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
☐ Is eighteen years or older	Photocopy of driver's license or ID
☐ Is diagnosed with AIDS	Physician's Assessment and Referral form
☐ 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.
☐ 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: ☐ Bathing ☐ Grooming/dressing ☐ Mobility/transfer ☐ Eating or toileting ☐ Laundry ☐ Shopping ☐ Transportation ☐ Housekeeping ☐ Cooking/meal preparation ☐ 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.

☐ Does not receive Group Adult Foster Care (GAFC) services	Signed Participant Rights and Responsibilities Agreement Form
☐ Does not receive case management services (as defined by TCM) from any other source	Signed Participant Rights and Responsibilities Agreement Form
☐ Has assessed client's ability to behave appropriately in an emergency situation	Case Management Assessment Form
☐ Has assessed client's ability to self-medicate	Case Management Assessment Form
☐ 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:

Infection/ Symptoms	***Past? (Please check)***	***Present? (Please check)***	***Treatment***	***Discharge Date***

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: _____

Anergy 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? _____

<u>Psychiatric/Mental Health Treatment</u> (Inpatient and Outpatient):

Problem	*Diagnosis*	*Dates*	*Where Treated*

Psychotherapist/Psychiatrist: _____ Phone: _____

Current Psychiatric Medications _____

_____

<u>Present Mental Status</u>: (check one)

Memory:	_____ normal	_____ short-term deficit	_____ long-term deficit
Insight:	_____ good	_____ fair	_____ absent
Judgement:	_____ good	_____ fair	_____ poor
Thought progression	_____ normal _____ loose _____ hallucinations	_____ fragmented _____ paranoid _____ hear voices	_____ tangential _____ delusional
Mood:	_____ relaxed _____ sad	_____ fearful _____ hostile	_____ anxious _____ depressed
Affect:	_____ appropriate	_____ inappropriate	
Status:	_____ suicidal	_____ 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:

Substance	*Age of First Use*	*Last Use*	*Frequency*	*Usual Route of Transmission*
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:

	# Times	*1st tx. Date*	*Last tx. Date*	*Longest sobriety*
Detox				
Rehab				
Outpatient				
Residential				
Methadone Clinic				
Acupuncture				
Other				

Past and present participation in recovery/prevention strategies

Type	*Past*	*Present*
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

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			
SERVICE DESCRIPTION	**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			
PTOT AND SPEECH						
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: _____/_____/_____

TARGETED CASE MANAGEMENT PROGRAM
PROGRESS NOTES

RESIDENT: _____

DATE (month/day/year)	**NOTES**