DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: ENHANCED CASE MANAGEMENT PROGRAM POLICY 4.17

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| Authority: | Title 71A RCW | Developmental Disabilities |
| | RCW 71A.12.320 | Risk of Abuse and Neglect—Process—Home Visits |
| | Chapter 388-829B WAC | Enhanced Case Management Program |
| Reference: | E2SSB 6564 (2016) | Providing Protections for Persons with Developmental Disabilities |
| | US Center for Disease Control and Prevention | Child and Teen BMI |
| | US Center for Disease Control and Prevention | Adult BMI |

## BACKGROUND

During the 2016 legislative session, Senate Bill 6564, *Providing Protections for Persons with Developmental Disabilities*, was signed into law. The Legislature allocated funds to the State Operating Budget for the Developmental Disabilities Administration (DDA) to increase home visits for clients who may be at higher risk of abuse and neglect.

## PURPOSE

This policy establishes criteria and operating procedures for the Enhanced Case Management Program (ECMP).

## SCOPE

This policy applies to DDA headquarters and field services staff.

## DEFINITIONS

**Ability to supervise caregiver** refers to whether the client can instruct a provider how to meet their needs and whether the client can notify someone when their needs are not being met.

Adult Protective Services or APS means the ALTSA Division that receives reports, conducts investigations, and collaborates with other agencies to offer protective services related to allegations of mistreatment of vulnerable adults under chapter 74.34 RCW.

ALTSA means the Aging and Long-Term Support Administration.

BMI or Body Mass Index means a measure of weight relative to height. For children and teens other factors are considered based on age and gender. BMI can help assess risk factors for certain health conditions.

CARE means the comprehensive assessment reporting evaluation tool under chapter 388-106 WAC.

Caregiver means a person who provides personal care or respite services to DDA clients.

Child Protective Services or CPS means the section of the Department of Children, Youth, and Families that responds to allegations of child abuse or neglect.

Client means a person eligible for DDA services.

Collateral contact means a person or agency that is involved in the client's life, such as a legal guardian, family member, provider, or friend.

CRM means the DDA case resource manager or social service specialist.

DDA assessment means an inventory and evaluation designed to measure the individual support needs of persons with intellectual and developmental disabilities over a broad spectrum of life areas and activities.

ECMP committee means a committee of ECMP regional supervisors, ECMP coordinators, and headquarters program managers who review, prioritize, and process transfers on and off the program, based on policy criteria and program capacity.

Legal representative means a parent of a client if the client is under age eighteen and parental rights have not been terminated or revoked, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act for the client.

Necessary supplemental accommodation means a person who is willing to receive copies of planned action notices and other DSHS correspondence to help a client understand the documents and exercise their rights.

SER means a service episode record in the case management system, Comprehensive Assessment Reporting and Evaluation (CARE).

## POLICY

A. The CRM must refer all clients who have an ECMP critical indicator referral in CARE to their supervisor and the regional ECMP coordinator for enrollment consideration and follow their regional process. DDA is eliminating the ECMP trigger for caregiver age and caregivers who are very stressed with concrete evidence of reduced care. A CARE change has been submitted. Please see "Procedures" for more information.

Note: The CRM may use the referral form DSHS 11-121, *Enhanced Case Management Referral Consideration*, as an eligibility guide.

B. DDA may enroll a client in the enhanced case management program if the client meets criteria under WAC 388-829B-300.

C. An enhanced case manager must visit a client at least once every four months. To address health and safety concerns, the CRM may add services, connect the client with resources, and visit the client more frequently.

D. A client is not eligible for ECMP if the client:

1. Is receiving services through the Children's Intensive In-Home Behavioral Support or Community Protection Waiver. These waivers require 90-day visits, which are more frequent than the ECMP home visit requirement.

2. Is receiving residential services from an adult family home, supported living, group home, or companion home provider. Services in these settings have other oversight.

3. Is a youth under 21 receiving services with more oversight than ECMP.

4. Is enrolled on another specialized caseload that provides additional case management support.

   Note: A client may only be on one specialized caseload at a time and regional staff will determine which specialized caseload is appropriate.

5. Is no longer receiving paid services, for example they have moved out of state or have transferred to the no-paid services caseload.

   Note: When transferring a client, the ECMP case manager and coordinator must follow DDA Policy 3.02, *Client Relocation and File Transfer*.

6. As verified by the ECMP committee:

   a. No concerns remain regarding the client's quality of care, isolation, or home environment; or

   b. The client has had at least two ECMP visits in the past eight months with no to slight concerns regarding quality of care, isolation, or home environment.

## PROCEDURES

### A. ECMP Referrals

1. An ECMP referral may occur at any time. A person may receive a critical care referral trigger for ECMP in their annual assessment. They may also have a current incident that indicates they are at a higher risk for abuse or neglect.

2. A CRM must refer to ECMP if there is a critical care referral trigger in a client's annual assessment and refer only interims or significant change assessments when there are new additional concerns regarding quality of care, isolation, or home environment that were not discussed at the annual assessment referral.

3. If a client receives an ECMP referral trigger for caregiver age or caregiver being very stressed with concrete evidence of reduced care and there are no concerns regarding the home environment, isolation, or quality of care then the CRM may decide not to refer and can enter an SER explaining reason for not referring to ECMP and follow their regional process.

4. Before referring a client to ECMP, the CRM must ensure ECMP eligibility information is accurate in CARE by reviewing information in the following CARE screens:

   a. Vision/Communication screen – whether the client has communication barriers.

   b. Contact Details screen – identify all formal caregivers, emergency contacts, backup caregivers, primary caregiver, and guardians.

   c. Cognitive Performance screen – ensure that if there is someone available to supervise the paid caregiver they are entered here.

   d. Safety screen – DDA has documented concerns that the home environment or quality of care may jeopardize the client's health or safety.

e. APS/RCS/CPS screen – ensure incidents or situations are reported appropriately.

f. Caregiver status screen – indicates concerns about caregiver stress level.

g. Health Indicator Screen – indicates the height and weight of the client.

Note: The Body Mass index (BMI) is calculated according to formulas from the US Center for Disease control. See references above. If the client has a referral for ECMP due to Low BMI, they will also have a corresponding critical care referral trigger for "Nutritional status affecting plan-BMI status: Underweight".

5. The ECMP coordinator will communicate with the CRM to determine if the case meets ECMP eligibility and inform the CRM of the decision per their regional process. An SER must be entered reflecting the results of the decision. When the CRM refers a client to ECMP, the ECMP coordinator will SER the results of the decision. When the CRM decides to not refer to ECMP the CRM must enter the SER regarding the reason to not refer.

6. For cases deemed appropriate by the region, a prior approval is completed in CARE *for "Enhanced Case Management Program – Enrollment"* and the ECMP Coordinator will submit to headquarters for approval. All questions must be answered.

7. The regional ECMP coordinator must maintain a list of clients determined eligible, but who remain unenrolled due to program capacity.

8. The ECMP Committee conducts final reviews and processes transfers onto the program as referrals are received.

9. When a CRM has a client on their caseload who is enrolling in ECMP, the CRM must coordinate with the ECMP CRM to ensure that introductions are made and that concerns regarding the transfer are addressed before the transfer takes place. Such coordination may occur by phone or by scheduling a home visit with both CRMs present.

10. The ECMP coordinator must ensure the DSHS 10-588, *ECMP Enrollment Letter,* is sent to the newly enrolled client and legal representative.

a. The ECMP coordinator must attend ECMP committee meetings monthly to review enrollments and disenrollments.
b. The ECMP coordinator is the primary point person for all emergent incident emails and case coordination when a client is in crisis.

B. ECMP Visit Frequency

1. The CRM must visit the client at least once every four months, which includes the annual home visit.

2. Each of the required visits must occur no more than four months apart. For example, if a visit occurs in January, the next visit must occur by the end of May.

3. An unannounced visit may replace a scheduled visit. Unannounced visits are not mandatory. The CRM must discuss unannounced visits with the ECMP coordinator.

4. If the CRM is unable to meet with the client for a scheduled visit, the CRM must schedule a follow-up visit within 30 days.

5. To determine whether more frequent visits are necessary, the CRM may consider any of the following:

   a. The client was recently referred to or is currently the subject of an APS or CPS investigation.

   b. Documented concerns about the client's safety, home environment, physical appearance, exploitation, health, or the caregiver's ability to deliver quality services.

   c. The CRM has learned of a destabilizing event involving the client, such as loss of primary caregiver, an arrest, hospitalization, or victimization.

      Note: If the client has been hospitalized for 30 days or more, follow the home visit schedule in the "Post-Move and Stabilization" section of the Case Manager Transitional Care Management Procedure Manual.

   d. The client or caregiver has not followed through with two or more scheduled visits.

   e. The CRM has attempted to schedule a visit, but neither the client nor the provider has responded via telephone or email.

C. Documenting Visits

1. For each home visit, the CRM must document in the ECMP node:

   a. Specific concerns, any referrals made, and outcomes from previous referrals or assistance provided;

   b. Observations and concerns related to:

      i. Isolation;
      ii. Home environment; and
      iii. Quality of care;

   c. Rapport between the client and caregivers, including whether the client is currently requesting services and whether the caregiver is supportive of the client having additional services at this time;

   d. Specific issues, concerns, and referrals addressed during the visit; and

   e. If the client refused or declined the home visit and the client's reason for refusing or declining the visit.

2. A service episode record must be entered for any contacts and activity related to the assessment, service planning, case management, or monitoring. When entering information into an SER regarding a service referral, include the reason for the referral. For example, "Nursing Care Consultant (NCC) referral made due to client being underweight and no plan in place to address the concern."

   Note: If the CRM records all the information into the ECMP node, it is not necessary to record in duplicate areas.

3. In between visits, the CRM must enter into the ECMP node any milestones that occur, such as authorizing new services, waiver approvals, guardian appointments, etc.

D. Declined and Refused Visits

1. The ECMP CRM must view the living quarters in person; this cannot be completed virtually. Additionally, a client has a right to decline or refuse a visit.

   a. A visit is considered declined if:

i. The client, the client's family, or the individual provider prefers not to have people in their home due to concerns about contagious illness; or

ii. The client, the client's family, or the individual provider chooses not to have the visit at the scheduled time or allow an unannounced visit.

b. A visit is considered refused if the client or representative:

i. Is not allowing a case manager to inspect the living quarters of the client as required by DDA Policy 14.03, *Viewing a Client's Living Quarters*; and

ii. Provides no reason, or a reason other than that in subsection (1)(a) above.

c. If two or more declined visits have occurred in a row, the CRM must discuss with the ECMP coordinator to help determine appropriate remedies under subsection (3) below.

d. If a visit does not occur due to other reasons besides declined or refused, it will show as 'Overdue' in the ECMP 0133 CARE report and should be completed as soon as possible.

2. Remedies for Declined and Refused Visits

a. If a client declines or refuses a visit, scheduled or unannounced, the CRM must document the reason for the declined or refused visit in a service episode record. The follow-up visit must occur no more than 30 days after the declined or refused visit and may be unannounced.

b. If the CRM is unable to complete an in-home visit, the CRM must discuss with an ECMP coordinator whether to contact local law enforcement, CPS, or APS for a wellness check.

c. As required under WAC 388-825-375 and WAC 388-113-0050(i), an individual provider must cooperate with monitoring visits.

d. If the provider does not comply with monitoring visits, the CRM may contact Consumer Direct Washington (CDWA) and inform them of their concerns regarding the provider for further action.

i. To contact the CDWA when there are concerns regarding the provider, dial 1-866-214-9899, then select #2 to enter ProviderOne ID and be connected to an assigned service coordinator.

ii. The CRM must document in an SER that CDWA has been contacted for not complying with home visits.

E. Coordination of Nursing Care Consultant (NCC) Consultation

1. If the client appears to need a nursing consultation, the CRM must complete the NCC Referral on the Nursing Services SharePoint site.

2. If a client is enrolled onto ECMP and has a low BMI or is underweight as indicated in the prior approval, the CRM must make a referral for an NCC consultation no more than 30 days after enrollment.

3. A client may need a nursing consultation if the client:

a. Needs a nursing assessment (may include in-person visit);
b. Client, family, or care provider needs training;
c. Needs health care consultation (may not include in-person visit);
d. Needs medication management;
e. Has a change in nutritional status;
f. Has immobility issues;
g. Is experiencing pain;
h. Has equipment needs;
i. Experiences frequent hospitalizations; or
j. Has skin integrity problems (other than skin observation protocol).

Note: The CRM must not use this NCC consultation process for Area Agency on Aging referrals, Home Health Agency referrals, nurse delegation, or skin observation protocol. Instead, current processes in place should be used, such as those in DDA Policy 6.15, *Nurse Delegation Services*, and DDA Policy 9.13, *Skin Observation Protocol*.

4. No more than two working days after receiving a request for a nursing consultation, the DDA Nursing Services Unit Manager must review and assign to a Regional NCC for a nursing consultation.

F. Transfers Off the ECMP

1. A client may transfer off the ECMP if:

   a. The client no longer meets eligibility criteria; and

   b. After two in-home visits in an eight-month period, the case manager has no to slight concerns regarding quality of care, the home environment, or isolation.

2. Before transferring, the CRM must discuss potential transfers off the ECMP with the ECMP supervisor and complete the ECMP node in CARE to document the lack of concern.

3. The ECMP Coordinator must complete the *"Enhanced Case Management Program – Archive File"* when:

   a. A client has moved to another state - only fill out the date of the client move.

   b. A client has deceased - fill in date client deceased and fill out the *"Justification of Request"* tab questions.

4. The ECMP Coordinator must complete the *"Enhanced Case Management Program – Disenrollment"* when:

   a. A client has moved into a residential setting to receive services - only enter the type of residential and the date the client moved.

   b. A client has requested to be disenrolled or the CRM or Region is recommending the disenrollment - answer all the questions on the different tabs.

5. The ECMP Committee conducts final reviews and processes disenrollment from the program. The CRM must send the DSHS 10-597, *ECMP Disenrollment Letter*, to the client and the client's legal representative.

6. If a client loses a paid provider or loses financial eligibility while enrolled in ECMP, the client may remain on ECMP if the client and legal representative are actively working on having services restored.

7. If a client will be transferring off ECMP due to no longer receiving services, the case manager must send a planned action notice per DDA Policy 5.07, *Planned Action Notices*.

G. Complaints and Grievances

If a case resource manager, supervisor, regional administrator or central office employee receives a complaint or grievance from a client, the employee must follow DDA 5.03, *Client Complaints*.

## EXCEPTIONS

Any exception to this policy must have written prior approval from the Deputy Assistant Secretary or designee.

## SUPERSESSION

DDA 4.17*, Enhanced Case Management Program*
Issued June 1, 2024

Approved: _____ Date: December 15, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration