Sonoma County Area Agency on Aging
Case Management Requirements 2024-2025

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Case Management Services: Definition and Program Overview[1]

- Case management is a service provided to an older individual (60+) at the direction of the individual or representative.
- The Case Management Program provides person-centered assistance to older adults (age 60+) who may no longer be able to manage daily living tasks by helping them maintain an optimum level of functioning in the least restrictive setting possible.
- The Case Management Program targets individuals age 60 or over who are at-risk of declining in their overall health, becoming depressed, and/or losing their independence because of diminished social and/or mental stimulation. Priority is given to those who may be one or more of the following: low-income, minority, Spanish speaker or limited English-proficient, socially isolated, residing in rural areas, and/or at risk of institutional placement.
- Case Management is a service of a minimum of three months' duration that includes comprehensive Assessment, a client-centered Care Plan, and coordination of care over multiple home visits and/or phone conversations. A single referral or a single visit is not case management and should not be documented as such.
- Case Management is a stand-alone program; an individual who is counted as a case management client must meet the full requirements outlined in the contract Scope of Work and these Case Management Requirements.
- Services provided by other programs should not be documented as case management services. For example, a nutrition Assessment visit or other program Assessment or service must not be reported as case management, even if the staff member provides a referral, resource, or other service that may be similar to or fall under the scope of case

[1] *As defined by the Older Americans Act (OAA) Section 102 (11) and the County of Sonoma Area Agency on Aging*

management.

- Contractor will ensure that Case Management Services include all of the following elements:
  - A comprehensive needs Assessment that includes:
    - Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL);
    - General health and health care needs;
    - Psychological, social support, and emotional needs;
    - Legal and/or financial assistance;
    - Housing;
    - Nutrition;
    - Mobility and transportation needs;
    - Home safety Assessment (stairs, equipment, clutter etc.);
  - Development of a Care Plan in partnership with the participant or their representative, which includes specific, quantifiable goals that address each identified need, and strategies for each goal. Goals and strategies should be updated at least quarterly in the WellSky Aging & Disability database. The Care Plan should be fully updated when the individual's case is closed.
  - Monthly monitoring of client by phone with documentation of monitoring in the WellSky Aging & Disability progress notes.
  - Quarterly home visits with documentation of Care Plan updates and monitoring in the WellSky Aging & Disability progress notes.
  - Reassessment of client needs should take place every 6 months.
- The case management screening to collect initial information and demographics may take place over the phone. The Intake Assessment and creation of the Care Plan must be completed in the participant's home.
- Case management contacts with the participant must include at a minimum:
  - Monthly phone contacts
  - Quarterly in-person visits
  - Reassessments every 6 months
- Contractor's hiring and recruitment process will ensure that each case manager is trained and qualified to provide comprehensive case management and care coordination to meet the needs of the older individual. Qualification requirements should include:
  - A Bachelor's Degree in a related field (social work, counseling, psychology, gerontology or related human service field) and/or a combination of equivalent experience and education.
  - Professional training in older adult case management. University of Boston's CADER Program is an example of a recommended program.

Documentation Requirements: Title III – Intake & Assessment Forms Guide

- Initial Assessment, Reassessments, Care Plans and progress notes must all be documented in Wellsky Aging & Disability as follows:
  - Care Plan updates must be documented in WellSky's Aging & Disability.
  - Progress notes must include the dates and actions for follow-up with participant.
  - Referral(s) to services or assistance provided must include dates for follow-up by phone or in-person, and documentation of services obtained toward Care Plan goals.
- Data Entry
  - Required fields to be entered into WellSky Aging & Disability for each participant:
    - Number of Hours (Service Units).
    - Registered Participant Detail: Birth Date, Zip Code, Rural Designation, Gender, Sexual Orientation Gender Identity (SOGI) questions, Race, Ethnicity, Poverty Status, Living Arrangement.
  - A participant may decline to state. "Decline to State" is included as a drop-downoption. "Missing" information errors occur when a participant is not asked the question or the information was not entered into the database.
- Assessment Form
  - An agency may use the standard CDA Assessment Form or create their own version of the Assessment Form, but the latter must include all elements of the version included with these guidelines, and a copy of the form must be provided to AAA Program Staff.
  - The Area Agency on Aging is able to tailor a Case Management Assessment Form within WellSky Aging & Disability.
  - Alternatively, Case Management Assessment Forms, if completed on paper, must be scanned into WellSky Aging & Disability.
- Care Plan
  - The Care Plan includes time frames of actions for each goal and documents these details in the WellSky Aging & Disability progress notes.
  - All updates to Care Plans must be documented in the WellSky Aging & Disability progress notes as changes occur, including at 12-month Reassessments and when a case is closed.

Initial Assessment

- The initial Assessment is completed by a trained case manager (OAA Section 102 (II)(A)(i)) in the participant's home.
- The Assessment includes documentation of ADL/IADL, general health, legal and/or fiscal assistance, housing, nutrition, social support and connection, access to transportation, safety within the home (stairs, equipment, clutter etc.), emotional well-being and quality of life.
- Assess participant's ability to remain independent (OAA Section 102 (II)(B)(i)).

Care Plan

- Care plans establish the individual needs & goals for case management
- All activity related to the Care Plan must be documented in the WellSky Aging & Disability progress notes.
- Care plan must include goals, strategies and outcomes to be achieved and services to be pursued. Each goal should link to a need identified through the Assessment process.
  - Document participant's participation and approval of their stated needs as well as their approval of the Care Plan's goals, strategies, and outcomes.
  - Coordinate with any other formal services, such as hospital discharge plans
  - Provide comprehensive and timely information about the availability of community resources.
- The Care Plan must be updated at the 12-Month Reassessment, documenting outcomes for each goal and that significant work went into each goal.

Reassessments

- The purpose of the Reassessment is to update the participants needs that may impact the Care Plan goals. Each Reassessment requires a home visit.
- A Reassessment requires the case manager to completely reassess the participant's needs that have changed since the Initial Assessment.
- Reassessments are documented in WellSky Aging & Disability.
- Reassessment is completed every 6 months.
- Every 12 months, there must be an Annual Reassessment that includes an update of the Care Plan which documents the outcome for each goal and demonstrates that significant work went into each goal.

Closing a Participant Case

- The duration of Case Management Services is based on the goals established in the Care Plan. A participant may choose to discontinue case management, but after a period of time, may return as a new participant as a result of changed circumstances.
- If a former case management participant requests to be reenrolled, the case manager must complete a new initial Assessment and Care Plan.
- The closing of a case must be documented in the WellSky Aging & Disability database, including the following:
  - Outcomes and strategies for each Care Plan goal with narrative describing whether each outcome and strategy was achieved.
  - Termination reason(s), which may include that the participant has declined services; or has received services as specified in the Care Plan and the identified goals have been achieved.
  - Status of participant's needs from their last Assessment, including any changes in

circumstances or needs as related to discontinuation of services.
  - Follow-up plan or continuation plan including participant's current supports and services.

Tracking of Case Management Hours

- Case Management hours are reported as the amount of time the case manager is in contact with the participant (phone calls and home visits) as well as travel time, documentation, and collateral contacts related to each participant.
- Only a trained case manager's time is to be reported; time that other program staff or volunteers spend with the participant is not to be included.
- When an individual requesting services does not live in the boundary of the Contractor's assigned service area, Contractor must refer the individual to the OAA-funded Case Management contractor in the appropriate service area.

Reference Materials

- Older Americans Act: See Section 102(11) "case management service" definition): https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf
- Welfare and Institutions Code – WIC Division 8.5 Mello-Granlund Older Californians Act: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=9007
- California Department of Aging (CDA) Title III B Supportive Services Program Overview https://aging.ca.gov/Providers_and_Partners/Area_Agencies_on_Aging/Supportive_Services/Program_Narrative_and_Fact_Sheets/
- California Department of Aging (CDA) Title III Intake and Assessment Forms Guide: https://www.aging.ca.gov/download.ashx?lE0rcNUV0zaN%2FY3P1Uwdgg%3D%3D
- CDA Older Americans Act Title IIIB Supportive Services Program Narrative https://aging.ca.gov/download.ashx?lE0rcNUV0zac5x5tGZUebw%3D%3D
- CDA Service Categories and Data Dictionary Revised July 2023: https://www.aging.ca.gov/download.ashx?lE0rcNUV0zYVluwocgk52g%3D%3D