17—21.4 (231) Case management service activities. Case management service activities include the following components.

21.4(1) *Client identification.* The provider of the service of case management may identify clients through public education, awareness, and outreach.

21.4(2) *Intake.* The provider of the service of case management shall follow a defined intake process developed or approved by the department. To become eligible for the service of case management, a potential client with case management needs shall:

a. Be a legal resident of the state of Iowa;

b. Be aged 60 or older;

c. Be in need of the service of case management based on a needs assessment as described in subrule 21.4(3);

d. Be funded through Title III (Grants to State and Community Programs on Aging) of the OAA or state funds distributed to the AAA based upon their current area plan; and

e. Not be entitled to receive case management services or case management service reimbursement from another source.

21.4(3) *Needs assessment.* A face-to-face comprehensive assessment, utilizing a standardized tool developed or approved by the department and preferably conducted in the client's home or place of residence, must be conducted for each case management client to identify the conditions and needs of the client and to establish goals for services provided.

21.4(4) *Service plan development.* Based on a standardized form developed or approved by the department, a written service plan shall be prepared for each client. The service plan shall utilize appropriate and available resources.

a. The service plan shall be developed within 20 calendar days of the needs assessment.

b. The service plan shall identify available services and problem-solving efforts to meet the client's determined needs and to enable the client to live with maximum possible independence.

c. A copy of the service plan shall be given to the client or the client's legal representative and shall be documented in the client's file.

21.4(5) *Service plan implementation.* A referral of the client to an appropriate resource for service provision and problem resolution shall be made and documented in the client's file. If the referral is made to an informal network (e.g., family, friends), the service and problem-solving arrangement agreed to regarding duties and responsibilities shall be documented in the client's service plan. The following services shall be performed for each client, as appropriate and needed:

a. Active intervention and advocacy on behalf of the client to access necessary services from community organizations and to resolve problems experienced by the client;

b. Establishment of connections with service providers for the prompt and effective delivery of services needed by the client, including submission of instructions for service delivery to the appropriate service providers;

c. Encouragement of informal care given by individuals, family, friends, neighbors, and community organizations, so that publicly supported services supplement rather than supplant the roles and responsibilities of these natural support systems.

21.4(6) *Follow-up and reassessment of client status.*

a. Follow-up. Monthly monitoring of each client shall be conducted through telephone or face-to-face contact to ensure prompt and effective service delivery and response to changes in the client's needs and status. All follow-up shall be documented in the client's file.

b. Reassessment. A face-to-face needs assessment of the client's condition and needs must be conducted in accordance with subrule 21.4(3), preferably in the home of the client, no later than the twelfth month from the last completed needs assessment. This needs assessment must be conducted

more frequently if a change in the client's circumstances is identified in a follow-up or a report from a third party.

21.4(7) *Client discharge.*

a. A client shall be discharged from the service of case management when any one of the following situations has occurred:

(1) The client dies;

(2) The client moves out of state;

(3) The client moves into a nursing facility and the stay is expected to be permanent;

(4) The client or the client's legal representative requests termination of case management service;

(5) The client is unwilling or unable to adhere to the agreed-upon service plan;

(6) The client or the client's legal representative refuses to provide access to information necessary for the development or implementation of the service plan;

(7) The service provider determines that the client's needs cannot be met in a way that ensures the client's health, safety and welfare;

(8) The service provider determines that the client's goals are achieved and the client no longer requires the service of case management;

(9) The client becomes eligible for a comparable case management service from another funding source; or

(10) The AAA determines that funding is no longer available to provide the service of case management.

b. A point of contact identified by the AAA shall be notified of and approve all discharges prior to initiation of discharge action.

c. If the discharge is due to the circumstances given in subparagraphs 21.4(7)*"a"*(5) to 21.4(7)*"a"*(9), the AAA providing the service of case management shall provide a 30-day written notice to the client or the client's legal representative stating the reasons for the discharge from case management and include the process for appealing the decision in accordance with rule 17—6.10(231).

21.4(8) *Transfer.* When a client moves from the AAA's geographic service area, the AAA shall, with the documented consent of the client or the client's legal representative, refer the client to the AAA serving the area to which the client has moved.

21.4(9) *Monitoring and follow-up.* The AAA shall, and the department may, monitor and follow up with providers of the service of case management.

a. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the client's service plan, including the amount of service provided, the client's attendance, and the client's participation in the service.

(2) The client has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are meeting the identified needs of the client, including the client's progress toward achieving the goals and actions determined in the service plan.

b. Monitoring shall include accessing and assessing the client, the places of service (including the client's home when applicable), and all services.

21.4(10) *Records and documentation.*

a. A case management service provider shall maintain individual client records in a paper file or in a case management software database approved by the department. The case file for each client shall minimally include the following information:

(1) Intake form(s);

(2) Comprehensive needs assessment;

(3) Copies of release of information (if needed);

(4) Service plan;
(5) Record of referral(s) and request(s);
(6) Correspondence related to the case;
(7) Formal case notes, which include documentation of the follow-up as noted in paragraph 21.4(6)*"a"* or of case closure.

b. Except by written consent of the client or the client's legal representative, the use or disclosure by any person of any information concerning a client for any purpose not directly connected with the administration of the responsibilities of the department, AAA or contractor is prohibited.

c. Upon change in AAA designation, the AAA which has been dedesignated shall transfer all specified records as prescribed by the department to the newly designated AAA.

These rules are intended to implement Iowa Code section 231.23A.

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