training records. According to the records, George did enroll in their training program about 8 months ago, but he left after taking only one module and did not earn a certificate. Without that certificate George doesn't meet state qualifications and should not have been hired.

Bill apologized for the oversight and assured Ruby that allowing George to begin work before he provided proof of certification was against Horizons Unlimited personnel policies. He promised to look into the breach. He also let Ruby know that George had been removed from Sam's care and a direct care supervisor was taking over until Ruby and Bill could discuss options.

Ruby went into Jane's office and explained the whole situation, looking for Jane's guidance on how to proceed:

Ruby: To tell you the truth, I was worried that I'd overstepped my role by asking Bill about George's records. But now I'm glad I did.

Jane: Ruby you did just what we need you to do! Your job is to make sure our participant's get the competent, quality services they need. I know its uncomfortable to question somebody's competence, but you didn't back down from the challenge. I'm proud of you!!

Ruby: So, my question now is, should I talk to Sam and his mother about finding another provider? Can HU be trusted?

Jane: (looking pensive) Well, through the years HU has been one of our best providers, so I do tend to see this as an isolated incident. (then more decisive) But I think we should do a few things.

CASE STUDY #2

EPISODE 5b

PROCESS QUESTION

Can you guess what Jane is going to suggest?

What might you suggest to Ruby?

CASE STUDY #2

EPISODE 6

Ruby made a visit to Sam to see how he was doing and to review whether he was getting the services outlined in his service plan. David, Sam's new support worker, has been on the job for 3 months and reports progress in Sam's skills training, including managing his own money. As an important step to independence, Sam is now able to directly access his savings account without needing his mother's co-signature.

Sam also is doing well at his job. Sam's friend, Ed, frequently gives him a ride home after work. Twice last week Sam asked Ed to stop at the bank on the way home from work. Two days ago Sam received an overdraft notice from the bank. Sam confided in Ed that he did not know what he was supposed to do and asked if Ed could go with him to straighten things out at the bank. Ed was glad to help. The bank clerk was pleasant and showed Sam the history of his withdrawals. Ed knew that Sam had withdrawn more money lately and wondered where this money was going.

Prior to Ruby's visit, Sam's mother called her after she found a copy of the overdraft notice on the kitchen table. Ruby knew that Sam's mom was not in favor of him having direct access to his bank account. This was an unfortunate setback and Ruby wanted to hear what happened from Sam directly.

Sam was with Ed when Ruby arrived. Sam nodded for Ed to stay. When Ruby asked Sam how things were going he seemed reluctant to talk. With some prompting, Sam eventually told Ruby about the overdraft notice. He knew his mother was upset. And he thought David, his support worker, would be upset too when he heard about the overdraft. Ruby reassured Sam that David would continue to help him with skills training and the overdraft could be taken care of. "But how will I pay David when he comes to help me?" Sam asked. At first Ruby was confused by this question. Then she became increasingly concerned when Ed asked Sam "what are you paying him for? Is that why we've been stopping at the bank?" Sam said yes. "David told me that I have to pay him out of my weekly check. That's how he gets paid for helping me. If I don't pay him, he will stop coming to help.

At this point, Ruby tells Sam that David isn't telling the truth. She tells him that David is paid by his agency and cannot force Sam to pay him to work.

CASE STUDY #2

EPISODE 6

PROCESS QUESTIONS

1. What should Ruby do next?

   a. Since Ruby didn't witness the interaction between Sam and his support worker, she should contact the direct support agency to report the situation, ask them to try to get Sam's money back, and to send a different male worker to help Sam.

   b. Ruby will facilitate a meeting with Sam and his mom to discuss access to Sam's bank account.

   c. Ruby knows that Sam might be vulnerable and this situation may warrant further outside investigation. She should talk to someone at Adult Protective Services (APS) to see if this might be financial exploitation.

   d. All of the above

2. Often situations are not as clear as the example with Ruby and Sam. Have you ever experienced a time when a situation looked like it *might* require reporting, but you weren't really sure? Talk in your group about experiences you have had and what you did. What types of situations are most challenging?

3. Provide three examples of how case managers can use the planning process to prevent future instances of abuse, neglect or exploitation.

Assurance #5
Administrative Authority

PROCESS QUESTIONS

1. Using the flip chart paper, draw a diagram of the organizational structure for your waiver. At the top, show the Medicaid Agency. At the bottom, show your case management agency. Identify organizational layers in between, including:
   - Unit within Medicaid agency if within an umbrella agency
   - The state Operating Agency if other than Medicaid.
   - Any regional/sub-state entities for the HCBS waiver.

2. Are the following statements True or False?

   a. The state Medicaid agency pays for services under the HCBS waiver but otherwise delegates all responsibility and oversight for waiver operations to other agencies or entities

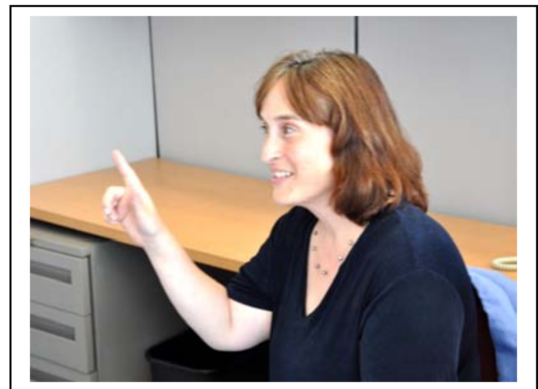
   b. As long as the waiver program is administered within state government, the Medicaid agency is assumed to have sufficient oversight.

   c. Rules governing the operation of the HCBS waiver must be promulgated through the Medicaid Agency.

CASE STUDY #2

EPISODE 7: Finale

Let's take ***one last look*** at our case study. At this point, Ruby has been on the job for over a year. She's learned a lot about the six Assurances and takes her role in meeting each Assurance seriously. Generally she is feeling much more comfortable in her role and really enjoys her work. But this has been a tense week: the state has been on-site all week conducting an audit. Ruby knows that the audit includes a review of case records as well as interviews with participants and their families. She also knows that the state was meeting with Jane and other administrators late yesterday afternoon to summarize their findings. She is anxious this morning to hear the results.



Jane has called Ruby into her office. She wants to share with Ruby the results of the recent state audit.

Jane: Hi Ruby. Thanks for stopping by. I wanted to give you some good news!

Ruby: Sounds like we did OK in the audit?

Jane: (Handing Ruby the report) Yes! Overall we did *very* well. As I told you, the purpose of the audit is to determine if we're meeting the six Assurances and fulfilling the terms of our contract. Take a look at the report. For each Assurance the report describes the federal requirements and how the state measures our performance on each requirement. As you can see, data from our participant records was a major source of information for the audit.

Ruby: I can see that – and it looks like we did great!

Jane: Yes. I especially wanted to thank *you* because in the state's random review of participant files they chose several of the people you work with. And they were very impressed --- they specifically praised your service plans and the way you document both the services needed and the way those services were provided. Your paperwork made it very clear that the services were eligible for reimbursement. They also noted the thoroughness of the plans and the inclusion of non-Medicaid and informal supports. You were one of our stars!

Ruby: Thanks. I appreciate the good feedback. I got off to a rocky start with Sam, but I really have been working hard since then to make sure everything is in place.

Jane: And it shows. Thanks to Case Managers like you we did very, very well.

Ruby: I have to admit that when you first talked to me about documentation I had a bad attitude. I was thinking "nobody is going to come here and look at all of these details – its impossible". But it was clear you meant business, so I did change my ways!

Jane: Absolutely. There's no guesswork involved: the state Medicaid Agency is *required* to provide oversight of the HCBS waiver, so they *will* come and they *will* take a good long look at our records. They even survey our participants and their families to find out if they're satisfied with our work.

Ruby: Right. Now I understand that we *need* to do all that paperwork so the agency gets credit in an audit.

Jane: (laughing) Well, wait a minute! That's not the whole story. Documentation is not *just* about "getting credit". It is also about good service. Documentation helps you think about what you're doing and check to see if you've thought of everything. It also helps other providers and workers understand what is happening with a participant.

Ruby: Yes, I've really seen how that works. Its true that the better I get at making notes the better able I am to keep up with my participant's needs. But right now I am just enjoying this audit report. Luckily for us, we did great!

Jane: Yes, we did very well. But there's no "luck" here. We did great because case managers like you not only delivered great services but also documented what you do.

Ruby: That's great news for our participants – and also good news for me. I really like my job and I know we only get the chance to continue if we keep our records up to date.

Jane: Thanks, Ruby for all of your hard work. You've made a real difference in the lives of your participants, and that's what this is all about.