Table of Contents

I. Intake 3
- A. Definitions 3
- B. Introduction and Overview 5
- C. Statutory Basis 5
  - 1. Mandates for the Appointee 6
  - 2. Procedures for Requesting Health Care Surrogate Services 6
- D. Eligibility Criteria 6
- E. Required Information 8
- F. Referral Triage/Disposition 9
  - 1. Accept/Screen Out 10
  - 2. Response Times 10

II. Assessment 12
- A. Adult Initial Assessment 12
  - 1. Time Frames 12
  - 2. Assessing Eligibility 13
  - 3. Decision-Making Capacity. 14
  - 4. Short-Term Service Planning 14
  - 5. Conclusion of Initial Assessment. 15
  - 6. Initial Assessment Disposition Options. 16
- B. Comprehensive Assessment 16
  - 1. Times Frames 17
  - 2. Information to Be Collected 17
  - 3. Conclusion of Comprehensive Assessment 20

III. Case Management 20
- A. Appointment of the Department as Health Care Surrogate 20
  - 1. Process for Appointment 21
  - 2. Explore All Potential Candidates Prior to DHHR Accepting 21
  - 3. Responsibility of the Worker 22
  - 4. Responsibility of the Supervisor 23
  - 5. Appointment for Individuals in State Operated Facilities 23
- B. Service Planning 24
  - 1. Inclusion of the Incapacitated Adult in Service Planning 25
  - 2. Determining the Most Integrated Level of Intervention 26
  - 3. Required Elements - General 26
- C. Decision-Making for the Incapacitated Adult 27
  - 1. Placement Decisions 28
  - 2. Medical Decisions 29
  - 3. End of Life Decisions 30
  - 4. Resolving Conflicts Between Advance Directives 32

5. Financial Decisions 31
6. Ethics Consultation 32
7. Foster Care Youth Turning 18 33
8. In State/Out of State Appointments 34

D. Case Review 35
1. Purpose 35
2. Time Frames 35
3. Conducting the Review 36
4. Documentation of the Review 37

E. Resignation/Termination of Health Care Surrogate 37

F. Assessment Prior to Case Closure 38

G. Reports 38
1. Adult Initial Assessment 38
2. Comprehensive Assessment 38
3. Service Plan 39
4. Appointment of Health Care Surrogate 39
5. Intake Summary 39
6. Ethics Consultation Intake Tool 39
7. Ethics Consultation Summary 39
8. Negative Action Letter (SS-13) 40

H. Transfer of Cases Between Counties 40
1. Timing of Transfers of Health Care Surrogate Cases (DHHR) 40
2. Sending County Responsibilities 40
3. Receiving County Responsibilities 41

I. Confidentiality 41
1. Confidential Nature of Adult Services Records 41
2. When Confidential Information May Be Released 42
3. Subpoenas, Subpoena duces tecum & Court Orders 43

J. Liability 43

V. Case Closure 44
A. Case Closure - General 44
B. Notification of Case Closure 44
C. Client's Right to Appeal 44

I. Intake

A. Definitions

Attending Physician: a physician selected by or assigned to the person who has primary responsibility for treatment and care of the person and who is a licensed physician.

Advanced Practice Nurse: a nurse with substantial theoretical knowledge in a specialized area of nursing practice and a proficient clinical utilization of the knowledge in implementing the nursing process and has met the applicable licensing requirements.

Conservator: a person appointed by the circuit court who is responsible for managing the estate and financial affairs of a protected person and includes a limited conservator or temporary conservator.

Do Not Resuscitate (DNR): A written, signed directive by a capacitated individual or their representative directing the health care provider not to administer cardiopulmonary resuscitation or any mechanical means to
prolong or continue life.

Durable Power of Attorney: A written, signed directive by a capacitated individual designating another person to act as their representative. The durable power of attorney specifies the areas in which this individual can exercise authority. It can either become effective upon the person becoming incapacitated or can remain in effect in the event the individual becomes incapacitated.

Guardian: a person appointed by the circuit court who is responsible for the personal affairs of a protected person and includes a limited guardian or temporary guardian.

Health Care Decision: a decision to give, withhold or withdraw informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation.

Health Care Facility: a facility including but not limited to hospitals, psychiatric hospitals, medical centers, ambulatory health care facilities, physician's offices and clinics, extended care facilities, nursing homes, rehabilitation centers, hospice, home health care and other facilities established to administer health care in its ordinary course of business practice.

Health Care Provider: any licensed physician, dentist, nurse, physician's assistant, paramedic, psychologist or other person providing medical dental or nursing, psychological or other health care services of any kind.

Health Care Surrogate: An individual 18 years of age or older or an authorized entity appointed or selected by an attending physician or advanced nurse practitioner to make medical decisions on behalf of an incapacitated individual.

Incapacity: The inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner.

Incompetence: A legal determination that an individual lacks the ability to understand the nature and effects of their acts and as a result is unable to manage his/her business affairs or is unable to care for his/her physical well-being thereby resulting in substantial risk of harm.

Life prolonging interventions: any medical procedure or intervention that, when applied to a person, would serve to artificially prolong the dying process or to maintain the person in a persistent vegetative state. Includes, among others, nutrition and hydration administered intravenously or through a feeding tube. Does not include administration of medication or performance of other medical procedure deemed necessary to provide comfort or alleviate pain.

Living will: A written, witnessed advanced directive governing the withholding or withdrawing of life prolonging intervention, voluntarily executed by a person in accordance with the provisions of article 30, chapter 16 of the West Virginia Code.

Medical power of attorney: A written, witnessed advanced directive that authorizes an individual that is at least 18 years of age to make medical decisions on behalf of another individual. A medical power of attorney must be duly executed prior to the individual becoming incapacitated and duly executed in accordance with the provisions of article 30, chapter 16 of the West Virginia Code or existing and executed in accordance with the laws of another state.

Most integrated setting: is defined in the Olmstead decree as a setting which enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

POST Form: the Physician Orders for Scope of Treatment (POST) is a form developed for the purpose of documenting orders for medical treatment and directives concerning provision of CPR, code/no code, level of intervention, etc. (§16-30-25).

Qualified physician: a physician licensed to practice medicine who has personally examined the person.

Qualified psychologist: a psychologist licensed to practice psychology who has personally examined the person.

Representative payee: An individual appointed by the funding source to handle that individual's benefits.

Surrogate decision-maker: means an individual or authorized entity identified as such by an attending physician and authorized to make health care decisions in accordance with the Health Care Decisions Act, article 30, Chapter 16 of the West Virginia Code.

B. Introduction and Overview

Adults have a constitutional right to live their lives as they see fit, within the confines of the law. Inherent in this is the right of self-determination. Because of this, one of the basic tenets of the Department is that any intervention must be the least intrusive/restrictive alternative that is appropriate to address the needs of the individual. Therefore, all potential options should be thoroughly explored prior to seeking appointment of a health care surrogate which will restrict the individual's rights to some degree. In addition, thorough exploration of the existence of advance directives such as a living will, medical power of attorney, durable power of attorney, etc. is to occur prior to seeking appointment of a health care surrogate.

There are times when an adult may become incapacitated to the extent they are no longer able to make health care decisions on their own behalf. When certain criteria are met, they may need a health care surrogate to be appointed to make health care decisions on their behalf. A health care surrogate may be appropriate when 1) the decisions with which assistance is needed are limited to medical decisions, 2) the adult has not designated anyone to assume health care decision-making for them, such as through execution of a durable power of attorney or medical power of attorney, etc., 3) the appointed health care decision-maker is not available and/or 4) there is no known other advanced directive to provide guidance about medical care and decisions.

A health care surrogate may be appointed to make health care decisions for an individual who is unable to make these types of decisions independently. In order for a health care surrogate to be appointed, a qualified physician, qualified psychologist, or advance practice nurse must have made a determination that the individual is no longer able to make decisions on their own behalf. The authority of the health care surrogate is limited to health care decisions effecting the individual. The Department of Health and Human Resources may be appointed to serve as health care surrogate in instances where there is no one willing and able to serve in this capacity. When the Department accepts appointment to serve as health care surrogate, this duty obligates the Department to act in the best interest of the individual.

Note: While determination of incapacity may be done by one or more of the following; a qualified physician, a qualified psychologist, or an advance practice nurse, actual appointment of a health care surrogate may only be done by a qualified physician or advance practice nurse. A second opinion is only required if treatment for mental illness and/or addiction will be needed.(see Appointment of the Department as Health Care Surrogate for additional information)

C. Statutory Basis

The West Virginia Health Care Decisions Act is contained in Article 30, Chapter 16 of the West Virginia State Code. This Act outlines the circumstances under which a health care surrogate

may be appropriate, the process to be followed in order for a health care surrogate to be appointed, and the duties and responsibilities of appointees. In situations where a health care surrogate is needed, but there is no one willing and able to serve in this capacity, the Department may be appointed.

1. Mandates for the Appointee:

Whenever the Department has agreed to serve as health care surrogate for an individual, the agency has the following responsibilities as it carries out it's duties in this capacity:

- making decisions related to the adult's health care;
- maintaining ongoing regular contact with the individual; and,
- considering the expressed desires and personal values of the individual, when known, in making decisions on their behalf and when these are not known, to act in the best interest of the individual, exercising reasonable care, diligence, and prudence.

2. Procedures for Requesting Health Care Surrogate Services:

Requests for appointment of a health care surrogate are usually made by a qualified physician or advanced practice nurse upon determining that the individual no longer has capacity to make health care decisions on their own behalf. In situations where it is believed that a health care surrogate is needed and no one is available or willing to serve in this capacity, the Department may accept appointment.

D. Eligibility Criteria

Whenever it is believed that an individual is in need of a health care surrogate, and based on a thorough search by the appointing physician or nurse practitioner, it is believed, that there is no one to act in this capacity, a request may be made for the Department to be appointed health care surrogate.

In order to be eligible to receive health care surrogate services provided by the Department, the individual must meet certain minimal criteria. The final determination about whether or not health care surrogate services will be provided can not be fully determined in most cases until after a thorough initial assessment is completed. The criteria which must be met at the intake phase of the case are as follows. The individual must meet all the following criteria:

- be at least 18 years of age;
- be a resident of West Virginia or physically located within the state;
- have been determined by a qualified physician, qualified psychologist or advance practice nurse to lack decision making capacity;
- need assistance with health care decisions;
- have no known advance directive duly executed and in effect **or** an advance directive is in effect but it does not adequately meet the individuals needs; and

- have no known person who is willing and able to serve as health care surrogate.

Often the Department is inappropriately called upon to become health care surrogate in circumstances where the hospital or doctor believes they need to perform emergency or time critical procedures. While it is generally required that a physician obtain consent prior to providing medical care, there are exceptions. Emergency situations are one such exception. **Consent is presumed in an emergency when there is an immediate threat to the patient's life, sight, or limb, unless the patient indicated that they do not want the procedure or treatment in a previously executed advance directive.*** When this is the situation, emergency care may be provided without consent so immediate appointment of a health care surrogate is not necessary. If the situation does not qualify as a true emergency as defined (above), the hospital or doctor is to follow the required process of attempting to identify and appoint an appropriate surrogate. It is the Department's responsibility to ensure that proper procedures are followed prior to accepting appointment as health care surrogate. The hospital is to follow their internal procedures for providing medical treatment in emergency situations. In these instances the Department should decline appointment to address the immediate/emergency medical need. This would not preclude the Department from accepting appointment after all other prospective decision-makers have been contacted and it has been determined that there is no one willing and able to serve.

* Information about this exception was provided by Dr. Alvin Moss, West Virginia University's Center for Health Ethics and Law.

Relationship to Other Department Social Services:

Adult Request to Receive Services:

If there is an active Adult Residential case for an individual that needs a health care surrogate appointed, a Request to Receive Services Intake must be completed and the referral accepted. After intake, the initial assessment is to be shown as an incomplete assessment and associated to the open Adult Residential case and appropriate merging of client ID numbers completed. In this instance the Adult Residential case would be the primary case type and the health care surrogate case would be the secondary case type.

If there is an active Guardianship case, appointment of a health care surrogate would not be necessary or appropriate unless the guardianship order of appointment specifically excluded health care decisions on the protected person's behalf. In this instance the guardianship case would be the primary case type and the health care surrogate case would be the secondary case type.

Adult Protective Services:

While a health care surrogate case may be open as a result of involvement with Adult Protective Services (APS), these two case types must **always** remain separate. In this instance, a Request to

Receive Services Intake must be completed, as well as the initial assessment and a health care surrogate case opened separate from the APS case. These cases must be associated and appropriate merging of client ID numbers completed.

Foster Care Services:

Whenever a child is in foster care and it is determined that he/she lacks medical decision-making capacity, the Department may be appointed as health care surrogate once the child reaches age 18. The adult service worker needs to become involved in planning once the youth reaches age 17. In this instance, the adult services worker will be an informal member of the MDT and will be identified as the secondary worker when the child reaches age 17 years 6 months. If the plan is for the Department to be appointed health care surrogate, a Request to Receive Services intake must be completed when the child reaches age 18. After completion of the intake, the initial assessment must be completed and a health care surrogate case opened. The foster care and health care surrogate cases must be associated and appropriate merging of client ID numbers completed. All health care surrogate criteria must be met.

E. Required Information

During the Intake process, information gathered must be as complete and thorough as possible. The individual identified as needing a health care surrogate in the intake process will become the "Adult Services client" within FACTS and will be reflected as such in the assessment and in the case areas. At a minimum, the following information must be gathered during the intake process and documented in FACTS:

Health Care Surrogate Referral:

Information that must be collected when a health care surrogate services referral is received for an individual includes the following:

- Name of adult(s);
- County of residence;
- Current location of the adult;
- Age/date of birth of adult;
- Name of the facility (if applicable);
- Contact person at the facility (if applicable);
- Address of the adult's home/facility;
- Phone number for the adult;
- Type of facility (if applicable);
- Directions to the home/facility;
- Information about efforts that have been made to identify a surrogate decision-maker prior to contacting the Department;
- Name(s) and address' of all known individuals who may be able/willing to serve as health care surrogate;

- Name(s) and address of all known individuals who are currently serving in a decision making capacity;
- Other individuals involved in or who have knowledge of the adult's circumstances;
- Information about any existing advance directives, if known;
- Physical description of the adult;
- Psychological description of the adult;
- Name of referent or indication that referral was made anonymously if the referent is unwilling to give their name;
- Relationship of the referent to the adult;
- How the referent knows of the information being reported/clients needs; and
- Any other relevant information.

In situations where referrals are received involving more than one household member as being in need of services (example: both a husband and his wife), each individual must be set up as a separate referral/case. Appropriate association of these intakes/cases and merging of client ID numbers must be completed.

At the conclusion of gathering the referral information, the intake worker may indicate if, in his/her opinion, the information reported constitutes imminent danger/emergency situation or a potential for danger requiring prompt attention by the supervisor. Selection of this choice will trigger a response time of "within 5 days". If there is no indication that either imminent danger or potential danger exists, FACTS will default to a 14 day response time. If the intake worker indicates that there is imminent danger or there is a potential for imminent danger, he/she must document the reason(s) for this determination. The final determination regarding assignment of the appropriate response time rests with the supervisor. (See the section titled Response Times for additional information)

When all referral information is gathered and documented in FACTS, a search of the FACTS system must be completed to determine if there are other referrals/assessments/cases for the identified client. Appropriate association of intakes/cases and merging of client ID numbers must be completed. The referral is then to be forwarded to the appropriate Adult Services supervisor for further action.

F. Referral Triage/Disposition

The supervisor is the primary decision maker at the intake stage of the health care surrogate casework process. This is consistent with other Department policy which recognizes the unique blend of experience, skill, and leadership which supervisor's provide. The supervisor's role includes 1) ensuring that all referrals are appropriately considered to determine if the referral is to be assigned for an Adult Services Initial Assessment or screened out and 2) for those assigned for assessment, determination of the required response time for the initial contact based on the degree of risk indicated in the referral information. Screening of the referral is to be done promptly, but in no instance is screening of the referral to exceed ten (10) calendar days from the date of referral.

1. Accept/Screen Out

The supervisor will:

a. Review the information collected at intake for thoroughness and completeness.

b. Identify/verify the type of referral.

c. If not previously completed by intake worker, conduct a search of the FACTS system to determine if other referrals/assessments/cases already exist for the identified client.

d. Create associations in FACTS between the current referral and other referrals/assessments/investigations/cases as appropriate, as well as merging all duplicate client ID numbers.

e. Determine if the referral will be accepted for an initial assessment or if the referral will be screened out and not accepted for an initial assessment. In determining whether to accept a health care surrogate referral or screen out the referral, the supervisor must consider:

- the presence of factors which do/could present a risk to the adult;
- the information related to the identified client and their current circumstances;
- whether the information collected appears to meet the eligibility criteria for health care surrogate services;
- the sufficiency of information in order to locate the individual/family; and
- the motives and truthfulness of the reporter.

f. If the referral is accepted,

- determine the appropriate response time for the referral based on the information presented on the intake; and,
- assign the referral for initial assessment.

g. If the referral is screened out,

- document the decision regarding screening;
- document the reason(s) for the screen-out decision; and,
- make referrals to other resources within and outside of the Department, if appropriate.

2. Response Times

A face to face contact must be made with the identified client within fourteen (14) days from the date the referral is received by the agency. Depending on the degree of risk to the client's health, safety and well-being, contact with the adult may require a face-to-face contact in less than fourteen (14) days. The policy rules for determining response time are as follow:

Response Time Options:

Response - Within 5 Days This time frame will apply in cases where it is determined that, based on the referral information, a *situation where a prompt response is critical* (Example - A situation or set of circumstances which present a substantial and immediate risk to the adult.) A face-to-face

contact with the identified client must be initiated within 5 days. This contact is to occur in the adult's usual living environment whenever possible.

Response - Within 14 Days This time frame will apply in cases where it is determined that, based on the referral information, a *situation where a prompt response is critical* does not currently exist and/or is not expected to develop without immediate intervention. A face-to-face contact with the client must be initiated within fourteen (14) days. This contact is to occur in the adult's usual living environment whenever possible.

Note: If "Time Critical Need" is selected by the intake worker, FACTS will trigger a response time of "5 days". If this is not selected by the intake worker, the response time will default to the "within 14 days" response time. The supervisor can change the response time recommended by the intake worker as long as this is done prior to the supervisor's approval of the intake.

Considerations in Determining Response Time

To assist with the determination of the appropriate response time for initiation of a health care surrogate initial assessment, the supervisor should consider the following:

- whether the information reported indicates the presence of a situation requiring prompt attention;
- the location of the adult at the time the intake is received;
- whether the circumstances that exist could change rapidly;
- whether the living arrangements are life threatening or place the adult at risk;
- whether the adult requires medical attention;
- whether the adult is without needed assistance and supervision;
- whether the adult is capable of self-preservation/protection;
- whether the adult/family is transient or new to the community;
- whether the adult is currently connected to any formal support system;
- whether there are any family or friends available for support;
- whether there is a caregiver(s) and if so, are they physically, cognitively and emotionally able to provide needed care to the adult;
- whether there is a past history of referrals or current referrals requesting assistance;
- whether there are injuries; and,
- other relevant information.

Once the supervisor has made a determination regarding the response time they will:

1. Document the decision in FACTS indicating the selected response time and the date of this decision;
2. Assign the referral to a social worker to begin the initial assessment; and
3. Follow-up to assure that the assigned social worker adhered to the designated response time.

II Assessment

A. Adult Initial Assessment

Once the referral is assigned to a social worker, work on the Initial Assessment is to begin promptly and must be completed and documented in FACTS within thirty (30)days. Completion of the Initial Assessment involves gathering a variety of information about the client and his/her current status. Information is to be gathered by conducting a series of interviews with the client, caregiver (if applicable), potential health care surrogates, others having knowledge of the situation, and other significant individuals. This is the initial assessment phase for health care surrogate services. Information gathered during this initial assessment process will be focused on determining 1) the level of risk the client's circumstances present to their well-being and safety, 2) whether or not health care services are indicated based on the adult's circumstances, 3) if health care surrogate services are not indicated, what other services may be needed, 4) the availability of persons willing and able to serve as substitute decision-maker, 5) the efforts made to explore/identify a decision maker prior to contacting the Department, and 6) the role the Department is to play beyond the initial assessment.

In addition to gathering information, several critical questions must be considered when completing the Initial Assessment and determining whether the case is to be opened for health care surrogate services or the initial assessment closed. These include the following:

- Is the adult safe or can his/her safety be arranged/assured through resources available to him/her? (Resources include financial, social, family, etc.)
- Does the adult appear to meet eligibility criteria for health care surrogate services?
- Has there been a medical determination that the adult does/does not have decision-making capacity?
- What type of decisions does the adult need assistance with? (health care only, some/all personal, some/all financial)
- How long is it anticipated that the alleged protected person will need assistance with medical decisions?
- Does the adult have an acting substitute-decision maker? (guardian, conservator, de facto guardian, de facto conservator, health care surrogate, medical power of attorney, power of attorney, representative payee, etc.)
- Does the adult have any advance directive in effect? (living will, DNR, Power of Attorney, Medical Power of Attorney, etc.)
- If health care surrogate services will not be provided, are referrals to other resources needed?

1. Time Frames

Time frames for initiation of the Initial Assessment are determined by the supervisor. It is critical that the social worker complete a face-to-face contact within the assigned time frame. The options are "within 5 days" and "within 14 days". This contact is to be documented in FACTS

within twenty-four (24) hours of completion of the contact. Documentation is to be pertinent and relevant to carrying out activities necessary to complete the initial assessment.

The initial assessment process, including all applicable documentation in FACTS, must be completed within thirty (30) calendar days from the day the referral is received. In order to complete the initial assessment process, in addition to the identified client, the caregiver (if applicable), current decision-makers (if applicable), potential decision-makers, involved family members, and all other relevant parties must also be interviewed.

2. Assessing Eligibility

In order for an individual to be eligible to receive health care surrogate services provided by the Department, the following criteria must be met. They must:

- be at least 18 years of age;
- be a resident of West Virginia or physically located within the state;
- have been determined by a qualified physician, qualified psychologist or advance practice nurse to lack decision making capacity;
- need assistance with health care decisions;
- have no known advance directive duly executed and in effect **or** an advance directive is in effect but it does not adequately meet the individuals needs; and
- have no known person who is willing and able to serve as health care surrogate.

Whenever the Department receives a request to serve as health care surrogate, the worker must thoroughly explore all individuals who may be able to serve in this capacity. This exploration is to include receipt of and review of information documented on the Appointment of Health Care Surrogate form about individuals who were previously contacted by the appointing medical professional to serve and the outcomes of those contacts. Any potential candidate is to be contacted by the medical professional prior to requesting appointment of the Department. Until written documentation is received and reviewed, the Department is not to accept appointment as health care surrogate. If there is any available candidate(s) who is willing and able to serve, the Department should encourage them to accept appointment rather than the Department being appointed. The Department should not accept appointment as health care surrogate if there is an appropriate candidate who is willing and able to serve.

West Virginia State Code specifies the individuals who are to be considered for appointment and the order of priority for consideration. The Department is not to be appointed until all potential candidates have been contacted. Individuals who are to be considered prior to appointment of the Department are:

- spouse;
- adult children;
- parent(s);
- adult siblings;
- adult grandchildren;
- close friends; and,

- any other person/entity, including but not limited to public agencies, public guardians, public officials, public and private corporations and other persons or entities which DHHR may from time to time designate (this is the category under which DHHR is authorized to serve)

Parties who may NOT serve as a health care surrogate include:

- treating health care provider of the individual;
- employees of the treating health care provider, not related to the individual;
- owner, operator or administrator of a health care facility serving the individual; and,
- employees of the owner, operator or administrator of a health care facility, not related to the individual (AFC, Medley, PCH, RB&C, Assisted Living, NH etc. are included in this category).

3. Decision-Making Capacity

Written documentation, completed by the adults physician, psychologist or advanced practice nurse, must be obtained during the initial assessment phase verifying that the client lacks the capacity to independently make health care decisions on his/her own behalf, to understand the consequences of those decisions and to act on these decisions to meet his/her needs. This determination of the client's decision-making capacity is to be documented in FACTS. Documentation must include information regarding a medical determination of incapacity.

For persons who are in need of treatment for mental illness or addiction, as opposed to treatment of physical needs, who have been determined by their attending physician or a qualified physician to be incapacitated, a second opinion by a qualified physician or psychologist that the person is incapacitated is required before the attending physician is authorized to select a surrogate.

4. Short-Term Service Planning

As the final part of the Initial Assessment, the social worker is to develop a short-term service plan. This is required if 1) a case will be opened for any social service **or** 2) a case will not be opened for any social service but there is some additional follow-up that is required in order to bring the initial assessment to resolution. Consideration is to be given to both short and long term planning including planning for eventual discharge from health care surrogate services as appropriate. The two situations when a short-term service plan is required are described below:

Department will provide social services beyond initial assessment:
In this situation, the short-term service plan is to briefly document the tasks that are to be accomplished in the immediate future. This plan should be of a very limited duration, and should in no instance exceed thirty (30) days. This plan will be in effect until the comprehensive assessment and regular service plan are completed.

Department will NOT provide social services beyond initial assessment:

In this situation, the short-term service plan is to document the tasks that have been accomplished during the initial assessment process. A brief statement of the task is to be documented on the plan (i.e. referral for in-home services, referral for home delivered meals, etc.). Specific information regarding a) who was contacted, b) when contact was made and c) the results of the contact(s) are to be made on the contact screen in FACTS. In this situation, the short -term service plan will end at the point the initial assessment is approved and closed.

Note: The short-term service plan is **primarily** intended to be a way for the worker to document what tasks the Agency has implemented/is going to implement until the initial assessment is completed or prior to completion of the regular service plan. This may also include tasks assigned to other parties. It is part of the initial assessment and does not require signatures.

5. Conclusion of Initial Assessment

The final step in the initial assessment process is to determine, based on the information gathered, whether or not health care surrogate services provided by the Department are needed and a health care surrogate services case opened. In order for a health care surrogate case to be opened, the adult must have been determined to meet the following criteria:

- be at least 18 years of age;
- be a resident of West Virginia or physically located within the state;
- have been determined by a qualified physician, qualified psychologist or advance practice nurse to lack decision making capacity;
- need assistance with health care decisions;
- have no known advance directive duly executed and in effect **or** an advance directive is in effect but it does not adequately meet the individuals needs;
- have no known person who is willing and able to serve as health care surrogate.
- have been determined by a qualified physician or advance practice nurse to be in need of a health care surrogate and have appointed the Department to serve; and,
- receipt by the Department of the completed Appointment of Health Care Surrogate form, which includes written verification of potential surrogates who were contacted prior to appointing the Department and the results of those contacts.

Note: Whenever the Department will be accepting appointment as health care surrogate, the original, signed Appointment of Health Care Surrogate form must be filed in the client's paper record and recorded in document tracking in FACTS. Faxed copies are not considered to be an original.

The following requirements apply regarding disposition of health care surrogate referrals/assessments:

- If the client meets all the eligibility criteria and the Department will be accepting appointment as health care surrogate, the case **MUST** be opened for health care surrogate services.

- Any time an individual is open in the FACTS system for multiple case types under Request to Receive Services, (i.e Adult Residential, Guardianship, Health Care Surrogate, Homeless), the case type with associated payments takes priority. If none of the case types have associated payments, and there is a Health Care Surrogate Case and Guardianship case open simultaneously, the Guardianship case will be the primary case type.
- If the worker is unable to complete an initial assessment for a legitimate reason (death of client, unable to locate/moved out of state, already an existing advance directive/surrogate decision-maker, etc) it should be recorded as an incomplete assessment in FACTS.

Note: If the Department is able to identify an individual who is willing and able to serve as health care surrogate during the course of completing the Initial Assessment, the assessment is to be completed and then closed without opening a case.

6. Initial Assessment Disposition Options

When the Initial Assessment is completed, all the information and findings are to be documented in FACTS. All areas identified as a problem area during the Initial Assessment process must be addressed on the service plan. The social worker will then submit the Initial Assessment, along with their recommendation about disposition of the assessment, to the supervisor for approval. The possible dispositions available to the social worker are:

- close the initial assessment and open a health care surrogate case;
- close the initial assessment and refer to other resources (internal/external to Department); or
- close the initial assessment with no additional action needed.

The disposition shall be based on all the information gathered during completion of the Initial Assessment. From this information, the social worker will determine eligibility of the client for health care surrogate services provided by the Department. Notification of the disposition is to be provided to the requester of services and the client by completion of the Notification of Application for Social Services (SS-13). When completed, a copy of this must be saved to the file cabinet in FACTS.

B. Comprehensive Assessment

A thorough assessment must be completed for each individual who is opened for health care surrogate services. In order to develop a detailed understanding of the client and his/her needs, a Comprehensive Assessment must be completed. For health care surrogate cases, information gathered while completing the Initial Assessment will carry forward into the case area of FACTS to create the first Comprehensive Assessment. The worker may also include additional information gathered during the Comprehensive Assessment. The social worker will use the information gathered during completion of the Comprehensive Assessment as the basis for the client's service plan. The Comprehensive Assessment screens will not necessarily reflect all of the information outlined in the following sections. It is, however, appropriate to gather all of the

following information as part of the assessment process. The information will be documented on the comprehensive assessment screens as well as various other screens in FACTS.

1. Time Frames

A Comprehensive Assessment, including the development of the service plan, must be completed for each individual who is opened for health care surrogate services. This assessment must be completed within thirty (30) calendar days following the date the case is opened. **A new Comprehensive Assessment must be completed annually**. Changes that occur in the client's circumstances before the next annual completion of the Comprehensive Assessment, are to be documented as a modification to the existing Comprehensive Assessment and are to be documented within forty-eight (48) hours of the time the worker becomes aware of the change.

2. Information To Be Collected

Identifying Information

Demographic information about the client, his/her family and his/her unique circumstances is to be documented. Information about individuals with whom the client has a relationship should be documented on the client screens and/or on the collateral screens as appropriate. This includes information such as: (not an all inclusive list)

- name;
- address (mailing and residence);
- date of birth/age;
- household members;
- other significant individuals;
- current legal representatives/substitute decision-makers (if applicable);
- potential decision-makers and indication of their willingness to serve;
- identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);
- gender/ethnicity;
- marital status;
- advance directives in effect; and,
- directions to the home.

Services Requested

Document the specific service(s) being requested. This should include information such as the following:

- the specific type(s) of assistance being requested;
- why assistance is being requested;
- how are needs currently being met; and,
- other relevant information

Living Arrangements

Document information about the client's current living arrangements. This should include information about where the client currently resides such as the following:

- client's current location (own home, relative's home, hospital, etc);

- is this setting considered permanent/temporary;
- type of setting (private home/residential facility);
- household/family composition;
- physical description of residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);
- interior/exterior condition of the residence;
- type of geographic area (rural, urban, suburban, etc.);
- access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational, religious affiliations, etc.

Client Functioning

Document information about the client's personal characteristics. This should include information about how the client's personal needs are currently met, including an assessment of their strengths, needs and supports in areas such as:

- activities of daily living (ADL);
- whether or not his/her needs are currently being met and by whom;
- caregiver functioning, if applicable;
- ability to manage finances;
- ability to manage personal affairs;
- ability to make and understand medical decisions; and
- assessment of decision-making capacity.

Physical/Medical Health

Document information about the client's current physical and medical conditions. This should include information about their physical condition, a description of the client as observed by the worker during face-to-face contact, and information about his/her diagnosed health status. Included are areas such as:

- observed/reported physical conditions of the client;
- primary care physician;
- diagnosed health conditions;
- current medications;
- durable medical equipment and supplies used/needed; and
- nutritional status.

Mental/Emotional Health

Document information about the client's current and past mental health status. This should include information about how the client is currently functioning, his/her current needs and supports, and his/her past history of mental health treatment involvement, if applicable. Included are areas such as:

- current treatment status;
- current mental health provider, if applicable;
- mental health services currently receiving;

- medication prescribed for treatment of a mental health condition;
- observed/reported mental health/behavioral conditions; and,
- mental health treatment history.

Financial Information

Document information about the client's current financial status. This should include information about the client's resources and their ability to manage these independently or with assistance. Included are areas such as:

- financial resources - type and amount;
- other resources available to the client - non-financial;
- assets available to the client;
- health insurance coverage;
- life insurance coverage;
- pre-need burial agreement in effect;
- information about client's ability to manage his/her own finances;
- outstanding debts/expenses;
- court ordered obligation for child support/alimony; and
- how/by whom finances are managed if client is unable to do so.

Educational/Vocational Information

Document information about the educational/vocational training the client has received or is currently receiving. This should include information such as:

- last grade completed;
- field of study;
- history of college attendance/graduation;
- history of special licensure/training; and,
- current educational/training needs.

Employment Information

Document information about the client's past and present employment such as:

- current employment status;
- current employer;
- prior employment history; and
- current employment needs.

Military Information

Document information about the client's military history, if applicable. This should include information such as:

- branch of service;
- type of discharge received;
- service related disability, if applicable; and,
- veteran's eligibility for benefits (contact local veteran representative).

Legal Information

Document information about the client's current legal status. This should include information about all known legal representatives, and the specific nature/scope of the relationship. This should include information such as:

- assessment of client's decision-making capacity by the social worker;
- information about legal determination of competence, if applicable;
- information about efforts to have client's decision-making capacity formally evaluated; and
- identification of specific individuals who assist the client with decision-making (formal and informal).

3. Conclusion of Comprehensive Assessment

When the Comprehensive Assessment is completed, all the information and findings are to be documented in FACTS. This, along with the service plan that was developed as a result of the assessment findings, is then to be submitted by the social worker to the supervisor for approval. Areas identified as problematic during the initial Assessment and Comprehensive Assessment processes are to be addressed on the service plan.

III. Case Management

Case management is the ongoing service provided by the Department for clients who have been opened for health care surrogate services. It consists of identification of client strengths and problem areas, identification of appropriate services and resources to address the identified problems, referral of the client to appropriate service agencies, and coordination of service delivery. In addition, the Department as health care surrogate is responsible for making decisions related to health care matters for the adult.

A. Appointment of the Department as Health Care Surrogate

Whenever an individual's ability to make health care decisions is impaired to such a degree that they are no longer able to make these decisions on their own behalf without assistance, appointment of a health care surrogate may be necessary to aid them in the decision-making process. Appointment of a health care surrogate must be made by a qualified physician or advanced practice nurse who has personally examined the adult and determined that they lack the capacity to make health care decisions on their own behalf. West Virginia State Code identifies the individuals who may be considered to be appointed in priority order. The Department may be appointed only if there is no one else who is able and willing to serve as health care surrogate.

For persons who are in need of treatment for mental illness or addiction, as opposed to treatment of physical needs, who have been determined by their attending physician or a qualified physician to be incapacitated, a second opinion by a qualified physician or psychologist that the person is incapacitated is required before the attending physician is authorized to select a surrogate.

If the adult has one or more advance directive in effect that adequately addresses their decision-making needs, it is NOT appropriate for the Department to be appointed health care surrogate. If it is believed that the designated decision-maker(s) is not adequately addressing the adult's decision-making needs, it may be appropriate to explore appointment of an alternate decision maker. If so, the reason(s) for seeking a change in decision-maker must be clearly documented. It may be appropriate for the appointing medical professional to seek appointment of another decision maker if:

- the current decision maker is no longer physically/mentally able to carry out their responsibilities
- the current decision maker is not acting in the best interest of the adult; or,
- the adult's decision making needs cannot be met by appointment of only a health care surrogate.

It is NOT appropriate to seek an alternate decision-maker solely because the physician or other family members are not in agreement with decisions made by the authorized decision maker. Whenever there are disagreements among family members, decision-makers, or others, the physician is to arbitrate to reach a solution.

Advance Directives, such as Medical Power of Attorney , Durable Power of Attorney with health care decisions, and/or Living Wills, take precedence over health care surrogate appointment. If, in the opinion of the medical professional, decisions are not being made in the best interest of the client, the medical professional should first attempt to arbitrate to resolve the issues. If this can not be accomplished, these instruments require court action to terminate before a health care surrogate may be appointed. It is the medical professionals responsibility to seek legal intervention. (See Resolving Conflicts Between Advanced Directives for additional information)

Note: While determination of incapacity may be done by one or more of the following, a qualified physician, a qualified psychologist, or an advance practice nurse, actual appointment of a health care surrogate may only be done by a qualified physician or advance practice nurse. A second opinion is only required if treatment for mental illness and/or addiction will be needed.

1. Process for Appointment

When the Department is requested to accept appointment as health care surrogate, the Appointment of Health Care Surrogate form must be completed by a qualified physician or advanced practice nurse who has personally examined the adult. This form must be completed and received prior to the Department accepting appointment as health care surrogate. The Department will not accept a verbal appointment as health care surrogate.

Note: the Appointment of Health Care Surrogate form is available as a DDE in FACTS)

2. Explore all potential candidates prior to DHHR accepting appointment

As an ongoing part of case monitoring and review, the worker must thoroughly explore all individuals they become aware of who may be able to serve in this capacity. Any potential

candidate is to be contacted by the worker to determine if they are willing and able to serve. If so, the Department should encourage them to accept appointment rather than the Department continuing to serve in this capacity. The Department should not continue to serve as health care surrogate if there is an appropriate candidate who is willing and able to serve.

West Virginia State Code specifies the individuals who are to be considered for appointment and the order of priority for consideration. The Department is not to be appointed until all potential candidates have been contacted. Individuals who are to be considered prior to appointment of the Department are, in order of priority:

- spouse;
- adult children;
- parent(s);
- adult siblings;
- adult grandchildren;
- close friends; and,
- any other person/entity, including but not limited to public agencies, public guardians, public officials, public and private corporations and other persons or entities which DHHR may from time to time designate (this is the category under which DHHR is authorized to serve)

While the physician must consider potential candidates in the order listed, they may actually appoint an individual at a lower level if the physician believes that the appointee is better qualified to serve as health care surrogate. When this occurs, the physician must document that an individual was passed over and the reason for this.

Parties who may NOT serve as a health care surrogate are:

- treating health care provider of the individual;
- employees of the treating health care provider, not related to the individual;
- owner, operator or administrator of a health care facility serving the individual; and,
- employees of the owner, operator or administrator of a health care facility, not related to the individual (Adult Family Care, Medley, Personal Care Home, Residential Board & Care, Assisted Living, Nursing Home etc. are included in this category).

3. Responsibility of the Worker

Prior to accepting appointment

- Complete Initial Assessment - within thirty (30) days of receipt of referral;
- Determine if it is appropriate for the Department to be appointed as health care surrogate;
- Request completion of Appointment of Health Care Surrogate form by a qualified physician;
- Contact all potential candidates to re-assess their willingness/ability to serve to the extent possible;

- Complete all documentation in FACTS;
- Submit Initial Assessment to supervisor for approval; and,
- If the Department is going to accept appointment, open the case in FACTS;.

Note: The tasks generally are listed in the order in which the worker would complete them however, there may be some that will be completed simultaneously such as in a situation where an emergency situation exists and appointment is needed immediately, the worker may be working on completion of the Initial Assessment and review of the Appointment of Health Care Surrogate form at the same time.

Following appointment

- **Complete Comprehensive Assessment within 30 days of opening the health care surrogate case;**
- Complete the Service Plan to be submitted to the supervisor along with the Comprehensive Assessment;
- Maintain ongoing contact with client, their family and friends to gather additional information about the client's wishes and to assess for other individuals who may be able to serve instead of the Department; and,
- Monitor the case on an ongoing basis.

4. Responsibility of the Supervisor

The supervisor is responsible for ensuring that applicable policies and procedures are followed. To do so, the supervisor must:

- Review and approve Initial Assessment;
- Approve case connect in FACTS if a case is to be opened;
- Sign/authorize the signing of the Appointment of Health Care Surrogate to authorize the Department to be appointed; and,
- Review and approve Comprehensive Assessment(s), Reviews and Service Plan(s).

5. Appointment for individuals in state operated facilities

When a substitute decision-maker is needed for an adult in one of these facilities, it is the responsibility of the facility to locate and arrange for a suitable decision-maker. In doing so, the facility is expected to explore all potential individuals and entities who may be able to serve in a decision-making capacity and to document the results of these efforts. As with individuals in other settings, the Department may be appointed to serve as health care surrogate only after it has been determined that there is no one who is willing and able to serve in this capacity. State operated psychiatric facilities include Sharpe Hospital and Mildred Mitchell Bateman Hospital. State operated long term care facilities include Pinecrest Hospital, Hopemont Hospital, Lakin Hospital, Marion Health Care Hospital, and Welch Emergency Hospital.

The worker is to explore suitable alternative individuals/entities to serve as health care surrogate on an ongoing basis in all instances where the Department is appointed to serve in this capacity. This is to be done as part of the case review process, and if a suitable alternate health care

surrogate is identified, the worker should request to have the other party appointed instead of the Department.

B. Service Planning

Following completion of the first comprehensive assessment process, a service plan must be immediately developed to guide the provision of services in the ongoing stage of the case, and should give consideration to both short and long term planning, including planning for eventual discharge from health care surrogate services as appropriate. The service plan is to be updated at least every six months in conjunction with the case review. Service planning must be primarily directed toward meeting the needs of the adult. In developing a service plan, consideration should be given to the major health care service needs that exist as well as the strengths and capabilities of the adult, their expressed wishes and personal values, if known, and their best interest if their personal wishes are not know and can not be determined. Based on the circumstances, it may also be appropriate to include a plan to reduce risk and assure safety of the adult.

Development of the service plan is to be based on the findings and information collected during the assessment/evaluation processes (i.e. initial assessment, comprehensive assessment, case review). Based on the information gathered, goals must be identified and set forth in the service plan. These will provide the milestones for assessing progress and success in the implementation of the plan. The service plan provides a written statement of the goals and desired outcomes related to the conditions identified through the assessment processes. **Each area identified in the Initial Assessment as a "problem area" must be addressed in the service plan.**

Development of the service plan is to be a collaborative process between the social worker, the client, and others such as financial representative, significant family members/others, residential provider and service providers. For adults who are in a supervised living setting, the adult may have more than one plan directing their care. The plan between the Department, the adult and other relevant parties is to specifically address the goals and objectives related to carrying out the duties as health care surrogate. This may include tasks such as referral, linkage and follow-up with appropriate health related resources, addressing medical/treatment needs not addressed by others, and others related to health care needs. It is not necessary to duplicate the details contained in the facility/agency plan but the Department's plan should address whether or not the facility/agency meets the adult's needs. A copy of the facility/agency plan should be filed in the client's paper record and it's location recorded in document tracking.

The service plan is to be reviewed on an ongoing basis and updated at least every six (6) months in conjunction with the formal case review process. In addition, the service plan may be updated more frequently as appropriate. Those individuals who were involved in the development of the Department's service plan should also be involved in making changes/modifications to the plan.

Document the details of the service plan in FACTS, clearly and specifically delineating the plan components. When completed, forward the service plan to the appropriate supervisor for approval. After review by the supervisor, a copy of the service plan is to be printed and required

signatures obtained. In the event an individual refuses to sign or is unable to sign, the worker should make a notation explaining why the signature was not obtained. Required signatures include the client or his/her legal representative(s), (if applicable), a representative from the supervised living setting, (if applicable) and all other responsible parties identified in the service plan. The signed copy is then to be filed in the client record and it's location documented in FACTS. A copy of the completed, signed service plan is to be provided to all of the signatories.

Note: The service plan is available as a DDE in the reports area of FACTS.

1. Inclusion of the Incapacitated Adult in Service Planning:

Inclusion of incapacitated adults in the service planning process presents the social worker with some unique challenges. Although determined to lack decision-making capacity, the client may have the capacity to participate in the development of the service plan and should be permitted and encouraged to participate in its development to the extent they are able, including signing of the completed document. Some special considerations for the social worker include the following:

- The health care surrogate is charged with the responsibility of acting in accordance with the known or expressed wishes and values of the adult to the extent possible, and when their wishes and values are not known, acting in their "best interest". When the "best interest" of the adult is in conflict with the their expressed wishes, **the final decision on health care matters rests with the health care surrogate and should take into consideration the client's values, strengths, and limitations**.

- When the Department has been appointed to serve as health care surrogate and the adult also has a financial decision-maker (conservator, representative payee, etc.) this representative must be respected as the spokesperson for the client's financial matters. Generally, their consent must be obtained in financial matters included on the service plan. If it appears that the acting or appointed financial decision-maker is unwilling or unable to fulfill their obligations, which negatively impacts the provision of needed health care for the client, the service plan must address seeking a change in the client's financial decision-maker.

- When the client has an ongoing informal support that will be continuing as part of the service plan (e.g. relative, neighbor, friend, etc), this individual should be included in the service planning process and may sign the service plan. The relationship of the informal representative is to be documented in the client record.

The situations listed above are the most likely to occur and require consideration by the social worker. Variations, however, may occur and could require consultation between the social worker and his/her supervisor to determine the most appropriate approach.

2. Determining the Most Integrated Level of Intervention:

In the provision of services to adults, the principle is well established both in law and policy that the least intrusive means of intervention should always be used. When applying this principle to individual situations there is some discretion in determining the appropriateness of the manner in which the Department intervenes in the life of the client and the level of care/assistance required in order to meet the client's needs. Intervention is to begin with the least intrusive approach that is appropriate to meet the client's needs. Intervention is to move from the least intrusive to the most intrusive option(s).

The principle of most integrated intervention requires a commitment to the maximum level of self-determination by the client. The client should be permitted and encouraged to participate in the decision-making process to the extent of their ability. Substitute decision-makers should participate within the scope of their authority. The service plan is used to document these choices and to ensure the integrity of the decision-making process.

It is important to clearly document the efforts made to assure the most integrated /least restrictive level of intervention. In the event these efforts are unsuccessful, this fact and the reason(s) they were not successful must also be clearly documented in the case record.

3. Required Elements - General:

The service plan must contain all the following components in order to assure a clear understanding of the plan and to provide a means for assessing progress.

- specific criteria which can be applied to measure accomplishment of the goals;
- specific, realistic goals for every area identified as a problem, including but not limited to those identified through the assessment processes. This will include identification of the person(s) for whom the goal is established, person(s)/agency (including DHHR when applicable) responsible for carrying out the associated task(s), identification of services, and frequency/duration of services;
- specific tasks which will be required in order to accomplish the goal. These are tasks or activities that are designed to help the client progress toward achieving a particular goal and should be very specific and stated in behavioral terms (specifically stating what action is to occur e.g. Mary Jones will attend physical therapy at least once weekly in accordance with physician's order to improve mobility and ambulation skills.). These tasks should be monitored frequently; and
- identification of the estimated date for goal attainment, if applicable. This is a projection of the date that the worker and the client expect that all applicable tasks will be achieved, that minimal standards associated with change will have been attained.

Other important considerations for the service planning process are:

- the client's real and potential strengths;
- client's known and expressed wishes and values;
- attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the service plan;
- the circumstances precipitating involvement by the Department;

- availability/accessibility of client resources, including human resources such as family and friends; and,
- levels of motivation.

G. Decision-Making for the Incapacitated Adult

A health care surrogate is responsible for making health care decisions, in consultation with the adult to the extent possible. Decisions are to be made in accordance with the individual's personal wishes and values when known and in accordance with their best interest when their wishes and values are not known and can not be reasonably determined. An assessment of the person's best interest is to include consideration of the following:

- the person's medical condition;
- the person's prognosis;
- the person's personal dignity and uniqueness;
- the possibility and extent of preserving the person's life;
- the possibility of preserving, improving or restoring the person's functioning;
- the possibility of relieving the person's suffering;
- the balancing of the burdens to the benefits of the proposed treatment or intervention; and
- other such concerns or values as a reasonable individual in the person's circumstances would wish to consider

The Department's authority as health care surrogate officially begins upon acceptance of the appointment. Whenever the health care surrogate is called upon to make difficult decisions, such as complex medical decisions and end-of-life decisions, the worker should do so in consultation with the supervisor. The authority of the health care surrogate ends immediately upon the death of the incapacitated adult **except** with regard to certain decisions. Specifically, they are permitted to assist with decisions regarding funeral and burial/cremation arrangements, organ and tissue donation, autopsy, etc.

Note: Decision-making for another individual is a difficult and delicate process. In carrying out the Department's responsibilities as health care surrogate, it is important for the decision-maker to ensure that decisions being made on behalf of the incapacitated adult are a reflection of the individual's values and beliefs rather than those of the worker.

Health care decisions that the surrogate may be involved in include the following:

- placement in/discharge from a medical/treatment setting;
- medical services/treatment required to address health care needs (hospital, psychiatric facility, ambulatory health care, physician's office, clinic, hospice, home health care, etc.);
- health care to be provided and/or withdrawn;
- authorization, withholding or withdrawal of life prolonging interventions;

- authorization of placement in a nursing facility or other health care setting appropriate to meet health care needs (extended care facility operated in connection with a hospital, private psychiatric hospital, nursing home, rehabilitation center, ICF/MR, etc.);
- decisions related to autopsy, organ/tissue donation, burial/cremation, and funeral arrangements AFTER the incapacitated adult is deceased (to the extent possible preparation for this should be discussed with the adult and plans made and documented in advance to ensure that the person's wishes are known and carried out);
- signing for release of the body to the funeral home;
- signing to authorize the funeral arrangements; and,
- authorize the release of medical records to third parties for placement, billing, treatment planning, provision of care, etc.

Note: Anytime the Department, as health care surrogate, signs any document, it must include a disclaimer that clearly states that the Department is not accepting any financial responsibility for these arrangements. Signature should be "West Virginia Department of Health and Human Resources by (worker's name)".

The health care surrogate may NOT make decisions in the following areas:

- decisions regarding services that are not related to addressing the adult's health care/medical needs;
- authorization of placement in/discharge from residential (non-health care) settings. This includes Adult Family Care, Residential Board and Care, Personal Care Homes, Specialized Family Care homes (Medley), etc;
- authorization of placement in Mildred Mitchell Bateman and Sharpe Hospitals (requires commitment proceeding to do involuntary placement in these settings); and,
- financial decisions.

Note: Though the health care surrogate has decision making authority for health care matters, there are limits to what a health care surrogate can do. Specifically, appointment of a health care surrogate can not GUARANTEE that the adult will be compliant with a recommended course of treatment and/or medical care. While the health care surrogate does have a responsibility to authorize appropriate care/treatment, and to educate the adult to the extent possible about the benefits and consequences of compliance/failure to comply, they can not force the adult to exercise good judgment, take medications as prescribed, comply with medical procedures, etc. Also, as the incapacitated adult's authorized representative the Department does have access to the health information necessary to carry out our responsibilities as health care surrogate [HIPAA Privacy Rule *45 CFR. I64.502(g)*]

1. Placement Decisions

The health care surrogate will be involved in making decisions regarding living arrangements/placement on behalf of the adult only when these decisions relate to placement in or discharge from a health care/treatment facility or program. As with all decisions made by the health care surrogate, the known and expressed wishes and values of the adult are to be considered when making these decisions. Examples of health care/treatment settings include:

- extended care facility operated in connection with a hospital;
- private psychiatric hospital;
- nursing home;
- rehabilitation center;
- ICF/MR Group Home.

While the health care surrogate is to be an active participant in determining the most appropriate health care/treatment placement option for the client and can authorize placement in this type of setting when appropriate, it is not solely the health care surrogate's responsibility to find the health care/treatment setting. It is appropriate for the health care surrogate to authorize the placement in this type of setting. The Department as health care surrogate is not to authorize placement in or discharge from any setting that is not a health care setting.

2. Medical Decisions

The authority of the health care surrogate is limited to making medical and health care related decisions on behalf of the incapacitated adult. As with all decisions made by the health care surrogate, the known and expressed wishes and values of the individual, and quality of life achieved or maintained by provision of care/treatment are to be considered when making these decisions. In addition, if the adult has one or more advance directives, such as a DNR, Living Will, or other documents that express the adult's personal wishes, medical decisions of the health care surrogate will be guided by these documents to the extent applicable. Examples of medical decisions that the health care surrogate may be called upon to make include decisions regarding the following. This is not intended to be an all inclusive list:

- routine medical care;
- emergency medical care;
- life prolonging measures;
- admission to/discharge from medical treatment facility (NH, ICF/MR, acute care hospital, psychiatric hospital, substance abuse treatment facility, etc);
- release of medical records;
- behavioral health services;
- therapeutic treatment; This form must be completed and signed by the attending physician. The worker should not complete the form but it would be appropriate for him/her to sign the completed form as the legal representative if the Department has been appointed as the guardian or health care surrogate..
- home health services; and,
- hospice care.

Some medical decisions can be very difficult to make, particularly when the adult is unable to communicate their wishes and their wishes/values are not known by the health care surrogate. Examples might include amputation of a limb, placement of an artificial feeding device, placement on/removal from a ventilator, exploratory surgery, medications, blood transfusions, etc. In these instances, an ethics consult may be necessary. Many times the health care facility providing treatment will have an internal ethics committee to assist with these decisions. If an

internal ethics committee is not available, or if the worker is not comfortable with the recommendation of the facility's internal committee, an ethics consultation may be requested by contacting the Office of Social Services, Adult Services specialist. (See Ethics Consultations for detailed information)

Note: When the Department is the health care surrogate, completion of the POST form by the physician/medical provider to document the existence of advance directives, medical decision-makers, etc. is to be encouraged. This form must be completed and signed by the attending physician. The worker should not complete the form but it would be appropriate for him/her to sign the completed form as the legal representative if the Department has been appointed as the guardian or health care surrogate. In addition, as the incapacitated adult's representative, the Department does have access to the health information necessary to carry out responsibilities as health care surrogate [HIPAA Privacy Rule *45 CFR. 164.502(g)*]

3. End of Life Decisions

The health care surrogate may be involved in making decisions on behalf of the adult regarding end of life care. As with all decisions made by the health care surrogate, the known and expressed wishes and values and quality of life achieved or maintained by provision of care/treatment of the adult are to be considered when making these decisions. In addition, if the adult has one or more advance directive, such as a DNR, Living Will, or medical power of attorney, end of life decisions of the health care surrogate will be guided by these documents to the extent applicable. Decisions that the health care surrogate may be called upon to make include the following:

- palliative care/comfort measures [pain management, etc.];
- use/removal of life support;
- organ/tissue/body donation;
- agreeing to a DNR (no code) when one does currently exist; and,
- arrangements regarding burial/cremation, funeral, etc.

End of life decisions can be very difficult to make, particularly when the adult is unable to communicate their wishes and their wishes/values are not known by the health care surrogate. Examples might include placement of an artificial feeding devise, placement on/removal from a ventilator, etc. In these instances an ethics consult may be necessary. Many times the health care facility providing treatment will have an internal ethics committee to assist with these decisions. If an internal ethics committee is not available, or if the worker is not comfortable with the recommendation of the facility's internal committee, an ethics consultation may be requested by contacting the Office of Social Services, Adult Services specialist. (See Ethics Consultations for detailed information)

While the health care surrogate is authorized to make certain decisions after the adult is deceased, it is essential that the worker discuss funeral arrangements and preferences with the adult, their family (when applicable), and the conservator (if applicable) in advance and facilitate the pre-need burial arrangement if possible. If the personal wishes of the adult are not known regarding organ, tissue, or body donation, donation will not be authorized by the Department.

Note: The Department SHALL NOT routinely authorize a DNR. Each individual situation must be considered thoroughly to determine if this is appropriate and supervisory approval must be obtained prior to signing a DNR.

4. Resolving Conflicts Between Advance Directives

There may be times when advanced directives are in conflict with one another or with decisions being made on behalf of the incapacitated adult. When a conflict exists, the following rules apply.

- Generally, directives set forth in a Medical Power of Attorney or Living Will are to be followed since these are the personal expression of the adult's wishes, executed prior to their becoming incapacitated;
- If there is a conflict between the adult's expressed wishes and the decisions made by the Medical Power of Attorney or Health Care Surrogate, the adult's expressed wishes are to be followed;
- If there is a conflict between two written advance directives executed by the adult, the one most recently completed takes precedence, but only to the extent needed to resolve the inconsistency; and,
- If there is a conflict between decisions of the Medical Power of Attorney or Health Care Surrogate and the adult's "best interest" as determined by the attending physician when the adults expresses wishes are unknown, the attending physician is to attempt to resolve the conflict by consulting with a qualified physician, an ethics committee or other means. If the conflict can not be resolved, the attending physician may transfer the care of the adult to another physician.

5. Financial Decisions

The financial situation of the adult can directly impact decisions made by the health care surrogate, however, the health care surrogate **is not** authorized to make financial decisions. Because the adult's financial situation is inter-related with the ability to meet their needs, it is essential that the health care surrogate work closely with the financial representative, whether a conservator, payee, trustee, etc., as decisions are being made. Whenever a goal on the adult's service plan will require expenditure of funds, and there is a financial representative for the adult, the goal must be approved by conservator/payee, etc. as applicable.

Anytime the Department, as health care surrogate, signs any document, it must include a disclaimer that clearly states that the Department is not accepting any financial responsibility for these arrangements. Signature should be "West Virginia Department of Health and Human Resources by (worker's name)".

Note: The Department as health care surrogate *may not* make application for benefits (SSA/SSI, Medicaid -application and reviews, Veterans Benefits, Medicaid Waiver services, etc).

6. Ethics Consultation

Making decisions for another person can be very demanding and difficult. The responsibility for making these decisions becomes more difficult when the health care surrogate does not have benefit of personal knowledge of the adult and the adult is no longer able to communicate their personal preferences. Most difficult of all, are those decisions related to dramatic life changing, medical procedures, and end of life care. Examples might include amputation of a limb, placement of an artificial feeding devise, placement on/removal from a ventilator, exploratory surgery, etc. In these instances an ethics consult may be necessary to aid the health care surrogate in making these decisions. Many times the health care facility providing treatment will have an internal ethics committee to assist with these decisions. If an internal ethics committee is not available, or if the worker is not comfortable with the recommendation of the facility's internal committee, an ethics consultation may be requested by contacting the Office of Social Services, Adult Services specialist.

The worker is encouraged to seek an ethics consultation when:

- the adult who has some degree of decision-making capacity will not agree to follow the course of action recommended by the health care surrogate and other professional (as applicable) and by not doing so may cause significant harm to him/herself or others;
- an impasse has been reached by local professionals on an ethical problem concerning the adult;
- a close relative or other interested party with a legitimate interest in the adult but who is not an authorized substitute decision-maker disagrees with a significant decision to be made by the worker;
- a decision must be made which is very unusual, unprecedented, or very complex ethically; or,
- a decision needs to made about whether or not to withhold or withdraw life-sustaining medical treatment for a client who totally lacks capacity and whose wishes and values are not well enough known to predict what the client would choose.

An ethics consultation may be initiated by the supervisor after consultation with the worker. Requests for consultation should be made by contacting the Adult Services Specialist in the Bureau for Children and Families serving the region where the incapacitated adult resides. It should be noted that decisions of the ethics committee are recommendations. The final decision rests with the Department as health care surrogate.

Consultation Protocol:

- the worker/supervisor will complete the Ethics Consultation Intake Tool and the supervisor will submit it to the Adult Services Specialist. Any other necessary information may be attached as well, as appropriate. This completed form may be faxed if necessary. The Adult Services Specialist will notify other members (at least one) of the Ethics Consultation Service group that a consultation has been requested and provide them, by fax if necessary, the information provided by the worker making the request.
- If possible, the specialist will arrange a conference call in order to discuss the consultation request. The worker/supervisor making the request, as well as any other

relevant local individuals, should participate in this call. If it is not possible to arrange a conference call, then:

- The specialist will discuss the consultation request with the members of the Ethics Consultation Service group and record their responses. More than one call to each member may be necessary. The resulting recommendation will be provided to the worker requesting the consultation.
- The Specialist will prepare an Ethics Consultation Summary documenting the consultation request and summarizing the consensus of the Ethics Consultation Service group members. This summary will be shared with the full Guardianship Ethics Committee at their next regularly scheduled meeting. To the extent possible, confidentiality shall be maintained by not identifying by name the client for whom the consultation was requested

7. Foster Care Youth turning 18

There may be times when a youth in foster care will need to be transitioned to the adult services system. This determination will be made based on the results of a thorough assessment of the youth while a foster child. Specifically, before it is decided that a youth will need to be transitioned to the adult services system, the foster care worker is to ensure that the following is completed:

- Administration of the Daniel Life Skills Assessment - this assessment tool is to be administered initially within sixty (60) days of the youth's fourteenth (14) birthday. Thereafter, it is to be re-administered bi-annually until permanency for the youth is achieved or the youth is discharged from foster care. This ongoing assessment is to provide a continuous evaluation of the youth's progress toward established permanency goals and barriers encountered.
- Development of a personalized transition plan - based on the results of the Daniel Life Skills Assessment. When the plan is for the youth to transition into the adult services system upon turning age eighteen (18), this must be clearly documented in the transition plan including the steps necessary to achieve a smooth transition.
- Use of the Phillip Roy Life Skills curriculum to continuously evaluate and measure progress and readiness in the areas of functional capabilities and mastery of core life skills areas.

If a youth is not progressing through the Phillip Roy Life Skills curriculum or the Special Needs curriculum, a comprehensive psychological evaluation, including an assessment of the youth's potential for independence when they reach adulthood, is to be obtained by the foster care worker.

At the point the determination is made, based on all of the identified assessment instruments, that self-sufficiency is not an appropriate goal for the youth and that transitioning to the Adult Services system is the likely goal, the foster care worker must begin planning for this transition. When the youth reaches age seventeen (17) the foster care worker must contact the local Adult Services staff to initiate their involvement in the case. The Adult Services worker must consult with their supervisor who will determine the appropriate action. Participation of the Adult Services staff at this point will be informal with the foster care worker retaining responsibility for

the case. The role of the Adult Services staff at this point will be limited to the following, for the purpose of meeting the youth and becoming familiar with their circumstances, needs and personal preferences:

- attendance at the youth's multi-disciplinary treatment team meetings;
- participation in scheduled case staffing; and,
- participation in the case review process.

Once the youth reaches age 17 years, 6 months, and if the plan continues to include transitioning to Adult Services and the Adult Services worker has an active role in implementing the youth's service plan, the Adult Services worker may become a secondary worker on the foster care case. The adult service worker should review the Daniels Life Skills and Phillip Roy Assessments that were previously completed to become familiar with the needs of the youth. From this point on, the foster care worker and the adult services worker should work jointly in planning for the youth's entry into adulthood and exit from foster care. Prior to the youth's 18th birthday, the Adult Services worker should request that the physician or advanced practice nurse complete the Appointment of Health Care Surrogate form to ensure that all possible candidates are considered prior to the Department being appointed to act as health care surrogate. Until the youth is discharged from foster care, the foster care worker will retain responsibility for the case. (see the Foster Care policy, Transition to Adult Care for detailed information)

When it is determined that a health care surrogate will need to be appointed for a youth who is transitioning from foster care into Adult Services, **a health care surrogate intake must be completed when the youth reaches age 18 years of age**. The health care surrogate intake/case is to be separate from the foster care case. However, the health care surrogate case and foster care cases should be associated in FACTS to show the relationship between the two and to maintain access to necessary information contained in the foster care case. Opening the health care surrogate case will involve completion of an intake, completion of the Initial Assessment and completion of case connect in FACTS.

8. In state/out of state Appointments

Health Care Surrogate Appointed in a State Other than West Virginia

When a incapacitated adult becomes a resident of West Virginia and the health care surrogate resides in another state or was appointed in another state, the existing health care surrogate may continue to serve if the appointment was executed in accordance with the laws of West Virginia or the state in which the appointment was made. If the existing health care surrogate wishes to transfer appointment to West Virginia, they should request appointment of a new health care surrogate by the adult's physician in West Virginia in accordance with West Virginia law. (See §16-30 of the West Virginia code). Generally, the Department will not be involved in these situations unless the Department is being appointed health care surrogate.

Incapacitated Adult Moves Out of State

The Department is **not** to retain the heath care surrogate appointment for an incapacitated adult who no longer resides in the state of West Virginia. Whenever the incapacitated adult is

transferring out of state, the worker must provide written notification to the medical professional who appointed the Department as health care surrogate and the client that we will no longer be able to serve. After completion of all notifications and the final assessment, the health care surrogate services case is to be closed.

D. Case Review

Evaluation and monitoring of the health care surrogate case and the progress being made should be a dynamic process and ongoing throughout the life of the case. Frequent monitoring is essential in order to ensure that the client's needs are adequately met and to make alternate arrangements in a timely manner as appropriate.

1. Purpose*:*

The purpose of case review is to first evaluate the client's functioning, needs, and capabilities and second, to consider and evaluate progress made toward goals and objectives set forth in the service plan. The social worker must consider issues such as progress made, problems/barriers encountered, effectiveness and continued appropriateness of the current plan in addressing the identified problem areas, and whether or not modifications/changes are indicated including whether or not a health care surrogate continues to be needed. An informal review is to be completed at each face-to-face contact with the client and a formalized review completed at six (6) month intervals.

2. Time Frames:

When a health care surrogate case is first opened, maintaining frequent contact with the adult is essential in order to establish a relationship between the worker and the adult as well as to provide an opportunity for the worker to monitor the their functioning and assess for additional needs. In order to do so effectively, the worker is to have frequent face-to-face contact with the adult.

Incapacitated Adult Resides in Community

For individuals living in a community setting, face-to-face contact should be made at least once weekly during the first month. Thereafter, the worker must have face-to-face contact with the adult at least once monthly. This is the minimum standard. Workers are strongly encouraged to have more frequent contact. The need for more frequent contact with the client should be determined based on the their unique needs and circumstances. These contacts are to be documented in FACTS within twenty-four (24) hours of completion of the contact. Documentation is to be pertinent and relevant to carrying out the activities set forth in the service plan.

Incapacitated Adult Resides in a Supervised Placement

For individuals living in a supervised placement setting, face-to-face contact should be made at least once during the first month. Thereafter, the worker must have face-to-face contact with the adult at least every ninety (90) days. This is the minimum standard. These contacts are to be documented in FACTS within twenty-four (24) hours of completion of the contact. Workers are

strongly encouraged to have more frequent contact. The need for more frequent contact with the client should be determined based on the their unique needs and circumstances.

Whenever there is an open health care surrogate case and adult residential services case, efforts should be made by the workers to coordinate visits with the client whenever possible. Supervised settings include:

- Adult Family Care;
- Assisted Living (RB&C and PCH);
- Nursing Homes;
- ICF/MR Group Home;
- MR/DD Waiver Group Home;
- Specialized Family Care Home (Medley); and,
- Others.

Regardless of where the adult resides, at a minimum, formalized case review must occur at six (6) months following opening of the health care surrogate case and again at six (6) months intervals thereafter until case closure. The worker should review the case record prior to initiation of the case review. The service plan and other applicable areas of the case record are to be updated as part of each six (6) month review process and between reviews if circumstances warrant. Any time there is a significant change in the client's circumstances, these are to be documented. This documentation is to include any changes necessary in the service plan and any modifications to the Comprehensive Assessment, as applicable.

3. Conducting the Review:

A formal review of the health care surrogate case must be completed at least at six (6) months following case opening and again at six (6) month intervals thereafter until case closure. The review process consists of evaluating progress toward the goals identified in the current service plan. This requires the social worker to review the service plan and have a face-to-face contact with the client and caregiver/provider, if applicable. Follow-up with other significant individuals and agencies involved in implementing the service plan, such as service providers, must also be completed. During the review process, the social worker is to determine the following:

- client's current functioning and whether or not there has been improvement or a decline in functioning since the previous review;
- extent of progress made toward goal achievement;
- services/intervention provided during the review period and the effectiveness of each;
- whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are needed;
- barriers to achieving the identified goals;
- recommendations regarding services, continued need for a health care surrogate, suggested changes, etc.; and,
- other relevant factors.

Note: In the event the Department is able to locate an alternate health care surrogate, the worker is to begin working toward having that individual/entity appointed in place of the Department and the health care surrogate. Once the new appointment is made, the case is to be closed.

4. Documentation of Review:

At the conclusion of the review process the social worker must promptly document the findings in FACTS. This includes summarizing the client's circumstances and progress, reviewing the service plan in FACTS and end dating any goals that have been achieved or are to be discontinued or modified for some other reason(s). Goals that have not been end dated on the service plan must be continued on the new service plan. New goals may be added as appropriate.

In addition, when there have been changes in the following areas, and the annual Comprehensive Assessment is not yet due, the updated information must be documented as a modification to the Comprehensive Assessment: 1) caregiver status, 2) client decision-making capacity, 3) client financial management capability, 4) client environment/household, 5) client behavioral functioning, and 6) client ability to meet ADL's. All documentation is to be pertinent and relevant to the Department carrying out it's responsibilities as health care surrogate.

When the review process is completed, the social worker must submit the new service plan and summary evaluation and, if applicable, the modified or annual Comprehensive Assessment to the supervisor for approval. Once approved, the social worker must print a copy of the revised service plan and secure all required signatures. Finally, they must provide a copy of the service plan to the client and to all signatories. The original signed service plan is to be filed in the client's case record (paper file) and recorded in document tracking.

E. Resignation/Termination of Health Care Surrogate

There are certain situations when the resignation or termination of the health care surrogate appointment is permitted. These include situations include when 1) the adult is no longer incapacitated or 2) when the surrogate is unwilling or unable to serve. In either situation the surrogate's authority will cease.

<u>Adult Regains Decision-Making Capacity</u>

In the situation where the individual is found to have regained capacity, this must be certified by a medical professionals (attending physician, qualified physician, qualified psychologist or advanced practice nurse). When termination is being done for this reason, the worker should request written verification of this determination. Upon receipt of this documentation this is to be filed in the case record and recorded in document tracking and the worker is to proceed with case closure. In the event written notification is not received, the Department is to send written notification to applicable medical professional advising of the Department's resignation as health care surrogate. In addition, the client and legal representative, if applicable, is/are to be notified in writing. (See Reports-Negative Action Letter for details about notification of the client/legal representative)

Surrogate No Longer Willing/Able to Serve

The Department may be unable to serve in certain situations. Examples include:

- unable to locate client;
- loss of contact with client;
- client moved out of state;
- inability to fulfill our responsibilities as health care surrogate due to client's failure to comply or refusal to comply with needed treatment/care; and,
- failure of the provider to share necessary medical information.

Whenever the Department resigns as health care surrogate, written notification must be sent by the worker to all medical professionals who have the Department identified as the health care surrogate of record. This notification is to advise these parties of the Department's resignation as health care surrogate. In addition, the client and legal representative, if applicable, is/are to be notified in writing. (See Reports-Negative Action Letter for details about notification of the client/legal representative)

F. Assessment Prior to Case Closure

A final evaluation must be completed as part of the case review process prior to closure of the health care surrogate case. Upon completion of the final review, the social worker must document the results of this review in FACTS and submit to the supervisor for approval of recommendation for case closure. Upon supervisory approval, the case is to be closed for health care surrogate Services. Case closure in FACTS is to be completed promptly but no later than thirty (30) days following completion of the final evaluation and review.

Note: It is essential that all documentation in the case be completed prior to closure of the case, including but not limited to the end dating of all tasks on the service plan.

G. Reports

1. Initial Assessment

The Initial Assessment is completed in the intake/assessment phase of the casework process. This form is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. The completed document must then be saved to the FACTS file cabinet for the case. Finally, creation of this report must be documented in the document tracking area of FACTS.

2. Comprehensive Assessment

The Comprehensive Assessment is completed in the assessment phase of the health care surrogate casework process. It is a compilation of elements from several areas of the system and is available as a DDE in FACTS, accessible through the report area. This report may be opened as a WordPerfect document, and will be populated with information that has been entered in FACTS. The social worker then can make modifications, as appropriate, before printing the

document. The completed document must then be saved to the FACTS file cabinet for the case. Finally, creation of this report must be documented in the document tracking area of FACTS.

3. Service Plan

The Service Plan is completed in the case management phase of the health care surrogate casework process. This form is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, and will be populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. Creation of this report must be documented in the document tracking area of FACTS. The completed document must then be saved to the FACTS file cabinet for the case. Finally, after printing the service plan the worker must secure all required signatures, provide the client and all signatories with a copy, file the original signed document in the client case record (paper record), and record in document tracking where the original signed document is located.

4. Appointment of Health Care Surrogate

The Appointment of Health Care Surrogate form is completed in the initial assessment phase of the Heath Care Surrogate casework process. This two page form is available as a DDE in FACTS and may be accessed through the report area. The first page is a statement of the appointment and the second page is a checklist to be completed by the appointing physician to document all contacts with potential surrogates that were made prior to appointment of the Department and to verify the results of those contacts. This report may be opened as a WordPerfect document and will be populated with limited client information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. This report is intended to be sent to the appointing physician form completion. The completed document, once received, must then be filed in the paper record and its receipt documented in the document tracking area of FACTS.

5. Intake Summary

The Intake Summary is available as an on-line report based on information entered in the intake/assessment phase of the case. It may be accessed through the report area.

6. Ethics Consultation Intake Tool

The Ethics Consultation Intake Tool is the form to be used by the worker whenever an Ethics Consultation is being requested. The worker is to complete this for and submit it to the appropriate Adult Services Specialist in the Bureau for Children and Families. The completed form may be faxed if necessary.

7. Ethics Consultation Summary

The Ethics Consultation Summary form to be completed by the Adult Services Specialist in the Bureau for Children and Families to document the consultation request. It also is used to summarize the consensus of the other committee members consulted on the case. When complete, the Summary will be retained on file in the Office of Social Services.

8. Negative Action Letter (SS-13)

Anytime a negative action is taken in a health care surrogate services case such as case closure or a reduction in services, the client or their legal representative must be provided with written notification of the action being taken. The action must be clearly and specifically stated, advising the client/legal representative of the action being taken and the reason(s) for the action. In addition to notification of the action being taken, the client or their legal representative must be made aware of their right to appeal the decision and advised of what they must do to request an appeal. This form, titled "Notification Regarding Application for Social Services", is available in the report area of FACTS.

H. Transfer of Cases Between Counties

There may be situations where a health care surrogate case must be transferred from one county to another. When it is necessary to transfer a case from one county to another, this is to be a planned effort with close coordination between the sending county and the receiving county. This will occur most frequently in situations where the incapacitated adult is moving to a new, permanent residence in another county/district. A transfer of the health care surrogate case in FACTS is to occur whenever the client physically relocates to another county/district.

Note: Whenever the client is being placed in another county for a temporary period of time (i.e. substance abuse treatment, in-patient psychiatric care, acute care hospital admission, etc.) the case is not to be transferred. If the placement, though temporary, is for an extended period of time and it is not possible for the assigned worker to maintain regular contact as required due to travel distance, etc., the supervisor in the county where the case record is maintained may contact the supervisor in the county where the client is physically located to request a courtesy visit.

1. Timing of Transfers of Health Care Surrogate Cases:

It is recommended that case transfers within DHHR be planned for the beginning or end of a month in order to minimize confusion if payments are being made on the client's behalf. If this is not possible, the social worker from the sending county must work closely with the individual who is responsible for handling the client's financial matters to ensure that payment for services and care are made appropriately.

2. Sending County Responsibilities:

When it is necessary to transfer a health care surrogate case from one county to another, the sending county is responsible for completing the following tasks:

- prior to arranging or actually completing a transfer to a provider in another county, the sending supervisor must call the supervisor in the receiving county to notify them that a client is being transferred to their county or to request placement assistance;
- provide a summary about the client's needs (e.g. reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable);
- complete all applicable case documentation prior to case transfer;

- immediately upon transfer of the client to the receiving county, send the updated client record (paper record) to the receiving county; and,
- notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the client's change of address.

If the client is being transferred to a health care setting in the receiving county, the sending county must do the following in preparation for the client's move:

- authorize discharge from current facility (if applicable) and admission to the new health care setting;
- authorize transportation for the client to the new setting, if necessary;
- assist with informing and preparing the client, to the extent possible, prior to the final move to the new setting, explaining where s/he is going, why s/he is going and what to expect upon arrival; and,
- ensure that the individual responsible for managing client's financial affairs is informed of the client's financial needs/changes; and,
- ensure that arrangements have been made for the client's clothing and medication to accompany him/her to the new residence, if applicable;

3. Receiving County Responsibilities:

The receiving county is responsible for completing the following tasks in preparation for the transfer:

- notify the DHHR Family Support staff of the client's arrival when the transfer is complete;
- complete all applicable documentation;
- assist the client, and provider if applicable, with adjustment to the new arrangement; and,
- assist with arranging or initiating any needed community resources.

When a health care surrogate case is transferred from one county to another, problems that arise during the first six (6) month period following the transfer are to be addressed jointly between the counties. When this occurs, the receiving county may request assistance from the sending county. If such a request is received, the sending county is to work cooperatively with the receiving county to resolve the problem(s). The receiving county's social worker should maintain frequent contact during this initial adjustment period to ensure a smooth transition for both the provider and the client. This will permit timely resolution of problems that may occur during this time.

I. Confidentiality

1. *Confidential Nature of Adult Services Records:*

Legal provisions concerning confidentiality have been established on both the state and federal levels. In federal law, provisions are contained in the Social Security Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). On the state level, provisions pertaining to confidentiality for health care surrogate cases are contained in Chapter 200 of the Department of Health and Human Resources, Common Chapters. Specifically, requirements in the Common Chapters address confidentiality of the case record of the Department.

Whenever the Department has been appointed as the health care surrogate, under HIPAA requirements the Department is considered to be the personal representative for the adult. As such, they are considered to stand in place of the adult, having the ability to act on their behalf with respect to use and disclosure of the adult's protected health information. Specifically, under the HIPAA Privacy Rule the health care surrogate has access to the protected health information of the incapacitated adult to the extent that the information is relevant to carrying out the duties as health care surrogate. The health care surrogate also may authorize disclosures of the adult's protected health information to the extent this is necessary, such as information necessary for insurance, billing and treatment purposes (*45 CFR 164.502(g) and 45 CFR 164.524*).

2. When Confidential Information May be Released:

All records of the Bureau for Children and Families concerning a health care surrogate services client shall be kept confidential and may not be released except as follows:

- Certain information may be released to the adult services client or their documented legal representative. When releasing information to these parties from the Department's case record, information that may NOT be included would be information and documents provided to the Department by another entity, such as medical reports, psychological reports, information from Social Security Administration, etc. In addition, prior to release of case information the worker and supervisor must review the record to determine if any of the information contained therein would be detrimental to the incapacitated adult. If so, this information is to also be excluded from the information provided for review. In the event the request appears to be unreasonable or questionable, supervisor/worker is to contact the regional attorney prior to release of any information.

- Upon written request, information about developmentally disabled adults may be shared with the federally recognized protection and advocacy entity within West Virginia (West Virginia Advocates or West Virginia EMS Technical Services Network). This request must state the specific information being requested and the reason(s) for the request. The recipient of this information must agree to keep all information shared confidential. (Sharing information does not apply to all advocacy groups - long-term care ombudsman, patient rights advocates, etc. It is limited to ONLY the federally recognized protection and advocacy entity.) In addition, the worker must document the items which were sent.

- In some instances the court will seek information for use in their proceedings. (See Subpoenas, Subpoena duces tecum & Court Orders for detailed information)

- For reporting and statistical purposes, non-identifying information may be released for the preparation of non-client specific reports.

- The Appointment of Health Care Surrogate may be presented, as appropriate, to provide verification of the Department's legal relationship to the incapacitated adult, and the scope of authority granted by state statute.

- The Department, in our capacity as health care surrogate, may release or authorize the release of necessary medical information about the incapacitated adult to third parties necessary for billing, insurance, and treatment purposes (*45 CFR 164.524*).

3. Subpoenas, Subpoena duces tecum & Court Orders:

The Department may be requested by the court or other parties to provide certain information regarding health care surrogate cases. The various mechanisms that may be used are 1) subpoena, 2) subpoena duces tecum, or 3) court order. Upon receipt of any of these, the Department MUST respond. Failure to comply is contempt of court and could result in penalties.

A subpoena commands a witness to appear to give testimony while a subpoena duces tecum commands a witness, who has in his/her possession document(s) that are relevant to a pending controversy, to produce the document(s) at trial. Subpoenas may be court ordered or administrative (ordered by a party other than the court). Though all subpoenas must be responded to, the manner in which this response occurs is somewhat different dependent on who issues the subpoena.

a. Court ordered Subpoenas:

These include subpoenas issued by the circuit court, the magistrate court or the mental hygiene commissioner. There may be times when a questionable court order or a subpoena requesting that confidential information be provided is received. In this event, the social worker must advise his/her supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General. In the event there is not sufficient time for the assistant attorney general to become involved in the situation, prior to the scheduled hearing, the Department should request a continuance until such time as legal representation can be arranged. If a continuance is not granted, the Department should comply with the subpoena or court order.

b. Administrative Subpoenas:

These include subpoenas issued by an attorney or administrative law judge (other than a DHHR administrative law judge). These subpoenas generally request that the social worker appear to provide testimony and/or produce the case record. The social worker should advise his/her supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General.

J. Liability

Health care surrogates have a responsibility to the incapacitated adult to act in their best interest. The Department is not financially liable for costs incurred by or on behalf of the incapacitated adult. The Department or the individual worker may be held accountable if found to be negligent in carrying out their duties as health care surrogate.

IV. Case Closure

A. Case Closure - General

A final evaluation must be completed as part of the case review process prior to closure of the health care surrogate case. The case should not be closed until all action by the health care surrogate on behalf of the client is completed, such as making arrangements for funeral and burial/cremation, etc. that must be completed after death. (See Assessment Prior to Case Closure for detailed information)

B. Notification of Case Closure

If the case is closed for health care surrogate services for any reason other than client death, written notification to the client or his/her legal representative is required. Notification is to be sent within five (5) working days of the date services were terminated. A form letter titled "Notification Regarding Application for Social Services" (Negative Action Letter: SS-13) is to be used for this purpose. This form is available in the Reports area of FACTS. (See Reports for additional information)

C. Client's Right to Appeal

A client or his/her legal representative has the right to appeal a decision by the Department at any time for any reason. To request an appeal, the client or his/her legal representative must complete the bottom portion of the "Notification Regarding Application for Social Services" and submit this to the worker's supervisor within thirty (30) days following the date the action was taken by the Department. The supervisor is to schedule a pre-hearing conference to consider the issues. If the client or his/her legal representative is dissatisfied with the decision rendered by the supervisor, the appeal and all related information is to be forwarded by the supervisor to the hearings officer for further review and consideration. (See Common Chapters for specific information regarding grievance procedures).