SUBCHAPTER 06D - CARE MANAGEMENT

SECTION .0100 - SCOPE OF SERVICE

10A NCAC 06D .0101 SCOPE OF CARE MANAGEMENT

Primary Service. Care Management is a coordinated care function which incorporates case finding, assessment and reassessments, negotiation, care plan development and implementation, monitoring, and advocacy to assist functionally impaired older adults targeted in Rule .0103 of this Section with obtaining the services necessary to be safely cared for within the home and community setting.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0102 DEFINITIONS

As used in this Subchapter, the following terms shall have the meanings specified:

(1) "Activities of daily living (ADL's)" include eating, dressing, bathing, toileting, bowel and bladder control, transfers, ambulation, and communication such as ability to express needs to others through speech, written word, signing, gestures, or communication devices.

(2) "Instrumental activities of daily living (IADL's)" include meal preparation, medication intake, house cleaning, money management, telephone use, laundering, reading, writing, transportation, mobility, shopping, and going to necessary activities.

(3) "Case closure" means the discontinuation of Care Management Services when the goals of the care plan have been met or when the client is no longer eligible for Care Management Services.

(4) "Functionally impaired" means individuals whose illness, disabilities, or social problems have reduced their ability to perform self-care and household tasks in an independent manner.

(5) "Complex care needs" means the presence of significant impairments in activities of daily living or instrumental activities of daily living, or both, with complicating mental, medical, social, or behavioral problems, which necessitates professional intervention.

(6) "Review" means a regular contact by an appropriate professional with the individual or family or both to note progress, maintenance or deterioration, changes in circumstances, and adequacy of the care plan in meeting the person's and family's needs, and to make any needed adjustments.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
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10A NCAC 06D .0103 TARGET POPULATION

The target population consists of functionally impaired older adults who are at risk of abuse, neglect, exploitation, or have complex care needs, or both; and who, due to a critical time factor or the complexity of services needed, are unable to access needed services in order to remain safely at home.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
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SECTION .0200 - SERVICE PROVISION

10A NCAC 06D .0201 CLIENT ELIGIBILITY

Care Management Services are limited to older adults 60 years of age or older and their spouses who meet the identified target population.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*

Eff. November 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0202 SCREENING

(a) Screening is a preliminary process used to determine if an individual appears to belong in the target population.
(b) A screening instrument must be completed for each person requesting Care Management Services.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. November 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0203 ASSESSMENT AND REASSESSMENT

(a) The assessment and reassessment are comprehensive multidimensional methods used to determine the client's level of functioning and confirm eligibility for Care Management Services.
(b) The initial assessment and all reassessments shall be conducted in the client's home and shall address the mental, social, environmental, economic, and physical health status of the client, as well as the ability to perform activities of daily living (ADL's) and instrumental activities of daily living (IADL's).
(c) The assessment and reassessment shall be conducted in the client's home by a Social Worker and a Registered Nurse.
(d) A full reassessment shall be completed at least every 12 months or more frequently as the client's condition warrants, based upon factors specified in Paragraph (b) of this Rule.
(e) The initial assessment and reassessments shall be signed and dated by the Social Worker and the Registered Nurse and shall be maintained in the client's file.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0204 CARE PLANNING

The purpose of the care plan is to identify the course of action to be followed:

(1) Care plans for an eligible client shall be developed within 12 working days of the initial screening.
(2) The care plan shall include, at a minimum, the following information:
    (a) Outcome oriented goal statements and conditions for case closure;
    (b) Both formal and informal services to be provided;
    (c) Agencies responsible for service provision;
    (d) Frequency of service provision;
    (e) Duration of service provision;
    (f) Signature of the client or designated representative indicating agreement with the care plan;
    (g) Signature of the Registered Nurse and the Social Worker developing the care plan;
    (h) Date of care plan development.
(3) Care plans shall be reviewed at least quarterly or more frequently as the client's condition warrants by both the Social Worker and the Registered Nurse based upon factors specified in Rule .0203(b) of this Section.
(4) All changes to the care plan must be documented and dated on the care plan by the Social Worker and Registered Nurse, or both.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0205 MONITORING

The purpose of monitoring is to guarantee continuity of services and to evaluate the client's continued eligibility for Care Management Services:

(1) At a minimum, a monthly contact must be made to the client.
(2) At least one contact per quarter must be conducted in the client's home.
(3) All monitoring activities must be documented in the client's file by the appropriate professional.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. November 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.

10A NCAC 06D .0206 DOCUMENTATION

Client records for Care Management Services shall include:

(1) A completed copy of the screening instrument;
(2) A completed copy of the initial assessment;
(3) Completed copies of all reassessments;
(4) Copies of the initial and any revised care plans;
(5) Documentation of all monitoring activities;
(6) Denial, termination or reduction of service when appropriate;
(7) Documentation of client's approval for release of information.

History Note: *Authority G.S. 143B-181.1(c); 143B-181.10;*
Eff. November 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. September 6, 2016.