

Section 10

Targeted Case Management - - Massachusetts specific

FORMS IN THIS SECTION

- Admission Checklist Targeted Case Management
- Case Management Assessment Form
- Physician's Assessment and Referral for Targeted Case Management Services
- Targeted Case Management Services: Participant Rights and Responsibilities Agreement Form
- Multidisciplinary Comprehensive Service Plan
- Targeted Case Management Program Discharge Form
- Progress Notes Targeted Case Management Program

RELEVANT STANDARDS OF CARE

- Confidentiality
- Residents' Records
- Protecting Residents' Rights

Introduction to Section 10

SECTION DESCRIPTION

This section refers to a program that is specific to Massachusetts' Medicaid Program.

Some AIDS Housing Programs in Massachusetts have become Medicaid Targeted Case Management providers. As Medicaid TCM providers, the AIDS housing program receives Medicaid reimbursement for case management services provided to eligible residents.

Medicaid TCM providers are required to maintain a certain level of documentation on the case management services provided to their residents. Included in this section is most, but not necessarily all, of the documentation required for this program.

For information on how to become a TCM provider, contact:

*The Executive Office of Elder Affairs
Office of Long Term Care
One Ashburton Place, 5th Floor
Boston, MA 02108
Tel: (617) 222-7482
Fax: (617) 727-9368*

ADMISSION CHECKLIST

TARGETED CASE MANAGEMENT

Provider Name: _____
 Client Name: _____ Start of TCM Service: _____
 MassHealth #: _____ DOB _____
 Primary Care Physician: _____ Tel # _____

Eligibility Criteria	Documentation Needed
<input type="checkbox"/> Is eighteen years or older	Photocopy of driver's license or ID
<input type="checkbox"/> Is diagnosed with AIDS	Physician's Assessment and Referral form
<input type="checkbox"/> Lives in a staffed, congregate HIV residential program which meets the DPH Standards of Care; and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom.	Copy of DPH contract will need to be available in the program's files or other documentation stating program meets DPH Standards of Care.
<input type="checkbox"/> Requires and receives from the AIDS housing program staff assistance with either activities of daily living (ADL) or instrumental activities of daily living (IADL). Check which apply: <input type="checkbox"/> Bathing <input type="checkbox"/> Grooming/dressing <input type="checkbox"/> Mobility/transfer <input type="checkbox"/> Eating or toileting <input type="checkbox"/> Laundry <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation <input type="checkbox"/> Housekeeping <input type="checkbox"/> Cooking/meal preparation <input type="checkbox"/> Medication management	The client's needs for ADLs and IADLs must be stated in the Physician's Assessment and Referral Form, the Case Management Assessment Form and the Multidisciplinary Comprehensive Service Plan.

Admission Checklist (cont.)

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<input type="checkbox"/> Does not receive Group Adult Foster Care (GAFC) services	Signed Participant Rights and Responsibilities Agreement Form
<input type="checkbox"/> Does not receive case management services (as defined by TCM) from any other source	Signed Participant Rights and Responsibilities Agreement Form
<input type="checkbox"/> Has assessed client's ability to behave appropriately in an emergency situation	Case Management Assessment Form
<input type="checkbox"/> Has assessed client's ability to self-medicate	Case Management Assessment Form
<input type="checkbox"/> Has been referred to these services by their Primary Care Physician	Physician Assessment and Referral Form

CASE MANAGEMENT ASSESSMENT FORM

Resident Name: _____ Preferred 1st Name _____

Date of Admission to AIDS Housing Program: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) _____ - _____ Phone Where Message May be Left: _____

Date of Birth: _____ Place of Birth: _____ Gender: _____

Racial or Ethnic Background: _____ Religion (*optional*): _____

Social Security Number: _____

Emergency Contact 1: _____ Relationship _____ Phone: _____

Aware of AIDS Status: _____

Emergency Contact 2: _____ Relationship _____ Phone: _____

Aware of AIDS Status: _____

Source of Referral to AIDS Housing:

_____ Mental Health Outpatient Clinic

_____ Emergency or Transitional Shelter

_____ Other Hospital or Medical Clinic

_____ Other Social Service Staff

_____ Alcohol or Drug Treatment Center

_____ Psychiatric Hospital

_____ Street Outreach Worker

_____ Self

_____ PHA Waiting List

_____ Police

_____ Church Staff

_____ Unknown

_____ Other (Specify) _____

Medical Information

(fill out in pencil based on applicant's recollection, finalize with doctor's report)

Does the applicant have an AIDS diagnosis? _____ Yes _____ No

Date of AIDS diagnosis: _____

Approximate date of HIV-related disability: _____

Physical Health Information:

HIV + Date: _____ Asymptomatic _____ Symptomatic _____

AIDS Date: _____ CD4# _____ Viral # _____

Verification: Physician, Date: _____

Lab Results, Date: _____

Method of Transmission: _____

Resuscitate: _____ Yes _____ No

Treat: _____ Yes _____ No

Using table below, list current and past HIV related illnesses/symptoms, as well as related medications and treatments:

<i>Infection/ Symptoms</i>	<i>Past? (Please check)</i>	<i>Present? (Please check)</i>	<i>Treatment</i>	<i>Discharge Date</i>

Are there any non-HIV related illness/physical conditions that we should know about? (asthma, hepatitis, etc.)?

Who will provide written corroboration of this diagnosis?

Address: _____

Phone: _____

Primary Care Provider: _____ Phone: _____

Hospital: _____ Phone: _____

Other Medical Providers: _____ Phone: _____

_____ Phone: _____

TB Screening: PPD: _____ Date: _____ Results: _____

Energy Panel: CXR _____ Date: _____ Results: _____

Treatments:

Transfusions: _____

Nutritional Support: _____

Alternative Therapies: _____

Is the client able to self-medicate? _____ Yes _____ No

Is the client able to behave appropriately in an emergency situation? _____ Yes _____ No

What types of practical supports and assistance do you need now in relation to AIDS/HIV related symptoms?

- _____ Remembering appointments? _____ Paying bills? _____ Doing laundry?
- _____ Transportation to appointments? _____ Managing finances? _____ Cooking?
- _____ Making appointments? _____ Personal care (bathing, dressing, etc.) _____ Shopping?
- _____ Remembering medications? _____ Cleaning/housekeeping? _____ Supervision for safety (while cooking, smoking, climbing stairs?)
- _____ Communicating needs to others? _____ Childcare?

Food and Nutrition:

Interest in or need for Food and Nutrition Services? _____ Yes _____ No

If Yes,	Nutrition Consult?	Y	N	Problems Food Prep?	Y	N
	Food Pantry?	Y	N	Problems Shopping?	Y	N
	Lunch Program?	Y	N	Local Flavor?	Y	N

Dietary Limitations? _____ Yes _____ No

If Yes, _____

Psychosocial

Family of Origin Genogram:

Family/Personal History (Include substance abuse, mental illness, current family involvement, etc.): _____

Identify social support system both informal (family, friends, caregivers) and formal (other agencies, support groups, spirituality):

NAME *Relationship/Agency* *Phone #* *Aware of HIV/AIDS Status*

Additional comments regarding support system: _____

_____ History of depression? _____

_____ History of anxiety disorders? _____

_____ Previous thoughts of suicide? _____

_____ # of actual suicide attempts? _____

_____ Present suicidal ideation? _____

_____ Psychiatric diagnosis? _____

Psychiatric/Mental Health Treatment (Inpatient and Outpatient):

<i>Problem</i>	<i>Diagnosis</i>	<i>Dates</i>	<i>Where Treated</i>

Psychotherapist/Psychiatrist: _____ Phone: _____

Current Psychiatric Medications _____

Present Mental Status: (check one)

Memory:	<input type="checkbox"/> normal	<input type="checkbox"/> short-term deficit	<input type="checkbox"/> long-term deficit
Insight:	<input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> absent
Judgement:	<input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> poor
Thought progression	<input type="checkbox"/> normal <input type="checkbox"/> loose <input type="checkbox"/> hallucinations	<input type="checkbox"/> fragmented <input type="checkbox"/> paranoid <input type="checkbox"/> hear voices	<input type="checkbox"/> tangential <input type="checkbox"/> delusional
Mood:	<input type="checkbox"/> relaxed <input type="checkbox"/> sad	<input type="checkbox"/> fearful <input type="checkbox"/> hostile	<input type="checkbox"/> anxious <input type="checkbox"/> depressed
Affect:	<input type="checkbox"/> appropriate	<input type="checkbox"/> inappropriate	
Status:	<input type="checkbox"/> suicidal	<input type="checkbox"/> homicidal	
Appearance:			

Other comments: _____

Describe the resident's self-perception: _____

Resident's Personal Strengths: _____

Personal coping mechanisms, recent successes _____

Resident's ability to perform daily living skills, maintain house chores, etc. _____

Additional Comments _____

Financial

Source	Monthly	Applied for? (date)
Salary/Wages		
AFDC		Date
EAEDC		Date
SSI		Date
SSDI		Date
Food Stamps		Date
Other		Date

Health Insurance (check all that apply):

Medicaid MassHealth, # _____
 Spend Down? Yes No When? _____ How Much? _____

Medicare, # _____

Private Insurance Company, #: _____

Ability to budget, access entitlements: _____

Legal

Criminal History (please include charges, sentences and location): _____

On Probation? Probation Officer: _____ Phone: _____

On Parole? Parole Officer: _____ Phone: _____

Pending court case? Nature: _____ Date due in court: _____

Outstanding warrants (list): _____

Plan for outstanding warrants: _____

Interest in or need for legal assistance? _____ Yes _____ No
If Yes, Will? Y N Power of Attorney? Y N
Health Care Proxy? Y N Guardianship? Y N

Spiritual

Has resident ever belonged to an organized religious group, church, or temple that was a meaningful experience for him/her? _____ No
_____ Yes What denomination? _____

Does resident wish to develop a relationship with a community based religious organization or representative of a local religious organization?
_____ No _____ Yes What denomination or with whom? _____

Social/Community Activity: _____

Religious/Spiritual Activity: _____

Hobbies/Interests: _____

Exercise/Sports: _____

Substance Abuse History

Begin this assessment with a general interview about the climate of drug and alcohol use in which the person was raised and has been living.

Family History of Drug/Alcohol Use

Father

Mother

Brother(s)

Sister(s)

Grandfather

Grandmother

Children

Other relative(s)

Other comments

Spouse/Partner History:

_____ Active User _____ Clean _____ Never Used _____ Dealer

Other Comments: _____

Personal History:

Age of first drink? _____ Age of first drug use? _____

What has been drug(s) of choice? _____

In what situations would use of alcohol or drugs increase? _____

How do you not use when triggered to do so? _____

Most recent drug of choice: _____

Frequency (per day, per week, etc.): _____

Number of attempts to reduce or stop drug/alcohol use: _____

What helped? _____

What did not help? _____

Who (friends, family, associates) is supportive of recovery? _____

Pattern of substance abuse:

<i>Substance</i>	<i>Age of First Use</i>	<i>Last Use</i>	<i>Frequency</i>	<i>Usual Route of Transmission</i>
Alcohol				
Cocaine				
Crack				
Marijuana/Hashish				
Heroin				
Non Rx Methadone				
Other Opiates				
PCP				
Oth. Hallucinogens				
Metamphetamine				
Oth. Ametamphetamine				
Other Stimulants				
Benzodiazepines				
Other Tranquilizers				
Barbituates				
Sedatives/Hypnotics				
Inhalants				
Over-the-Counter				
Other				

Alcohol/Drug Treatment Experience:

	<i># Times</i>	<i>1st tx. Date</i>	<i>Last tx. Date</i>	<i>Longest sobriety</i>
Detox				
Rehab				
Outpatient				
Residential				
Methadone Clinic				
Acupuncture				
Other				

Past and present participation in recovery/prevention strategies

<i>Type</i>	<i>Past</i>	<i>Present</i>
Member of recovery group/support group		
Working with individual counselor, buddy, therapist		
Attending meetings/12 step		
Having a sponsor		
Phone contacts/networks		
"Service" at meetings, e.g. setting up chairs, etc.		
Contracting		
Setting goals		
On-going commitments		
Other:		

What is the resident's understanding of the "triggers" that may set off relapse for himself/herself (HALT: Hunger, Anger, Loneliness, Tiredness)?

What areas of life have been most affected by substance use/abuse (relationships, job, education, spirituality, self esteem, etc.)?

Assessment completed by: _____ Date: _____

Signature: _____

**Physician's Assessment and Referral
For Targeted Case Management Services**

Date: _____

Name of Client: _____

Mass Health # _____

Date of birth of client: _____

AIDS housing residence: _____

Name of Primary Care Provider Conducting Assessment/Referral: _____

Affiliation (hospital, clinic): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) _____ - _____

Medicaid Provider #: _____

.....

I, _____, (please print name) provide primary medical care for the person identified above. I have conducted a medical assessment of the person identified above and here are my findings.

AIDS Diagnosis

- Yes.** Based on my assessment, I certify that the client has been diagnosed with AIDS based on the definition of AIDS published by the Federal Center for Disease Control (CDC).
- No,** my client does not have an AIDS diagnosis.

Current Medical Conditions

The current medical conditions both associated with AIDS diagnosis and the general health of the client are as follows:

Need for Assistance

with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other tasks.

- I concur with the assessment provided by the case manager which identifies the following types of supports and assistance needed for the client. (Case Manager to check appropriate boxes)

ADLs

- Bathing
- Grooming/dressing
- Mobility/transfer
- Eating or toileting

IADLs

- Laundry
- Shopping
- Transportation
- Cleaning/housekeeping
- Cooking/meal preparation
- Medication management

Other

- Supervision for safety
- Personal care
- Communicating needs to others
- Making appointments
- Remembering appointments
- Diet/nutritional counseling
- Mental health therapy
- Substance abuse detox services
- Relapse prevention
- Financial counseling and support
- Legal services

Physician's Assessment and Referral Form
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Based on my assessment, I believe that my client is in need of case management services provided on-site at the AIDS housing program where s/he resides. I have also reviewed the attached Multidisciplinary Comprehensive Service Plan and agree with the service needs assessed and the plan of care. Any suggested changes to the plan have been made below.

Signature _____

Date _____

TARGETED CASE MANAGEMENT SERVICES

PARTICIPANT RIGHTS AND RESPONSIBILITIES AGREEMENT FORM

Participant Name _____

Address _____

Mass Health # _____ Start of TCM Service _____

AS A PARTICIPANT, YOU HAVE THE RIGHT:

1. To expect continuity in the case management services provided.
2. To receive your case management in a timely and confidential manner.
3. To be treated by a primary care physician, to participate in the planning of your care, and to communicate with your physicians and others planning for your medical, social and mental health care without restriction.
4. To refuse treatment or medication.
5. To examine your records at the program during office hours after giving reasonable notice.
6. To receive a prompt response to reasonable questions you have about your record, your plan of care, and what may happen if you refuse to follow your plan of care.

AS A PARTICIPANT, YOUR RESPONSIBILITY IS:

1. To give the case manager complete and accurate information about health and support services you are receiving; previous medical advice and medications or treatment you are following; and medical insurance information.
2. To follow your plan of care and be as responsible for your health and social needs as possible.
3. To receive targeted case management services from the AIDS housing program where you reside.
4. To not be enrolled in Medicaid's Group Adult Foster Care program. Enrollment in GAFC would terminate your participation in the Targeted Case Management program.

AIDS HOUSING PROGRAM'S RESPONSIBILITY IS:

1. To maintain up-to-date assessments and evaluations of client.
2. To coordinate the development of a comprehensive individualized service plan for each client which most adequately responds to the client's needs.
3. To ensure the comprehensive individualized service plan is implemented.

4. To monitor the delivery of specified services.
5. To amend the service plan as the client's needs change.
6. To locate, coordinate and monitor all medical, social and mental health services.
7. To coordinate and arrange rehabilitation and support services.
8. To coordinate accurate participant records.
9. To coordinate medical and social service referrals for participants.
10. To terminate participant from the program if/when client is no longer eligible.

REVIEW OF SERVICES

Each month, the case manager will review your service plan with you to determine whether or not the services being offered to you are still appropriate. They may be revised with your involvement in the event your condition changes.

YOU MAY BE DISCHARGED FROM TCM SERVICES WHEN:

1. You stop living in a congregate AIDS housing program;
2. You are able to do your own case management, receive your case management services elsewhere, or you cease to require case management;
3. You receive Group Adult Foster Care services; or
4. You elect to discontinue participation in the Targeted Case Management program.

I, _____, understand the above Participant Rights and Responsibilities and the Targeted Case Management Agreement.

I also understand that I may choose to withdraw from Targeted Case Management at any time. If so, I agree to give the Case Manager two weeks' written notice. Should I fail to give two weeks prior written notice, I release my TCM provider from any responsibility for me or my disposition.

I hereby authorize representatives of Targeted Case Management to discuss my condition and care plan with appropriate persons and providers; and to request medical records which may pertain to my care plan in the Targeted Case Management program.

_____	_____
Resident signature	Date
_____	_____
Case Manager signature	Date

MULTIDISCIPLINARY COMPREHENSIVE SERVICE PLAN

(to be updated monthly)

RESIDENT NAME: _____

DATES: From _____ to _____

REVIEWED BY:

Initials/date

Initials/date

Initials/date

Initials/date

Initials/date

Initials/date

TYPE OF PROVIDER KEY: H=AIDS Housing Program Staff providing service

O=Other agencies providing service

I=Informal support from friends, family, etc.

SERVICE DESCRIPTION	TYPE OF PROVIDER (Circle one)			NAME OF PROVIDER	FREQUENCY OF SERVICE DELIVERY	SERVICE PERIOD
MEDICAL						
Homehealth aide	H	O	I			
Homemaker	H	O	I			
Visiting Nurse	H	O	I			
Medication management	H	O	I			
Diet/nutrition	H	O	I			
Gyn/family planning	H	O	I			
Transportation	H	O	I			
Other	H	O	I			
ADL NEEDS						
Bathing	H	O	I			
Dressing/Grooming	H	O	I			

Eating/Feeding	H	O	I			
SERVICE DESCRIPTION	H	O	I	NAME OF PROVIDER	FREQUENCY OF SERVICE DELIVERY	SERVICE PERIOD
Ambulating	H	O	I			
Toileting	H	O	I			
Transferring	H	O	I			
IADL NEEDS						
Housework	H	O	I			
Laundry	H	O	I			
Meal preparation	H	O	I			
Getting Around Outside	H	O	I			
Medication Management	H	O	I			
Shopping	H	O	I			
Money Management	H	O	I			
Transportation	H	O	I			
MENTAL HEALTH						
Therapy – individual	H	O	I			
Therapy – group	H	O	I			
Inpatient treatment	H	O	I			

Transportation	H	O	I			
<i>SERVICE DESCRIPTION</i>	TYPE OF PROVIDER Circle one			NAME OF PROVIDER	FREQUENCY OF SERVICE DELIVERY	SERVICE PERIOD
SUBSTANCE ABUSE						
Relapse prevention	H	O	I			
Detox – day tx	H	O	I			
Detox – inpatient	H	O	I			
Transportation	H	O	I			
Other	H	O	I			
<i>PTOT AND SPEECH</i>						
Physical therapy	H	O	I			
Occupational therapy	H	O	I			
Speech therapy	H	O	I			
Other	H	O	I			
FINANCIAL						
Budgeting	H	O	I			
Accessing entitlements	H	O	I			
Accessing medical insurance	H	O	I			
Other	H	O	I			

SERVICE DESCRIPTION	TYPE OF PROVIDER (Circle one)			NAME OF PROVIDER	FREQUENCY OF SERVICE DELIVERY	SERVICE PERIOD
LEGAL						
Child guardianship	H	O	I			
Health proxy	H	O	I			
Living will	H	O	I			
Will	H	O	I			
Probation/Parole	H	O	I			
Other	H	O	I			
SPIRITUAL						
Other	H	O	I			
SOCIAL						
Recreation	H	O	I			
Child care	H	O	I			
Parenting skills	H	O	I			
Disclosure issues	H	O	I			
Other family/child issues	H	O	I			
Educ/vocational training	H	O	I			
Basic needs (clothing, food)	H	O	I			
Transportation	H	O	I			

Other:	H	O	I			
Other:	H	O	I			
Other:	H	O	I			

Case Manager Signature: _____

Date: _____

TARGETED CASE MANAGEMENT PROGRAM

DISCHARGE FORM

Name _____

Enrollment Date _____

Discharge Date _____

Choose one reason for discharge:

- The participant no longer requires case management services.
- The participant no longer lives in the congregate AIDS housing program.
- The participant has chosen to discontinue her/his participation in the program.
- The participant has died.

If the participant has left the congregate AIDS housing program, will participant require continued case management services?

Yes No

If yes, what has the case management program done to secure the needed services?

Case Manager Signature: _____

Date: ____/____/____

