



January 23, 2013

Louisiana Department of Health & Hospitals
Ms. Lou Ann Owen, Medicaid Deputy Director
PO Box 90130
Baton Rouge, LA 70821-9030

Dear Ms. Owen:

Louisiana Nursing Home Association is delighted to respond to the department's Request for Information regarding Medicaid Long Term Services and Supports. Medicaid is a federal/state partnership originally designed to meet the health care needs of the destitute. It has evolved into a program of many services, including social welfare services for the poor, home care monitoring and waiver services.

Home Care Monitoring

An example of a social welfare program is the Long Term Personal Care Services Program. A potentially more cost efficient service to replace or reduce the personal care service program is the home sensor network. There are a number of companies which have monitoring devices that could be installed in beneficiaries' homes at a low cost. Beneficiaries with ailments, such as diabetes, arthritis, hypertension and other chronic conditions, can use devices on a daily basis and electronically send the readings on the devices to a technician for interpretation. The system could remind individuals if they haven't performed their daily medical checks. Inexpensive cameras and/or audio monitors could be installed to further ensure safety.

Certain long term care companies and/or the LNHA Service Corporation can contract with a sensing company to provide these services. The Medicaid Agency would determine a fair rate for this service and reimburse the contractor for monitoring the sensory devices and for reporting any concerns. This is a home and community based service that would truly be cost effective. LNHA has met with several companies and is ready to assist the department in developing a new telehealth home-based monitoring program for Medicaid eligibles.

Coordinated Care

Coordination of care among a myriad of providers is difficult, and a lack of coordination between providers leads to poor health outcomes and increased cost for the Medicaid program. The Louisiana Legislature in the 2011 Regular Session recognized this and enacted Act 299 which provided, in part, for the Department of Health and Hospitals to "provide for the use of



organized health care delivery systems as an option for the provision of Medicaid-funded home and community-based services.” It is our understanding that a Medicaid State Plan amendment to provide for the use of organized health care delivery systems has been submitted to CMS for approval.

As nursing facilities are the experienced leaders in providing services to this population, we would propose that nursing facilities (or their operating companies) qualify as an organized health care delivery system responsible for establishing a comprehensive delivery system and coordinating care for recipients of Home and Community Based Services. Nursing facility operators have the expertise and the capacity to provide for the medical and social needs of the population within the walls of their facilities and can meet those needs in the community as well. Unlike most other providers of HCBS services, nursing facility operators are materially invested in their communities, providing stability and accountability. DHH could, also, allow other qualified health care providers the ability, based on DHH established criteria, to qualify as an organized health care delivery system in order to provide coordinated care. Participation should be voluntary for both providers and recipients.

Based on a successful model implemented in Georgia, we propose implementation of the coordinated care component, possibly called “Circle of Care,” to achieve the following program objectives:

1. Integrate primary care, specialty care and home-based care to eliminate fragmentation.
2. Reduce emergency room use, hospital and nursing home admissions by eliminating preventable medical complications.
3. Stabilize social and lifestyle factors that affect compliance, health status and quality of life.
4. Address any current gaps in Medicaid benefits so they do not negatively affect health outcomes.
5. Reduce the demand of long-term institutional expenditures.

The benefit of a coordinated care program is primarily in coordination between the provider and the various Medicaid or Medicare providers utilized by the recipient. This coordination is accomplished through a care manager. The focal point of this coordination is the care manager’s connection to the recipient’s primary care physician and continual monitoring of the recipient’s physical and mental health status. The care manager would assume the responsibility that the physician’s orders are followed and provide feedback to the physician and other providers regarding changes in condition. This is where the State will see immediate savings in having a proactive approach to providing the right care, at the right time, and in the right place.

A 2006 study performed by Myers and Stauffer regarding Georgia's program (SOURCE) demonstrated the cost effectiveness of this model.

Comprehensive Plan for Delivery of Quality Services

The department should work with stakeholders to address shortcomings in the delivery of home and community based services. DHH should develop and implement an accreditation process. It must beef up compliance standards to ensure that quality services are being delivered. And, it must revise and strengthen the procedures for the billing of home and community based services to reduce fraud, waste and errors.

Improvement can be attained through stringent cost reporting requirements, revisions to streamline the delivery of support coordination, including service delivery by operators of nursing homes without the need to apply for multiple licenses, rate methodology revisions to promote administrative efficiencies, utilization of technology, such as home monitoring as set forth in the first topic of this letter, modifications to Medicaid enrollment to prevent fraud and errors.

These two programs – (1) home monitored remote care and (2) an organized health care delivery system with an effective care coordination component – should create efficiencies that can lead to savings in Medicaid. And, a comprehensive plan to cleanse home and community based services of its weaknesses will result in better care at a lower cost. We trust you will agree and allow us to help you implement them.

Sincerely,


Joseph A. Donchess
Executive Director

JAD:jb

NAVIGATE

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Home > Work > Health Buddy II

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HEALTH BUDDY II FOR HEALTH HERO NETWORK

A next generation device for in-home health monitoring

As a patient service provider, Health Hero Network places foremost value on the ease-of-use and effectiveness of its technology devices for remote health monitoring and management. One of the company's leading products is the Health Buddy, an IDEO-designed tabletop device for at-home elderly and chronically ill patients.

Looking to define the next generation Health Buddy, Health Hero Network returned to IDEO for an update that increased usability by speaking to advances in technology and connectivity. IDEO created a fan-shaped base to accommodate ports and enable connectivity for other medical devices, such as blood pressure and glucose monitors. In addition to increasing the functionality of the back of the device, the base also provides stability as the user pushes buttons to input data and access the Health Hero Network. On the front of the device, a color LCD screen was added, along with a speaker for sound alerts.

The final design updated the visual appearance of its predecessor with a slimmer, more contemporary aesthetic that maintains the professional look of a health device without looking clinical. In addition to supporting a growing number of health management programs, the Health Buddy system has improved self-care and reduced hospitalizations for patients with persistent asthma and chronic heart failure.

Project date: 2009



1 of 3



RELATED PROJECTS



Health Buddy

Health Hero Network

Tabletop device to care for elderly or chronically ill



LifePort Kidney Transporter

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Revolutionizing the blood-glucose meter for people with diabetes

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Careers

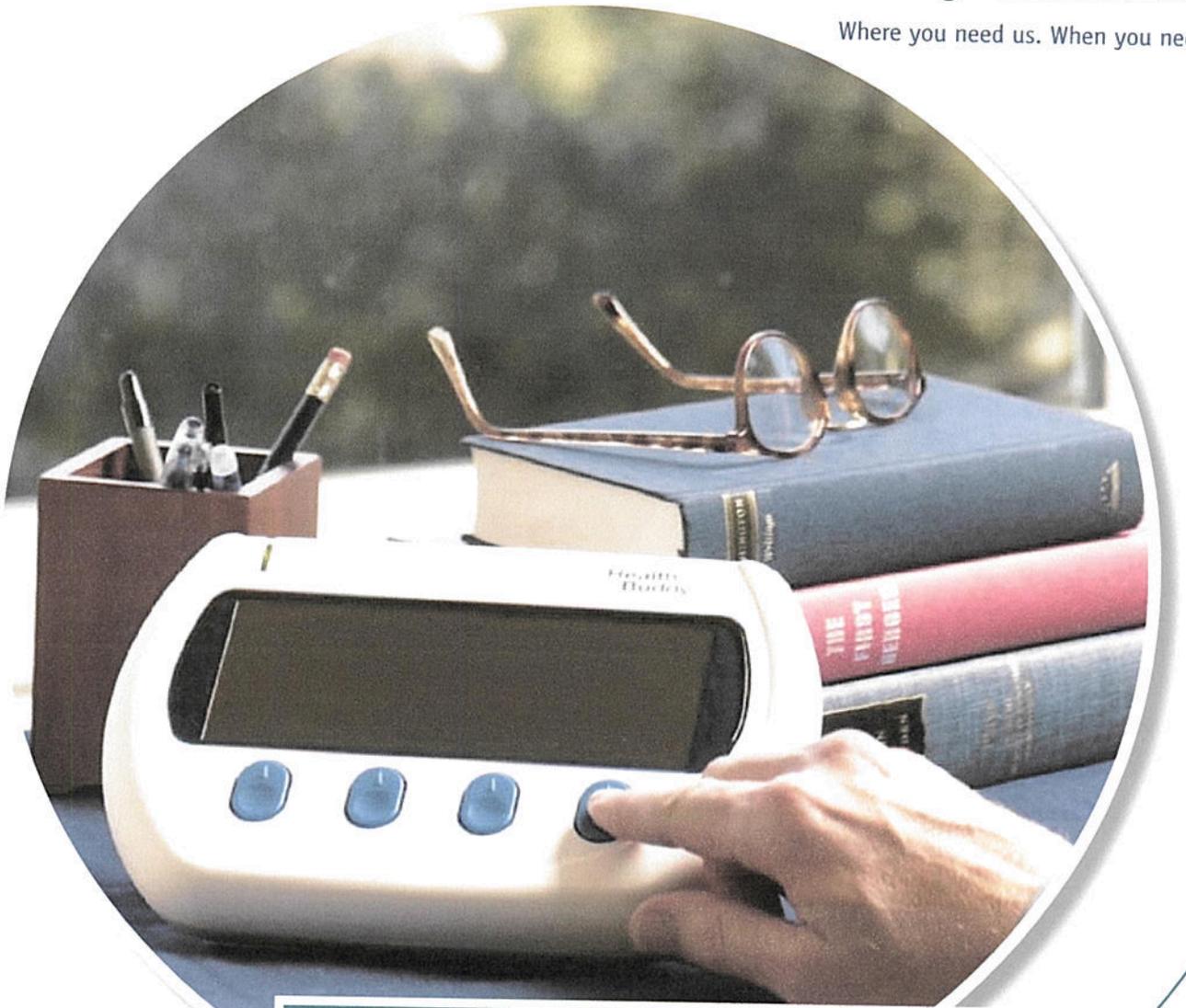
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The Health Buddy is an easy-to-use device that helps you give your doctor and home care nurses important information about your condition on a daily basis. You use the device to record your progress right from the comfort of your own home. The information is sent to our nurse via the telephone or internet.

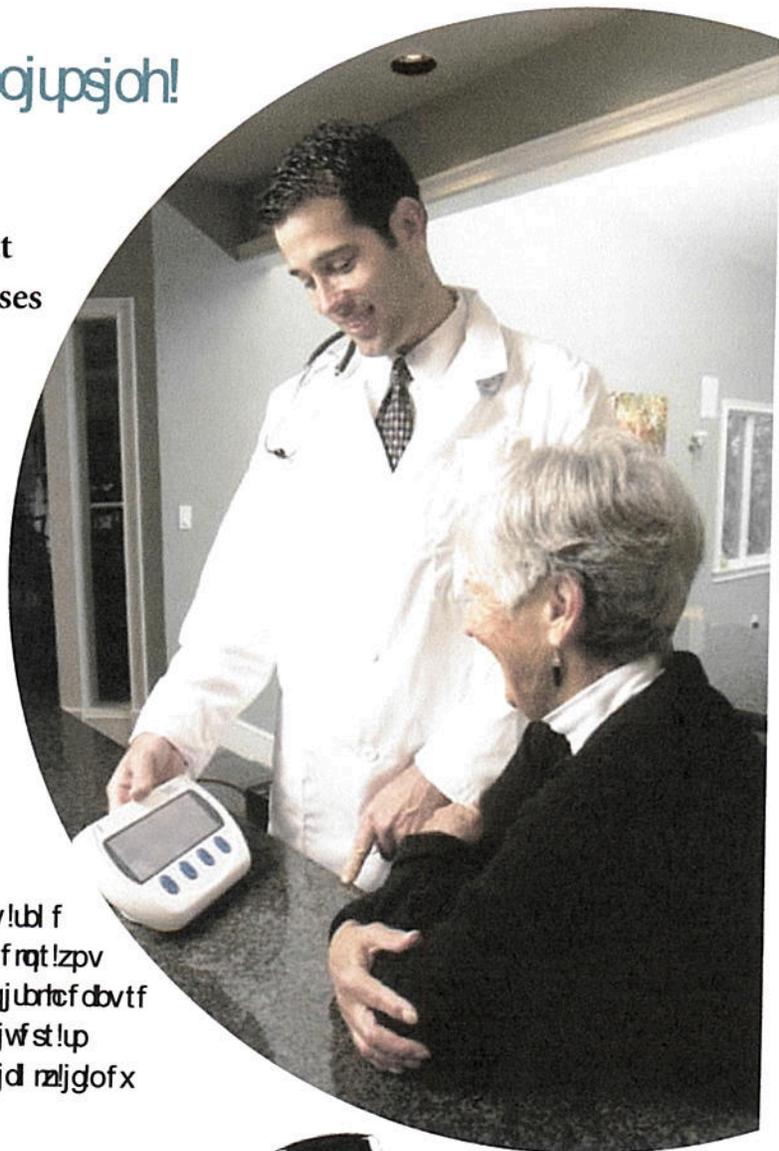
The nurse will review your results from a remote location to make sure you are staying well.

This is part of your home care service and there will be op!beej j pobrt apt ulp!zpv.

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- Blood Pressure
- Heart Rate
- Weight
- Oxygen saturation
- Medications
- Symptoms like breathing, swelling or fatigue
- Diet



Here's how the Health Buddy works:

The Health Buddy device plugs into your telephone line or internet access and an electrical outlet. When you start the device, you will be asked simple questions about your health status. You answer by pushing one of four buttons. The Health Buddy will ask you to check your weight, blood pressure, blood glucose and oxygen levels. The tools to check these things are attached to the Health Buddy. They are very easy to use. The process takes only a few minutes.

After you complete your session, your Health Buddy will automatically dial a toll-free number to send your information to the nurse. The device will also receive new questions and helpful information for your next session. Your doctor and home healthcare team will be able to access the information to evaluate your progress. This will help them to provide you with specific care to better meet your needs.

Become An Active Member Of Your Own Healthcare Team

Easy

The simple design of the Health Buddy makes it easy to use. Just read the questions and reminders that appear on the screen. Answer by pushing one of four buttons.

Confidential

The information collected during your daily Health Buddy sessions is secure and confidential. No one will have access to your data unless they have been authorized by you and your healthcare provider.

Your nurses and therapist cannot visit your home every day. With the Health Buddy appliance, they can still check up on you each day. The Health Buddy appliance provides important information about how you feel and your vital signs. Your caregivers use this information to determine whether you are getting better, or whether you need attention from your doctor. Health Buddy devices are proven to reduce the number of times patients are readmitted to the hospital. They have also proven to help patients recover more quickly and maintain a better quality of life.

Confidential

The information collected during your daily Health Buddy sessions is secure and confidential. No one will have access to your data unless they have been authorized by you and your healthcare provider.

Frequently Asked Questions:

Why would I want to use a Health Buddy?

Your nurses and therapist cannot visit your home every day. With the Health Buddy appliance, they can still check up on you each day. The Health Buddy appliance provides important information about how you feel and your vital signs. Your caregivers use this information to determine whether you are getting better, or whether you need attention from your doctor. Health Buddy devices are proven to reduce the number of times patients are readmitted to the hospital. They have also proven to help patients recover more quickly and maintain a better quality of life.

How do I know if I am eligible for a Health Buddy®?

If your doctor feels that your condition could be improved by using a Health Buddy device, you may be eligible for a Health Buddy device.

Health Buddy devices are proven to reduce the number of times patients are readmitted to the hospital. They have also proven to help patients recover more quickly and maintain a better quality of life.



Will there be any charges or costs for using the Health Buddy device?

No. While you are receiving home care with MedStar Health VNA, there is no cost to you for use of the Health Buddy. The Health Buddy dials a toll-free number. No charges will show up on your phone bill if you have standard phone service. Your Health Buddy uses less power than the light bulb in your refrigerator. You should see no noticeable increase in your electric bill.

Can I use my telephone while it is connected to the Health Buddy device?

Yes, you can use your phone or internet access as usual. If you happen to pick up the telephone while your Health Buddy is using the line, it will automatically stop and reschedule its call so you can use the phone.

Where is the best place to put my Health Buddy device?

You can put your Health Buddy anywhere there is an electrical outlet and a working telephone or internet access point. Many people put their Health Buddy in the kitchen or next to their favorite reading chair in the living room. Be sure that you connect the Health Buddy to an electrical outlet that cannot be turned on and off by a wall switch.

What if I accidentally press the wrong button when answering a question?

No problem. At the end of each session you will have the option to review and change your answers.

Do I need to have a computer or know how to access the Internet?

No. All you need to do is read the screen and press one of the four buttons.

Is the Health Buddy device difficult to install?

No. MedStar Health VNA will install the Health Buddy for you and teach you how to use it.

To learn more about the Health Buddy, call 1-800-862-2166.



MedStar Health
Visiting Nurse Association

Where you need us. When you need us.

1-800-862-2166 • medstarhealthVNA.org

4061 Powder Mill Rd., Suite 210
Calverton, MD 20705

MedStar Health Visiting Nurse Association is part of MedStar Health, a not-for-profit, regional healthcare system with nine hospitals and more than 20 other health-related services in the Maryland and Washington, D.C., region. More than a half-million patients trust their care to MedStar Health each year. medstarhealth.org

PROTECTING
YOUR
PARENTS

2 of 3

TECH

by Kim
Clark

THE STRESS AND EXPENSE
OF CARING FOR AGING PARENTS
CAN MOUNT QUICKLY.
NEW PRODUCTS AND SERVICES
EASE THE BURDEN AS YOU HELP ...

KEEP THEM SAFE @ HOME

Is Dad mixing up his pills? What happens the next time Mom falls?

If you have an elderly parent, chances are you've spent more than one sleepless night worrying about such things. Sure, moving him or her to an assisted-living facility or a nursing home might help. But the average annual cost is \$38,000 and \$67,500, respectively, and that doesn't include the hefty emotional price: Surveys show that seniors fear nursing homes more than they do death itself. • Thankfully, the past few years have seen a boom in technical innovations that can prolong their independence and help you to be a more effective caregiver, even from afar. They include automatic activity sensors, smart pillboxes, and communicators that share health data with you or a medical pro. These gizmos (and the monitoring services that typically come with them) can be pricey, ranging from a few hundred dollars to several thousand a year—and neither

90 / MONEY June 2011 / Illustration by SHOUT

Medicare nor most private health insurers typically cover them (though some will if they're prescribed by a doctor). Still, because these devices can extend the time your parent is able to live safely at home, the best ones may save money and heartache in the long run, says Laurie Orlov, founder of market research firm Aging in Place Technology Watch. "We've entered a really great new world," she says.

Navigating this new world isn't easy: There's little regulation or independent testing of many of these products. And it's hard to comparison-shop because many manufacturers don't post prices on their websites or quote them over the phone but rather direct you to salespeople. So MONEY interviewed a dozen experts who are familiar with the latest elder-care technology—and identified cost-effective choices for three challenges, starting with the most common.

Manage Medications

• **THE CHALLENGE:** Mixing up pills, forgetting them, or taking them at the wrong time can have dire consequences. "It's one of the primary reasons elders can no longer live alone," says Elinor Ginzler, a vice president at AARP.

• **THE OLD FIX:** Those \$2.99 plastic pillboxes you get at the drugstore, with a compartment for each day of the week. Many pharmacists will pre-sort meds into them. But seniors who are forgetful or have complicated drug regimens need more help, says Julie Menack, a geriatric-care manager in Oakland, Calif.

• **THE NEW FIX:** High-tech pillboxes that set off alarms if your parent fails to take a dose. They range from basic \$17 models to \$75-a-month machines that connect to a monitoring service via a phone line and send alerts if pills are missed.

BOOKMARK THESE SITES

Benefitscheckup.org tells you what financial benefits your parent may be eligible for.

Caring.com offers support and advice from 100,000 registered users, also caregivers.

Eldercare.gov is the federal government's clearinghouse for all services for older people.

Lotsahelpinghands.com has tools that help you organize multiple caregivers and visits.

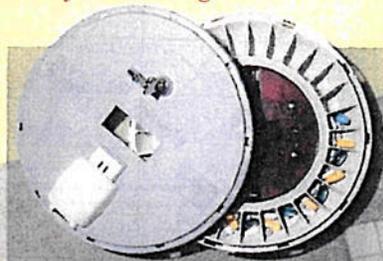
Jeffrey Gornstein, the founder of comforthouse.com, a seller of household gadgets, says he's been pitched dozens of these devices, many of which have "terrible instructions or buttons that are too small."

A good pick for most people, experts say: the pie-dish-size **1 MED-READY 1650FL** (medreadyinc.com; \$218 and up, plus \$16 a month). Load prescriptions into a carousel, then program it to open internal boxes up to four times a day. Mom doesn't take a pill on schedule? The MedReady flashes and beeps. If the meds haven't been removed after 30 minutes, the device sends voice or text messages to you or another caregiver. Since her parents got the MedReady, says Karen Ballou, 53, of Livermore, Calif., they've stopped sleeping through their scheduled pill-taking times: "It's a blessing for us as caregivers."

• **THE CAVEAT:** If an alarm will upset your parent, or if he or she might

How Tech Helps Caregivers

Depending on your parents' mental and physical condition, one or more of these gizmos can help them live independently longer—thereby saving money and lowering stress.



1 MEDREADY PILL DISPENSER
Dishes out the right meds and alerts you to missed doses.



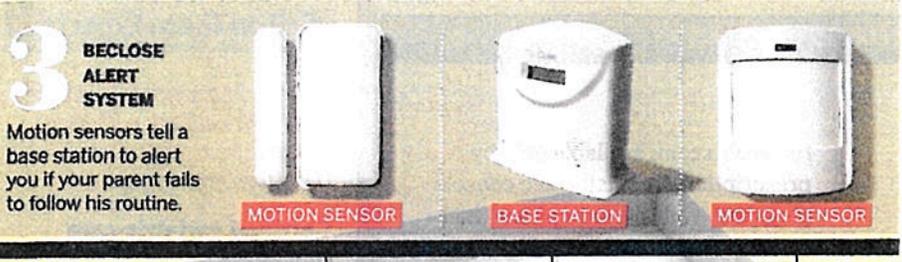
2 MYHALO FALL DETECTOR
Senses when your parent falls—and calls for help.

not swallow a pill after removing it, this isn't a good choice.

• **COVERED BY HEALTH INSURANCE?** Not by Medicare or big private insurers. Most long-term-care policies (and Medicaid in 16 states) will cover it if prescribed.

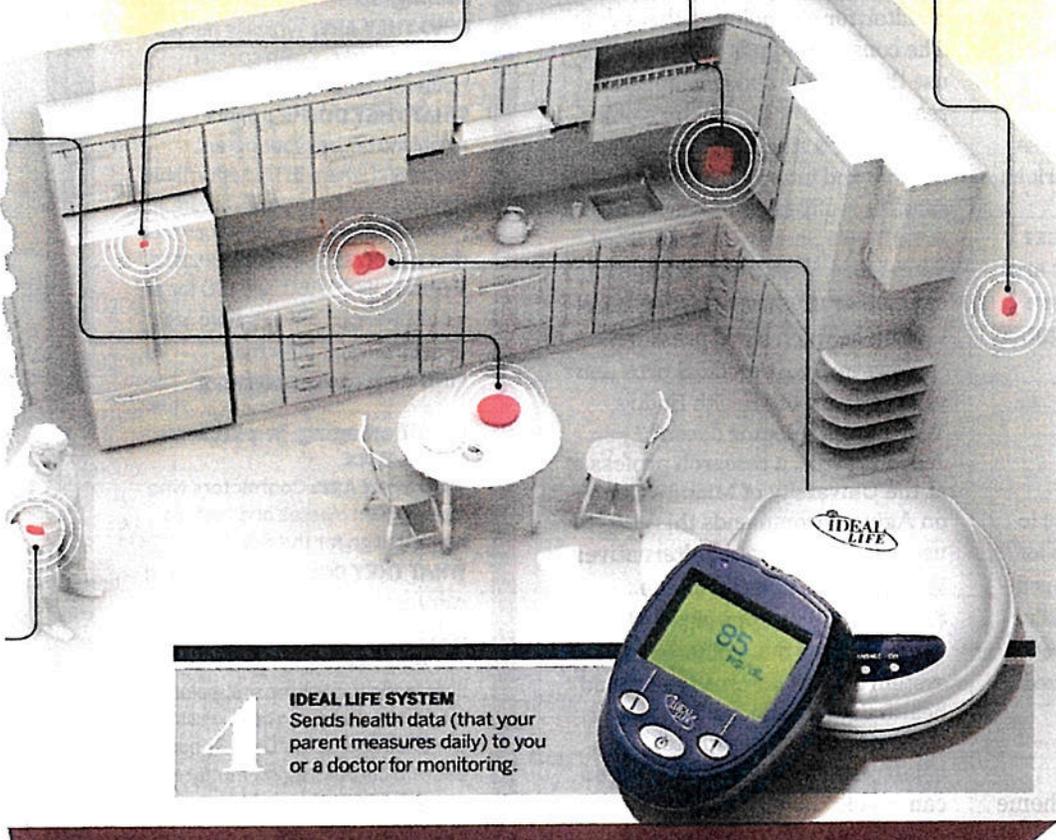
Make Falls Less Damaging

• **THE CHALLENGE:** Installing grab bars and making other home modifications (see "Call on These Experts," page 94) reduce the risk of falling but don't eliminate it. Research shows that seniors who get quick help after a tumble are about 20% less likely to need hospitalization.



3 BECLOSE ALERT SYSTEM
Motion sensors tell a base station to alert you if your parent fails to follow his routine.

MOTION SENSOR BASE STATION MOTION SENSOR



4 IDEAL LIFE SYSTEM
Sends health data (that your parent measures daily) to you or a doctor for monitoring.

• **THE OLD FIX:** One of those “I’ve fallen and I can’t get up” pendants. Many seniors are reluctant to wear the conspicuous devices because they advertise frailty. And a 2008 British study of people over the age of 90 who wore such pendants found that 80% never pushed the alert button after a fall, either because they didn’t want to bother anyone or were unable to do it.

• **THE NEW FIX:** A wearable device that can automatically sense falls, thanks to a built-in accelerometer that measures movement and orientation. When it detects a fall, it sends an alert, typically to a monitoring service and to you.

PHOTOGRAPHS BY RYAN MESINA

Several companies now offer such devices, which run from \$30 to \$60 a month, hardware included. Among them, Halo Monitoring’s **MYHALO** (halomonitoring.com; \$49 a month) was singled out for an award recently by a panel of nurses and caregiving pros assembled by a health trade publisher.

MyHalo looks like a pager and can be clipped to a belt. When it detects a fall, a base unit plugged into a phone line beeps. If your parent doesn’t hit the unit’s reset button, you get a voice or text message, and a Halo staffer calls your parent’s home (then you if there’s no answer). Can’t get over there right

away? Halo calls 911.

Choose this device only if you’re confident your parent will wear it and keep it charged. Otherwise, says Stacey Pierce, a certified aging-in-place specialist in Charleston, S.C., you’re better off installing a fall-alert system in his or her home. The latest include wireless motion-detecting sensors that can alert you if they don’t pick up movement typical of your parent. For example, if Dad gets the paper and eats breakfast every morning, put sensors on the front door and the refrigerator and program the system to call or text you if they aren’t opened by, say, 9 a.m.

Installing such detectors kept Karla Barham, 52, of Shreveport, La., from having to rush to her mother’s apartment in a panic several times a week whenever her phone calls went unanswered. Now

Barham spends her time with Mom cooking dinner or going out: “We have a much better relationship.”

Top-of-the-line systems may include audio and video and run into the thousands of dollars. But you need not spend that much. Susan Estrada, an independent seller of caregiving products who has a reputation among elder-care experts for posting reliable product reviews at happyathome.me, suggests the following cost-effective system:

1 **BECLOSE** (beclose.com; \$300 for enough hardware for a small apartment, plus \$49 a month).

• **THE CAVEATS:** A wearable monitor is no help at times your parent

doesn't have it on. Motion-detector systems work well only if you place and program them correctly—and some parents dislike the “little daughter turning into Big Brother” aspect. (To convince them, stress that motion detectors also work as burglar alarms.)

• **COVERED BY HEALTH INSURANCE?** Usually not. But these devices are covered by some long-term-care policies (and Medicaid in 44 states) if prescribed by a health pro.

Monitor Health Problems

• **THE CHALLENGE:** Seniors who fail to follow standard medical guidelines for chronic ailments such as diabetes and heart disease—for example, neglecting to measure blood sugar or pressure—get sicker and have to be hospitalized far more often than those who do.

• **THE OLD FIX:** Blood-pressure gauges and other devices for home use. But there's no way to check that your parent is using them or to read results remotely.

• **THE NEW FIX:** “Telehealth” devices that automatically transmit data to medical pros or caregivers. A recent Department of Veterans Affairs study shows that people with chronic conditions who use the kind monitored by doctors are 20% less likely to wind up in the hospital. What's more, they're keeping more than 49,000 veterans from having to enter nursing homes, says Adam Darkins, a physician who oversees the VA's telehealth program.

One system proved effective in Medicare and VA studies: the **BOSCH HEALTH BUDDY** (bosch-

telehealth.com; available only by prescription). A small video console plugs into your parent's phone line; another device—a blood-sugar monitor, for example—gathers data. The console reminds your parent to use the monitor and transmits the reading to his or her doctor's office. The doctor's staff keeps an eye on the info and intervenes if necessary. “It really gives me peace of mind,” says Shelley Costello, 57, of Wenatchee, Wash., whose 81-year-old mother uses the device to keep tabs on her high blood pressure.

However, most medical pros don't yet work with the Health Buddy.

Your parent's doctor doesn't? Joseph Sharit, a research professor at the University of Miami's Center on Aging, recommends this easy-to-use, reasonably priced alternative: **IDEAL LIFE** (ideallifeonline.com; \$200 to \$450 upfront plus \$8 to \$50 a month). The main difference: This system doesn't automatically send health data to a doctor but to you (or someone you designate), via a smartphone alert or a website you can check.

• **THE CAVEAT:** Getting the data yourself won't do much good unless you know how to interpret it. Consult your parent's doctor to find what numbers are worrisome and what to do if he or she hits them.

• **DOES INSURANCE COVER IT?** Usually, if the system is prescribed and overseen by a health pro.

Fortunately, competition to provide newer and better elder-care aids is accelerating, which promises to drive down prices, Orlov says. That's good news for older Americans—and for caregivers who want to help their parents stay at home, worry-free, as long as possible. ■

Call on These Experts

http://www.southcoastarchitects.com

Parents who won't take advice from their children will often accept it from professionals. Get these three on your team.

Certified geriatric-care managers

WHO THEY ARE: Typically nurses or social workers with special training in elder care.

WHAT THEY DO: Help figure out what kind of care your parent needs and where to find affordable (or free) assistance, says Linda Fodrini-Johnson, a certified geriatric-care manager in San Francisco.

TYPICAL FEE: \$160 to \$400 for an initial two-hour consultation; \$80 to \$160 an hour after that.

FIND ONE: caremanager.org

Certified aging-in-place specialists

WHO THEY ARE: Contractors who have passed classes and tests in home design for the elderly.

WHAT THEY DO: Recommend and carry out home modifications to reduce the risk of falls.

TYPICAL FEE: \$250 to install grab bars in the bathroom; more elaborate renovations can cost well into the thousands, says Louis Tenenbaum, a certified aging-in-place specialist in Potomac, Md.

FIND ONE: nahb.org

Certified driver-rehabilitation specialists

WHO THEY ARE: Health pros such as occupational therapists who have passed courses on driver training, safety, and rehabilitation.

WHAT THEY DO: Determine if your parent is still safe on the road and offer training or equipment to improve his or her driving skills. (Ask your parent's doctor to prescribe

an appointment, which can persuade Mom or Dad to participate.)

TYPICAL FEE: \$300 to \$500 for a two- to three-hour assessment; \$500 to \$700 for a typical five-session retraining course.

FIND ONE: driver-ed.org

PART II - CHAPTERS 600 - 1411

**POLICIES
AND
PROCEDURES
FOR
SERVICE OPTIONS USING RESOURCES
IN COMMUNITY ENVIRONMENTS
(SOURCE)**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

Published OCTOBER 1, 2010

**PART II - POLICIES AND PROCEDURES FOR
SERVICE OPTIONS USING RESOURCES IN COMMUNITY ENVIRONMENT
(SOURCE)**

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	Appendix BB	SOURCE Discharge Summary,
	Appendix CC	Billing
	Appendix DD	NATIONAL CODE TABLE
Rev 10/08	Appendix EE	SOURCE Case Management Provider Main Offices
	Appendix FF	Enhance Primary Care Case Management Application
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Rev 07/09	Appendix HH1	Member Request Form
Rev 07/09	Appendix HH2	Instructions
Rev 10/09	Appendix II	Urgent Admission Documentation Form
Rev. 10/09	Appendix JJ	SOURCE Site Monthly Activity Report

PREFACE

Policies and procedures in this manual apply to all SOURCE Case Management Provider. All services providers must refer to Community Care Services Program for specific program requirements for policies and procedures specific to each service type, unless otherwise indicated by the SOURCE DCH Policy and Procedure Manual.

Part II	Chapter 1100	Adult Day Health
Part II	Chapter 1200	Alternative Living Services
Part II	Chapter 1300	Home Delivered Services
Part II	Chapter 1400	Personal Support Services
Part II	Chapter 1500	Out-of-Home Respite Care
Part II	Chapter 1600	Emergency Response
Part II	Chapter 1700	Home Delivered Meals

All SOURCE Case Management Provider and service providers must adhere to Part I – Policies and Procedures Applicable to All Medicaid Providers, unless otherwise indicated by the SOURCE Policy and Procedure Manual.

Definitions/Abbreviations

Rev. 07/08

As used in this policy manual, unless the content indicates otherwise, the term:

Activities of Daily Living (ADLs) – include fundamental activities related to community living, such as eating, bathing/dressing, grooming, transferring/locomotion and toileting.

Caregiver (CG) – Person providing significant non-paid support to a SOURCE member; most typically a family member. Has formal or informal authority to receive information and participate in decision –making on behalf of a SOURCE member.

Carepath – A standardized set of expected outcomes for each SOURCE level of care, with an individualized plan for each member to achieve them. SOURCE Carepaths address risk factors associated with chronic illness and functional impairment. Replacing conventional HCBS care plans, SOURCE Carepaths provide structure and accountability for case management practices of a chronic care population.

Carepath Variance – When an expected Carepath outcome doesn't occur; a Carepath goal not met. Variances require action on the part of the Case Manager to ensure that issues are promptly resolved and goals will be met in the following review period.

Case Management Supervisor (CM Supervisor) – The staff member with direct supervisory authority over Case Managers; may also serve as Program Manager. Responsible for ensuring that CMs address Carepath variances and work in accordance with program goals. Assists CM in problem solving, reviews documentation and monitors provider performance.

Case Manager (CM) – The staff person serving as the SOURCE member's liaison and representative with other program key players; the CM's primary responsibility is to ensure that goals of the program and of individual members are met. Performs functions of needs assessment, Carepath monitoring and coordination with other health system or social service personnel.

Case Note – An entry in a SOURCE member's chart by a Case Manager or Case Management Supervisor. Case notes document contacts with or on behalf of SOURCE members; actions taken on behalf of SOURCE members; or observations/follow-up planning by case management staff. Case notes should give the date, the person contacted, the setting and a description of the exchange. Case notes are used to note problems identified, to document resulting follow-up activity and to indicate when problems are resolved. Notes written on SOURCE Contact Sheets are considered case notes.

Community Care Services Program (CCSP) – Medicaid funded program in Georgia providing a range of community-based services to nursing home eligible persons, administered by the state's Department of Human Resources under a 1915 (c) waiver.

Community Services – The menu of possible services reimbursed through SOURCE according to the care path plan authorized by the site, provided in a home or community setting.

Community Service Provider – An organization participating in the program as a provider of community services authorized by the CM and reimbursed through SOURCE.

Concurrent Review – The process of regular and thorough review of essential information about individual SOURCE members, by a Case Manager and key players; used to ensure that Carepath and program goals are met.

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Enhanced Primary Care Case Management – The service provided through the SOURCE program, blending primary medical care with case management and community services for Medicaid recipients with chronic illness.

Rev 01/09

MDS-HC – Minimum Data Set – Home and Community Assessment to determine Level of Care. SOURCE program uses Version 9.

Medicaid – A jointly funded, federal/state healthcare assistance program administered by the Division of Medical Assistance (DMA) under the Georgia Department of Community Health, serving primarily low-income individuals: children, pregnant women, the elderly, blind and disabled. SOURCE falls under DMA's Aging and Community Services.

Home and Community Based Services (HCBS) – Supportive services delivered in a home or community setting, as opposed to a nursing home or other institution. Personal care services and home delivered meals are examples of HCBS. In addition to a private residence, HCBS settings also include personal care homes and adult day health centers.

Instrumental Activities of Daily Living (IADLs) – include supportive activities related to community living, such as meal preparation, housekeeping, using the telephone, financial management, etc.

Key Players – Individuals or organizations bearing major responsibility for ensuring that program and Carepath goals are met: SOURCE members and/or informal caregivers, Case Managers, CM Supervisors, PCPs and service providers.

Member Information Form (MIF) – Form used to record communication between SOURCE Case Management Provider and SOURCE providers. Required for documenting key exchanges (service level changes, etc.), the MIF may be initiated by either party.

Program Manager – The staff member responsible for implementing all policies and procedures of the SOURCE program. Primary responsibilities include coordination among key players, developing site-specific policies and procedures, leading data analysis and serving as liaison with the Department of Community Health.

Rev.

10/09

SOURCE Level of Care and Placement Instrument (Appendix F) – Document used to formally enroll Medicaid members into the SOURCE program .

SOURCE Member – A Medicaid recipient who is formally enrolled in the SOURCE Enhanced Primary Care Case Management program.

SOURCE Primary Care Provider (PCP) – The chief clinical partner in providing enhanced case management to SOURCE members; may be a physician or a nurse practitioner. Responsibilities include direct primary medical care and coordinating with other key players in the program. All SOURCE members must be under the care of a PCP participating in the program.

SOURCE Enhanced Case Management – The entity under contract with the Georgia Department of Community Health, Division of Medical Assistance, to provide the “enhanced primary care case management” service described in this manual and in the SOURCE Memorandum of Understanding. Program components may be provided directly by the entity holding the contract or by sub-contract, but the site bears responsibility for implementation of program policies and procedures.

ABBREVIATIONS

Behavior – abbreviation for the behavior Carepath outcome

Clin – abbreviation for the clinical indicators/lab value Carepath outcome

Comm – abbreviation for the community residence Carepath outcome

Housing – abbreviation for the housing Carepath outcome

Incont – abbreviation for the incontinence Carepath outcome

Inf support – abbreviation for the informal support Carepath outcome

Meds – abbreviation for the medication Carepath outcome

Nutr'n – abbreviation for the nutrition Carepath outcome

Skin – abbreviation for the skin Carepath outcome

Trans/mob – abbreviation for the transfer/mobility Carepath outcome

PART II – CHAPTER 600
SOURCE Overview

601. Introduction to SOURCE

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services Medicaid Waiver approved by the Centers for Medicare and Medicaid Services. Individuals eligible for the enrollment in SOURCE must be eligible for Medicaid based on receipt of Supplemental Security Income (SSI) or SSI categorically related Medicaid and meet the Intermediate Level of Care for Nursing Home placement. Individuals served by SOURCE must be physically, functionally impaired and in need of services to assist with the performance of the activities of daily living (ADLs). Without waiver services, eligible SOURCE members would require placement in a nursing facility. While individuals, participating in SOURCE under the Elderly and Disabled waiver, do not have specific exclusions related to age, the waiver targets individuals who are elderly and physically disabled. SOURCE through its case management model, Enhanced Primary Care Case Management (EPCCM), links primary care to community services. SOURCE, through EPCCM, is distinguished as Georgia's only waiver case management model which actively incorporates primary care physicians into the overall management of each member's service plan addressing medical needs and need for community based long-term care services. Using the tenets of managed care, the SOURCE case management model provides a framework to manage members across all lines of service, diagnosis and disability. Case Managers, as the functional center of the framework, employ Carepaths as the essential tool and concurrent review as the essential process. Case Managers and key players, through Carepaths and concurrent review, work toward recognized program goals held in common - the last essential component of the model's framework.

SOURCE Case Management Provider is contracted with DCH to provide Enhanced Primary Care Case Management (EPCCM) services for eligible older and physically disabled Medicaid recipients. The model is comprised of three principal components – primary medical care, community services and case management – integrated by the site's authority to approve Medicaid-reimbursed services.

SOURCE sites receive an enhanced case management fee per member per month. Community and physician services for SOURCE members are covered under conventional Medicaid fee-for-service reimbursement with authorization by the site. For dually insured members, Medicare remains the primary payer for services traditionally covered by Medicare. While the SOURCE Case Management Provider is expected to coordinate services delivered under Medicare, no authorization is required for Medicare reimbursement. For services covered by Medicaid, in addition to community and physician services (hospitalizations, lab/diagnostics, co-pays for dually insured members, etc.), the SOURCE Enhanced Case Management authorization number may be required.

602. SOURCE Goals

Goals identified for SOURCE include:

- a) Reducing the need for long-term institutional placement and increasing options in the community for older and disabled Georgians, by designing an effective model replicable across the state
- b) Preventing the level of disability and disease from increasing in members with chronic illness
- c) Eliminating fragmented service delivery through managed care principles, outcome-based case management and relief from programmatic constraints
- d) Increasing the cost-efficiency and value of Medicaid LTC funds by reducing inappropriate emergency room use, multiple hospitalizations and nursing home placement caused by preventable medical complications; also by promoting self-care and informal support when possible for individual members

603. Core Refinements to Traditional HCBS

The SOURCE Program tests four core refinements to traditional HCBS programs:

- a) SOURCE financially and operationally integrates primary medical care with the case management of home and community-based services, significantly bolstering the effectiveness of each.
- b) SOURCE enhances case management authority and scope of responsibility to ensure active advocacy as staffers address all components of members' healthcare on a 24/7 basis, including inpatient and outpatient hospital encounters and home health services. Removal of programmatic barriers translates to rapid amendments to service plans in response to member need. Case Managers further assist members as needed in areas outside the scope of direct medical or community services (housing, eligibility, supplies, etc.).

SOURCE has developed and implemented a series of Carepaths for chronically ill persons (targeted conditions include: diabetes, high blood pressure, Alzheimer's Disease, dementia, stroke, heart disease, asthma or other pulmonary conditions) at different functional levels, replacing the traditional HCBS care plan. Carepaths constitute a structured case management accountability system that regularly measures the achievement of key objectives for individual members, for the caseload of each Case Manager or Primary Care Physician and for the entire program.

- c) SOURCE measures the performance of providers of community services by standards that exceed basic licensing requirements. Providers of personal/extended support services (the most highly accessed category of service) will honor member and site expectations of:

Reliability of service, including early morning or late evening visits
Competency, compatibility and consistency of staffing
Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver
Coordination with Case Manager

The provider's role in achieving care path objectives – including member satisfaction with services – is regularly measured, addressed with performance improvement strategies as indicated and used to determine case assignments.

- d) SOURCE uses three Carepath levels (I, IIc and IIc) to define functional needs of individuals. The Carepath level designations do not automatically assign members to a single or limited choice of services but do in the aggregate predict costs and scope of care though wide variations existing within each level.

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604. SOURCE Themes

The SOURCE vision of an ethical and disciplined community-based long term care system is described by several key themes that apply broadly to all members in the program (sites, members, providers, DMA):

- a) Integration:
Empowerment via the authority to enforce expectations of key players by authorizing payments
Communication – scheduled and as needed to meet individual and program goals
Common objectives that keep members at the center
- b) Member centered approach:
Member/family contribution and cooperation encouraged and valued
Advocacy for individual members, across all settings
Inclusiveness of varying ages, disabilities and functional capacities
- c) Continuous improvement:
Collecting and reviewing data regularly to identify problem areas
Marshalling resources to help individuals address problems
Redesigning systems to help DMA address problems for chronic care populations

605. Partnership with DCH

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04/10

All sites will maintain a partnership with DCH to continuously improve overall program performance and to ensure that individual sites are working toward stated goals. The partnership may be fulfilled by sites in several ways:

- a) Participation at scheduled meetings with DCH staff to discuss program guidelines, performance improvement strategies and site-specific updates
- b) Monthly reporting to DCH on program activity
- c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

606. Enrolling as a SOURCE Enhanced Case Management Provider

A. SOURCE contractors receive a per member, per month case management fee billed on the CMS 1500, in return for providing Enhanced Primary Care Management.

Rev 04/08

If you are interested in enrolling to become an EPCCM provider, you must complete the Medicaid enrollment application located at the GHP Portal www.ghp.georgia.gov. The SOURCE Enhanced Case Management Application, which is included in Appendix FF-, must also be completed. Completed applications should be mailed to Department of Community Health, Long Term Care Section, 2 Peachtree Street NW, 37th Floor, Atlanta, GA 30303.

B. Compliance – Applicants must demonstrate maintenance of a satisfactory record of compliance with federal and state laws and regulations, and must not be currently or previously prohibited from participation in any other federal or state healthcare program or have been convicted or assessed fines or penalties for any health related crimes, misconduct, or have a history of multiple deficiencies cited by Utilization Review and/or deficiencies that endanger the health, safety, and welfare of the member.

In addition, the provider agency must have no deficiencies within the past 3 years from any licensing, funding, or regulatory entity associated with enrollment in any Medicaid services, or with the provision of any related business unless such deficiencies have been corrected to the satisfaction of the imposing entity.

C. Sponsor or Parent Organization – If a provider has a sponsor or parent organization, the sponsor or the parent organization must maintain full responsibility for compliance with all conditions of participation. Daily operation of the program may be delegated to a subdivision or subunit of the sponsor or parent organization.

Rev 04/08

D. Application Review - DCH will approve new applications for EPCCM Providers based on the following criteria:

- Successful completion of the provider application located on the GHP website: www.ghp.georgia.gov
- Successful completion of the EPCCM Application (see Appendix FF)
- If DCH is unable to recommend approval of the application as submitted, the applicant will be notified in writing (including electronic mail) of any additional information required. The applicant must return the requested information within 30 days. If the applicant fails to return the additional information within 30 days, and/or the additional information is not acceptable to the Department of Community Health, DCH will deny the application.
- DCH will conduct site visits, if applicable. If the site visit results in unsatisfactory review, DCH will deny the enrollment application.

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- If the application is denied, DCH will notify the applicant of the reason for the denial. Applicant agencies have the right to appeal enrollment denial as indicated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.
- If the enrollment material meets submission and enrollment requirements, and no other information is required, the applicant will be notified in writing by DCH of its approval to become an EPCCM Agency.

Rev 04/08

NOTE: Applicant may not re-apply as an EPCCM for one (1) year after date of denial

607. Expansion Procedures

Prior to opening any new office or expansions to additional counties **by an existing office**, all sites that have been previously approved for SOURCE Enhanced Primary Care Case Management (EPCCM) must submit an expansion application to the Department of Community Health, Long Term Care Section for review and approval(see Appendix GG)

Rev 04/08

Department of Community Health
Long Term Care Section
Two Peachtree Street N.W.
37th Floor
Atlanta, Georgia, 30303

NOTE: Newly approved EPCCM Sites may not apply for additional counties for six (6) months after date of approval.

Providers seeking expansion are required to be in compliance with all applicable laws, rules, regulations, policies and procedures of all services the provider is currently enrolled to provide. DCH will not process an expansion request for a provider against whom there are unresolved complaints/deficiencies cited by Utilization Review/ Program Integrity or other licensing or regulatory agencies.

Rev 04/08

Note: New provider EPCCM agencies as well as Expansion EPCCM agencies that have more than one location must have a separate provider number for each approved location

608 Community Service Provider Enrollment Procedure

- A. All participating SOURCE providers must first be enrolled as a CCSP provider for the same services. Please note that a separate SOURCE provider number must be obtained prior to rendering services.

Rev 7/08

Note: Provider agencies requesting to become a SOURCE Provider must have completed a minimum of 6 months as a CCSP provider before applying to become a SOURCE Provider.

- B. A Letter of Intent from an Approved EPCCM Agency must accompany the provider application.

C. Providers must complete the following enrollment steps:

- Complete the Provider Enrollment Application located on the GHP website: www.ghp.georgia.gov
- Attach the following documentation with the provider application:
Statement of Participation
W9
Disclosure of Information,
Electronic Funds Transfer Form
Voided Check
Payee Form (all forms can be located in the GHP Website)
Letter of intent from EPCCM agency
- Mail the completed provider enrollment application to ACS- address located on the application.

Rev 01/24/04

B. DCH will review the SOURCE Provider applications to determine if enrollment materials meet submission and enrollment requirements. If no further action is required, DCH will notify the applicant of approval of the Medicaid enrollment.

Rev 04/08 609

SOURCE Early Admission

Criteria for Approving Urgent SOURCE Admissions

Current federal policy stipulates that persons may not be enrolled in more than one Medicaid case management program at the same time. Current DCH policy stipulates that persons may opt out of one case management program to enroll in another only at the end of a calendar month. SOURCE screening staff is responsible for review of member program participation through the GHP web portal prior to initiation of the member face to face assessment. The member will be educated about services available in SOURCE versus his/her current case management program during the face to face assessment with the SOURCE nurse. While the SOURCE case manager is in the home, a case conference will be conducted, telephonically, during which the member will verbalize his/her choice. Information from the case conference should be documented on the Member Request form (Appendix HH). Members are then eligible for enrolling in the SOURCE program effective the 1st of a following month as described below:

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- Persons who request to opt out between the 1st – 20th days of the month are dis-enrolled effective the end of the current month.
- Those who request to opt out between the 21th day and the end of the month are dis-enrolled effective the end of the month following the current month.

On occasion, there are persons who may have an urgent need to transfer from DSM, CMO or any other Managed Care Program to SOURCE before the time lapse indicated above or to enter SOURCE prior to the 1st of the month. In that instance, the SOURCE

case management provider must submit a written request to DCH requesting that DCH approve early admission for the member to be locked into SOURCE on an expedited basis.

In order to request an override, the SOURCE case management provider must provide DCH with documentation that the member has a major functional impairment with insufficient resources to meet the need as evidenced by meeting ALL of the following criteria:

A. Member must have a functional deficit, defined as:

- ADL impairment (excluding bathing/dressing), at least one of the following
 - Transferring – unable or risk of falls
 - Mobility
 - Eating
 - Toileting

AND/OR

- Cognitive impairment, at least one of the following
 - Substantial memory deficits
 - Impaired judgment for daily decision making
 - Problem behavior
 - Undetermined cognitive patterns that cannot be assessed; for example, due to aphasia

B. Member must also have a lack of available resources, defined as:

- No informal caregivers available.
- Informal caregivers are not available often enough to render adequate assistance (member lives alone, working caregiver, etc.).
- Informal caregivers are not reliable.
- Informal caregivers are cognitively or physically impaired themselves.
- Informal caregiver has an acute illness that compromises their ability to provide assistance.
- Home health and other medical or community resources are either not sufficient to meet the non-skilled needs or are not available.

C. Member must also be at imminent risk of institutionalization, defined as:

- Housing at risk
- Member's physical safety threatened
- Health status endangered (clear and present threat of loss of life or major function due to illness).

D. Written attestation by a physician that all of the above criteria are met.

Rev, 10/09 Refer to Appendix II-1 for documentation form.

PART II - CHAPTER 700
Eligibility

701. Eligible Members

Individuals eligible for SOURCE are:

Rev. 04/05

- a) Aged 65 and older, or under 65 and disabled
- b) Receiving Medicaid under SSI* or Public Law categories* *
- c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care

Rev. 04/10

- d) Cost of necessary services can be provided by SOURCE at less cost than the Medicaid cost of nursing facility care
- e) Willing participants who choose enrollment in the SOURCE Program (Member choice)
- f) Residing in a SOURCE Enhanced Case Management's designated service area; and
- g) Capable, with assistance from SOURCE and/or informal caregivers, of safely residing in the community (with consideration for a recipient's right to take calculated risks in how and where he or she lives)

Rev 04/08

A person may not participate in more than one Medicaid waiver program at the same time. Individuals may transfer from one waiver to another, contingent upon eligibility and available funding.

Rev 07/10

SOURCE operates under authority of the Georgia Elderly and Disabled 1915-C Medicaid Waiver and provides Home and Community Based Services to elderly and physically disabled members who are functionally impaired and require assistance to perform the activities of daily living and who meet the Intermediate Nursing Home Level of care for placement in a nursing facility.

(*Supplemental Security Income is a federally administered financial assistance program which provides payments and Medicaid benefits to low income individuals who are aged, blind or disabled; **Public Law recipients meet specific criteria for certain deductions from their income; if the person is eligible for SSI after these deductions, he or she can qualify for Medicaid.)

A member enrolled in SOURCE cannot be enrolled in Hospice or any other Medicaid Waiver Program

Rev. 01/10

Member Exclusions

- Members who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing facilities, hospital swing bed units, hospice, intermediate care facilities for mentally ill, or correctional institutions

- Members currently enrolled as members in the Georgia Families program
- Children enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Childrens Medical Services
- Children in foster care or otherwise in the custody of the State
- Participants in other waiver programs (BCC Waiver, Independent Care Waiver, Mental Retardation, Laurens County Waiver
- Participants in the Recipient Lock-In program (GEXP, GBHC, PASRR, HMO, GAPP)
- Children enrolled in the Georgia Pediatric Program (GAPP)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the TRIS or PRTF program
- Children who are receiving services under Title V (CMS) funding

Rev 04/09 **The following activities are not appropriate for SOURCE providers of any type:**

- Soliciting clients from other providers or other programs
- Developing Carepaths, using amount or frequency of services, to encourage member choice of providers

PART II – CHAPTER 800

Scope of Services

801 – Levels of Care

- Rev 07/08 801.1 Carepath Levels
- a) All members are assigned one of three Carepath levels, with criteria for each based on intensifying needs for medical monitoring and assistance with functional tasks. Carepath Level One members are the most in need of assistance. To tailor Carepaths more precisely, Carepath Level Two members are further divided into Carepath Level 2-F (based on functional impairments due to physical disability) and Carepath Level 2-C (based on cognitive impairment).
- Rev. 04/05
- b) SOURCE Carepath levels are not defined by diagnosis (see Appendix G– Carepath Level Criteria). The Carepath Level criteria is applied consistently across SOURCE sites; with established triggers for applying individual Carepath evaluations (see Appendix – Applications). Case Managers gather information for assigning Care Path levels at the initial assessment. If the new member has visited the SOURCE PCP prior to enrollment, the primary care provider and staff may also have additional knowledge relevant to assigning a Carepath level. .
 - c) SOURCE members are compromised in their ability to live independently, and are at significant risk of institutionalization due to health conditions and substantial physical and/or cognitive limitations. Although wide variation exists among individuals at each Carepath level, community services in the aggregate are more heavily utilized by lower Carepath level members.
- Rev. 07/08 801.2 Level Of Care Criteria
- a) SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement. The SOURCE RN/LPN, through the use of the MDS-HC (v-9), Level of Care criteria (Appendix I), and professional judgment, determines the Level of Care (LOC) for members during the assessment process. Assessments and re-assessments completed by the LPN **must** be signed and certified by the designated RN within 10 business days of completion.
- Rev. 04/10,
07/10
- b) SOURCE services rendered to a member will be ordered by a physician and listed on the Carepath. The Doctor/Medical Director’s signature on the LOC confirms Level of Care assessment.
- Rev. 01/09
- c) Providers may render SOURCE Services only to members with a current LOC as reflected on current SOURCE Level of Care and Placement Instrument (APPENDIX F) and completed MDS-HC (v9) assessment.
- Rev. 10/09

- d) Members must meet all SOURCE eligibility criteria to participate in the program.
- e) Each SOURCE member is given an approved LOC certification for program participation. A LOC certification is approved for no more than 12 months and expires on the last day of the month as indicated on the LOC and Placement Instrument (APPENDIX F).

Example: If member LOC certified by physician signature on September 25, 2009; then, LOC expires on September 30, 2010.

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801.3 Procedures

- 1) Complete MDS-HC with member
- 2) If member meets Intermediate Level of Care Criteria (ILOC), obtain member signature on the SOURCE Level of Care and Placement Form (Appendix F)
- 3) MDS-HC document, placement form and all assessment documents and member information to the multidisciplinary team meeting with the Medical Director (physician)
- 4) If physician agrees that member meets ILOC, physician signs SOURCE Level of Care and Placement Form
- 5) RN certifies ILOC by his/her signature on the SOURCE Level of Care Placement Form
- 6) Forward signed placement form to Department of Community Health/Division of Medicaid/Long Term Care Unit via facsimile (404 463 2889)

NOTE: Prior to completing the MDS-HC Assessment the RN and/or LPN who conducts or coordinates the assessment process must attend an annual MDS-HC training session scheduled through the Department of Community Health (DCH). Once the MDS-HC assessment is completed by the RN/LPN, the level of care assessment tool can be accessed by an authorized user designated by the SOURCE Site. Should training be needed for new RN's sooner than the annual training, contact the SOURCE Program Specialist.

All SOURCE team members who have access to the MDS-HC System must be an authorized user approved by the Department of Community Health.

802 Primary Medical Care

SOURCE Case Management Provider engages a limited panel of primary care providers to work closely with Case Managers on meeting program and Carepath goals for members. An effective enhanced case management model demands from participating Primary Care Physicians a commitment of time, energy and focus. Providers include physicians, (e.g. Internal Medicine, Family Practice and geriatricians), and nurse practitioners.

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04/10

In addition to traditional functions of evaluation/ treatment for episodic illness and minor injury, key features of SOURCE primary care are:

- a) Initial visit upon enrollment, unless member is already under the care of their Primary Care Physician prior to enrollment
- b) Chronic disease management, including:
 - Risk factor modification and secondary disease prevention
 - Monitoring key clinical indicators, including review of data from ancillary services
 - Education for members/caregivers about disease treatments, common complications and preventive interventions
 - Medication review and management, with current medication list on file
 - Referral and authorization for specialists or diagnostic services, as needed
 - Coordination of ancillary services

See also Section 1310, Disease State Management.

- c) 24-hour a day medical advice/triage
- d) Regularly scheduled conferencing between Primary Care Physicians and CMs
- e) Accessibility of PCP to case management staff, as needed
- f) Reliance by Primary Care Physician on case management staff for information on:
 - Carepath variances
 - Home environment
 - Informal support
 - Community services
- g) Case management role includes assisting members in carrying out Primary Care Physician orders and interventions
- h) Review by PCP of Carepaths and service plans, upon enrollment and periodically until discharge
- i) Referral, coordination and authorization for specialists, hospitalizations, home health and ancillary services, etc.
- j) Wellness promotion and preventive health measures, including immunizations, cancer screenings, vision and hearing screening, etc.

803 Site Medical Director

The Site Medical Director occupies a unique position of influence in local perceptions of Community Based Long-Term Care. To ably serve the site's membership, the Medical Director must be committed to program goals of community residence, prevention of increased disability and cost effectiveness. The Medical Director will ideally have a strong history and connection with the local medical community, facilitating understanding of the model and fostering support for member and program goals. The Medical Director will participate actively on the site's multidisciplinary team, and will

advocate on behalf of the program or individual member with the local health system or other physicians.

Specific responsibilities of the Medical Director include working with the Multi-disciplinary team to:

- a) Advise on the local site's policies/procedures
- b) Advise on the local site's internal grievances
- c) Advocate on behalf of the program or individual member with the local health system(s), other site physicians or non-participating community physicians
- d) Review, sign and date Carepaths and APPENDIX F forms of all members
- e) Confirm Level of Care determination as confirmed by the MDS-HC assessment tool, signing the APPENDIX F form for new members, and reassessments, at least annually.
- f) Confirm and sign APPENDIX F when member fails to meet nursing home Level of Care and requires discharge
- g) Review service delivery issues
- h) Review repeated hospital encounters for individual members
- i) Review issues of chronic non-compliance
- j) Review Carepath variances as requested by case management staff
- k) Review discharges to nursing homes, prior to the date of discharge
- l) Review utilization data
- m) Review complex referrals

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804 Case Management

Case Management is a collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet individual needs and making referrals as needed. SOURCE case managers consist of nurses, RN and LPN, currently licensed in Georgia and social services workers.

The four components of case management are described as follows:

- Assessment and periodic reassessment – determines service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessments are comprehensive in nature and should address all needs of the individual, including an individual's strengths and preferences, and consider the individual's physical and social environment.
- Development and periodic revision of the Carepath – specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, as collected through an assessment or reassessment.

- Referral and related activities – help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs.
- Monitoring and follow-up activities – include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. These activities should take place at least on a quarterly basis for face to face contacts and at least monthly for phone contacts. The monitoring and follow-up activity determines whether the services are being furnished in accordance with the individual’s care plan; services are adequate to meet the needs of the individual; and there are changes in the needs or status of the individual.

Note: **The Department of Community Health requires that new SOURCE Case Managers complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).**

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805 Case Management Supervision

In working to support people with physical and cognitive impairments in living outside of institutions, Case Managers regularly face difficult situations requiring sound judgment and painstaking review of options. To best assist members in maintaining, sometimes fragile and complex Carepath plans, Case Managers need active supervisory support. An engaged supervisor will ensure that Case Managers have benefit of an additional perspective in developing, implementing and adapting responsive Carepaths.

To help meet program and member goals, the case management supervisor’s role includes:

- a) Regular conferencing to review case management activity around each member and signing SOURCE contact sheets.
- b) Availability between supervisory conferences to help Case Managers solve problems around key member issues.
- c) Administrative support for Case Managers making significant decisions or recommendations.

The case management supervisor may serve in other program capacities, such as the overall program manager.

Note: **The Department of Community Health requires that new SOURCE Case Management Supervisors complete training in SOURCE Policies and Procedures within 90 days of employment as well as annually thereafter, as provided by the DCH approved contractor(s).**

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806 SOURCE Case Management Team

Each SOURCE Enhanced Case Management Team convenes a formal multidisciplinary team meeting at least weekly, to perform the following functions:

- a) Review new admissions and confirm/verify level of care
- b) Authorize service plans for new members
- c) Develop site-specific policies and procedures
- d) Track and analyze repeated hospital encounters for individuals
- e) Hear issues of non-compliance and involuntary discharge
- f) Review chronic Carepath variances and potential nursing home discharges
- g) Review provider or service delivery complications
- h) Review discharges to nursing homes, prior to the date of discharge
- i) Review utilization data
- j) Review complex referrals

Membership on the team may be fluid but will at least include the Medical Director, the program manager, case management supervisory staff, an RN/LPN and case manager presenting new members or information. Other clinical, case management or administrative staff members may participate as needed. At the team meetings, the **Medical Director confirms the Level of Care for new members initial assessments as well as annual re-assessments (or members with a change in level of care) by signature on the member's Carepath and SOURCE Level of Care and Placement Instrument (APPENDIX F) form.**

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807 Community Services

All community services providers must first be enrolled under CCSP and will comply with CCSP policies and procedures unless indicated otherwise in this manual. Rather than enrolling all organizations licensed to provide HCBS, the SOURCE design limits participation through a preferred provider approach. Exchanging a volume of business for compliance with increased performance expectations, SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members.

Reimbursed services through SOURCE are:

- Personal Support Services/Extended Personal Support (PSS/EPS)
- Adult Day Health (ADH)
- Home Delivered Meals (HDM)
- Alternative Living Services (ALS)
- Emergency Response System (ERS)
- Home Delivered Services (HDS)
- Skilled Nursing Services (SNS) (only used when all other home health agency options have been exhausted, ref. chapter 1900 of CCSP Manual)

The need for paid community services is not a prerequisite for membership in SOURCE. Case management alone provides sufficient support for some members to maintain residence in the community; tasks may include conferencing with physicians, making appointments or transportation arrangements, resolving equipment or supply needs, ensuring that monitoring efforts are effective, assisting in housing issues, etc. Self-care and informal sources are first maximized before accessing HCBS in SOURCE. Triggers for referral to the SOURCE program include cognitive loss or physical impairments, acute illness or exacerbation of a chronic illness, and an unmet need for assistance with ADLs and IADLs due to the lack of an adequate and/or reliable informal support network.

Community services primarily offer assistance to members in activities of daily living (ADLs) or instrumental activities of daily living (IADLs). The Community Care Services Program provider manuals may be referenced for definitions of these service categories. Unless otherwise noted in this document, Community service providers will operate in accordance with CCSP provider-specific manuals. Copies of CCSP provider-specific manuals are available through the GHP Website: www.ghp.georgia.gov.

Key characteristics of the SOURCE provider role:

- a) Intensified communication/coordination with case management staff, over conventional HCBS programs
- b) Commitment to continued service for members with challenging personal situations or diagnoses
- c) Demonstrated efforts to serve manpower shortage areas
- d) Service for members needing PSS/EPS hours both above traditional service levels and below
- e) Willingness to flex service levels as authorized by Case Manager, in response to the complex or unpredictable status of individual members
- f) Customer satisfaction standards exceeding basic licensing requirements; specific areas of accountability include:

Reliability of service, including early morning or late evening visits

Competency, compatibility and consistency of staffing

Responsiveness to member and staff concerns, including the scope of care as described by the member or caregiver

Coordination with Case Manager

- g) Regular measurement of performance
- h) Monthly utilization and reconciliation reports of all providers
- i) Carepath measurement of customer/site satisfaction with services every quarter
- j) Monthly score generated for PSS/EPS providers
- k) An active 24-hour on-call service that coordinates dependably with Case Manager and members/Caregiver

(*Applicable only to PSS/EPS providers, the service category most heavily utilized by SOURCE members.)

PART II – CHAPTER 900

SOURCE Member ENROLLMENT

901. Screening

Potential SOURCE members will be screened to determine eligibility and to gather data for the Division of Medical Assistance on persons seeking long-term care. SOURCE screening may be performed by the SOURCE Enhanced Case Management or under sub-contract. Screening may be by phone or in person. Referrals may come from many sources, including but not limited to:

- a) Hospital discharge planners
- b) Physician offices
- c) Family members or other informal caregivers
- d) Community social service agencies
- e) Home health agencies or other health system organizations

Procedures:

- a) Inquiries will be recorded using a SOURCE screening form, to ensure comprehensive and standardized data collection and to facilitate follow-up activity.
- b) Telephone inquiries and other referrals will be screened by designated staff. A full description of the program will be provided for potential members or caregivers. Designated screening staff must have a full grasp of SOURCE and other local long-term care options available.
- c) Screening staff will access the GHP website to confirm a potential member's eligibility status. For persons not eligible for SOURCE or not interested in joining the program, appropriate referrals to other services or organizations will be made (including referral to the Social Security Administration if the person screened may be eligible for SSI). See also Policy No. 1405, Right to Appeal.
- d) For those meeting SOURCE eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be provided to the case management staff and an assessment scheduled.
- e) Screening shall be completed within three business days of the initial inquiry. Extenuating circumstances which prevent meeting the standard of promptness will be documented on the screening form (Appendix A).

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902. Assessment

All persons joining SOURCE will be formally assessed in their homes by the site case management staff and/or RN/LPN (exceptions noted below) prior to initiation of services, using the MDS-HC (v9) and other SOURCE approved Assessment Tools. The purposes of assessments are:

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- a) Evaluation of the member's medical and health status; functional ability; social, emotional and environmental factors related to illness, and support system, formal and informal. Level of Care determination, Carepath development and delivery of community services.
- b) Identification of urgent problems which require prompt attention.
- c) Gather data regarding the population served by the program, for DMA review and to develop protocols for care.
- d) Evaluate the member's home environment (assessing the physical structure and home safety, meeting caregivers or family members as indicated to assess informal support system, etc.). See Section 1005, Self Care and Informal Support.

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Exceptions to member "in home" assessment

- a) Member is receiving in-patient care in an acute care facility awaiting discharge to a community based environment
- b) Member is currently residing in a nursing home

Procedures:

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- a) Following screening, case management staff/RN/LPN schedules the initial assessment.
- b) A Case Manager or assessment nurse may complete the Assessment Addendum Form; nurses will assess all potential members using the MDS-HC(v9) assessment tool and determine eligibility for the Program based on ILOC criteria..
- c) Assessments will take place in the home of the potential member, unless enrollment is necessary prior to discharge from a hospital, nursing home or rehabilitation facility.

- d) A caregiver, family member or advocate shall be present whenever possible during assessments for members with:
 - (1) A legally appointed guardian
 - (2) A known diagnosis of Alzheimer's or dementia
 - (3) Other known significant cognitive or psychiatric conditions
- e) While an informal caregiver may assist with answering assessment questions as needed (see above in particular), the potential new member is the primary source of information whenever possible, and is interviewed in person.
- f) The Case Manager will review the program's operations with the potential member following the assessment, including selection of the site as primary care provider.
- g) The following forms will be reviewed with the SOURCE member and signed (see Appendices).
 - (1) SOURCE Rights and Responsibilities, obtaining signatures on two copies (one left with the member, one for filing in the administrative chart) and including information on a member's right to appeal decisions of the site, signed at admission and at reassessment, at least annually.
 - (2) Consent for Enrollment form signed at admission.
 - (3) Records Release Authorization signed at admission and at reassessment, at least annually.
 - (4) SOURCE Level of Care and Placement form, formally selecting SOURCE as primary care provider under Medicaid at admission and level of care status.
 - (5) Member Request Form (Appendix HH), if member is currently enrolled in GEC/DSM Program, obtaining signatures on two copies (one copy left with Member).
- h) The Case Manager will provide the member/caregiver with the names of participating Primary Care Physicians. All members enrolling must select and agree to use a designated Primary Care Physician.
- i) All new members, not currently an established patient of a SOURCE physician must have an initial visit with the program Primary Care Physician selected. The member/informal caregiver OR the Case Manager may schedule the initial visit.

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Rev. 7/10 j) The assessment process will be completed within five business days of screening.. In situations where the standard of promptness is unmet, justification for failure to meet standard will be documented in the case notes of the member file

04/05 k) The Case Manager/must include directions to the member's home starting from the local SOURCE Enhanced Case Management office to member's home address.

l) Following completion of the admission assessment, the Case Manager will record all recommended services on the Services Recommended Form. The Case Manager will request and record member feedback and signatures from both member and Case Manager will be secured.

Rev. 7/08 **903. Program Admission**

SOURCE admission occurs with four steps following assessment:

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1. Review of new members by a multidisciplinary team
 2. Approval of the nursing home level of care as determined by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Justification
 3. Conveying new member information to the Georgia Health Partnership.
 4. Assignment of the Carepath Level
 5. Upon completion of enrollment and initiation of services, case manager will:

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A. Provide the following completed documents to all community service providers:

- MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T) with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
- Level of Care Justification (Appendix I)
- The Source Carepath
- Member version of carepath
- Rights and Responsibilities
- Authorization for Release
- Member Referral Form
- Member Information Form, if applicable
- Advance Directives (See Section 903, Procedure (j))
- Directions to the member's home, starting from the SOURCE site to the member's home address(See Section 902, Procedures (k))

- B. Provide the following completed documents to the member:
- Member participation form
 - Carepath-Member Version

Procedures:

- a) Case Managers will use the following format in presenting new members to the weekly admissions meeting of the multidisciplinary team:
- (1.) Member name, age and diagnoses
 - (2.) Caregiver information, if applicable
 - (3.) ADL/IADL score from SOURCE Assessment (if completed) or another assessment instrument as approved by DCH
 - (4.) Current medications
 - (5.) SOURCE physician selected from panel
 - (6.) Factors complicating Carepath planning (lack of informal support, recent hospitalization, etc.)
 - (7.) Recommended SOURCE services
 - (8.) Other community services planned or in place
 - (9.) Level of Care as determined by the RN/LPN.
 - (10.) ADH level recommended

LEVEL 1 Client Profile:

1. Requires watchful oversight to ensure safety.
2. Requires medical monitoring on a weekly basis.
3. Requires minimal assistance with activities of daily living (Refer to Section 1103.4C for a list of task).
4. May require assistance with self-care or verbal cues to perform self-care (e.g. safely entering and existing a shower or assistance with toileting).

LEVEL 11, Client Profile:

1. Requires watchful oversight to ensure safety.
2. Requires medical monitoring at least twice a week.
3. Requires moderate assistance with personal care. Client requires assistance with activities of daily living such as transfers, ambulation, bathing, or eating.
4. May require specialized therapy.
5. May require specialized nursing services such as bowel or bladder retraining, catheter care, dressing changes, or complex medication management.

The team reviews information to ensure that:

- (1.) Informal support is analyzed and maximized

- (2.) Services recommended are logical and cost effective
- (3.) Key health status issues are identified, with urgent problems addressed

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b) Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS-HC and other SOURCE approved assessment tools, with the RN/LPN presenting justification as needed.

c) The team recommends confirmation of the the Level of Care,

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d) The Medical Director indicates the member meets the nursing home Intermediate Level of Care on the SOURCE Level of Care and Placement Instrument (Appendix F) by signature and his/her signature on the Carepath confirms the service level. Medical Director must sign the Level of Care Placement form within sixty (60) calendar days of the member signature.

e) If applicable, the team also assigns the ADH level of service.

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f) Following the team meeting, the Case Manager faxes the Level of Care Placement Form to the Department of Community Health.

The APPENDIX F form must include:

- (1.) New member's name (printed)
- (2.) New member's signature
- (3.) Date of assessment
- (4.) New member's Medicaid number
- (5.) Site's GHP number
- (6.) Signature of the SOURCE Medical Director or the Primary Care Physician to verify Level of Care

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SOURCE Level of Care Placement form should be faxed to DCH at 404-463-2889 for enrollment.

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g) For HCBS provider billing, SOURCE members are locked into the site effective the first day of the following month if received prior to the 20th of the month based on the date of the member's signature on the APPENDIX F. Any APPENDIX F received after the 20th enrolls the member on the first of the following month.

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h) In cases of urgent need, supportive services or medical care will be arranged immediately, rather than waiting on the multidisciplinary team meeting. The Case Manager's supervisor and/or an RN/LPN will approve these referrals and assign a programmed Carepath level, with a formal review and approval occurring at the next meeting of the multidisciplinary group.

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- i) To formally notify DCH of changes if a member no longer meets Level of Care, the site will take the current APPENDIX F form and write discharged with the date on the top of the form. The Medical Director will initial the change and the Case Manager will fax the changed APPENDIX F form, to DCH at 404-463-2889.
- j) All sites shall maintain in the front of each chart for each active member a current Face Sheet with basic demographic information, to include at least the following:
 - Name
 - Date of Birth
 - Address/Phone
 - Male/Female
 - Medicare/Medicaid or SSN numbers
 - Directions to member's home
 - Responsible party information (phone, address) if applicable
 - Emergency contact information (phone, address)
 - SOURCE PCP
 - SOURCE Case Manager
 - Date of SOURCE enrollment
 - Diagnosis
 - Advance Directives- Yes/No
 - Discharge date

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- k) The enrollment process will be completed within ten days of assessment.

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When the MDS-HC is completed by an LPN, within ten (10) days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T. Appendix T confirms the RN supervisory review and agreement with the MDS-HC completed by the LPN.

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- l) Upon completion of enrollment and initiation of services, case manager will provide the following completed documents to all community service providers:

- MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T) with RN signature and date
- SOURCE Level of Care and Placement Instrument (Appendix F); must contain required signatures (physician and RN) and date of signatures
- Level of Care Justification (Appendix I)
- The Source Carepath
- Member version of carepath
- Rights and Responsibilities
- Authorization for Release

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- Member Referral Form
 - Member Information Form, if applicable
 - Advance Directives (See Section 903, Procedure (j))
 - Directions to the member's home, starting from the local SOURCE site to the member's home address (See Section 902, Procedures (k))
- 2) Case managers will provide the following completed documents to the member:
- Member participation form
 - Carepath-Member Version

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904 Reevaluations

Source members are evaluated for continued eligibility as least annually, and more often as necessary (e.g. return to service from nursing facility stay). Reevaluations are to be completed by a licensed nurse (currently licensed in the state of Georgia). Reevaluations completed by an LPN must be reviewed and approved by a supervising RN. Reevaluations confirm that the member continues to meet criteria for:

- Intermediate Level of Care for nursing home placement.
- Continued eligibility, appropriateness, and need for SOURCE services
- Allows for adjustment of the CarePath goals and service plan

Procedures:

- a) RN or LPN schedules face to face meeting with member
- b) Review with member/member representative all documents
- c) Complete MDS-HC (v9) Assessment
- d) Complete SOURCE Level of Care Placement Instrument (Appendix F)
- e) Discuss with member continued eligibility
- f) Develop new CarePath with input from member/member representative
- g) Present member information and documentation at multi-disciplinary team meeting
- h) Obtain certification of LOC and continued participation in SOURCE
- i) Provide copies of reassessment documents to community service providers within five (5) business days. The following documents are maintained as part of the SOURCE member clinical record:
 - The MDS-HC, Source Assessment Addendum, and MDS-HC signature page (Appendix T), with RN signature and date
 - SOURCE Level of Care and Placement Instrument (Appendix F), with required signature (s) and date (s)
 - Level of Care Justification (Appendix I)
 - The SOURCE Carepath

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- Member Version of the Carepath
- Member Referral Form
- Member Information Form (if applicable)
- Rights and Responsibilities
- Authorization for Release
- Advance Directive (See Section 903, Procedure (j))
- Directions to the member's home, starting from the local SOURCE site to the member's home address (See Section 902, Procedures (k))

NOTE: If members no longer meet eligibility criteria for SOURCE participation refer to Section 1405 and 1406 of this manual.

PART II - CHAPTER 1000

SOURCE CAREPATHS

1001. Carepaths

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SOURCE utilizes Carepaths, standardized sets of goals and expected outcomes for each Carepath level, to develop a plan of care for SOURCE members. Carepaths, designed around indicators associated with chronic illness and functional impairment, with individualized plans, are written and implemented for each member. Carepaths, while not disease-specific, address risk factors held in common by people at the same Carepath level. In SOURCE, members are assigned to one of three Carepath levels: Level I, Level II-Functional or Level II-Cognitive. The SOURCE Assessment nurse, with input from the case manager, is responsible for development of the member carepath at initial assessment and at each re evaluation.

Members and informal caregivers, service providers, Primary Care Physician staff, RN's/LPN's and Case Managers, together, implement the Carepath, adjusting the plan when necessary to meet key outcomes and goals.

The program uses Carepaths to:

- a) Standardize case management practices
- b) Identify roles for specific players
- c) Identify gaps in self-care/informal support, creating a framework for paid SOURCE services
- d) Target and analyze problem areas for individual members and across the entire program

SOURCE promotes member independence, self care and assistance from informal care givers. When appropriate, the case manager may coordinate education or training for members or informal care givers to teach direct care, patient education, and monitoring of chronic conditions. Self Care and informal support are reflected in the development and implementation of each carepath. At minimum, the member Carepath will address the following:

- Community residence (related to care path outcomes ie. keeping medical appointments, member satisfaction with services)
- Nutrition/weight
- Skin care
- Key clinical indicators (blood pressure, blood sugar, weight monitoring and lab studies)
- Medication compliance
- Performance of ADLs and IADLs

- Transfers and mobility
- Problem behavior (s), if applicable
- Informal care giver support

Carepath addendums are available for care planning to meet housing goals/outcomes to address incontinence issues. These additional care planning tools can be used with all members, regardless of care path level

1002 Carepath Development and Completion

Carepath development requires that the CM/LPN/RN use information gathered from many sources to produce and maintain a consensus between members/caregivers and Primary Care Providers in order to meet individual and program goals. The Source assessment nurse and case manager will evaluate the member's need for assistance with performance of his/her activities of daily living and instrumental activities of daily living, monitoring of chronic medical conditions and other areas which impact the member's ability to continue living in the community. Evaluation begins with the referral and screening process through the initial assessment and continues for the duration of the member's length of stay in the program. Assessment nurses and case managers will:

- involve the member in development of the Carepath
- determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM's will meet with informal caregivers to discuss care planning)
- use SOURCE Carepath Levels (Appendix G) as a guide to determine a Carepath level when information is obtained from the member/family during the assessment
- complete the Carepath within fourteen (14) days of the completion of the MDS-HC
- present the Carepath at the Inter-Disciplinary Team (the Medical Director reviews the completed Carepath, recommends changes, as needed, and signs indicating approval)
- sign the cover page of the carepath with the date the carepath is completed

See instructions for completing the Carepath document at the end of Chapter 1000.

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NOTE: When a new service is required as the result of a change in member support or functional capacity; the physician signature and date on the Carepath will confirm his or her review and approval of the new plan of care.

1003 Completed Carepaths

Completed SOURCE Carepaths will have understanding and agreement from the member/care giver and the Primary Care physician staff. The Case Manager will formally review the carepath goals every quarter.

Initial review of the carepath with the member confirms that:

- member understands expected outcomes
- plan accurately describes self-care capacity and informal resources
- reimbursed services are offered at the appropriate level

Case managers will review carepath goals during regularly scheduled contacts with the member to ensure that the plan is current and continues to support the member's ability to remain in the community

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During the initial review of the individualized member carepath with the PCP or designee (PA, NP or RN), the following exchange of information will occur:

- PCP role in patient education and treatment
- monitoring of chronic conditions at home
- self care capacity/informal supports identified
- reimbursed services ordered

Upon completion of the PCP review, the CM will obtain the PCP's signature on the completed carepath during the member's first PCP conference following member enrollment/reassessment. CM documents in case notes PCP recommendations. (Subsequent PCP conferences will include review of variances of carepath goals)

member's individual circumstances to the PCP. Review of the carepath with the PCP

Service provider review of Carepath allows provider agencies to:

- confirm the authorized service levels
- understand and acknowledge service provider role in supporting member carepath goals
- understand the member and caregiver role (s) in meeting carepath goals

Carepaths are discussed with provider on new enrollment/reassessments and with changes during provider meetings to ensure provider awareness of their role. MIF, referral, or other documented communication will be amended by the case notes as indicated to reflect changes in the carepath

During regular monthly case management supervision conference, the SOURCE case management supervisor will review and sign completed carepaths for new members, reassessed members or those members with Carepath level changes.

1004. Carepath Formal Review

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Case Managers formally review Carepaths each quarter with members and with Primary Care Physicians. Formal reviews are conducted face to face. Based on Case Manager's observation and information received from members or caregivers, Primary Care Physicians, providers and/or other parties involved, goals are recorded as "met" or "not met." For all members, every goal that is not met requires corrective action by the Case Manager (see Policies III A-E, Concurrent Review and Policy II F, Carepath Variances).

1005. Member Version

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Each SOURCE Carepath is accompanied by an abbreviated Member Version, of the same level, that lists desired outcomes and the plan for achieving them. The member version includes formal/informal support care givers. The document serves as an educational tool for members/informal caregivers throughout their participation in SOURCE. Case Manager/LPN/RN will complete the member version carepath within fourteen (14) days of the completion of the MDS-HC .

Upon on a new member's admission, the Member Version will be faxed or mailed with the referral information to the service provider along with all other documentation as specified in 1401.

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Instructions for completion of Carepath document

- 1) Complete member name and the effective date of the carepath. Effective date is the date of the case manager assessment or the date the nurse completed the MDS-HC, whichever is later.
- 2) Complete each page of the carepath by documenting which tasks will be performed
- 3) Document the name of the individual responsible for performance of the task in the "responsible party" section
- 4) Additional information for meeting goals is documented in the "Notes" section found on each page
- 5) For issue specific goals, outside the scope of the carepath; CM will fully document the goals, plan and responsible party, using the final page of the care path document. Additional goals, outside the established Carepath outcomes must be approved by the Case Management supervisor, by signature and date. Each outcome/goal must be reviewed and progress documented at quarterly intervals plan

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When utilizing an additional carepath such as incontinence (Appendix R), the case manager or assessment nurse determines the need for its use and creates a plan. The effective date for an additional carepath is the date that the CM or nurse is adding the addendum..

Changes in the carepath must be documented in the Case Manager's notes and on the Carepath document by drawing a single line through the previous entry with CM/nurse initials and date.

PART II - CHAPTER 1100

REIMBURSED SERVICE

1100 Reimbursed Services

To implement the Carepath, the Case Manager will refer the new member for reimbursed services, if applicable. Information provided to the agency must be sufficient to allow for effective service delivery and accurate billing.

Procedures:

- a) If the member has a preference for a certain provider in the SOURCE network, the Case Manager will make the referral accordingly.
- b) If the member has no preference, the Case Manager will follow site-specific guidelines on selecting providers, based on capacity, geography, specialized skills, agency performance, etc.
- c) Due to the complexity of care involved, Case Managers will discuss new referrals by phone or in person, for the following service categories:
 - (1) Personal support/extended personal support
 - (2) Adult Day Health
 - (3) Alternative Living Services
 - (4) Home Delivered Services
- d) Home delivered meals and emergency response system referrals will not require a phone call prior to making the referral in writing.
- e) The Case Manager will complete the SOURCE Referral Form.
- f) In addition to demographic information, the Referral Form must include specific units of service requested and the authorization number.
- g) Additional information pertinent to service delivery for an individual member will be noted in the "Comments" section at the end of the Referral Form.
- h) All providers will also receive copies of the following which are maintained as part of the SOURCE member clinical record:
 - The MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T)
 - SOURCE Level of Care and Placement Instrument (Appendix F)
 - Level of Care Justification (Appendix I)
 - The SOURCE Carepath
 - Member Version Carepath

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 - Rights and Responsibilities
 - Authorization for Release

Rev. 4/1/05 i) Providers will send the Case Manager a Member Information Form confirming the service level and the date services will begin.

Rev. 10/08 j) If the Member Information Form does not match the Initial Referral Form, the Case Manager will call the provider to clarify the referral.

- k) Changes in service level will require the following steps:
- (1) The Case Manager will confirm the appropriate service level by assessment to determine that a different service level is required to meet Carepath goals.
 - (2) The Case Manager will review the recommended service change(s) with his/her supervisor.
 - (3) If the supervisor approves the change, the Case Manager will authorize the new service level in writing, by completing the Member Information Form and sending a copy to applicable providers.
 - (4) The original Member Information Form is filed in the member's chart.
 - (5) The Case Manager will amend the Carepath and the Member Version as indicated, forwarding an updated copy to the member/caregiver and the Primary Care Physician

Rev. 07/09 **NOTE:** Member Information Forms (Appendix W) are acknowledged, in writing by the receiving agency and returned to the initiating agency within three (3) business days.

l) Changes in paid assistance will be documented in the Case Manager's notes and on the Carepath, by drawing a single line through the earlier Carepath entry, and initialing and dating the current entry. See also Section 1405, Right to Appeal (regarding decreasing or terminating services).

Rev. 07/08 m) All participating SOURCE providers must first be enrolled as a CCSP provider for the same services for 6 months prior to providing SOURCE services. SOURCE providers must provide the community based services that are listed on their SOURCE Referral Form from the SOURCE Enhanced Case Management. Any altering of this form is subject to dismissal as a SOURCE or Medicaid provider or may hinder reimbursements.

PART II - CHAPTER 1200

CAREPATH VARIANCES

1200. Carepath Variances

Simply stated, a variance is when an expected outcome doesn't occur. In SOURCE, a variance describes a Carepath goal not met by a member at any point during a quarterly review period. For any goal not met, corrective action by the Case Manager is required. The Case Manager will act quickly to help members resolve variances, to prevent further complications that may jeopardize health or functional status.

Procedures:

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a) Case Manager will identify the variance, recognizing problematic issues as goals not met and uncovering the source(s) of the problem.

b) Case Manager will act to resolve the variance. Specific steps taken will depend on the member's individual circumstances, and on which goal was not met and why. Examples of corrective action may include:

- Arranging patient education for the member or informal caregiver
- Scheduling an appointment with Primary Care Physician
 - Increasing service levels or changing service categories
 - Coordinating with provider on service delivery issues

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c) The Case Manager will document all variances appropriately:

(1) The Case Manager will indicate "not met" in the Carepath quarterly review column for that goal.

(2) The Case Manager will complete a Variance Report form to indicate the source of the variance and specific corrective actions taken.

(3) If the variance was discovered or noted before the quarterly home visit, the Case Manager will also indicate the variance on the Contact Sheet in the Monthly Contact section as applicable.

Rev. 4/05

(4) If the variance was discovered or noted at the quarterly review home visit, indicate the variance on the Contact Sheet Quarterly Review section.

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(5) If the variance was discovered at the Primary Care Physician conference, indicate the variance on the Contact Sheet Primary Care Provider conference section.

- d) The Case Manager will further document corrective actions in the member's case notes, on the Member Information Form to providers approving service level changes, on the Carepath if a change to the plan was made, etc., as applicable.
- e) For variances repeating for a second quarter or longer, the Case Manager – in conjunction with the case management supervisor or program administrator– will increase efforts and resources employed to resolve the variance.

PART II - CHAPTER 1300

CONCURRENT REVIEW

1300. Concurrent Review

Communication is key to the SOURCE concept of integration. Defined formally in the program as concurrent review, there are four fundamental principles to SOURCE communication:

- Preventive efforts will be effective and current
- Problems will be quickly identified
- Action will be promptly taken by the appropriate parties to resolve problems
- Resources will be appropriately targeted for maximum results and cost efficiency

Case Managers and Carepaths are at the core of concurrent review in SOURCE. To reach the program's stated goals, Case Managers initiate and facilitate communication with SOURCE members/caregivers, Primary Care Physicians, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.

All key players in SOURCE may possess information on the member's current condition and on Carepath variances; however, by virtue of increased contact, familiarity or specific skills, each contributes unique perspectives as well:

Members/CG:	current condition (primarily self-report); preferences; capabilities; household dynamics/informal support
Primary Care Physicians:	clinical condition, recommended treatments and compliance; information from diagnostic procedures, specialist visits, etc.
Providers:	current condition as observed by trained staff; household dynamics/informal support as observed externally

In addition to the program's key players, concurrent review includes other entities as appropriate, on an individual basis (example: dialysis center patients) or for a limited period of time (example: hospitalizations).

The job of the Case Manager and his or her supervisor is to analyze and use all information received to help the SOURCE member stay as healthy as possible and to meet Carepath goals.

Communication with key players falls into two categories: scheduled or PRN (as needed in response to recognized triggers). Scheduled contacts serve as an overview for key players, an opportunity to spot patterns or trends and respond

preventively. PRN contacts more typically address individual issues as they arise.

1301. Scheduled Contacts with Members

The Case Manager will regularly initiate contact with the members/caregivers, and will make follow up contacts as needed with providers, Primary Care Physicians, etc., on a member's behalf. The Case Manager will also respond to calls initiated by SOURCE members/caregivers or on behalf of members, again taking follow-up steps as necessary. While minimum standards for contact are described below, the Case Manager will communicate with or on behalf of members as often as necessary to meet Carepath goals and to stabilize or improve health status.

Direct contact between members/caregiver and providers or Primary Care Physicians also occurs frequently in the model; the Case Manager encourages engagement of the members/caregivers to the fullest extent possible in working toward optimal health and functional status.

Scheduled contacts with members/caregiver will occur according to the following timetable, at a minimum. The Contact Sheet and the Carepath will be used to record scheduled member contacts, appended by member case notes as necessary.

Monthly case notes must reflect what type of contact the Case Manager had with the member and a summary of what was discussed. Quarterly case notes must reflect review of member's Carepath, which will include goals not met, and a plan of improvement/correction. Case notes must reflect follow up to assure the plan is working, and resolution of identified problems.

1302. Procedures for Scheduled Contacts:

- a) **SOURCE Service Confirmation:** The Case Manager will confirm initiation of services with the SOURCE member within two weeks of referral. The CM will take any follow-up steps required if services have not begun. Service referrals and confirmation will be indicated in case notes, on a Member Information Form (MIF) or on a SOURCE Referral Form.
- b) **Monthly Contacts:** The Case Manager will contact all members a minimum of once each month, to be documented on the Contact Sheet and in case notes if necessary.
 - (1) The Case Manager will indicate the method of contact (phone, home visit, other).
 - (2) The Case Manager will review goals of the Carepath with the member/caregiver and will ask the member/caregiver to report any additional health or functional status issues, including initial PCP visit as applicable. On the Contact Sheet goals that are met will be checked; goals not met (variances) will be circled.

- (3) For Carepath outcomes with multiple goals, the Case Manager will indicate which particular goal was not met.
- (4) The Case Manager will take appropriate follow-up actions as indicated.
- (5) The Case Manager will sign and date the Contact Sheet for each monthly contact. Contact sheet notes are considered an addendum to case notes.
- (6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary. Issues covered will include as indicated Carepath variances, SOURCE-reimbursed services and overall health and functional status.

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c) **Quarterly Reviews:** The Case Manager will formally review Carepath goals every quarter.

- (1) At the member's home, the Case Manager will review goals of the Carepath with the member/caregiver. Goals will be documented and as "met" or "not met" and dated in the third column of the member's Carepath. On the Contact Sheet, goals that are met will be checked; goals not met (variances) will be circled.
- (2) The Case Manager will review the existing Carepath plan, making updates as indicated due to changes in health/functional status of the member, informal support changes, etc.
- (3) For a goal not met, the Case Manager will discuss with the member/caregiver options on how best to resolve variance.
- (4) The Case Manager will ask the member/caregiver to report any other issues potentially jeopardizing health or functional status.
- (5) The Case Manager will observe the member's household for cleanliness and safety.
- (6) Quarterly contacts will be documented by the Case Manager on the contact sheet, appended by case notes if necessary.
- (7) Following the home visit, the Case Manager will review additional information from Primary Care Physicians, providers, etc., on Carepath variances for individual members.
- (8) The Case Manager will follow policy for Carepath variances.
- (9) The Case Manager will take any additional follow-up actions indicated by the quarterly review.
- (10) Changes to the Carepath plan will be documented, dated and signed by the Case Manager on the Carepath and the Member Version.
- (11) New copies of the amended Member Version will be provided to:
 - The member
 - The Primary Care Physician
 - All Providers

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d) **Re-evaluations:** A formal re-evaluation will be completed for all members annually at minimum

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- (1) RN/LPN will complete the MDS-HC (V9) level of care assessment and the Case Manager/RN/LPN will complete the SOURCE Assessment form or another DCH approved Assessment tool. A new Records Release Authorization and Member Rights and Responsibilities must be signed and dated.
- (2) The Case Manager will review the existing Carepath plan, services and any issues jeopardizing the health or functional status of the member at the re-evaluation, following the procedures for quarterly reviews.
- (3) A new Carepath will be developed and reviewed for each member, following procedures from Policies II A, Self-care and Informal Support, II B, Completing the Carepath Document and II C, Initial Review of the Carepath.

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- (4) The level of care will be reviewed by the Case Manager and confirmed by the Primary Care Physician or the Medical Director signature on the new Carepath, attesting to the member's current health and functional status. A new Level of Care is completed initially and annually by the RN/LPN with the use of the MDS-HC (v9) (see Appendix S) and Level of Care Justification form.

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- (5) Recommended changes in the Level of Care will be reviewed by the site's multidisciplinary team as determined by the MDS-HC assessment as conducted by the RN/LPN.

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- (6) The team will confirm the Level of Care; no longer meeting level of care will require that a APPENDIX F be sent to GHP with discharge date written on the top of the APPENDIX F with the Medical Director or Primary Care Provider signature. APPENDIX F must be completed, at least, annually to verify continued Level of Care eligibility. Annual APPENDIX F's must be completed and signed but does not need to be submitted to DCH.

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- (7) The re-evaluation will be further documented on the Contact Sheet by completing the annual re-evaluation section.

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- (8) The Case Management Supervisor will review and sign the new Carepath at the next monthly supervisory conference for each member.

1303. Scheduled Contacts with Primary Care Provider

Case Manager-PCP

Primary care providers will routinely conference with the Case Manager to exchange information on the current status of the member, identifying problems quickly and targeting resources (informal and paid) effectively to resolve them.

1304. Procedures

Rev. 7/03

- a) For all SOURCE members, formal conferencing between the Case Manager and the primary care provider will take place at least quarterly. The conference may take place at any point during the quarter for an individual

member. Members/caregivers do not typically attend the conferences.

Rev. 07/10 **NOTE:** A primary care physician may utilize physician assistants (PA) and/or nurse practitioners (NP) within the scope of his or her practice to manage and treat patients. If a PA provides routine medical care to the a SOURCE member assigned to the practice, under the supervision of a PCP, the PA is permitted to participate in the quarterly conferencing.

b) The site will provide a list of the patients due for conferencing, with sufficient time for the PCP office to schedule and prepare for the conference.

Rev. 07/10 c) The Primary Care Provider office will have patient charts pulled for the conference and will have ancillary staff (typically nursing staff) attend.

d) For established members:
Review the following, noted by PCP or Case Manager or RN/LPN since last conference, as applicable:
(1) Changes in health or functional status (including LOC changes)
(2) Carepath variances, with corrective actions discussed
(3) Changes in Carepath since last conference
(4) Equipment/supply needs
(5) Other factors jeopardizing continued community residence
(6) Repeated hospital encounters, inpatient or emergency department
(7) Administration of flu or pneumonia vaccines, when applicable

Rev. 11/03 e) For new members: Review Carepath and significant findings from the initial PCP visit.

f) PCP will sign and date new member Carepaths.

a) Recommendations by the Primary Care Provider – including changes to Carepath plan – will be noted by the Case Manager in the PCP Conference section of the Contact Sheet for discussion with the member. Extensive comments will be noted in the member's case notes. Notes from PCP conferences may also be kept in a separate notebook.

Rev. 7/03 h) Variances noted will be marked by circling the appropriate goal in the Primary Care Provider Conference section of the Contact Sheet.

i) The Primary Care Provider and the Case Manager will sign and date the Contact Sheet in the PCP Conference section for all members.

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- j) Participating Primary Care Provider, PA, NP, or RN will attend conferences in person; additional PCP office staff (typically nursing personnel) may attend as indicated.
- k) The Case Manager Supervisor will decide staffing at Primary Care Provider conferences; all Case Managers may attend PCP conferences, or a representative from the case management staff may be designated if information is provided on current status of members from all caseloads.
- l) The Case Manager designated will review all PCP recommendations with appropriate case management staff, following the conference.
- m) The Case Manager working with a member having chronic Carepath variances will attend the PCP meeting in person to discuss possible resolution, as applicable.

1305. Scheduled Contacts with Service Providers

Rev 04/08

In addition to the four principle themes of concurrent review described earlier, scheduled contacts ensure that the SOURCE Enhanced Case Management and providers share the same understanding of service levels and responsibilities.

1306. Procedures:

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- a) **Initial Referrals:** see SOURCE-Reimbursed Services.
- b) All providers will submit to the site monthly reports of actual services delivered.
- c) For members with services not delivered as ordered by the Case Manager, providers will include a brief explanation (hospitalization, service canceled by member or Case Manager, transportation problem, agency failure, etc.).
- d) Each month, the site will reconcile the report with the actual services ordered.
- e) Discrepancies will be identified and the site will follow-up as indicated with the provider, member/caregiver, etc.
- f) For services over the level ordered or authorized by the site, the provider will complete an Adjustment Request Form to accompany refunds to the State for any reimbursement for unapproved services (Note: CM may temporarily authorize community support services differing from the ordered hours, for a specific period of time and documented on a MIF; see SOURCE-reimbursed Services).
- g) The provider will copy the Adjustment Request Form to the SOURCE Enhanced Case Management.

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- h) The site will send a correction in writing to the provider (using a MIF), listing the actual level of services authorized.
- i) Due to complexity of care involved, the case management staff will meet at least monthly with staff from agencies providing the following services:
 - Adult Day Health
 - Personal Support/Extended Personal Support
 - Alternative Living Services

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NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, monthly conferences may take place either face-to-face or by a mutually agreed upon electronic method.

- j) Provider conferences will include for members served by the agency, efforts to resolve:

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- Member Carepath variances
- Potential nursing home placement
- Member service issues and service delivery complications
- Discrepancies in services ordered/authorized
- Provider performance issues
- Provider training and education needs
- Review of documentation needs for the service provider's member record and provision of same

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- k) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and sites may choose to document individual member's file for additional information as well.

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- l) The Case Manager will provide follow-up action necessary following provider conferences (examples: communicating with family to ensure that adequate food or supplies are available, following up with members not home for service, discussing with Primary Care Physician a referral for behavioral care for an ALS resident, etc.)
- m) Following completion of the annual re-evaluation for each SOURCE member, the case manager will send to each provider the updated Member Version of the Carepath. Changes in service units or schedules or significant changes in responsible parties will be accompanied by a MIF to provider affected.
- n) For discharges initiated by the SOURCE Enhanced Case Management, the provider will confirm notice of a service discharge by sending a completed Member Information Form (see Appendix W) to the Case Manager.

- o) For discharge initiated by the provider, the provider will notify the site of a discharge using the Member Information Form. Discharge by a provider should ONLY occur after:
 - (1) The provider has exhausted all possible avenues to resolve issues complicating service delivery
 - (2) The provider has included the site in attempts to resolve issues complicating service delivery, from the initial identification of a problem
 - (3) The provider has followed waiver requirements for giving notice prior to a discharge date

1307. Scheduled Contacts with Case Management Supervisor

A formal supervision process supports the Case Manager in negotiating complex situations among multiple parties. Case Management supervision serves four main functions, ensuring that:

- The Case Manager has benefit of the supervisor’s additional experience and perspective
- The Case Manager has administrative support in making difficult decisions
- Individual member’s Carepath goals are met
- The program’s direction is sustained

1308. Procedures

- a) The status of all members will be reviewed by the Case Manager and Case Management Supervisor at least monthly, to:
 - Discuss Carepath variances and subsequent corrective actions
 - Update support service plans as necessary to meet Carepath goals
 - Analyze repeat hospital encounters
 - Resolve other issues possibly jeopardizing health or functional status
 - Review and sign Carepaths for new and re-assessed members
- b) Recommendations on changes of the Carepath level or Level of Care will be included in supervisory meetings.
 - (1) The Case Manager will request the RN/LPN complete a new Level of Care Assessment using the MDS-HC.
 - (2) The Case Manager will present the LOC change for review and approval by the multidisciplinary staff committee; the SOURCE medical director or PCP will sign the Carepath, confirming the new service level or the APPENDIX F to demonstrate the interdisciplinary teams agreement that the member does not meet LOC.
- c) Recommendations for changes in Carepaths will be reviewed at supervisory meetings. The Case Management Supervisor will approve all changes in service plans (see SOURCE-Reimbursed Services).

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- d) The SOURCE member's chart will be reviewed by the Case Management Supervisor to ensure that Carepaths and Contact Sheets are completed, current and signed.
- e) The Case Management Supervisor will sign the Contact Sheet within thirty days following the quarterly home visit.

Rev. 07/10

1309. PRN Contacts

Rev. 04/05

Problems complicating the lives of people with chronic illness may not coincide with scheduled monthly or quarterly Case Manager contacts. The SOURCE model places responsibility on Case Managers to ensure that communication with or between the right players happens at the right time to meet program and Carepath goals.

Rev 04/08

Communications with members (and subsequent follow-up actions) that fall between scheduled contacts are made in response to member need. While most such contacts fall into areas related to clinical/functional status or service delivery, members may also contact Case Managers about eligibility, housing, items not covered by third party payers, etc. – in short, any issue potentially jeopardizing their ability to continue living in the community.

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Access to Primary Care Physicians – as needed to manage clinical or behavioral complications of members – is a cornerstone of the program. Effective Primary Care Physician participation is key in helping Case Managers extend the limits for chronically ill people living safely in the community. Given the vulnerable nature of the population SOURCE serves, Primary Care Physician response to unscheduled interactions must be characterized by promptness, creativity and perseverance in problem solving.

Providers (particularly PSS/EPS, ADH and ALS) frequently develop a close relationship with members/CG for several reasons:

- The frequency with which they encounter members/CGs
- The intensely personal nature of community services
- The social isolation of some members

Given these factors, participating providers are in an unrivaled position – and have an unrivaled responsibility – to assist members by ensuring that communication channels stay open.

Communication with the Case Manager Supervisor around identified triggers is also critical, allowing the Case Manager to share the substantial responsibility of

making decisions and taking actions that best support members in community living.

Procedures:

1. All key players in the program will be encouraged to report to Case Manager's any issues that threaten a member's health status or ability to live in the community.
2. All key players will be educated on using the SOURCE 24-hour phone number for case management and primary care assistance offered from the site.
3. All key players will identify a key contact person to facilitate and communication for SOURCE members (may be the actual member, as indicated).
4. The individual SOURCE CM assigned to a member is the contact person identified for key players.
5. Triggers for PRN communication between players are:
 - Carepath variances
 - Potential nursing home placement
 - Hospital encounters—inpatient or emergency department
 - Acute illness/exacerbation of chronic condition
 - Significant change in function—physical or cognitive
 - Suspected abuse or neglect
 - Service delivery complications
 - Housing/other residential issues
 - Family dynamics/informal support changes
 - Transportation needs
 - Member's desire to appeal a Case Manager decision (see Policy III G, Internal Grievance Process)
 - Other factors jeopardizing health/functional status or community residence

Additional PRN communication with PCPs includes:

- New patients with SOURCE (review Carepath; file copy on chart)
 - Episodic/acute illness or exacerbation of chronic illness
 - Medical triage/advice
 - Referral to/communication with specialists (or ancillary services, diagnostic, etc.)
 - Scheduling appointments
 - Urgent equipment/supply needs
 - Pharmacy/prescription needs
6. Triggered information will always flow from other key players to the CM.

7. If a specific CM is unavailable, the key player can relate information to the CM on call or to a CM supervisor.
8. Triggered information will flow from the CM to key players as indicated to resolve problems and achieve Carepath goals; in the interest of member privacy and staff energy, care will be taken to involve only player's essential in resolving/preventing a specific problem.
9. Case Manager's will document PRN contacts and follow-up actions in a member's case notes, on Contact Sheets or on Carepaths as indicated.
10. Case Manager's will take any follow-up actions indicated to resolve outstanding issues (see also Policy II F, Carepath Variances), facilitate services or prevent further complications. Examples of follow-up actions includes:
 - Changing Carepath levels, increases or decreases
 - Evaluating functional changes by a home/hospital visit
 - Scheduling a medical appointment
 - Arranging a family conference to resolve care giving responsibilities
 - Making transportation arrangements
 - Referral for DME
 - Assisting member in obtaining non-covered supplies
 - Changes in Level of Care as determined by MDS-HC (discharge only requires active APPENDIX F to be submitted to DCH with "Discharge" and the date written on the top of the form.)
11. Changes in service level will require approval by the Case Manager and the Case Manager supervisor or program manager.
12. The Case Manager will communicate changes to the provider on the MIF (see Appendix W); a return MIF from the provider confirming the new service level is required.
13. For communication with or on behalf of members falling between scheduled monthly or quarterly contacts, the Case Manager will use a case note narrative format with the contact's name, date and manner of exchange (phone, home visit, etc.) and a brief description of the exchange (see Definitions, Case Notes). Examples include contact regarding service delivery, arranging transportation, etc. Problems, follow-up activity and problem resolution should be documented in case notes. All contacts will be initialed and dated by the Case Manager.

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1310. Disease State Management

Rev. 7/10

The SOURCE Disease Management design primarily employs Carepath variances to identify high-risk patients within the program, and incorporates traditional DM protocols of tracking, education and self management into the existing SOURCE

structure and processes. DM principles are consistent with the SOURCE focus on outcome measures, primary medical care, regular feedback to all key players and the inclusion of informal support in providing care.

DISEASE MANAGEMENT STRATIFICATION/INTERVENTIONS:

1. SOURCE will primarily identify members requiring the new level of disease management using two criteria: diagnosis and variances. (Additional avenues into disease management will be noted at the end of the stratification section.)
2. All sites will have an internal mechanism for indicating on member charts the current DM stratification level.
3. Disease states targeted include diabetes and hypertension, with additional conditions as identified by the Department of Community Health.
4. Variances targeted:

All Disease States

- Clinical indicators (BS, BP, weight as indicator of illness, lab values)
- Nutrition Goal B. (diet recommended by PCP)
- Medication compliance

Dementia/Mental Health – additional variance

- Behavior Goal B. (problem behavior management)

Obesity – additional variance

- Nutrition Goal A. (weight posing critical health risk)

Members identified for high-risk disease management must meet both the diagnosis criteria and the variance criteria described below.

5. SOURCE uses three levels of stratification (low, medium and high) based on variances. Each level of stratification will involve applying escalating resources. While the first two levels (low and medium) will receive patient education around their disease states, only the third level (high risk) will be included in the full disease management program.

A. Low risk – well managed (i.e., meeting Carepath goals, no variances)

PLAN:

Conventional SOURCE enhanced primary care case management for preventive measures

INTERVENTIONS:

- Protocols
Carepath development

Concurrent review

- Member education on targeted disease states
- Time frame – at first quarterly home visit following enrollment

TRACKING:

- Carepath outcomes
- Hospital encounters
- Time frame – formally recorded each quarter

DURATION:

- Preventive efforts - ongoing for length of stay in SOURCE

B). Moderate risk – occasional variances of targeted Carepath goals

PLAN:

Conventional SOURCE enhanced primary care case management with PRN response to individual variances. Review of variance and options for corrective action by case management supervisor and SOURCE PCP. Adjustment of Carepath plan as indicated.

INTERVENTIONS:

- Protocols
 - Carepath
 - Concurrent review
 - Variance protocols (corrective action)
- Member education on targeted disease states
- Time frame – at or before next quarterly home visit

TRACKING:

- Carepath outcomes
- Hospital encounters
- Time frame – formally recorded each quarter

DURATION:

- Corrective actions - until resolution of Carepath variance; preventive efforts - ongoing for length of stay in SOURCE

C). High risk – members with three consecutive variances of the same targeted goal*

PLAN:

Conventional SOURCE EPCCM; review by case management supervisor, PCP and medical director for chronic variances; disease management for targeted conditions

INTERVENTIONS:

- Protocols
 - Carepath
 - Concurrent review
 - Variance protocols
 - Evidence-based practice protocols/tracking logs
 - Self-management goals
- Member education

- Time frame: additional home visit at next monthly contact (replaces phone contact) following identification of consecutive variance

TRACKING:

- Carepath outcomes – formally recorded each quarter
- Hospital encounters
- Clinical outcomes specified by EBP protocols on tracking logs for targeted condition

DURATION:

Resolution of variance(s) and/or recommendation by PCP

*Sites may also choose – on a case by case basis – to review members for high-risk disease management of targeted conditions under the following circumstances.

Hospitalizations – repeat encounters, within 30 days

New admissions into SOURCE, based on history of poorly managed chronic condition

New onset of a targeted condition

PCP recommendation based on poor management of a targeted condition.

Targeted variances other than three consecutive variances of the same goal, **with site recommendation** (example: sequential variances but not of the same goal; simultaneous variances within a quarter, etc.)

Prior to implementing high-risk DM under any of the alternative routes described above, the DM referral shall be reviewed by the CM supervisor and the site Medical Director.

HIGH-RISK DISEASE MANAGEMENT:

1. In addition to meeting established stratification criteria, the member's PCP must also concur that the member is appropriate for high-risk DM. At any point during high-risk disease management, the PCP may also recommend DM disenrollment based on non-compliance or other clinically complicating factors.
2. Tracking logs will be completed to the best of the CM/PCP team's ability. Information requested that is not available will be so indicated on the tracking log, in the appropriate section. To indicate that a protocol was not followed (example: no foot exam performed at an office visit on the diabetes log), a straight line should be drawn across the appropriate section.

3. Self-management goals are educational materials that do not require PCP signature but are considered generically applicable to all SOURCE members on high-risk DM.
4. PCPs will indicate review of any applicable DM tracking logs by signature on the SOURCE contact sheet in the PCP conference section (amended contact sheets will include a statement to that effect).
5. SOURCE Case Management Provider will promote use of evidence-based practices by key players in the following ways:
 - a). Track key protocols – SOURCE DM tracking logs for targeted conditions
 - b). Track key clinical measures – SOURCE tracking logs for targeted conditions
 - c). Track self-management goals for targeted conditions
 - d). CM and PCP are a team in monitoring indicators. Tracking tool will be kept in CM chart, optionally in PCP chart as well
 - e). Medical Director/PCP blanket sign off on education plan/self management goals – CMs to reinforce PCP recommendations with educational material; clinical questions referred to PCP
 - f). Education initiatives for CMs
 - Basic explanation of disease process
 - Education on materials to be used
 - Commonly asked questions
 - Education on protocols
 - g). Standardized education materials written for potentially low-literacy population:
 - Brief
 - Simple
 - Large type
 - Emphasize small changes in lifestyle
 - Meaningful in laymen's terms
6. To facilitate self-management of condition, sites will, as feasible:
 - a). Include key players in education and management of condition
 - Member
 - Informal caregivers
 - SOURCE providers
 - Provide PSS/ALS/ADH providers with education recommendations

ID specific related tasks: meal prep, med. /monitoring cueing, etc.

Implement self-management goals

b). Ensure proper equipment

Examples:

1-Touch
log book
scales
diet/food diaries
exercise logs

7. Routine reporting and feedback will be accomplished in SOURCE by incorporating DM issues and protocols into the conventional concurrent review process - scheduled and PRN.

- Member/caregiver contacts
 - Additional education visit at outset of DM
 - Monthly contacts
 - Quarterly home visits
- Weekly medical director meetings as indicated
- Quarterly PCP meetings (including clinical measures and protocol reviews)
- Monthly provider meetings
- PRN contacts as needed with all key players re: adherence to protocols, education issues, other follow-up

8. Collaboration among providers will be ensured via:

- a). Incorporating disease management into existing concurrent review processes (see above)
 - Key players
 - Ad hoc players (skilled nursing, hospital CM or d/c staff, etc.)
- b). Considering as appropriate use of skilled nursing in patient education and tracking (Medicare, Medicaid or waiver HDS)
- c). Incorporating meeting DM goals into concurrent review, as well as Carepath outcomes

9. The following outcomes measures will be employed through SOURCE disease management:

- a). Carepath outcomes (targeted goals – see Section 1310, No. 4)
- b). Clinical measures from tracking logs for targeted conditions

PART II - CHAPTER 1400

RELATED POLICIES AND PROCEDURES

1400. Provider Performance Monitoring

Rev. 10/09

To function effectively and assist members in meeting program goals, all key players in SOURCE must provide accessible, effective and reliable service. Enhanced Primary Care Case Management providers will comply with all monitoring and reporting activities as required by the Department of Community Health/Division of Medical Assistance. Sites are responsible for routinely monitoring the performance of network providers, both primary care physicians and HCBS agencies.

Procedures:

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SOURCE sites will provide the following:

- Source Programmatic Report monthly by the 15th of the month following the report month (See Appendix JJ) .

HCBS providers will be monitored for the following:

- Services delivered as ordered by the case manager, including – as applicable – units of service, service schedule, tasks, time frame, personal preferences as feasible, etc.
- Prompt and effective communication with sites and members/informal caregivers, at all points during a member’s tenure with a provider, as described in Concurrent Review Policies No. 1306 and 1309
- Commitment to serve members with challenging personal situations or diagnoses
- Demonstrated efforts to serve manpower shortage areas
- Willingness to flex service levels as authorized by the case manager, in response to the complex or unpredictable status of individual members
- Customer satisfaction standards that exceed basic licensing requirements; specific areas of accountability include:
 - Reliability of service
 - Competency, compatibility and consistency of staffing (where applicable)
 - Responsiveness to member and staff concerns, including Carepath variances
 - Complete and timely submission of monthly service delivery reports and resolution
 - Continued status in good standing as a Medicaid provider
 - Adequacy of on-call arrangements for after-hours and weekends

Monitoring methodologies for HCBS providers include but are not limited to the PSS/EPS service delivery score and the quarterly Carepath goal related to satisfaction with all HCBS services.

PCPs will be monitored by sites for the following:

- Appointments – ease of scheduling, initial visit and ongoing appointments
 - Conference logistics – scheduling, preparation, wait time, space
 - Conference – adequate time allotted quality of PCP participation in discussion and grasp of SOURCE, etc.

 - PRN contacts – accessibility (response time of PCP and/or office staff); effectiveness of PCP and office response; on-call response; appropriately identifies existing patients needing referral to SOURCE
 - Disease management – accessibility of clinical data required and quality of participation in discussion
4. HCBS providers or PCPs not performing in accordance with standards set by the site or by the DCH SOURCE policy and procedure manual may be subject to review for continued participation with the site.

1401. Utilization Management

As stewards of significant state funding via the authorization of HCBS services, SOURCE Case Management Provider must ensure that the value of Medicaid's long-term care dollars is maximized. Sites will develop an internal system of monitoring and managing utilization of authorized home and community based services.

Procedures:

1. Case managers will capitalize on self-care capability and informal support whenever feasible, and family care will be supplemented rather than replaced. Case managers will facilitate informal support with training and equipment as necessary.
2. At the site's admission committee, the case management team (including the medical director) will review recommendations to ensure the appropriateness of each service category; generally, least restrictive setting or service to achieve goals is preferred by members and is often less costly.
3. Sites will work to maintain function and overall health by addressing areas that may lead to increased impairment and higher HCBS costs – effective medical care, adequate housing, Carepath goals (nutrition, medication adherence, etc.).
4. Case managers will use creativity in developing Carepath plans, employing community resources other than Medicaid-reimbursed services that will contribute to meeting Carepath goals.

5. Sites will maintain case manager awareness of the relationship between age and/or progressive illnesses and the increased need for paid services; case managers will develop initial Carepath that are sufficient to meet goals but do not have extra capacity, to ensure that members may receive additional services if their level of impairment or informal support changes.
6. Sites will benchmark service plan costs by level, according to site averages or using information provided by the Department of Community Health for all SOURCE Case Management Provider.
7. Upon admission, sites will calculate service plan costs for comparison to the benchmarked standards.
8. Outliers will be reviewed further by the medical director, site manager and case management supervisor. Adjustments to service plans will be made when appropriate; balancing costs of care with achieving program and Carepath goals.
9. Sites will develop an internal method for the ongoing identification of outliers that exceed benchmarked standards established by the site or by DCH. Triggers may be service costs, units of service, etc.
10. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T-must contain the RN signature and date of signature)
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath
- Member Version of the Carepath
- Rights and Responsibilities
- Authorization for Release
- Member Referral Form
- Member Information Form(s) (Appendix W), if applicable
- Advance Directives if available to Case Management (See Section 903 (j))
- Directions to the member's home, starting from the local Source site Office to the member's home address (See Section 902, Procedures (k))

1402. 24-Hour Phone Line

SOURCE Case Management Provider will maintain a 24-hour a day/seven days per week/365 days per year on-call system that will:

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- Optimize primary medical care for members by offering prompt attention to clinical complications or illness
- Assist members and informal caregivers in addressing after-hours service delivery issues promptly
- Help members avoid unnecessary emergency room visits by medical triage and advice

All sites will maintain a 24-hour phone line answered by a live voice.

- a) At assessment, the case manager will leave for the member written information on how to contact the SOURCE Enhanced Case Management, including the 24-hour phone number.
- b) Education for members by the Case Manager on using the 24-hour line will be included at the assessment home visit.
- c) Access to the following services will be provided or facilitated via the 24-hour phone line:
 - (1) After hours medical triage and advice
 - (2) After hours medical consultation by SOURCE Primary Care Physician or designated qualified medical professional
 - (3) Assistance in resolving service delivery complications, after hours
 - (4) Authorization of medical services
- d) Except for authorization of medical services (see below), sites may contract for components of the on-call service; however, contracted personnel must have access to SOURCE case management and Primary Care Physician staffs if needed to adequately provide the services listed above.

Examples of Medicaid-reimbursed medical services that may require authorization are specialists' visits, lab/diagnostic studies, hospitalizations, etc.

- e) Authorization of community services (also using the site specific SOURCE number) must come from Case Management staff, with confirmation on the appropriate forms.

1403. Health System Linkages

SOURCE differs from conventional HCBS in Georgia in part by including primary care providers as partners in case management. To meet program and Carepath goals, SOURCE Case Management Provider assume responsibility for coordinating overall healthcare services for members. Sites must work with local healthcare facilities in collaborative arrangements to reduce conflicting and duplicative efforts. Sharing information on current health conditions, assistance

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needed and resources available benefits the members and promotes program goals. **Coordination between the site and healthcare organizations (particularly hospitals) ensures that decisions for nursing home placement of members will not occur without:**

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- Exploration of all possible routes to a community-based plan
- Primary Care Physician consultation
- Advocacy efforts by CM, in coordination with family/informal caregivers

For all services delivered by non- reimbursed organizations, the Case Manager must take three steps: identify when a service is in place, coordinate efforts with the staff and track the service until discharge.

Procedures:

1. Hospital Linkages:

- a) SOURCE Case Management Provider will maintain ongoing coordination with acute care facilities, ensuring hospital coverage of the entire service area.
- b) Areas included for coordination are:
 - (1) Communication with family members around hospitalizations
 - (2) Discharge planning, emphasizing community plans over institutionalization and referral to SOURCE-affiliated providers
 - (3) Treatment conferences for extended LOS patients
 - (4) Preventive efforts re: repeated hospital encounters
- c) Case Manager will educate members/caregiver on using hospitals affiliated with the SOURCE Enhanced Case Management, upon enrollment and throughout the member's length of stay.
- d) Sites will track inpatient admissions, by following protocols of the Hospital Tracking Form (see Appendix), facilitating discharge. The Hospital Tracking Form may replace a case note regarding the hospitalization for that member.
- e) Hospitals coordinating with SOURCE are requested to generate a daily log for the site indicating members with hospital encounters, allowing the Case Manager to initiate follow-up plans.

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2. Home Health Services

- a) SOURCE Case Management Provider will maintain ongoing coordination with home health agencies, ensuring effective and non-duplicative home health services for members indicated.

- b) Areas for coordination include:
 - (1) Services provided by agency and by SOURCE
 - (2) Communication with Primary Care Physicians
 - (3) Resolution of Carepath variances
 - (4) Preventive efforts to meet Carepath goals
 - (5) Discharge planning
- c) Case Manager will educate members/caregiver and hospital staffs on using home health agencies affiliated with SOURCE, upon enrollment and throughout the member's length of stay.
- d) Sites will track home health services by completing the Skilled Care Tracking Form. The Skilled Care Tracking Form will replace a case note.

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3. Dialysis Centers:

- a) SOURCE Case Management Provider will maintain ongoing coordination with area dialysis centers, ensuring effective and non-duplicative dialysis services for all members indicated.
- b) Areas included for coordination include:
 - (1) Provision of primary care services
 - (2) Authorization of healthcare services
 - (3) Case management responsibilities
 - (4) Resolution of Carepath variances
 - (5) Preventive efforts to meet Carepath goals
 - (6) Hospitalizations
- c) A dialysis center physician may serve as a participating Primary Care Physician, if he or she agrees to perform the functions described under "SOURCE Primary Medical Care" and in the Scheduled Contacts – Primary Care Physicians and Policy, PRN Contacts.

1404. Internal Grievance Process

Case Managers will be guided by a member's needs, resources and stated preferences, in developing the individualized plan to reach Carepath goals. For Members/CG disagreeing with a decision by the site, resolution will be sought through an internal grievance process prior to the formal appeals process of the Division of Medical Assistance.

An internal grievance process ensures that members receive consistent and objective treatment, with the member granted the opportunity to be heard by the program's administrative staff. If a member disagrees with the outcome, he or she has the right to a hearing.

Procedures:

- a) During the initial assessment, the Case Manager performing the assessment will include education on the site's internal grievance process.
- b) The Case Manager will attempt to resolve any differences with the SOURCE member/caregiver over the development or implementation of a plan to achieve outcomes of the Carepath.
- c) Upon determining that the Case Manager is unable to resolve a difference with a member/caregiver, the Case Manager will have seven business days to provide the Case Management supervisor with all relevant details of the situation.
- d) The Case Management supervisor will personally contact the member/caregiver in an attempt to resolve the difference(s), consulting as indicated the PCP, support service providers, family members, etc.
- e) If the Case Management supervisor is unable to resolve the difference(s), a Grievance Committee will be convened to hear the member or caregiver's request face to face, within 30 days of the Case Management supervisor or manager confirming the member's request to appeal a decision.
- f) On the same day, the Grievance Committee will additionally hear the Case Manager staff's recommendation, as presented by the Case Manager.
- g) The Grievance Committee will recommend a solution, within 7 business days of the Committee's convening.
- h) Pending resolution of the grievance, the SOURCE member will continue to receive services at existing levels.
- i) The Grievance Committee will be comprised of the site's:
Program Manager (chair)

Chief Executive Officer
Medical Director
Staff member designated as Committee Secretary
Other administrative staff may be substituted as necessary to serve on the Grievance Committee; the Case Manager and direct Case Management supervisor will not serve as members of the committee.

- j) The designated Secretary of the Committee will formally record the proceedings, providing copies to the member/caregiver and to the Department of Medical Assistance.
- k) If the site's grievance process is unable to resolve the differences, the Case Manager staff will provide the member/caregiver with information on initiating the DMA appeals process.

1405. **Member Discharge**

The Case Manager will exhaust all means to ensure that members continue their enrollment in the program, for several key reasons:

- Members constitute a vulnerable population due to chronic illness, disability, advanced age and low-income
- Eligibility constraints and lack of capacity in other HCBS may make transferring difficult
- Managing non-compliance is a core function of the CM/Primary Care Physician team
- DCH expects sites to meet or exceed consumer expectations

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Discharge from the program may be either voluntary or involuntary. Reasons for discharge include:

- Member moves from the site's service area
- Member enrollment in Hospice services
- Member does not meet Intermediate Nursing Home Level of Care Criteria
- Member is no longer eligible for SSI or SSI related Medicaid
- Member death
- Member transfers to another waiver program
- Member is admitted to a nursing home
- Member Choice
- Member is chronically non-compliant
- Member health and safety needs cannot be met in the community

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Note: Discharges due to failure to meet Intermediate Nursing Home Level of Care require the signature of the physician
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This section is appended by Section 1406, Right to Appeal.

- a) Voluntary Discharge

Enrollment in SOURCE is strictly voluntary. Case Managers will make all feasible efforts to meet the reported and observed needs of persons in service. However, a voluntary discharge will be effective immediately as of the date requested by the member, guardian or custodial caregiver.

Procedures:

- (1) A Case Manager's efforts to reconcile the source(s) of a member's dissatisfaction with the program may include as indicated:
 - Conferences with providers, Case Manager and members/Caregivers
 - Changing provider, PCP or Case Manager
 - Discontinuing an individual service or otherwise altering the Carepath plan
 - Involvement of the supervisor, Primary Care Physician or program management
- (2) If efforts to resolve a member's or caregiver's dissatisfaction with SOURCE are unsuccessful, the consequences of disenrollment from SOURCE will be explained:
 - Case Management services from site discontinued
 - Community services reimbursed by SOURCE discontinued
 - PCP services coordinated through site discontinued
- (3) If other HCBS programs are enrolling the member following discharge from SOURCE, the Case Manager will work to make the transition happen smoothly.
- (4) Services reimbursed by SOURCE will be discontinued effective on the date so requested by the member, or the date the member becomes ineligible.
- (5) Upon learning of an effective discharge date, the Case Manager will notify:
 - SOURCE providers, by completing the Discharge section of the Member Information Form (MIF)
 - Providers not reimbursed through SOURCE
 - The SOURCE PCP office
- (6) The member's PCP may continue providing primary care services following discharge from the program if requested by the member and agreed to by the PCP.
- (7) Following actual discharge, the site will notify GHP by sending the original APPENDIX F form to DCH, with the date of dis-enrollment and a brief explanation added.
- (8) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix Z), to be filed in the member's chart.

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b) **Involuntary Discharge**
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Effectiveness of SOURCE services depends heavily on the participation of members/caregivers in developing and implementing the Carepath plan. A prolonged or repeated pattern of deliberate non-compliance may result in involuntary discharge from SOURCE.

Discharge from SOURCE, however, does not end a member's Medicaid eligibility. The State continues to fund services covered by the Medicaid State Plan. For recipients with major non-compliance issues, the loss of coordination of care will likely result in greater inefficiencies in how recipients access Medicaid services. The site's partnership with DMA to increase the value of the Medicaid LTC funding further increases the site's responsibility to attempt to make SOURCE function effectively for recipients.

Only after thorough efforts by the site to resolve patterns of non-compliance will SOURCE members be involuntarily discharged. Examples of non-compliance include but are not limited to:

- Failure to keep scheduled Primary Care Physician appointments
- Avoiding or refusing Case Manager visits or other contacts
- Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
- Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
- Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Carepath variances, delivery or clinical issues
- Failure to use designated SOURCE providers or affiliates for services

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Discharge occurs when:

1. The case manager determines that the member is no longer appropriate or eligible for services under SOURCE
2. DMA's Utilization Review (UR) staff recommends in writing that a member be discharged from service
3. Member/member's representative consistently refuses service(s)

Member's physician orders the member's discharge from SOURCE

4. Member enters a nursing facility. The provider must send the notice of discharge immediately upon the member's placement in a nursing facility.

NOTE: All member services are discharged and Appendix Z is sent to member via Certified Mail. Please refer to Section 1406 of this manual. The fifteen

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day waiting period does not apply to discharge based on admission to a nursing facility.

5. Member exhibits and/or allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.
6. Member/member's representative or case manager requests immediate termination of services. The provider must document in the member's record the member's request for a change in provider.
7. Member moves out of the planning and service area to another area not served by the provider. (If needed a transfer of services needs to be coordinated by case management to ensure continuity of care)
8. Member expires.
9. Provider can no longer provide services ordered on the Carepath.
10. Member is non compliant. Examples of non-compliance includes:
 - Failure to keep scheduled Primary Care Physician appointments
 - Avoiding or refusing Case Manager visits or other contacts
 - Refusal to allow or facilitate the delivery of community services as agreed on in the Carepath plan
 - Failure to provide essential information affecting SOURCE's ability to help members live in healthy and functionally independent ways
 - Refusing to participate in problem solving discussions and efforts with Case Manager's, PCP's, physicians or providers around Carepath variances, delivery or clinical issues
 - Failure to use designated SOURCE providers or affiliates for services

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Procedures:

- (1) The assigned Case Manager will communicate clearly at admission the program's expectations of members/caregiver.
- (2) Single, minor or isolated instances of non-compliance will not result in formal action; the Case Manager will address these issues with members/caregiver as they occur.
- (3) The Case Manager will take action steps indicated for repeated instances of non-compliance, involving as indicated the member's PCP, supervisor or program manager (see Policy II F, Carepath Variances).
- (4) Issues of non-compliance and efforts at resolution will be documented in the member's case notes, on the Carepath, in Variance Reports, etc.
- (5) The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance.
- (6) The Case Manager (with assistance from the Supervisor as indicated) will present information to the Admissions Committee.
- (7) The Primary Care Provider will be informed of pending involuntary discharge prior to the disenrollment's effective date.
- (8) Prior to discharge, a member (or custodial caregiver or guardian) will receive from the Case Manager – following approval by the site's multidisciplinary group – written warning of potential discharge with a suggested course of action required to avoid discharge.
- (9) For members/caregiver unable to read, the Case Manager will read the letter over the phone or in person; the letter will also be mailed to the member's house.
- (10) Should the first written warning fail to resolve a pattern of non-compliance, members (or custodial caregivers or guardians) will receive from Case Manager (with approval from the multidisciplinary group) a written deadline for the course of action necessary to avoid discharge.
- (11) If the member fails to meet the letter's deadline, the Case Manager will initiate steps to discharge.
- (12) The Case Manager will make referrals to other programs or agencies if the disenrolling member so requests.

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- (13) The Case Manager will facilitate the transition to other agencies in all ways possible.
- (14) Members will be informed in writing of the formal date of discharge from SOURCE.
- (15) Members may seek to appeal an involuntary discharge through the site's internal grievance process.
- (16) Members may further seek to appeal an involuntary discharge upheld by the internal grievance process through the Department of Medical Assistance's appeal process.
- (17) Members may be involuntarily discharged immediately from SOURCE by the site's multidisciplinary staff group for physical aggression toward providers, CM or PCPs, bypassing procedures 3 through 13.
- (18) Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety (Appendix Z), to be filed in the member's chart.

1406. Right to Appeal

A. SOURCE members and applicants have the right to appeal the following actions of a SOURCE Enhanced Case Management:

- Refusal to screen/assess based on initial information
- Denial of eligibility (category of eligibility other than SSI or Public Law or no category; failure to meet nursing home level of care; refusal based on other factors like service area, available housing, safety concerns, etc.)
- Reduction in services (any reduction in service, even resulting from a temporary increase)
- Termination of services (discharge from SOURCE or from an individual service like PSS)

The Department of Community Health will notify sites when a request for an appeal is made, and when a request is made to maintain services at the current level. Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures:

1. Case managers and CM supervisors will attempt to reach consensus with members and potential members (or legal guardians if applicable) on decisions made about the member's care.
2. Following discussion of an action falling into a category described above, the site will inform the member clearly of the action to be taken.
3. If a member informs the site that he or she does not concur with the reduction or termination, sites will not reduce or terminate services. The internal grievance process will be triggered (see Policy No. 1403) and completed prior to implementing the Right to Appeal policy. NOTE: Eligibility issues at screening are exempt from this process (proceed to Procedure 4).
4. Should the internal grievance process fail to resolve the issue OR if services will be decreased following the grievance process, sites will give the member written notice, sent via Certified Mail, of actions for any of the categories, using the Appendix Z-1 letter, NOTICE OF DENIAL, TERMINATION, REDUCTION IN SERVICE OR DELAY IN STARTING SERVICES FROM THE SOURCE PROGRAM. The form will be dated the day the form is mailed.
5. The original Z-1 letter is mailed to the SOURCE member via Certified Mail, along with the Appendix Z-2 Notice of Right to a Hearing form. A copy is kept in the SOURCE chart.
6. For members concurring with the intended action, the Appendix Z-1 letter and the Appendix Z-2 form will also be completed and provided to members as described above.
7. Members have 30 days from the date of their Appendix Z-1 letter to request a hearing in writing; in cases of decreasing or terminating services, members may retain their services at their current level by notifying DCH in writing within fifteen days of the Appendix Z-1 letter's date.
(Discharge to nursing home requires immediate discharge of without fifteen (15) waiting period. Refer to Section 1405-Involuntary Discharges)
8. Case managers should follow up the Appendix Z-1 letter with a call within 15 days to determine if the member (or legal guardian if indicated) has any questions concerning the adverse action notice.
9. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.
10. The case manager should ensure the member has information on obtaining assistance in appealing an action (see Appendix Z-2 Notice of Your Right to a Hearing form).

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11. If no appeal is filed, Case Managers will wait fifteen days from the date of the Appendix Z letter before decreasing or terminating service. Should the member request that a SOURCE community support service be terminated, the Case Manager should put the service on hold with the provider and wait until 15 days from the date of the Appendix Z-1 letter have passed before formally discharging the service.

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12. Members requesting discharge from SOURCE are exempt from the 15-day waiting period. Case managers should immediately send in a APPENDIX F form with the date requested for discharge by the member. The member will no longer receive SOURCE EPCCM or community based services as of the date indicated on the APPENDIX F. See also Policy No.1405 (a) Voluntary Discharge.

13. However, in the above case of a member's request for discharge, note that formal discharge from SOURCE is subject to GHP lock-in procedures. Should the member wish to see a new PCP before the lock-in date has passed, sites may provide the site authorization number for the new PCP.

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14. A SOURCE member has the right to represent him/herself or have an attorney, paralegal or any other person to represent him/her. Case managers should notify members of the availability of local services for legal assistance to older or low-income persons.

15. If an appeal is filed by the members, the site will present information at the appeal supporting the adverse action taken.

B. Failure to Meet Nursing Home Level of Care

Members who fail to meet the Nursing Home Level of Care criteria will be reviewed by the Interdisciplinary team prior to issuance of the Appendix Z (notification of adverse action). The assessment nurse will present, or, at a minimum, be available to answer questions about the member's MDS-HC assessment, additional assessments and any other documents used in the LOC determination, to the interdisciplinary team for review and discussion. If the team agrees that the member does not meet nursing home ILOC, the Medical Director and/or PCP will indicate same in item 34 of Appendix F and sign his/her name as required.

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Additionally, the Interdisciplinary team, with the case manager, will review other resources to meet the member's needs. Appropriate discharge planning and referral assistance will be provided to the member by the case manager. CM will notify member of the planned discharge and provide the member with information regarding the appeal process, as directed in Medicaid Part I Policy and Procedures section 500.

NOTE: Prior to review by the Interdisciplinary team, the assessing nurse shall review the member's LOC with the member's PCP to ensure concurrence with

member health and functional status as documented on the MDS-HC

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Procedures:

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1. SOURCE assessment nurse will conduct an assessment and determine if the member meets the LOC criteria. If determined that the member does not meet LOC, then case manager will send the member an Appendix Z form. The Appendix Z Form states why the member does not meet the LOC criteria, and cites applicable policy. The member has thirty (30) days to request a hearing.
2. If the member request a hearing, the member will send his/her hearing request to DCH Legal Services.
3. Upon receipt of the hearing request, DCH Legal Services will contact the SOURCE Program Specialist to request a copy of the file/records used to make the LOC determination
4. SOURCE Program Specialist will inform the SOURCE site that the member has requested a hearing. Program Specialist will obtain a copy of the records and provide this information to DCH Legal Services. The benefits must continue.
5. Upon receipt of the records, DCH Legal will assign the case to an attorney and transmit the case to OSAH for a hearing.
6. OSAH will issue a notice of hearing setting a specific hearing date, time, and location.
7. While waiting for the hearing to occur, the benefits must continue
8. During this waiting period, if the member decides that he/she does not want to proceed with the hearing, **it is the member or the member's representative's duty to inform DCH.OSAH that the member no longer wishes to proceed with the hearing. SOURCE does not represent the member. SOURCE is not an agent of the state. The right to a hearing belongs to the member.**
9. If the member decides to proceed with the hearing, the administrative hearing will occur and the administrative law judge will issue a decision. Continue member benefits pending the judge's decision
10. If the judge rules in favor of DCH, the member's benefits will be reduced or terminated. The member can appeal to the next level.
11. If the judge rules in favor of the member, the benefits will continue. DCH can appeal to the next level.

Re-Assessment Procedures

1. If while waiting for a hearing, SOURCE re-evaluates the member and determines that the member now meets the LOC, this does not negate the previous Appendix Z. The previous adverse action still stands. If SOURCE determines that the previous assessment was not performed correctly; then, DCH will withdraw the adverse action and the case will be removed from the calendar. No action is required by the member in this scenario
2. The member can still proceed with the hearing although a subsequent re-assessment has occurred. A subsequent re assessment and approval does not mean that the member is not entitled to a hearing on the previous denial.

1407. Confidentiality of Member Information

Integration of care for chronically ill people requires significant sharing of information between key players. To a greater extent than conventional HCBS, SOURCE Case Management Provider access, review and maintain patient records of all types, due to:

- Increased accountability standards for CM, across all treatment settings
- Coordination with participating primary medical care providers
- Formal linkages with health system providers

Ensuring appropriate access to medical and case management information by individuals involved in direct care or in monitoring care must be balanced with concern for member privacy. Offenses of confidentiality fall into two categories: **unauthorized access** of confidential data (looking at a member's chart or other data when there is no "need to know)," and the **unauthorized use, dissemination or communication** of clinical or other confidential data.

SOURCE Case Management Providers are required to act in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Procedures:

- a) Each site will maintain a confidentiality policy specific to the organization.
- b) The site-specific policy will include an "Employee Statement of Confidentiality" with disciplinary actions described for policy violations.

- c) Upon admission, all members will sign a consent form to permit the release of information, as necessary to individuals or entities participating in the program.
- d) Only case management, medical records and administrative staff will have direct access to member charts, excluding regulatory agency staff.
- e) Charts will be maintained after hours in a secure environment.
- f) Release of information to participating providers will be only on an as needed basis, and according to the policies and procedures of the site and DMA.
- g) All charts will be maintained per the guidelines as specified in Part I Policies and Procedures for Medicaid/Peachcare for Kids.

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1408. Non-Reimbursed Items and Services

In helping members continue residing in the community, CM will frequently discover needs for items or services not covered by conventional third-party payers like Medicaid or Medicare or by other traditional community resources. Often these items or services are critical to achieving Carepath outcomes for members, but the costs may be far out of reach for the member/caregiver to pay for privately. Sites will develop or have access to funds to bridge gaps in coverage for essential items or services. Typical examples include incontinence supplies, nutritional supplements and certain prescription medications; other examples are moving expenses, pest control, specific pieces of DME, etc.

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If funds for non-covered items or services do not exist in the local community, a site may consider applying to local charitable foundations, accepting donations from civic organizations, individuals, churches and other faith-based organizations, etc., to build a fund. Sites must comply with all applicable local, state and federal requirements.

Payment for such items or services by the site does not set a precedent for such funding for all members. Consideration should be on an individual, case-by-case basis and will depend on the amount of funding and guidelines established.

Procedures:

- a) The Case Manager will review any available options to cover a needed item or services, including the member/caregiver's own resources.
- b) When other potential sources are ruled out, the Case Manager will submit a request in writing to the Case Manager Supervisor documenting specifically the service or item needed a time frame if applicable and a brief rationale.

- c) The Case Manager Supervisor or Program Manager will have authority to approve the expenditure and will maintain a record of all items/services covered.
- d) The Case Manager will forward the approved request to the organization or staff member (if internal) in charge of dispersing funds.
- e) If the items/services are not approved, the Case Manager will continue to work with the SOURCE member/Caregiver to attempt to obtain the item or services from other sources or to find a suitable substitute.
- f) For items/services funded on an ongoing basis, the Case Manager assigned will be responsible for reviewing every quarter the need for continued assistance.
- g) Non-reimbursed services for members will be documented, for potential analysis of service packages.

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1409. Due Process

SOURCE providers have the right to an Administrative Review should they be removed from a SOURCE Enhanced Case Management's panel of participating providers. Sites must notify providers in writing of the action. The provider shall have ten (10) days from the date of the written notice of removal from the DCH SOURCE referral list from the SOURCE Case Management Provider to submit a written request for the Review. All requests for reviews must be submitted to the address specified in the corrective action notice to the provider. The written request for an Administrative Review must include all grounds for appeal and must be accompanied by any supporting documentation and explanations that the provider wishes the Department of Community Health to consider. Failure of the provider to comply with the requirements of administrative review, including the failure to submit all necessary documentation, within ten (10) days shall constitute a waiver of any and all further appeal rights, including the right to a hearing, concerning the matter in question.

Rev. 07/10

The Division of Medicaid shall render the Administrative Review decision within thirty (30) days of the date of receipt of the provider's request for an Administrative Review.

Rev. 7/03

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding removal from the preferred provider list will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the preferred provider list, the provider may appeal the decision of the SOURCE Enhanced Case Management. The appeal must be in writing and received by the Commissioner's office within ten (10) business days of the date the Administrative Review decision was received by the provider. The appeal shall be determined within forty-five (45)

days of the date on which the Commissioner's office received the request to appeal.

Rev. 7/03

The request for the appeal must include the following information:

- ◆ A written request to appeal the decision of the Administrative Review
- ◆ Identification of the adverse administrative review decision or other SOURCE action being appealed
- ◆ A specific statement of why the provider believes the administrative review decision or other SOURCE action is wrong; and
- ◆ Submission of all documentation for review

An appeal shall state the action appealed.

Rev. 07/10

The Department of Community Health and the Division of Medicaid will reach a decision within thirty (30) days of receiving the appeal. If the Commissioner's decision upholds that of the SOURCE Enhanced Case Management, removal from the preferred provider list shall remain in effect for the time specified.

The decision of the DCH Commissioner is final. No further appeal rights will be available to the provider.

Rev. 10/03

1410. HIPPA Regulations

A federal law about health care, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides new health privacy regulations.

The Privacy Rule under HIPPA establishes privacy protections that assure Medicaid recipients and all health care patients that their medical records are kept confidential. The rules will help to ensure appropriate privacy safeguards are in place as we manage information technology to improve the quality of care provided to patients. The new protections give recipients greater access to their own medical records and more control over how their personal information is used by their health insurance plans (including Medicaid) and by health care providers.

The DCH Notice of Privacy Practices explains how Georgia Medicaid uses and discloses individuals' health information and how individuals may access their information. The notice was mailed to all Medicaid recipients with the April 2004 eligibility cards.

1411. SOURCE Sentinel Event Policy

Case Managers will complete the SOURCE Sentinel Event Report in the event of an unanticipated incident that results in death or significant injury of a SOURCE member. Excluded are deaths, injuries or impairments due to acute illness that can be reasonably considered a potential outcome in consideration of a member's age or health status.

Sentinel events most typically involve:

- abuse
- neglect or reckless disregard for the member's well being
- criminal activity
- serious accidents

Procedures:

1. In the event of a sentinel event, the Case Manager will complete the Sentinel Event Report, in consultation with the Case Management supervisor.
2. The SOURCE PCP or Medical Director will also be consulted as indicated, to accurately complete the report.
3. Sites shall notify the DCH SOURCE Program Specialist of all sentinel events, by mailing or faxing the Sentinel Event Report upon completion (and by a phone call if indicated).
4. Again in consultation with the Case Management supervisor, the Case Manager will implement any follow-up activities indicated.

1412. Transfers Between SOURCE Case Management Agencies

Transfers between SOURCE Enhanced Case Management fall into two categories: a member moves to a new area of the state not served by the existing site OR a member remains in the same community but chooses to enroll with a competing site over their existing case management provider. To promote continuity of care and help members meet program goals, DCH has established a protocol to minimize the disruption of support services for members transferring to a new case management agency. Members should be encouraged to move toward the end of the month if possible, taking into consideration existing lock-in procedures of DCH.

MEMBER RE-LOCATION

Procedures:

Rev 04/09

1. When a member reports a planned move to an area not served by the existing case management company, the Case Manager will promptly notify the Case Management Supervisor.
2. The CMS will offer the member a list of case management agencies that provide service in the new area (use Appendix Z-12 in the SOURCE DCH manual).
3. The member will select a site and notify the Case Manager of their choice.
4. The Case Manager will notify the CMS, who will contact the new site to make a referral, give the new site an anticipated relocation date if possible and coordinate discharge and admissions processes to best serve the member.
5. Members will be counseled by case management staff to plan moves (and discharge from the existing site) in consideration of lock-in procedures, in order to lessen the member's time without HCBS.
6. With the member's permission and a signed release, the existing site may forward a copy of the member's chart or selected case management documentation to the new site.
7. Upon moving, the new site will work to expedite the assessment process to the extent possible, to determine any changes in status (caregiver/informal support, HCBS and primary care needs) related to the move, in order to lessen the member's time without HCBS.
8. Upon completing the admissions process at the new site, the member's APPENDIX F will be faxed to GHP according to the SOURCE DCH manual, Section 903 (f) Program Admission.
9. Members transferring to another site will be subject to existing SOURCE lock-in procedures for HCBS.

Rev 01/09,
10/09

MEMBER TRANSFER TO A COMPETING CASE MANAGEMENT AGENCY

Procedures:

1. The new site will notify the existing site of the member's choice of a planned transfer, to best coordinate provision of services for the member.
2. Upon learning of a member's choice to be enrolled with another SOURCE CM agency, the case manager from the existing site will request that the member make the transfer at the end of the month if possible.

3. The new site may assess the member at any point during the month, but will not be responsible for case management until the member is discharged from the existing site.
4. Until discharge, the existing agency is responsible for all aspects of case management.
5. Upon completion of the admissions process by the new site, the member's APPENDIX F will be faxed to GHP according to the SOURCE DCH manual, Section 903 (f) Program Admission.
6. As SOURCE is a voluntary program, the existing CM agency will discharge the member according to the date requested by the member.
7. Members transferring to another site will be subject to existing SOURCE lock-in procedures for HCBS.

1413 **Georgia Enhanced Care (GEC)**

Rev.
04/10

GEC is a statewide disease management program that is performance-based healthcare for the Aged, Blind and Disabled (ABD) Medicaid population. GEC is an expansion to the current Georgia Better Health Care (GBHC) Primary Care Case Management program that matches Medicaid members to a Primary Care Provider (PCP). Members must be enrolled in GBHC in order to receive GEC services. The Department of Community Health (DCH) contracts with two major disease state management organization (APS Health Care and United Health Care) to coordinate and deliver disease management services. GEC services include 24-hour Nurse Call centers, initial baseline assessments, risk stratification to develop treatment plans and provide preventive and treatment interventions to improve members' health outcomes and improve self-management skills.

Rev 01/09

Disease State Management (DSM) is a collaborative comprehensive approach to the delivery of healthcare services designed to decrease hospital admissions, inpatient days and inappropriate emergency room visits. Health conditions to be covered in DSM include but will not be limited to: asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, hemophilia and schizophrenia along with other co-morbid conditions and risk factors related to chronic illness. ***GEC is a voluntary program on an "opt-out basis" for the following eligibility categories:*** SSI Aged, Blind and Disabled Categories of Eligibility (COE) that are currently eligible for enrollment in the GBHC program including those that participate in the Deeming Waiver or the Community Care (CCSP) waiver program.

Member Exclusions

- Members who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in a institution, including skilled nursing facilities, hospital swing bed units, hospice, intermediate care facilities for the mentally ill, or correctional institutions and personal care homes;

- Members with dual Medicaid and Medicare eligibility; Qualified Medicare Beneficiaries (QMBs);
- Members who have other Third Party Liability coverage; Members of a federally recognized Indian Tribe;
- Members that are Members who are enrolled in the Georgia Families program;
- Rev 01/09 • Children enrolled in the Medical Services Program administered by the Georgia Division of Public Health;
- Members enrolled in the Service Options Using Resources In Community Environment (SOURCE) program;
- Children in foster care or otherwise in the custody of the State;
- Participants in the some waiver programs (BCC Waiver, Independent Care Waiver, Mental Retardation Waiver, Laurens County Waiver, HIV Waiver and Cystic Fibrosis Waiver);
- Rev 04/09 • Participants in the Recipient Lock-in program (GEXP, GBHC, SOURCE, PASSR, HMO, GAPP);
- Children enrolled in the Georgia Pediatric Program (GAPP);
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the TRIS or PRTF program;
- Children who are receiving services under Title V (CMS) funding

Specific Instructions for SOURCE members:

Rev 04/09

The Department of Community Health will reimburse only one provider agency for case management services. To ensure that billing for more than one case management agency or Medicaid provider, are not reimbursed for the same member in the same calendar month, the Department's billing system has been modified to reflect the following:

- To include edits to ensure only one provider agency or Medicaid Provider that renders case management is reimbursed.
- A hierarchy (see below) for case management services was established to prevent payment of more than one case management services per month.
 1. COS 830 – CMO
 - To include: COS 767 – DMO
 2. COS 851 – SOURCE CM
 3. COS 100 – Dedicated Case Management
 - To include: Waiver Members –
 - COS 680 - MRWP/NOW
 - COS 681 - CHSS/COMP
 - COS 660 – ICWP
 4. COS 764 – Child Protective Services Targeted Case management
 5. COS 800 – Early Intervention Case Management
 6. COS 765 – Adult Protective Services Targeted Case Management
 7. COS 763 – At Risk of Incarceration Targeted Case Management
 8. COS 760 – Children At Risk Targeted Case Management
 9. COS 762 - Adults with AIDS Targeted Case Management
 10. COS 790 – Rehab Services/DSPS
 11. COS 100 – Dedicated Case Management – Non-Waiver Members
 12. COS 960 - Children Intervention Service – End Date 6/30/2004

In addition to the system modifications above, the billing system has been further modified to ensure hierarchy is followed and the Case Management Agency has been paid appropriately for services rendered. Effective for dates of service on and after January 1, 2009, the Case Management agency or Medicaid Provider submitting claims for the same member in the same calendar month:

Rev 04/09

- If two claims are submitted for CM services the hierarchy determines which provider will be paid.
- If the lower hierarchy provider has been reimbursed the claim amount will be recovered and payment made to the CM provider first in the hierarchy.
 1. The two edits providers will see on the remittance are as follows:
 - Edit representing Denial - 6049 (Two Case Management Claims Cannot be Paid for the Same Calendar Month).
 - Edit representing Recovery - 6029 (Case Management Claim Cannot be Billed in the Same Calendar Month as a Paid Claim From the Same or Another Case Management Program).

DISENROLLMENT FROM GEC/DSM

Should a member be enrolled in GEC/DSM the following procedures should be followed to dis-enroll a member:

Rev 07/09

1. Confirm via the web portal, member participation in GEC prior to completing any initial visits with a perspective member
2. If the member is already locked into GEC/DSM, using the Member Request Form (Appendix HH), the case manager educates the member about the services offered by GEC/DSM and SOURCE during the initial face to face visit. While the SOURCE case manager is in the home, a case conference will be conducted, telephonically, during which the member will verbalize his/her choice.
3. Results of the case conference should be documented through the use of the Member Request Form (Appendix H). Member documents his/her choice of case management participation, GEC/DSM or SOURCE, in writing.
4. CM provides a copy of the Member Request Form to the member
5. CM submits a copy of the Member Request Form to the GEC/DSM vendor via facsimile
6. Within ten calendar days, CM contacts GEC/DSM vendor by telephone to confirm dis-enrollment or date that dis-enrollment will occur
7. CM submits APPENDIX F and cover sheet with dis-enrollment information to DCH

Members must be advised that enrollment in either of these programs is voluntary; thus his/her choice must be made clear to both providers. Time frames must be followed as stipulated in this manual, Chapter 900, Section 903 (G).

NOTE: If member chooses GEC/DSM, SOURCE intake/assessment interview terminates.

APPENDIX A
SOURCE Screening Form

Screener _____ Referral Date _____ Screening Date _____

Name _____ DOB ___/___/___ Sex ___ Medicaid ___ Yes/___ No

SSN ___-___-___ Medicaid Number _____ Medicare Number _____

SSI: Yes ___/No ___ If no, is monthly income SSI level or below? _____

Address _____ Phone _____

Housing: Alone _____ With relative/friend _____ Hospital _____
Personal Care Home _____ Nursing Home _____ Other _____

Physician _____ Date of last visit _____
Diagnoses _____

Initial caller _____ Referred by _____

Referral/screening notes _____

Primary caregiver/relationship _____

Phone _____ Address _____

Willing to use SOURCE PCP: ___ Yes ___ No

Referred for SOURCE assessment _____

Not eligible/reason _____

Referred for other services _____

Other _____

APPENDIX B

**Service Options Using Resources in Community Environments
SOURCE Program Participation**

Date / /

Dear _____

Welcome to the SOURCE Program. The SOURCE multidisciplinary team reviewed your situation and recommended community –based services through SOURCE.

Services will begin after the providers listed below have visited you. Someone from the following agency(s) will be contacting you.

1. _____
Provider Agency

Contact Person

Telephone Number

2. _____
Provider Agency

Contact Person

Telephone Number

3. _____
Provider Agency

Contact Person

Telephone Number

4. _____
Provider Agency

Contact Person

Telephone Number

As a participant in the SOURCE Program:

1. You will not lose any medical assistance benefits that you are currently receiving by participating in the SOURCE Program.
2. You may withdraw from SOURCE at any time.

Please contact the Case Manager listed below or you may have someone call on your behalf if you have questions or need additional information.

Case Manager

Telephone Number

APPENDIX C

SOURCE ASSESSMENT ADDENDUM

Member: _____ Date: _____

1. Home Assessment:

List people who live in the home:

Name/Relationship	Age	Work: FT, PT, Night	Status: Permanent, Temporary, Intermittent	School: Yes or No

Is there usually someone with you at night? Y _____ N _____

Do you have someone who could stay with you if you were sick? Y _____ N _____

If yes, provide name and contact information: _____

Plans for evacuation or disaster: _____

2. Physical Environment:

Features:	Yes	No	Features:	Yes	No
Electrical hazards			Space heater(s)		
Stove/refrigerator on premises			Telephone		
Signs of careless smoking			Smoke detectors		
Washer/dryer on premises			Running water		
Other fire hazards			Indoor toilets		
Pets (specify)			Adequate ventilation		
Satisfied with living situation			Planning to move		

Comments: _____

3. Medications:

Pharmacy name and telephone number: _____

How do you get your medications? _____

Member: _____

Date: _____

4. Psychosocial:

In the past year have there been any significant changes in your life, such as:

	Yes	No		Yes	No
Illness/injury			Change in marital status		
Change in job, residence			Victim of crime or Exploitation		
Losses or deaths			Other (specify)		

5. Advance Directives:

Do you have a signed Advance Directive? Yes ___ No ___

If yes, where is the copy kept? _____

Does the family know of the Advance Directive? Yes ___ No ___

6. Proxy Decision Makers:

Name: _____ Relationship: _____

Telephone: _____

Type: guardian ___ payee ___ power of attorney ___

7. Financial Information:

Monthly Income \$ _____

Social Security _____

SSI _____

Other _____

Checking Account? Yes ___ No ___

Savings Accounts? Yes ___ No ___

Who manages money for member? _____

8. Nutrition:

Has your doctor told you to eat a special diet? _____

Are you compliant with your diet order? Yes ___ No ___

Do you use alcohol? Yes ___ No ___; tobacco? Yes ___ No ___; or recreation drugs?
Yes ___ No ___

If yes, what drugs? _____

9. Home Monitoring:

If applicable, in addition to your doctor, who is responsible for monitoring ___ BS ___ BP
___ weight? ___ self care ___ others assisting _____

How often? _____
 Member: _____ Date: _____

List any monitoring equipment and supplies you have (blood pressure cuff, One-Touch type machine, scales, etc.) _____

10. Labwork:

Do you currently require any ongoing labwork/diagnostics or other medical procedures (blood machine, scales, etc)? _____

Procedure _____ Frequency _____

Reason _____ Provider _____

11. IADL/ADL:

Instrumental Activities of Daily Living

Category:	WHO helps and WHEN? (include ALL assistance – family/friends AND formal services)
Telephone	
Shopping	
Food preparation	Breakfast/Lunch/Supper
Housekeeping	
Laundry	
Mode of Transportation	
Medications	
Finances	

Member: _____

Date: _____

Basic Activities of Daily Living – If assistance is required:

Category	WHO helps and WHEN? (ALL informal AND paid support)
Bed mobility:	
Transfer:	
Locomotion:	
Dressing:	
Eating:	
Toilet use:	
Personal hygiene:	
Bathing:	
Continence:	

Are existing caregivers willing/able to continue providing assistance at current levels?

Yes ___ No ___ Comments: _____

12. Physician Information

Doctor's Name _____ Phone No. (____) _____

Reason _____

Doctor's Name _____ Phone No. (____) _____

Reason _____

Member: _____

Date: _____

13. Medical Treatment

Do you currently receive any of the following medical treatments? (If yes, list who provider and telephone number.)

Treatments:	Provider/Telephone Number:
Pressure sore treatment	
Wound or other skin care treatment	
Skilled therapy (PO/OT/speech)	
Colostomy/ostomy care	
Oxygen	
Other	

14. Other Programs

Cross reference with other programs:

15. Education

What is the highest grade completed in school? _____

16. Special Equipment

- | | | |
|---|---|--|
| <input type="checkbox"/> Bed Rail | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Incontinence pads |
| <input type="checkbox"/> Catheter | <input type="checkbox"/> High toilet seat | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Brace (back) | <input type="checkbox"/> Prosthesis _____ | <input type="checkbox"/> Cane/walker |
| <input type="checkbox"/> Blood glucose monitor | <input type="checkbox"/> Adaptive eating equipment | <input type="checkbox"/> Grab bars |
| <input type="checkbox"/> Bathing equipment | <input type="checkbox"/> Bedside commode | <input type="checkbox"/> Other vision |
| <input type="checkbox"/> Lift (manual/electric) | <input type="checkbox"/> Wheelchair (manual/electric) | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Other _____ | | |

Care Manager Signature _____ Date _____

Member _____

SOURCE SERVICES RECOMMENDED

Issues Noted	Services Recommended	Provider Recommended	Frequency	Participant Feedback

Member Signature

Date

Case Manager Signature

Date

SOURCE Consent for Enrollment

I, _____, voluntarily agree to enroll in SOURCE. I understand that SOURCE will provide primary medical care, case management and support services, under the Georgia Better Health Care program.

I understand that I will be required to use a doctor or nurse practitioner participating in SOURCE, who will provide or coordinate all medical care I may need. Any support services I may need will also be arranged and monitored by SOURCE. If I am currently enrolled in another Medicaid waiver program, my enrollment and services will be changed to SOURCE.

I further understand that SOURCE staff will be coming to my home to evaluate my current status and my need for support services, on an ongoing basis. SOURCE will also provide information to participating SOURCE providers, as needed for effective service delivery.

Information gathered on the type and amount of service I receive and on my medical condition may also be used in evaluating this program or to develop future healthcare programs and guidelines in Georgia. MY NAME OR OTHER IDENTIFYING INFORMATION WILL NOT BE USED FOR THIS PURPOSE.

Person giving consent

Date

Relationship to SOURCE member if not member

Date

Witness

Date

APPENDIX D

SOURCE Manual Member Rights and Responsibilities

In order for you to have a positive and healthy experience in SOURCE, the staff must ensure that your rights are respected.

Your rights, in the SOURCE program:

You have the right to receive:

- Considerate and respectful care, without discrimination as to race, religion, sex or national origin.
- Clear and current information about your health, medical treatments and Carepath plan.
- The name of any doctor, Case Manager or other SOURCE Enhanced Case Management staff member involved in your care.
- Information necessary to give consent before any procedure and/or treatment, and information on potential alternatives.
- Privacy and confidentiality of your treatment and medical records. Information about you will be released only as necessary for providing effective care, and only with your consent (see attached Consent for Enrollment Form).
- Information on how to make a complaint or an appeal about care received through the SOURCE Enhanced Case Management.
- You have the right to reasonable participation in decisions involving your care.
- You have the right to refuse treatment to the extent allowed by law, and to be informed of the likely medical consequences.
- You have the right to choose a primary care doctor from the SOURCE Enhanced Case Management's list of participating physicians.
- You have the right to choose from the SOURCE Enhanced Case Management's list of participating providers, for support services indicated by your Carepath plan.

The SOURCE program is designed to help you stay as healthy and independent as possible.

To achieve these goals, you must be an active partner in working with your Case Manager and SOURCE doctor.

Your responsibilities, in the SOURCE program:

You are responsible for providing clear and complete information regarding your overall health and healthcare, including illnesses/injuries, hospitalizations, medications or anything else that may affect how SOURCE delivers medical and supportive services.

You are responsible for helping to develop and carry out your SOURCE plan by:

- Giving complete and timely information to your Case Manager about your own abilities and those of your family or friends who are caregivers
- Carrying out assigned responsibilities as you agreed with your Case Manager
- Letting your Case Manager know if you or others (including paid providers) are not able or willing to carry out responsibilities as agreed, so the Case Manager can help make other arrangements
- Working with SOURCE staff to solve problems in key areas, identified by your Case Manager as goals during your enrollment in the program
- Using providers (hospitals, home care and home health agencies, etc.) who participate in the SOURCE program.

You are responsible for keeping all medical appointments as part of your SOURCE plan, or for notifying SOURCE if you cannot keep an appointment.

You are responsible for maintaining a safe and healthy home environment. Your Case Manager may assist you in finding help with home repairs or in moving to a new home, if necessary.

You are responsible for treating your Case Manager, doctors and service providers in a courteous and respectful manner.

SOURCE Member/Caregiver

Date

SOURCE Case Manager

Date

APPENDIX E

**AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS/MEDICAL INFORMATION**

I hereby authorize SOURCE to receive information from the medical records of:

Patient _____ SSN _____

Date of Birth _____ Date(s) of Service: _____

Information requested: _____

Requested by: _____ Phone No. _____

Purpose or need for information: Enrollment in SOURCE "Enhanced Case Management"

All information I hereby release to be obtained will be held strictly confidential and cannot be released without my consent. I understand that this authorization will remain in effect for one year, unless I specify an earlier date here: _____

Signature of Patient or Authorized Person

Date

Relationship if Not Patient

Signature of Witness

Date

Please send all information to: _____

APPENDIX F

Georgia Department of Community Health

SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information		2. Patient's Name (Last, First, Middle Initial):							
1. SOURCE ASSESSMENT TEAM NAME ADDRESS		3. Home Address:							
		4. Telephone Number;				5. County			
6. Medicaid Number		7. Social Security Number				8. Mother's Maiden Name:			
		9. Sex	10. Age	11. Birthday	12. Race	13. Marital Status	14. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Reassessment		15. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance with necessary information including medical data.

16. Signed _____ 17. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed

18. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached)			19. Is Patient free of communicable disease?			1. ICD	2. ICD	3. ICD
1. Primary _____ 2. Secondary _____ 3. Other _____			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					

Medications (including OTC)				Diagnostic and Treatment Procedures			
20. Name	Dosage	Route	Frequency	21 Type Frequency			

22. SOURCE SERVICES ORDERED :

23. Diet	24. Hours Out of Bed Per Day	25. Overall Cond	26 Restorative Potential	28. Mental and Behavioral Status			
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input type="checkbox"/> Intake <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Bedfast <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning	<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None	<input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert	<input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction	

28. Decubiti	29. Bowel	30. Bladder	31. Indicate Frequency Per Week: Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date	<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy	<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter							

32 Record Appropriate Legend	IMPPAIRMENT										ACTIVITIES OF DAILY LIVING							
1. Severe																		
2. Moderate	Sight	Hear	Speech	Ltd Motion	Para-lysis	1. Dependent	2. Needs Asst.	Eats	Wheel-Chair	Trans-fers	Bath	Ambu-lation	Dressing					
3. Mild	<input type="checkbox"/>	3. Independent		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4. None						4. Not App												

33. This patient's condition <input type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input type="checkbox"/> SOURCE or <input type="checkbox"/> Home Health Services.	37. Physician's Name (Print)		
34. I certify that this patient <input type="checkbox"/> requires <input type="checkbox"/> does not require the intermediate level of care provided by a nursing facility.	38. Physician's Address (Print)		
35. I certify that the attached plan of care addresses the client's needs for Community Care.	39. Date Signed By Physician	40. Physician's Licensure No.	41. Physician's Phone No.
36. Physician's Signature _____			

ASSESSMENT TEAM USE ONLY

42. Nursing Facility Level of Care <input type="checkbox"/> Yes <input type="checkbox"/> No	43. L.O.S	Certified Through Date
44. Signed by person certifying LOC: _____	Title _____	Date Signed _____

SOURCE

LEVEL OF CARE AND PLACEMENT INSTRUMENT-INSTRUCTIONS

Purpose: The Level Of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for SOURCE services. In addition, the LOC page represents the physician's order for all waived services provided by SOURCE.

Who Completes Form: Initial assessments are completed by a licensed nurse (RN or LPN), case manager. The LOC is always assigned by the RN. The agency medical director or client's physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

When the Form is Completed: The case manager completes the LOC page at initial assessments and reassessments.

Instructions:

SECTION I A. IDENTIFYING INFORMATION

Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, of care coordination team.
2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.
3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.
4. Enter client's area code and telephone number.
5. Enter client's county of residence.
6. Enter client's Medicaid number exactly as it appears on the Medicaid card.
7. Enter client's nine-digit social security number.
8. Enter client's mother's maiden name.
- 09, 10, 11. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).
12. Enter client's race as follows:
A = Asian/Pacific Islander H = Hispanic W = White
B = Black NA = Native American
13. Enter client's marital status as follows:
S = Single M = Married W = Widowed
D = Divorced SP = Separated
14. Check (T) appropriate type of recommendation:
 1. Initial: First referral to SOURCE or re-entry into SOURCE after termination
 2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.
15. Enter referral source by name and title (if applicable), or agency and type as follows:
MD = Doctor S = Self HHA = Home health agency
NF = Nursing facility FM = Family PCH = Personal Care Home
HOSP = Hospital ADH = Adult Day Health
O = Other (Identify fully)
- 16, 17. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to Case Manager regarding level of care determination.

SECTION IB. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

Section B is completed and signed by licensed medical person completing medical report.

18. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses. (Nurse assessor may enter client diagnoses, but through review and signature on Appendix F, the physician or nurse practitioner confirms the diagnoses)
- NOTE:** When physician, nurse practitioner or Medical Director completes signature, the case management team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Case management teams secure codes from ICD code book, local hospitals or client's physician.
19. The physician or nurse practitioner or Medical Director checks "yes" box to indicate if client is free of communicable diseases; if the member has a communicable disease or it is unknown, check "no".
 20. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.
 21. List all diagnostic and treatment procedures the client is receiving.
 22. List all waived services ordered by case management team.
 23. Enter appropriate diet for client. If "other" is checked (✓), please specify type.
 24. Enter number of hours out of bed per day if client is not bedfast. Check (✓) intake if client can take fluids orally. Check (✓) output if client's bladder function is normal without catheter. Check (✓) all appropriate boxes.
 25. Check (✓) appropriate box to indicate client's overall condition.
 26. Check (✓) appropriate box to indicate client's restorative potential.
 27. Check (✓) all appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.
 28. Check (✓) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.
 29. Check (✓) appropriate box.
 30. Check (✓) appropriate box.
 31. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.
 32. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.
 33. Case Management team with the Medical Director (admitting physician) indicates whether client's condition could or could not be managed by provision of Home and Community Services or Home Health Services by checking (✓) appropriate box.
NOTE: If physician indicates that client's condition cannot be managed by provision of Home and Community Services and/or Home Health Services, the member will not be admitted to SOURCE and should be referred to appropriate institutional services.
 34. Medical Director, admitting physician with Multidisciplinary Team certifies that client **requires** or **does not require** level of care provided by an intermediate care facility and signs on #36.
 35. Admitting/attending physician certifies that CarePath, plan of care addresses patient's needs for living in the community. If client's needs cannot be met with home and community based services, **the member will not be admitted to SOURCE and will be referred to appropriate services.**
 36. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. **Only a physician (MD or DO) or nurse practitioner may sign the LOC page.**

NOTE: Physician or nurse practitioner signs within 60 days of case manager's completion of form. Physician or nurse practitioner's signature must be original. Signature stamps are not acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable.

37, 38, 39, 40, 41. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

NOTE: The date the physician signs the form is the service order for SOURCE services to begin. UR will recoup money from the provider if date is not recorded.

42, 43, 44. REGISTERED NURSE (RN) USE ONLY

45. The registered nurse checks (√) the appropriate box regarding Nursing Facility Level of Care (LOC). When a level of care is denied, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.
46. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months. Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.
47. Licensed person certifying level of care signs in this space and indicates title (R.N.) and date of signature.

NOTE: Date of signature must be within 60 days of date care coordinator completed assessment as indicated in Number 17. Length of stay is calculated from date shown in Number 43. The RN completes a recertification of a level of care prior to expiration of length of stay.

Distribution: The original is filed in the case record. Include a copy with the provider assessment/ reassessment packet

APPENDIX G

SOURCE Carepath Levels

SOURCE Level	CRITERIA: Based on GA Nursing Home ICF and SNF Levels
I	Patient requires skilled nursing services daily; OR 1,2,3 AND 4 listed below
II	Patient has: 1) a medical condition which requires physician monitoring AND 2) the need for medical monitoring for one of the following: nutritional status; skin care; catheter use; therapy services; clinical indicators/lab studies; restorative nursing care; or medication management. AND EITHER 3 or 4: 3) a documented mental problem – IIC 4) a documented physical problem – II-F

INSTRUCTIONS/GUIDE for Determination of ILOC

Level of Care Criteria: SOURCE Applications

I. Medical Status: Must satisfy Question #1 and any one of #2 through #8

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Has at least one chronic condition . . ."	Examples: HTN, diabetes, heart disease, pulmonary disease, Alzheimer's, spinal cord injury, CVA, arthritis, etc.
2. Nutritional management . . ."	Medical record reflects status as underweight or morbidly obese; need for therapeutic diet d/t exacerbation chronic condition (HTN, diabetes, skin condition, etc.); dialysis patients (hydration); others at risk of dehydration.
3. "Maintenance and preventive skin care . . ."	Diabetics; SRC members spending significant time in wheelchair or bed; existing wound care/skin issues or history of; members with incontinence
4. "Catheter care . . ."	Self explanatory
5. "Therapy services . . ."	Self explanatory
6. "Restorative nursing services . . ."	Self explanatory
7. "Monitoring of key clinical indicators, laboratory studies or weights . . ."	Diagnosis requiring ongoing monitoring of clinical indicators: hypertension, pulmonary disease, diabetes, cardiovascular disease, etc. (key clinical indicators include but are not limited to blood pressure, pulse, respiration, temperature, weight, blood sugar for diabetics); medications indicating ongoing laboratory studies (Coumadin, Dilantin, Tegretol, Digoxin, Phenobarbital, liver profiles, certain cholesterol medications, etc.); CHF and dialysis patients for monitoring of weight.
8. "Management and administration of medications . . ."	SRC members needing assistance with management OR administration of medications (d/t cognitive or physical impairments). May be paid care or informal support providing assistance.

II. Cognitive Status Must Satisfy one of #1 through #4

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Documented short or long-term memory deficits . . ."	Linked to a diagnosis (CVA, TBI, dementia, Alzheimer's, psychiatric diagnosis, etc.) documented in medical record; review MMSE score.
2. "Documented moderately or severely impaired cognitive skills . . ."	Same as above. Allow for eccentricities.
3. "Problem behavior . . ."	Self-explanatory. Allow for eccentricities.
4. "Undetermined cognitive patterns which cannot be assessed by a mental status exam . . ."	Rarely used. Aphasia listed as example.

OR

III. Functional Status: Must satisfy one of #1 through #4 (with the exception of #5)

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Transfer and locomotion performance requires limited/extensive assistance . . ."	"One person physical assist" is key indicator. Not someone who lives alone with no support (paid or informal) in place or planned. "Locomotion" viewed as primarily in home.
2. "Assistance with feeding."	May be due to significant physical or cognitive impairment. Cueing and set-up help required together (i.e., not just an IADL issue).
3. "Direct assistance . . . to maintain continence."	"Assistance of another person" is key indicator (i.e., not just using incontinence products). May be due to physical (transfers, etc.) or cognitive impairments.
4. "Documented communication deficits . . ."	Must be profound and documented in medical chart.
5. "Assistance . . . dressing/personal hygiene"	Self-explanatory. See "another deficit" requirement described.

APPENDIX I

Level of Care

Column A Medical Status

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician

In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following plus one item from Column B or C

2. Nutritional management; which may include therapeutic diets or maintenance of hydration status

3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions or healing decubiti

4. Catheter care such as catheter change and irrigation

5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy, (3 times per week or less)

6. Restorative nursing services such as range of motion exercises and bowel and bladder training

7. Monitoring of vital signs and laboratory studies or weights

8. Management and administration of medications including injections

Column B

Mental Status

The mental status must be such that the cognitive loss is more than occasional forgetfulness

1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement

2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement.

3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention

4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia

Column C

Functional Status

One of the following conditions must exist (with the exception of #5)

1. Transfer and locomotion performance of the resident requires limited/extensive assistance by staff through help of one person physical assist.

2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set up of meals.

3. Requires direct assistance of another person to maintain continence.

4. Documented communication deficits in making self understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.

5. Direct stand-by supervision or cueing with one person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required.)

*Service Options Using Resources
In
Community Environments*

LEVEL I - CAREPATH

Member _____ Medicaid # _____

SOURCE Case Manager _____

Signature _____ Date _____

SOURCE Case Management Supervisor _____

Signature _____ Date _____

SOURCE PCP _____

Signature _____ Date _____

SOURCE Medical Director _____

Signature _____ Date _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member resides in community, maintaining maximum control possible over daily schedule and decisions.</p> <p>GOALS:</p> <p>A. Member/caregiver contributes to the design and implementation of community-based services plan.</p> <p>Key member responsibilities:</p> <ul style="list-style-type: none"> • Accept services as planned with manager; • Provide accurate information on health status and service delivery; and • Maintain scheduled contact with case manager. <p>B. Member keeps scheduled medical appointments.</p> <p>C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers.</p> <p>Key provider performance areas:</p> <ul style="list-style-type: none"> • Reliability of service • Competency and compatibility of staffing; • Responsiveness to member concerns and issues; and • Coordination with Case Manager. 	<p>Stabilize chronic conditions and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness.</p> <p>PCP: _____ Case Mgr. _____</p> <p><i>SOURCE PCP role:</i></p> <p>Evaluate and treat episodic /acute illness</p> <p>Manage chronic disease, including:</p> <p>Risk factor modification/monitoring of key clinical indicators</p> <p>Coordination of ancillary services</p> <p>Education for members/informal caregivers</p> <p>Medication review and management</p> <p>Conference/communicate regularly with Case Manager</p> <p>Review support service plans</p> <p>Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services</p> <p>Promote wellness, including immunizations, health screenings, etc.</p> <p><i>SOURCE Case Manager role:</i></p> <p>Maintain contact with member, for ongoing evaluation:</p> <p>Monthly by phone or visit (minimum)</p> <p>Quarterly by visit (minimum)</p> <p>PRN as needed</p> <p>Educate members on patient responsibilities</p> <p>Encourage/assist member in keeping all medical appointments</p> <p>Conference/communicate regularly with PCP; assist patients in carrying out PCP orders</p> <p>Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work</p> <p>Coordinate with informal caregivers and paid providers of support services</p> <p>Educate or facilitate education on chronic conditions</p> <p>Assist members in ALL issues jeopardizing health status or community residence</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (__/__/__):</p> <p>A. __ met __ not met</p> <p>B. __ met __ not met</p> <p>C. __ met __ not met</p> <p>2nd review period (__/__/__):</p> <p>A. __ met __ not met</p> <p>B. __ met __ not met</p> <p>C. __ met __ not met</p> <p>3rd review period (__/__/__):</p> <p>A. __ met __ not met</p> <p>B. __ met __ not met</p> <p>C. __ met __ not met</p> <p>4th review period (__/__/__):</p> <p>A. __ met __ not met</p> <p>B. __ met __ not met</p> <p>C. __ met __ not met</p>

MEMBER _____

DATE _____

Level 1 Page 2

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions</p> <p>GOALS:</p> <p>A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (PCP, ADH or other report).</p> <p>B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).</p>	<p>MEMBER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MEAL PREPARATION:</p> <p>___ self-care (total) _____</p> <p>___ assistance by informal caregiver(s) _____</p> <p>___ home delivered meals _____</p> <p>___ ALS (alternative living service) _____</p> <p>___ PSS aide (includes G-tube) _____</p> <p>MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HDM, PSS or ALS):</p> <p>Mon ___ B ___ L ___ S Thurs ___ B ___ L ___ S</p> <p>Tues ___ B ___ L ___ S Fri ___ B ___ L ___ S</p> <p>Wed ___ B ___ L ___ S Sat ___ B ___ L ___ S</p> <p>Sun ___ B ___ L ___ S</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>2nd review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>3rd review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>4th review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p>

MEMBER _____ DATE _____

MEMBER

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti.</p> <p>GOALS:</p> <p>Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>____ SOURCE PCP/PCP staff</p> <p>____ SOURCE educational material</p> <p>____ other _____</p> <p>MONITOR SKIN for integrity:</p> <p>____ SOURCE PCP</p> <p>____ self care</p> <p>____ informal caregiver _____</p> <p>____ ADH</p> <p>____ specialist _____</p> <p>____ PSS aide/PSS RN every 62 days</p> <p>____ ALS</p> <p>____ skilled nursing provider: _____</p> <p>Dates of Service: _____</p> <p>Assistance required:</p> <p>____ turning/repositioning (see page _____)</p> <p>____ continence (see page _____)</p> <p>____ nutrition (see page _____)</p> <p>NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>2nd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>3rd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>4th review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p>

MEMBER _____

DATE _____

Level 1 Page 4

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist.</p> <p>NOTE: Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the SOURCE PCP, according to the member's diagnosis and current medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal.</p> <p>The PCP will advise on any additional monitoring required for each member.</p> <p>Additional monitoring required, if applicable:</p> <p>____ blood glucose</p> <p>____ blood pressure</p> <p>____ weight (as indicator of illness, for CHF patients, etc.)</p> <p>____ labs</p> <p>____ other _____</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>____ SOURCE PCP/PCP staff</p> <p>____ SOURCE educational material</p> <p>____ other _____</p> <p>MONITOR CLINICAL INDICATORS:</p> <p>____ SOURCE PCP (OV)</p> <p>ADDITIONAL MONITORING REQUIRED:</p> <p>____ self care</p> <p>____ ASSISTANCE REQUIRED</p> <p>____ informal caregiver _____</p> <p>____ ADH _____</p> <p>____ PSS aide _____</p> <p>____ ALS _____</p> <p>____ RN provider: _____</p> <p>other _____</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>2nd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>3rd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>4th review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p>

MEMBER _____

DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager).</p>	<p>MEMBER/CAREGIVER EDUCATION: SOURCE PCP/PCP staff _____ SOURCE educational material _____ other _____</p> <p>MEDICATION ADMINISTRATION/MANAGEMENT: self care _____ informal caregiver _____ ADH/DHC _____ ALS _____ PSS aides (cueing) _____ RN provider _____ Dates of Service: _____</p> <p>OBTAINING MEDICATIONS: self care _____ informal caregiver _____ pharmacy delivery _____ other _____</p> <p>PHARMACY: _____</p> <p>NOTES: _____ _____ _____ _____ _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS: 1st review period (____/____/____): ___ met ___ not met</p> <p>2nd review period (____/____/____): ___ met ___ not met</p> <p>3rd review period (____/____/____): ___ met ___ not met</p> <p>4th review period (____/____/____): ___ met ___ not met</p>

MEMBER _____ **DATE** _____ **Level 1 Page 6**

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments.</p> <p>GOALS:</p> <p>No observations by Case Managers or reports from mbr./caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.</p>	<p>ASSISTANCE REQUIRED: (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service):</p> <p>_____ bathing _____ dressing _____ eating _____ transferring _____ toileting/continence _____ turning/repositioning</p> <p>_____ errands _____ chores _____ financial mgt. _____ meal prep.</p> <p>_____ informal caregiver(s) providing assistance: _____</p> <p>_____ home delivered meals _____ ADH _____ ALS _____ ERS _____ incontinence Carepath _____ PSS aide</p> <p>Total hours/week: _____ Indicate no. of hours:</p> <p>Monday _____ AM _____ PM Thursday _____ AM _____ PM Tuesday _____ AM _____ PM Friday _____ AM _____ PM Wednesday _____ AM _____ PM Saturday _____ AM _____ PM Sunday _____ AM _____ PM</p> <p>NOTES: _____ _____ _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____): _____ met _____ not met</p> <p>2nd review period (____/____/____): _____ met _____ not met</p> <p>3rd review period (____/____/____): _____ met _____ not met</p> <p>4th review period (____/____/____): _____ met _____ not met</p>

MEMBER _____ **DATE** _____ **Level 1 Page 8**

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Transfers and mobility will occur safely.</p> <p>GOALS:</p> <p>Member has no falls due to unsuccessful attempts at transferring or mobility.</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>__SOURCE PCP/PCP staff</p> <p>__SOURCE educational material</p> <p>other _____</p> <p>ASSISTANCE REQUIRED:</p> <p>__informal caregiver(s) to provide assistance with transfers and mobility:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PSS aide for assistance if/when informal support is unavailable</p> <p>__ALS</p> <p>ADH program for assistance if/when informal support is unavailable</p> <p>Adaptive equipment as indicated, with training as required (specify):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Home modifications as indicated (specify):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>__ met</p> <p>__ not met</p> <p>2nd review period (____/____/____):</p> <p>__ met</p> <p>__ not met</p> <p>3rd review period (____/____/____):</p> <p>__ met</p> <p>__ not met</p> <p>4th review period (____/____/____):</p> <p>__ met</p> <p>__ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE pt.</p> <p>GOALS:</p> <p>No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).</p>	<p>Ongoing SOURCE case management/support service plan</p> <p>Referral to support group _____</p> <p>In-home respite Extended Personal Support (EPS) schedule: _____</p> <p>Out-of-home respite provider: _____ schedule: _____</p> <p>ADH for respite purposes for informal caregiver</p> <p>NOTES: _____ _____ _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____): ____ met ____ not met</p> <p>2nd review period (____/____/____): ____ met ____ not met</p> <p>3rd review period (____/____/____): ____ met ____ not met</p> <p>4th review period (____/____/____): ____ met ____ not met</p>

MEMBER _____

DATE _____

Level 1 Page 10

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>GOALS:</p>		<p>GOALS:</p> <p>1st review period (___ / ___ / ___): _ met _ not met</p> <p>2nd review period (___ / ___ / ___): _ met _ not met</p> <p>3rd review period (___ / ___ / ___): _ met _ not met</p> <p>4th review period (___ / ___ / ___): _ met _ not met</p> <p>-----</p> <p>1st review period (___ / ___ / ___): _ met _ not met</p> <p>2nd review period (___ / ___ / ___): _ met _ not met</p> <p>3rd review period (___ / ___ / ___): _ met _ not met</p> <p>4th review period (___ / ___ / ___): _ met _ not met</p>
<p>GOALS:</p>		
<p>GOALS:</p>		

Name _____ Date _____

GOOD NUTRITION

Proper meals _____

HEALTHY SKIN

Checking skin for problems _____

KEEPING IT UNDER CONTROL

_____ Blood pressure _____ Blood sugar
_____ Weight _____ Unsafe behavior

Monitoring each: YOUR SOURCE DOCTOR

Others: _____

NOTES: _____

Member signature/date _____
Case Manager signature/date _____

Welcome to SOURCE!

Our goals are helping you:
Stay as healthy as possible
AND
Continue living in your own home.

Your SOURCE CASE MANAGER:

SOURCE 24-hour Phone: _____

Your SOURCE DOCTOR:

Phone: _____

Hospital for emergencies:

Besides treating you when you're sick, your SOURCE doctor will give you ADVICE and TREATMENT in the areas listed on this sheet, areas that are very important for your good health. Also listed are any people who may be helping you with each.

Please call the SOURCE 24-hour phone line before going to the emergency room, unless it is a life-threatening emergency.

TAKING MEDICINES PROPERLY

Current medications: Contact your case manager or doctor's office.

Drug store used _____

Picking up medicines _____

Help with taking medicines _____

GETTING UP, DOWN AND AROUND SAFELY

EQUIPMENT _____

HELP from another person _____

GETTING HELP IN AN EMERGENCY

Plan for getting help in an emergency:

MEDICAL CALL 911 FIRE CALL 911

HURRICANE OR OTHER NATURAL DISASTER: _____

TAKING CARE OF MY HOME AND MYSELF

CLEANING _____

ERRANDS _____

LAUNDRY _____

BATHING/DRESSING _____

OTHER SUPPORT _____

SOURCE SUPPORT SERVICES

NOTES:

Level 1

MEMBER VERSION FOR LEVEL I

APPENDIX L

*Service Options Using Resources
In
Community Environments*

**SOURCE
LEVEL II - C CAREPATH**

Member _____

Medicaid No. _____

SOURCE Case Manager _____

Signature _____ Date _____

SOURCE Case Management Supervisor _____

Signature _____ Date _____

SOURCE Physician _____

Signature _____ Date _____

SOURCE Medical Director _____

Signature _____ Date _____

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Revised 07/01/01

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member resides in community, maintaining maximum control possible over daily schedule and decisions.</p> <p>GOALS:</p> <p>A. Member/caregiver contributes to the design and implementation of community-based services plan.</p> <p>Key member responsibilities:</p> <ul style="list-style-type: none"> • Accept services as planned with Case Manager; • Provide accurate information on health status and service delivery; and • Maintain scheduled contact with Case Manager. <p>B. Member keeps scheduled medical appointments.</p> <p>C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers.</p> <p>Key provider performance areas:</p> <ul style="list-style-type: none"> • Reliability of service • Competency and compatibility of staffing • Responsiveness to member concerns and issues • Coordination with Case Manager. 	<p>Stabilize chronic conditions and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness.</p> <p>PCP: _____ Case Mgr. _____</p> <p><i>SOURCE PCP role:</i></p> <p>Evaluate and treat episodic /acute illness</p> <p>Manage chronic disease, including:</p> <p>Risk factor modification/monitoring of key clinical indicators</p> <p>Coordination of ancillary services</p> <p>Education for members/informal caregivers</p> <p>Medication review and management</p> <p>Conference/communicate regularly with Case Manager</p> <p>Review support service plans</p> <p>Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services</p> <p>Promote wellness, including immunizations, health screenings, etc.</p> <p><i>SOURCE Case Manager role:</i></p> <p>Maintain contact with member, for ongoing evaluation:</p> <p>Monthly by phone or visit (minimum)</p> <p>Quarterly by visit (minimum)</p> <p>PRN as needed</p> <p>Educate members on patient responsibilities</p> <p>Encourage/assist member in keeping all medical appointments</p> <p>Conference/communicate regularly with PCP; assist patients in carrying out PCP orders</p> <p>Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work</p> <p>Coordinate with informal caregivers and paid providers of support services</p> <p>Educate or facilitate education on chronic conditions</p> <p>Assist members in ALL issues jeopardizing health status or community residence</p> <p>NOTES: _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>2nd review period (____/____/____):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>3rd review period (____/____/____):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>4th review period (____/____/____):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p>

DATE _____

MEMBER _____

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions</p> <p>GOALS:</p> <p>A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (weight loss/gain according to PCP recommendations).</p> <p>B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).</p>	<p>MEMBER EDUCATION:</p> <p>____ SOURCE PCP/PCP staff</p> <p>____ SOURCE educational material</p> <p>____ other _____</p> <p>MEAL PREPARATION:</p> <p>____ self-care (total)</p> <p>____ assistance by informal caregiver(s) _____</p> <p>____ HDM (home delivered meals)</p> <p>____ ALS (alternative living service)</p> <p>____ meal preparation by PSS aides (include G-tube)</p> <p>MEAL PREPARATION schedule (indicate SELF, INF, HDM, PSS or ALS):</p> <p>Mon ____ B ____ L ____ S Thurs ____ B ____ L ____ S</p> <p>Tues ____ B ____ L ____ S Fri ____ B ____ L ____ S</p> <p>Wed ____ B ____ L ____ S Sat ____ B ____ L ____ S</p> <p>Sun ____ B ____ L ____ S</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>A. ____ met</p> <p> ____ not met</p> <p>B. ____ met</p> <p> ____ not met</p> <p>2nd review period (____/____/____):</p> <p>A. ____ met</p> <p> ____ not met</p> <p>B. ____ met</p> <p> ____ not met</p> <p>3rd review period (____/____/____):</p> <p>A. ____ met</p> <p> ____ not met</p> <p>B. ____ met</p> <p> ____ not met</p> <p>4th review period (____/____/____):</p> <p>A. ____ met</p> <p> ____ not met</p> <p>B. ____ met</p> <p> ____ not met</p>

MEMBER _____

DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti.</p> <p>GOALS:</p> <p>Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MONITOR SKIN for integrity:</p> <p>___ SOURCE PCP</p> <p>___ self care</p> <p>___ informal caregiver _____</p> <p>_____</p> <p>___ ADH</p> <p>___ specialist _____</p> <p>___ PSS aide/PSS RN every 62 days</p> <p>___ skilled nursing/provider: _____</p> <p>Dates of service: _____</p> <p>___ assistance required</p> <p>___ turning/repositioning (see I/ADL page)</p> <p>___ continence issues (see I/ADL page)</p> <p>___ nutrition issues (see NUTR'N page)</p> <p>NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___ / ___ / ___): ___ met ___ not met</p> <p>2nd review period (___ / ___ / ___): ___ met ___ not met</p> <p>3rd review period (___ / ___ / ___): ___ met ___ not met</p> <p>4th review period (___ / ___ / ___): ___ met ___ not met</p>

MEMBER _____ **DATE** _____ **LEVEL 2-C Page 4**

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Key clinical indicators and lab values regularly fall within parameters acceptable to SOURCE PCP or treating specialist.</p> <p>NOTE: Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the SOURCE PCP, according to the member's diagnosis and current medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal.</p> <p>The PCP will advise on any additional monitoring required for each member.</p> <p>Additional monitoring required, if applicable:</p> <p>___ blood pressure</p> <p>___ blood glucose</p> <p>___ weight (as indicator of illness)</p> <p>___ labs</p> <p>___ other _____</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MONITOR CLINICAL INDICATORS:</p> <p>___ SOURCE PCP (OV)</p> <p>ADDITIONAL MONITORING REQUIRED:</p> <p>___ self care</p> <p>___ ASSISTANCE REQUIRED</p> <p>in formal caregiver _____</p> <p>ADH _____</p> <p>PSS aide _____</p> <p>ALS _____</p> <p>RN provider: _____</p> <p>other _____</p> <p>_____</p> <p>_____</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>___ met</p> <p>___ not met</p> <p>2nd review period (____/____/____):</p> <p>___ met</p> <p>___ not met</p> <p>3rd review period (____/____/____):</p> <p>___ met</p> <p>___ not met</p> <p>4th review period (____/____/____):</p> <p>___ met</p> <p>___ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager).</p>	<p>MEMBER/CAREGIVER EDUCATION: _____ SOURCE PCP/PCP staff _____ SOURCE educational material _____ pharmacist _____ other _____</p> <p>MEDICATION ADMINISTRATION/MANAGEMENT: _____ self care _____ informal caregiver(s) _____</p> <p>_____ PSS aides (cueing) _____ ALS _____ ADH/DHC _____ RN provider _____ Dates of Service: _____</p> <p>OBTAINING MEDICATIONS: _____ self care _____ informal caregiver _____ pharmacy delivery _____ other _____</p> <p>PHARMACY: _____</p> <p>NOTES: _____ _____ _____ _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____): _____ met _____ not met</p> <p>2nd review period (____/____/____): _____ met _____ not met</p> <p>3rd review period (____/____/____): _____ met _____ not met</p> <p>4th review period (____/____/____): _____ met _____ not met</p>

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Regular performance of ADLs and IADLs will not be interrupted due to functional limitations.</p> <p>GOALS:</p> <p>No additional observations by Case Managers or reports from Member/caregiver or provider (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.</p>	<p>_____ self care (total)</p> <p>_____ ASSISTANCE REQUIRED (S=SELF; INF=informal support; PSS=PSS aide; S=SELF; HDM=home delivered meals; ALS = alternative living service):</p> <p>_____ errands _____ household chores</p> <p>_____ financial mgt. _____ meal preparation</p> <p>_____ bathing/dressing</p> <p>_____ primary informal caregiver(s): _____</p> <p>_____ home delivered meals</p> <p>_____ ALS</p> <p>_____ ERS</p> <p>_____ PSS aide</p> <p>Total hours/week: _____ Indicate no. of PSS hours:</p> <p>Monday: _____ AM _____ PM Thursday: _____ AM _____ PM</p> <p>Tuesday: _____ AM _____ PM Friday: _____ AM _____ PM</p> <p>Wednesday: _____ AM _____ PM Saturday: _____ AM _____ PM</p> <p>Sunday: _____ AM _____ PM</p> <p>NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>2nd review period (____/____/____):</p> <p>3rd review period (____/____/____):</p> <p>4th review period (____/____/____):</p>

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE Member</p> <p>GOALS:</p> <p>No reports or other indicators of caregiver exhaustion (self-report, observed by Case Manager, etc.).</p>	<p>ongoing SOURCE case management/ support service plan</p> <p>referral to support group</p> <p>_____</p> <p>in-home respite</p> <p>out-of-home respite</p> <p>ADH for respite purposes for informal caregiver</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____): ___ met ___ not met</p> <p>2nd review period (____/____/____): ___ met ___ not met</p> <p>3rd review period (____/____/____): ___ met ___ not met</p> <p>4th review period (____/____/____): ___ met ___ not met</p>

MEMBER _____

DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>GOALS:</p>		<p>MEASURES:</p> <p>1st review period (__ / __ / __): _ met _ not met</p> <p>2nd review period (__ / __ / __): _ met _ not met</p> <p>3rd review period (__ / __ / __): _ met _ not met</p> <p>4th review period (__ / __ / __): _ met _ not met</p> <p>-----</p> <p>1st review period (__ / __ / __): _ met _ not met</p> <p>2nd review period (__ / __ / __): _ met _ not met</p> <p>3rd review period (__ / __ / __): _ met _ not met</p> <p>4th review period (__ / __ / __): _ met _ not met</p>

Name _____ Date _____

GOOD NUTRITION

Proper meals _____

HEALTHY SKIN

Checking skin for problems _____

KEEPING IT UNDER CONTROL

_____ Blood pressure _____ Blood sugar
_____ Weight _____ Unsafe behavior

Monitoring each: YOUR SOURCE DOCTOR

Others _____

NOTES: _____

Member signature/date: _____
Case Manager signature/date: _____

Welcome to SOURCE!

Our goals are helping you:

Stay as healthy as possible
AND

Continue living in your own home.

Your SOURCE CASE MANAGER:

SOURCE 24-hour Phone: _____

Your SOURCE DOCTOR:

Phone: _____

Hospital for emergencies:

Besides treating you when you're sick, your SOURCE doctor will give you ADVICE and TREATMENT in the areas listed on this sheet, areas that are very important for your good health. Also listed are any people who may be helping you with each.

Please call the SOURCE 24-hour phone line before going to the emergency room, unless it is a life-threatening emergency.

TAKING MEDICINES PROPERLY

Current medications: Contact your case manager or your doctor's office.

Drug store used _____

Picking up medicines _____

Help with taking medicines _____

GETTING HELP IN AN EMERGENCY

Plan for getting help in an emergency:

MEDICAL CALL 911 FIRE CALL 911

HURRICANE OR OTHER NATURAL DISASTER:

Handwritten notes:
I have a plan for getting help in an emergency. I have a plan for getting help in an emergency.

TAKING CARE OF MY HOME AND MYSELF

CLEANING

ERRANDS

LAUNDRY

BATHING/DRESSING

OTHER SUPPORT

SOURCE SUPPORT SERVICES

NOTES:

Level 2-C

*Service Options Using Resources
In
Community Environments*

**SOURCE
LEVEL II - F CAREPATH**

Member _____

Medicaid No. _____

SOURCE Case Manager _____

Signature _____ Date _____

SOURCE Case Management Supervisor _____

Signature _____ Date _____

SOURCE Physician _____

Signature _____ Date _____

SOURCE Medical Director _____

Signature _____ Date _____

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MEMBER

DATE

Level 2-F Page 1

MEMBER	KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
	<p>Member resides in community, maintaining maximum control possible over daily schedule and decisions.</p> <p>GOALS:</p> <ul style="list-style-type: none"> A. Member/caregiver contributes to the design and implementation of community-based services plan. Key member responsibilities: • Accept services as planned with case manager; • Provide accurate information on health status and service delivery; and • Maintain scheduled contact with Case Manager. <p>B. Member keeps scheduled medical appointments.</p> <p>C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers.</p> <p>Key provider performance areas:</p> <ul style="list-style-type: none"> • Reliability of service • Competency and compatibility of staffing; • Responsiveness to member concerns and issues; and • Coordination with Case Manager. 	<p>Stabilize chronic conditions and promptly treat episodic/acute illness through long-term management by a SOURCE PCP/Case Manager team. The team will monitor risk factors for institutionalization, responding with medical and support services provided at the time, setting and intensity of greatest effectiveness.</p> <p>PCP: _____ Case Mgr. _____</p> <p><i>SOURCE PCP role:</i></p> <p>Evaluate and treat episodic /acute illness</p> <p>Manage chronic disease, including:</p> <ul style="list-style-type: none"> Risk factor modification/monitoring of key clinical indicators Coordination of ancillary services Education for members/informal caregivers Medication review and management Conference/communicate regularly with Case Manager Review support service plans <p>Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services</p> <p>Promote wellness, including immunizations, health screenings, etc.</p> <p><i>SOURCE Case Manager role:</i></p> <p>Maintain contact with member, for ongoing evaluation:</p> <ul style="list-style-type: none"> Monthly by phone or visit (minimum) Quarterly by visit (minimum) PRN as needed <p>Educate members on patient responsibilities</p> <p>Encourage/assist member in keeping all medical appointments</p> <p>Conference/communicate regularly with PCP; assist patients in carrying out PCP orders</p> <p>Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work</p> <p>Coordinate with informal caregivers and paid providers of support services</p> <p>Educate or facilitate education on chronic conditions</p> <p>Assist members in ALL issues jeopardizing health status or community residence</p> <p>NOTES: _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (_/_/_):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>2nd review period (_/_/_):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>3rd review period (_/_/_):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p> <p>4th review period (_/_/_):</p> <p>A. ___met ___not met</p> <p>B. ___met ___not met</p> <p>C. ___met ___not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions</p> <p>GOALS:</p> <p>A. SOURCE member's body mass supports functional independence and does not pose a critical health risk OR progress is made toward this goal (weight loss/gain according to PCP recommendations).</p> <p>B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).</p>	<p>MEMBER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MEAL PREPARATION:</p> <p>___ self-care (total)</p> <p>___ assistance by informal caregiver(s) _____</p> <p>___ home delivered meals</p> <p>___ ALS (alternative living service)</p> <p>___ meal preparation by PSS aides (include G-tube)</p> <p>MEAL PREPARATION schedule (indicate SELF, INF, HDM, PSS or ALS):</p> <p>Mon ___ B ___ L ___ S Thurs ___ B ___ L ___ S</p> <p>Tues ___ B ___ L ___ S Fri ___ B ___ L ___ S</p> <p>Wed ___ B ___ L ___ S Sat ___ B ___ L ___ S</p> <p>Sun ___ B ___ L ___ S</p> <p>NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>2nd review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>3rd review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p> <p>4th review period (___/___/___):</p> <p>A. ___ met ___ not met</p> <p>B. ___ met ___ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti.</p> <p>GOAL:</p> <p>Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MONITOR SKIN for integrity:</p> <p>___ SOURCE PCP</p> <p>___ self care</p> <p>___ informal caregiver _____</p> <p>_____</p> <p>___ ADH</p> <p>___ specialist</p> <p>___ PSS aide/PSS RN every 62 days</p> <p>___ skilled nursing/provider: _____</p> <p>Dates of service: _____</p> <p>___ assistance required</p> <p>___ turning/repositioning (see below)</p> <p>___ continence issues (see below)</p> <p>___ nutrition issues (see below)</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___ / ___ / ___): ___ met ___ not met</p> <p>2nd review period (___ / ___ / ___): ___ met ___ not met</p> <p>3rd review period (___ / ___ / ___): ___ met ___ not met</p> <p>4th review period (___ / ___ / ___): ___ met ___ not met</p>

MEMBER _____

DATE _____

Level 2-F Page 4

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist.</p> <p>NOTE: Key clinical indicators and lab values deemed applicable are determined and monitored for each member by the SOURCE PCP, according to the member's diagnosis and medical condition. The CM role is to assist the member in carrying out PCP orders, to facilitate achieving this goal.</p> <p>The PCP will advise on additional monitoring required for each member.</p> <p>Additional monitoring required, if applicable:</p> <p>___ blood pressure</p> <p>___ blood glucose</p> <p>___ weight (as indicator of illness)</p> <p>___ labs</p> <p>___ other _____</p>	<p>MEMBER/CAREGIVER EDUCATION:</p> <p>___ SOURCE PCP/PCP staff</p> <p>___ SOURCE educational material</p> <p>___ other _____</p> <p>MONITOR CLINICAL INDICATORS:</p> <p>___ SOURCE PCP (OV)</p> <p>ADDITIONAL MONITORING REQUIRED:</p> <p>___ self care</p> <p>___ ASSISTANCE REQUIRED</p> <p>___ informal caregiver _____</p> <p>___ ADH _____</p> <p>___ PSS aide _____</p> <p>___ ALS _____</p> <p>___ RN provider: _____</p> <p>___ other _____</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p> <p>2nd review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p> <p>3rd review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p> <p>4th review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p>

MEMBER _____

DATE _____

Level 2-F Page 5

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager).</p>	<p>MEMBER/CAREGIVER EDUCATION: ___ SOURCE PCP/PCP staff ___ SOURCE educational material other _____</p> <p>MEDICATION ADMINISTRATION/MANAGEMENT: ___ self care ___ informal caregiver(s) _____</p> <p>___ PSS aides (cueing) ___ ALS ___ ADH/DHC ___ RN provider _____ Dates of Service: _____</p> <p>OBTAINING MEDICATIONS: ___ self care ___ informal caregiver ___ pharmacy delivery _____ other _____</p> <p>PHARMACY: _____</p> <p>NOTES: _____ _____ _____ _____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (___/___/___): ___ met ___ not met</p> <p>2nd review period (___/___/___): ___ met ___ not met</p> <p>3rd review period (___/___/___): ___ met ___ not met</p> <p>4th review period (___/___/___): ___ met ___ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Regular performance of ADLs and IADLs will not be interrupted due to functional limitations.</p> <p>GOALS:</p> <p>No observations by Case Managers or reports from member/caregiver or provider (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.</p>	<p>ASSISTANCE REQUIRED (S=SELF; INF =informal support; PSS=PSS aide; HDM= home delivered meals; ALS =alternative living service):</p> <p>_____ bathing _____ dressing _____ eating _____ transferring</p> <p>_____ toileting/continence _____ turning/repositioning</p> <p>_____ errands _____ chores _____ financial mgt. _____ meal prep.</p> <p>_____ informal caregiver(s) providing assistance: _____</p> <p>_____ home delivered meals</p> <p>_____ ADH</p> <p>_____ ALS</p> <p>_____ ERS</p> <p>_____ incontinence Carepath</p> <p>_____ PSS aide</p> <p>Total hours/week: _____ Indicate no. of PSS hours:</p> <p>Monday: _____ AM _____ PM Thursday: _____ AM _____ PM</p> <p>Tuesday: _____ AM _____ PM Friday: _____ AM _____ PM</p> <p>Wednesday: _____ AM _____ PM Saturday: _____ AM _____ PM</p> <p>Sunday: _____ AM _____ PM</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____): A. _ met _ not met B. _ met _ not met</p> <p>2nd review period (____/____/____): A. _ met _ not met B. _ met _ not met</p> <p>3rd review period (____/____/____): A. _ met _ not met B. _ met _ not met</p> <p>4th review period (____/____/____): A. _ met _ not met B. _ met _ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE Member</p> <p>GOALS:</p> <p>No reports or other indicators of caregiver exhaustion (self-report, observed by Case Manager, etc.).</p>	<p>_____ ongoing SOURCE case management/ support service plan</p> <p>_____ referral to support group</p> <p>_____</p> <p>_____ in-home respite</p> <p>_____ out-of-home respite</p> <p>_____ ADH for respite purposes for informal caregiver</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(Providers and units/schedules listed on Member Version)</p>	<p>GOALS:</p> <p>1st review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>2nd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>3rd review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p> <p>4th review period (____/____/____):</p> <p>____ met</p> <p>____ not met</p>

MEMBER _____

DATE _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
<p>GOALS:</p>		<p>GOALS:</p> <p>1st review period (__/__/__): _ met _ not met</p> <p>2nd review period (__/__/__): _ met _ not met</p> <p>3rd review period (__/__/__): _ met _ not met</p> <p>4th review period (__/__/__): _ met _ not met</p> <p>-----</p> <p>1st review period (__/__/__): _ met _ not met</p> <p>2nd review period (__/__/__): _ met _ not met</p> <p>3rd review period (__/__/__): _ met _ not met</p> <p>4th review period (__/__/__): _ met _ not met</p>
<p>GOALS:</p>		
<p>GOALS:</p>		

Name _____ Date _____

GOOD NUTRITION

Proper meals _____

HEALTHY SKIN

Checking skin for problems _____

KEEPING IT UNDER CONTROL

_____ Blood pressure _____ Blood sugar
_____ Weight

Monitoring each: YOUR SOURCE DOCTOR

Others: _____

NOTES: _____

Member signature/date: _____

Case Manager signature/date: _____

Welcome to SOURCE!

Our goals are helping you:

Stay as healthy as possible
AND
Continue living in your own home.

Your SOURCE CASE MANAGER:

SOURCE 24-hour Phone: _____

Your SOURCE DOCTOR:

_____ Phone: _____

Hospital for emergencies:

Besides treating you when you're sick, your SOURCE doctor will give you ADVICE and TREATMENT in the areas listed on this sheet, areas that are very important for your good health. Also listed are any people who may be helping you with each.

Please call the SOURCE 24-hour phone line before going to the emergency room, unless it is a life-threatening emergency.

TAKING MEDICINES PROPERLY

Current medications: Contact your case manager or doctor's office.

Drug store used _____

Picking up medicines _____

Help with taking medicines _____

GETTING UP, DOWN AND AROUND SAFELY

EQUIPMENT

HELP from another person: _____

GETTING HELP IN AN EMERGENCY

MEDICAL CALL 911 FIRE CALL 911

TAKING CARE OF MY HOME AND MYSELF

CLEANING

ERRANDS

LAUNDRY

BATHING/DRESSING

OTHER SUPPORT

SOURCE SUPPORT SERVICES

NOTES:

Level 2-F

APPENDIX R

SOURCE

HOUSING, INCONTINENCE CAREPATHS

Service Options Using Resources in Community Environments (SOURCE)

MEMBER _____

DATE _____

HOUSING Page 1

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
<p>Member will reside in housing that is safe, affordable and accessible.</p> <p>Issues identified:</p> <ul style="list-style-type: none"> ___ substandard physical structure ___ unaffordable ___ not accessible ___ geographic isolation ___ family/household dynamics ___ other _____ <p>GOALS:</p> <p>No reports or observations of the above.</p>	<p>___ Member preference is to explore relocating to a new home.</p> <p>___ Member preference is to remain in existing home and explore repair options as feasible.</p> <p>___ SOURCE RELOCATION ASSISTANCE:</p> <p>___ Assess Member's own circumstances, preferences and financial resources for housing.</p> <p>___ Identify a contact person – if available – to explore housing options on behalf of the Member, if applicable.</p> <p>___ Offer list of housing resources maintained by ___ For Members with inadequate informal support, review available options.</p> <p>___ Complete application process (gathering necessary documentation).</p> <p>___ Follow-up on application once submitted (review waiting list if applicable, contact regularly to check)</p> <p>___ Relocation checklist:</p> <ul style="list-style-type: none"> ___ security deposit ___ utilities ___ transfer ___ new service (deposit) ___ change of address with Social Security, DFCS, etc. ___ notification of providers 	<p>G</p>	<p>MEASURES:</p> <p>1st review period (___ / ___ / ___):</p> <ul style="list-style-type: none"> ___ met ___ not met <p>2nd review period (___ / ___ / ___):</p> <ul style="list-style-type: none"> ___ met ___ not met <p>3rd review period (___ / ___ / ___):</p> <ul style="list-style-type: none"> ___ met ___ not met

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
<p>Member will reside in housing that is safe, affordable and accessible. (CONT'D, Page 2)</p>	<p>Moving arrangements: ___ family/informal support ___ PSS aide; provider _____ Date moved: _____ Date refused to relocate: _____</p> <p>___ HOME REPAIR, renter: ___ Broadly describe nature of repairs needed: ___ structural ___ electrical ___ plumbing ___ infestation ___ heating/cooling ___ major accessibility modifications ___ other _____</p> <hr/> <p>___ Identify informal support to provide assistance, if available. _____ ___ Provide SOURCE resources to informal support. ___ Obtain permission to contact landlord if applicable, if no informal support available for this assistance.</p>		<p>MEASURES: 1st review period (___ / ___ / ___): ___ met ___ not met 2nd review period (___ / ___ / ___): ___ met ___ not met 3rd review period (___ / ___ / ___): ___ met ___ not met</p>

MEMBER _____

DATE _____

HOUSING Page 3

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
<p>Member will reside in safe, affordable and accessible housing. (CONT'D, page 3)</p>	<p>___ Identify and contact landlord, describing nature of need repairs.</p> <p>___ One-month follow-up</p> <p>___ repairs acceptable ___/___/___</p> <p>___ repairs in progress ___/___/___</p> <p>___ no repairs initiated ___/___/___</p> <p>___ Notify appropriate authority:</p> <p>___ City Inspection Department ___/___/___ (structural, plumbing, wiring)</p> <p>___ Health Department ___/___/___ (infestation, sewage)</p> <p>___ Fire Department ___/___/___ (electrical, wiring, smoke alarms)</p> <p>___ One month follow-up with Member</p> <p>___ repairs in progress/completed</p> <p>___ repairs not initiated</p> <p>___ Re-contact appropriate authority</p> <p>Final disposition:</p> <p>___ repairs made</p> <p>___ repairs not made</p> <p>___ Member preference is to relocate (see relocate plan) ___</p> <p>___ Member preference is to remain in home under present conditions</p>		<p>MEASURES:</p> <p>1st review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p> <p>2nd review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p> <p>3rd review period (___/___/___):</p> <p>___ met</p> <p>___ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
<p>Member will reside in safe, affordable and accessible housing. (CONT'D, page 4)</p>	<p>HOME REPAIRS, owner: ___ Review Member/family personal resources for home repair ___ If unavailable, identify a family member capable of pursuing other options for Member ___ Provide SOURCE collection of local resource information. ___ Broadly describe nature of repair work needed ___ structural ___ electrical ___ plumbing ___ infestation ___ heating/cooling ___ major accessibility modifications ___ other _____ ___ Explore available funding from other sources: _____</p>		<p>MEASURES: 1st review period (____/____/____): ___ met ___ not met 2nd review period (____/____/____): ___ met ___ not met 3rd review period (____/____/____): ___ met ___ not met</p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	Quarterly Reviews
<p>Member will reside in safe, affordable and accessible housing. (CONTD, page 5)</p>	<p> <input type="checkbox"/> One month follow-up <input type="checkbox"/> repairs acceptable ___/___/___ <input type="checkbox"/> repairs in progress ___/___/___ <input type="checkbox"/> no repairs initiated ___/___/___ <input type="checkbox"/> Re-contact appropriate funding source <input type="checkbox"/> Final disposition: <input type="checkbox"/> repairs made <input type="checkbox"/> repairs not made <input type="checkbox"/> Member preference is to relocate (see "Relocation" section) <input type="checkbox"/> Member preference is to remain in home under present conditions </p>		<p> MEASURES: 1st review period (___/___/___): <input type="checkbox"/> met <input type="checkbox"/> not met 2nd review period (___/___/___): <input type="checkbox"/> met <input type="checkbox"/> not met 3rd review period (___/___/___): <input type="checkbox"/> met <input type="checkbox"/> not met </p>

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE	FUNDING	QUARTERLY REVIEWS
<p>Member's incontinence will be managed to promote skin integrity and adequate personal hygiene.</p> <p>GOALS:</p> <p>A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care</p> <p>B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP).</p> <p>C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.</p>	<p>paper continence products supplier: _____ Member/informal caregiver _____ Community Benefits _____ assistance by informal caregiver _____ assistance by PSS aide provider: _____ schedule: _____</p> <p>catheterization _____ in-and-out _____ assistance by informal caregiver _____ assistance by LPN/RN provider: _____ schedule: _____</p> <p>_____ in-dwelling _____ assistance by informal caregiver _____ assistance by RN/LPN provider: _____ schedule: _____</p> <p>_____ external _____ assistance by informal caregiver _____ assistance by PSS aide provider: _____ schedule: _____</p> <p>_____ ostomy _____ Member/caregiver education _____ SOURCE PCP _____ SOURCE RN _____ self-care</p> <p>Assistance required: _____ assistance by informal caregiver _____ assistance by PSS aide provider: _____ schedule: _____ _____ assistance by LPN/RN provider: _____ schedule: _____</p>		<p>MEASURES:</p> <p>1st review period (____/____/____): A. _____ met _____ not met A. _____ met _____ not met B. _____ met _____ not met C. _____ met _____ not met</p> <p>2nd review period (____/____/____): A. _____ met _____ not met B. _____ met _____ not met C. _____ met _____ not met</p> <p>3rd review period (____/____/____): A. _____ met _____ not met B. _____ met _____ not met C. _____ met _____ not met</p> <p>4th review period (____/____/____): A. _____ met _____ not met B. _____ met _____ not met C. _____ met _____ not met</p>

			met _ not met

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SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

- 0. *Independent*—Decisions consistent, reasonable, and safe
- 1. *Modified independence*—Some difficulty in new situations only
- 2. *Minimally impaired*—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
- 3. *Moderately impaired*—Decisions consistently poor or unsafe; cues / supervision required at all times
- 4. *Severely impaired*—Never or rarely makes decisions
- 5. *No discernable consciousness, coma* [Skip to Section G]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

- 0. Yes, memory OK 1. Memory problem
- a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
- b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
- c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bed room, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS

[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]

- 0. Behavior not present
- 1. Behavior present, consistent with usual functioning
- 2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
- a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
- b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; lose train of thought
- c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

- 0. No 1. Yes
- 5. **CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)**
- 0. Improved 2. Declined
- 1. No change 3. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

- 0. *Understood*—Expresses ideas without difficulty
- 1. *Usually understood*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- 2. *Often understood*—Difficulty finding words or finishing thoughts AND prompting usually required
- 3. *Sometimes understood*—Ability is limited to making concrete requests
- 4. *Rarely or never understood*

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able, with hearing appliance normally used)

- 0. *Understands*—Clear comprehension
- 1. *Usually understands*—Misses some part / intent of message BUT comprehends most conversation
- 2. *Often understands*—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- 3. *Sometimes understands*—Responds adequately to simple, direct communication only
- 4. *Rarely or never understands*

3. HEARING

Ability to hear (with hearing appliance normally used)

- 0. *Adequate*—No difficulty in normal conversation, social interaction, listening to TV
- 1. *Minimal difficulty*—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)

- 2. *Moderate difficulty*—Problem hearing normal conversation, requires quiet setting to hear well
- 3. *Severe difficulty*—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly, or person reports that all speech is mumbled)
- 4. *No hearing*

4. VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- 0. *Adequate*—Sees fine detail, including regular print in newspapers / books
- 1. *Minimal difficulty*—Sees large print, but not regular print in newspapers / books
- 2. *Moderate difficulty*—Limited vision; not able to see newspaper headlines, but can identify objects
- 3. *Severe difficulty*—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- 4. *No vision*

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days
- a. **Made negative statements**—e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
- b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
- c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
- d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
- e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
- f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
- g. **Crying, tearfulness**
- h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
- i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
- j. **Reduced social interactions**
- k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"

2. SELF-REPORTED MOOD

- 0. Not in last 3 days
- 1. Not in last 3 days, but often feels that way
- 2. In 1-2 of last 3 days
- 3. Daily in the last 3 days
- 8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

- a. **Little interest or pleasure in things you normally enjoy?**
- b. **Anxious, restless, or uneasy?**
- c. **Sad, depressed, or hopeless?**

3. BEHAVIOR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

- 0. Not Present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days
- a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
- b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
- c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
- d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings
- e. **Inappropriate public sexual behavior or public disrobing**
- f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

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SECTION F. PSYCHOSOCIAL WELL-BEING

- 1. SOCIAL RELATIONSHIPS**
[Note: Whenever possible, ask person]
 0. Never
 1. More than 30 days ago
 2. 8 to 30 days ago
 3. 4 to 7 days ago
 4. In last 3 days
 8. Unable to determine
- a. **Participation in social activities of long-standing interest**
- b. **Visit with a long-standing social relation or family member**
- c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail
- d. **Conflict or anger with family or friends**
- e. **Fearful of a family member or close acquaintance**
- f. **Neglected, abused, or mistreated**
- 2. LONELY**
Says or indicates that he / she feels lonely
 0. No 1. Yes
- 3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)**
Decline in level of participation in social, religious, occupational or other preferred activities
 IF THERE WAS A DECLINE, person distressed by this fact
 0. No decline
 1. Decline, not distressed
 2. Decline, distressed
- 4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)**
 0. Less than 1 hour
 1. 1-2 hours
 2. More than 2 hours but less than 8 hours
 3. 8 hours or more
- 5. MAJOR LIFE STRESSORS IN LAST 90 DAYS**—e.g., episode of severe personal illness; death or severe illness of close family member/friend; loss of home; major loss of income/assets; victim of a crime such as robbery or assault; loss of driving license/car
 0. No 1. Yes

SECTION G. FUNCTIONAL STATUS

- 1. IADL SELF PERFORMANCE AND CAPACITY**
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS
Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.
0. *Independent*—No help, setup, or supervision
 1. *Setup help only*
 2. *Supervision*—Oversight /cuing
 3. *Limited assistance*—Help on some occasions
 4. *Extensive assistance*—Help throughout task, but performs 50% or more of task on own
 5. *Maximal assistance*—Help throughout task, but performs less than 50% of task on own
 6. *Total dependence*—Full performance by others during entire period
 8. *Activity did not occur*—During entire period
 [DO NOT USE THIS CODE IN SCORING CAPACITY]
- a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
- b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
- c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
- d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
- e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
- f. **Stairs**—How full flight of stairs is managed (12-14 stairs)
- g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION

- h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)

- 2. ADL SELF-PERFORMANCE**
Consider all episodes over 3-day period.
If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.
Otherwise, focus on the three most dependent episodes (for all episodes if performed fewer than 3 times). If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.
0. *Independent*—No physical assistance, setup, or supervision in any episode
 1. *Independent, setup help only*—Article or device provided or placed within reach, no physical assistance or supervision in any episode
 2. *Supervision*—Oversight /cuing
 3. *Limited assistance*—Guided maneuvering of limbs, physical guidance without taking weight
 4. *Extensive assistance*—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
 5. *Maximal assistance*—Weight-bearing support (including lifting limbs) by 2+ helpers —OR—Weight-bearing support for more than 50% of subtasks
 6. *Total dependence*—Full performance by others during all episodes
 8. *Activity did not occur during entire period*

- a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
- b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
- c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
- d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
- e. **Walking**—How walks between locations on same floor indoors
- f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
- g. **Transfer toilet**—How moves on and off toilet or commode
- h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
- i. **Bed mobility**—How moves to end from lying position, turns from side to side, and positions body while in bed
- j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

- 3. LOCOMOTION /WALKING**
- a. **Primary mode of locomotion**
 0. Walking, no assistive device
 1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
 2. Wheelchair, scooter
 3. Bedbound
- b. **Timed 4-meter (13 foot) walk**
 [Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]
Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test.
Then say: "Begin to walk now" Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.
Then say: "You may stop now"
 Enter time in seconds, up to 30 seconds.
 30: 30 or more seconds to walk 4-meters
 77. Stopped before test complete
 88. Refused to do the test
 99. Not tested—e.g., does not walk on own

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c. **Distance walked**—Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)

- 0. Did not walk
- 1. Less than 15 feet (under 5 meters)
- 2. 15-149 feet (5-49 meters)
- 3. 150-299 feet (50-99 meters)
- 4. 300+ feet (100+ meters)
- 5. 1/2 mile or more (1+ kilometers)

d. **Distance wheeled self**—Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)

- 0. Wheeled by others
- 1. Used motorized wheelchair / scooter
- 2. Wheeled self less than 15 feet (under 5 meters)
- 3. Wheeled self 15-149 feet (5-49 meters)
- 4. Wheeled self 150-299 feet (50-99 meters)
- 5. Wheeled self 300+ feet (100+ meters)
- 8. Did not use wheelchair

4. ACTIVITY LEVEL

a. **Total hours of exercise or physical activity in LAST 3 DAYS**—e.g., walking

- 0. None
- 1. Less than 1 hour
- 2. 1-2 hours
- 3. 3-4 hours
- 4. More than 4 hours

b. In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)

- 0. No days out
- 1. Did not go out in last 3 days, but usually goes out over a 3-day period
- 2. 1-2 days
- 3. 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

- 0. No
- 1. Yes

a. **Person believes he / she is capable of improved performance in physical function**

b. **Care professional believes person is capable of improved performance in physical function**

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

- 0. Improved
- 1. No change
- 2. Declined
- 3. Uncertain

7. DRIVING

a. **Drove car (vehicle) in the LAST 90 DAYS**

- 0. No
- 1. Yes

b. **If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving**

- 0. No, or does not drive
- 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

- 0. **Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device
- 1. **Control with any catheter or ostomy over last 3 days**
- 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3. **Occasionally incontinent**—Less than daily
- 4. **Frequently incontinent**—Daily, but some control present
- 5. **Incontinent**—No control present
- 8. **Did not occur**—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)

- 0. None
- 1. Condom catheter
- 2. Indwelling catheter
- 3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE

- 0. **Continent**—Complete control; DOES NOT USE any type of ostomy device
- 1. **Control with ostomy**—Control with ostomy device over last 3 days
- 2. **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3. **Occasionally incontinent**—Less than daily
- 4. **Frequently incontinent**—Daily, but some control present
- 5. **Incontinent**—No control present
- 8. **Did not occur**—No bowel movement in the last 3 days

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4. PADS OR BRIEFS WORN

- 0. No
- 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease code

- 0. Not present
- 1. Primary diagnosis, diagnoses for current stay
- 2. Diagnosis present, receiving active treatment
- 3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

MUSCULOSKELETAL

- a. **Hip fracture during last 30 days (or since last assessment if less than 30 days)**
- b. **Other fracture during last 30 days (or since last assessment if less than 30 days)**

NEUROLOGICAL

- c. **Alzheimers disease**
- d. **Dementia other than Alzheimers disease**
- e. **Hemiplegia**
- f. **Multiple sclerosis**
- g. **Paraplegia**
- h. **Parkinson's disease**
- i. **Quadriplegia**
- j. **Stroke / CVA**

CARDIAC OR PULMONARY

- k. **Coronary heart disease**
- l. **Chronic obstructive pulmonary disease**
- m. **Congestive heart failure**

PSYCHIATRIC

- n. **Anxiety**
- o. **Bipolar disorder**
- p. **Depression**
- q. **Schizophrenia**

INFECTIONS

- r. **Pneumonia**
- s. **Urinary tract infection in last 30 days**

OTHER

- t. **Cancer**
- u. **Diabetes mellitus**

2. OTHER DISEASE DIAGNOSES

Diagnosis	Disease Code	ICD code
a.		
b.		
c.		
d.		
e.		
f.		

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS

- 0. No fall in last 90 days
- 1. No fall in last 30 days, but fell 31-90 days ago
- 2. One fall in last 30 days
- 3. Two or more falls in last 30 days

2. RECENT FALLS

[Skip first assessed more than 30 days ago or if this is first assessment]

- 0. No
- 1. Yes
- [blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

Code for presence in last 3 days

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1 of last 3 days
- 3. Exhibited on 2 of last 3 days
- 4. Exhibited daily in last 3 days



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<p>BALANCE</p> <p>a. Difficult or unable to move self to standing position unassisted <input type="checkbox"/></p> <p>b. Difficult or unable to turn self around and face the opposite direction when standing <input type="checkbox"/></p> <p>c. Dizziness <input type="checkbox"/></p> <p>d. Unsteady gait <input type="checkbox"/></p> <p>CARDIAC OR PULMONARY</p> <p>e. Chest pain <input type="checkbox"/></p> <p>f. Difficulty clearing airway secretions <input type="checkbox"/></p> <p>PSYCHIATRIC</p> <p>g. Abnormal thought process—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality <input type="checkbox"/></p> <p>h. Delusions—Fixed false beliefs <input type="checkbox"/></p> <p>i. Hallucinations—False sensory perceptions <input type="checkbox"/></p> <p>NEUROLOGICAL</p> <p>j. Aphasia <input type="checkbox"/></p> <p>GISTATUS</p> <p>k. Acid reflux—Regurgitation of acid from stomach to throat <input type="checkbox"/></p> <p>l. Constipation—No bowel movement in 3 days or difficult passage of hard stool <input type="checkbox"/></p> <p>m. Diarrhea <input type="checkbox"/></p> <p>n. Vomiting <input type="checkbox"/></p> <p>SLEEP PROBLEMS</p> <p>o. Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep <input type="checkbox"/></p> <p>p. Too much sleep—Excessive amount of sleep that interferes with person's normal functioning <input type="checkbox"/></p> <p>OTHER</p> <p>q. Aspiration <input type="checkbox"/></p> <p>r. Fever <input type="checkbox"/></p> <p>s. GI or GU bleeding <input type="checkbox"/></p> <p>t. Hygiene—Unusually poor hygiene, unkempt, disheveled <input type="checkbox"/></p> <p>u. Peripheral edema <input type="checkbox"/></p> <p>4. DYSPNEA (Shortness of breath)</p> <p>0. Absence of symptom <input type="checkbox"/></p> <p>1. Absent at rest, but present when performed moderate activities <input type="checkbox"/></p> <p>2. Absent at rest, but present when performed normal day-to-day activities <input type="checkbox"/></p> <p>3. Present at rest <input type="checkbox"/></p> <p>5. FATIGUE</p> <p>Inability to complete normal daily activities—e.g., ADLs, IADLs</p> <p>0. None <input type="checkbox"/></p> <p>1. Minimal—Diminished energy but completes normal day-to-day activities <input type="checkbox"/></p> <p>2. Moderate—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities <input type="checkbox"/></p> <p>3. Severe—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities <input type="checkbox"/></p> <p>4. Unable to commence any normal day-to-day activities—Due to diminished energy <input type="checkbox"/></p> <p>6. PAIN SYMPTOMS</p> <p>[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]</p> <p>a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)</p> <p>0. No pain <input type="checkbox"/></p> <p>1. Present but not exhibited in last 3 days <input type="checkbox"/></p> <p>2. Exhibited on 1-2 of last 3 days <input type="checkbox"/></p> <p>3. Exhibited daily in last 3 days <input type="checkbox"/></p> <p>b. Intensity of highest level of pain present</p> <p>0. No pain <input type="checkbox"/></p> <p>1. Mild <input type="checkbox"/></p> <p>2. Moderate <input type="checkbox"/></p> <p>3. Severe <input type="checkbox"/></p> <p>4. Times when pain is horrible or excruciating <input type="checkbox"/></p>	<p>c. Consistency of pain</p> <p>0. No pain <input type="checkbox"/></p> <p>1. Single episode during last 3 days <input type="checkbox"/></p> <p>2. Intermittent <input type="checkbox"/></p> <p>3. Constant <input type="checkbox"/></p> <p>d. Breakthrough pain—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain</p> <p>0. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/></p> <p>e. Pain control—Adequacy of current therapeutic regimen to control pain (from person's point of view)</p> <p>0. No issue of pain <input type="checkbox"/></p> <p>1. Pain intensely acceptable to person; no treatment regimen or change in regimen required <input type="checkbox"/></p> <p>2. Controlled adequately by therapeutic regimen <input type="checkbox"/></p> <p>3. Controlled when therapeutic regimen followed, but not always followed as ordered <input type="checkbox"/></p> <p>4. Therapeutic regimen followed, but pain control not adequate <input type="checkbox"/></p> <p>5. No therapeutic regimen being followed for pain; pain not adequately controlled <input type="checkbox"/></p> <p>7. INSTABILITY OF CONDITIONS</p> <p>0. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/></p> <p>a. Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating) <input type="checkbox"/></p> <p>b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem <input type="checkbox"/></p> <p>c. End-stage disease, 6 or fewer months to live <input type="checkbox"/></p> <p>8. SELF-REPORTED HEALTH</p> <p>Ask: "In general, how would you rate your health?"</p> <p>0. Excellent <input type="checkbox"/></p> <p>1. Good <input type="checkbox"/></p> <p>2. Fair <input type="checkbox"/></p> <p>3. Poor <input type="checkbox"/></p> <p>8. Could not (would not) respond <input type="checkbox"/></p> <p>9. TOBACCO AND ALCOHOL</p> <p>a. Smoke tobacco daily</p> <p>0. No <input type="checkbox"/></p> <p>1. Not in last 3 days, but is usually a daily smoker <input type="checkbox"/></p> <p>2. Yes <input type="checkbox"/></p> <p>b. Alcohol—Highest number of drinks in any "single sitting" in LAST 14 DAYS</p> <p>0. None <input type="checkbox"/></p> <p>1. 1 <input type="checkbox"/></p> <p>2. 2-4 <input type="checkbox"/></p> <p>3. 5 or more <input type="checkbox"/></p> <p>SECTION K. ORAL AND NUTRITIONAL STATUS</p> <p>1. HEIGHT AND WEIGHT (INCHES AND POUNDS—COUNTRY SPECIFIC)</p> <p>Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.</p> <p>a. HT (in.) <input type="text"/> <input type="text"/> <input type="text"/> b. WT (lb.) <input type="text"/> <input type="text"/> <input type="text"/></p> <p>2. NUTRITIONAL ISSUES</p> <p>0. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/></p> <p>a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS <input type="checkbox"/></p> <p>b. Dehydrated or BUN / Cre ratio > 25 [Ratio, country specific] <input type="checkbox"/></p> <p>c. Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day) <input type="checkbox"/></p> <p>d. Fluid output exceeds input <input type="checkbox"/></p> <p>3. MODE OF NUTRITIONAL INTAKE</p> <p>0. Normal—Swallows all types of foods <input type="checkbox"/></p> <p>1. Modified independent—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown <input type="checkbox"/></p> <p>2. Requires diet modification to swallow solid food—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods <input type="checkbox"/></p> <p>3. Requires modification to swallow liquids—e.g., thickened liquids <input type="checkbox"/></p> <p>4. Can swallow only pureed solids—AND—thickened liquids <input type="checkbox"/></p> <p>5. Combined oral and parenteral or tube feeding <input type="checkbox"/></p> <p>6. Nasogastric tube feeding only <input type="checkbox"/></p> <p>7. Abdominal feeding tube—e.g., PEG tube <input type="checkbox"/></p> <p>8. Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN) <input type="checkbox"/></p> <p>9. Activity did not occur—During entire period <input type="checkbox"/></p>
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- 4. DENTAL OR ORAL**
0. No 1. Yes
- a. Wears a denture (removable prosthesis)
- b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
- c. Reports having dry mouth
- d. Reports difficulty chewing

SECTION L. SKIN CONDITION

- 1. MOST SEVERE PRESSURE ULCER**
0. No pressure ulcer
1. Any area of persistent skin redness
2. Partial loss of skin layers
3. Deep craters in the skin
4. Breaks in skin exposing muscle or bone
5. Not codeable, e.g., necrotic eschar predominant
- 2. PRIOR PRESSURE ULCER**
0. No 1. Yes
- 3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER**—e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer
0. No 1. Yes
- 4. MAJOR SKIN PROBLEMS**—e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds
0. No 1. Yes
- 5. SKIN TEARS OR CUTS**—Other than surgery
0. No 1. Yes
- 6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION**—e.g., bruises, rashes, itching, mothling, herpes zoster, intertrigo, eczema
0. No 1. Yes
- 7. FOOT PROBLEMS**—e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers
0. No foot problems
1. Foot problems, no limitation in walking
2. Foot problems limit walking
3. Foot problems prevent walking
4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

- 1. LIST OF ALL MEDICATIONS**
- List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS
- [Note: Use computerized records if possible; hand enter only when absolutely necessary]
- For each drug record:
- a. Name
- b. Dose—A positive number such as 0.5, 5, 150, 300.
[Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]
- c. Unit—Code using the following list
- | | | |
|-----------------|------------------------|-------------|
| gts (Drops) | mEq (Milli-equivalent) | Puffs |
| gm (Gram) | mg (Milligram) | % (Percent) |
| L (Liters) | ml (Milliliter) | Units |
| mcg (Microgram) | oz (Ounce) | OTH (Other) |
- d. Route of administration—Code using the following list
- | | | |
|----------------------|-----------------|--------------------|
| PO (By mouth/oral) | REC (Rectal) | ET (External Tube) |
| SL (Sublingual) | TOP (Topical) | TD (Transdermal) |
| IM (Intramuscular) | IH (Inhalation) | EYE (Eye) |
| IV (Intravenous) | NAS (Nasal) | OTH (Other) |
| Sub-Q (Subcutaneous) | | |
- e. Freq—Code the number of times per day, week, or month the medication is administered using the following list
- | | |
|-------------------------|--------------------------|
| Q1H (Every hour) | 5D (5 times daily) |
| Q2H (Every 2 hours) | Q2D (Every other day) |
| Q3H (Every 3 hours) | Q3D (Every 3 days) |
| Q4H (Every 4 hours) | Weekly |
| Q6H (Every 6 hours) | 2W (2 times weekly) |
| Q8H (Every 8 hours) | 3W (3 times weekly) |
| Daily | 4W (4 times weekly) |
| BEH (At bedtime) | 5W (5 times weekly) |
| BID (2 times daily) | 6W (6 times weekly) |
| (includes every 12 hrs) | 1M (Monthly) |
| TID (3 times daily) | 2M (1 twice every month) |
| QD (4 times daily) | OTH (Other) |
- f. PRN 0. No 1. Yes

g. Computer-entered drug code

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. ATC or NDC code
1.						
2.						
3.						
4.						
5.						

[NOTE: Add additional lines, as necessary, for other drugs taken]
[Abbreviations are Country Specific for Unit, Route, Frequency]

- 2. ALLERGY TO ANY DRUG**
0. No known drug allergies 1. Yes
- 3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN**
0. Always adherent
1. Adherent 80% of time or more
2. Adherent less than 80% of time, including failure to purchase prescribed medications
3. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

- 1. PREVENTION**
0. No 1. Yes
- a. Blood pressure measured in LAST YEAR
- b. Colonoscopy test in LAST 5 YEARS
- c. Dental exam in LAST YEAR
- d. Eye exam in LAST YEAR
- e. Hearing exam in LAST 2 YEARS
- f. Influenza vaccine in LAST YEAR
- g. Mammogram or breast exam in LAST 2 YEARS (for women)
- h. Pneumovax vaccine in LAST 5 YEARS or after age 65
- 2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)**
0. Not ordered AND did not occur
1. Ordered, not implemented
2. 1-2 of last 3 days
3. Daily in last 3 days
- TREATMENTS**
- | | |
|---|---|
| a. Chemotherapy <input type="checkbox"/> | h. Tracheostomy care <input type="checkbox"/> |
| b. Dialysis <input type="checkbox"/> | i. Transfusion <input type="checkbox"/> |
| c. Infection control—e.g., isolation, quarantine <input type="checkbox"/> | j. Ventilator or respirator <input type="checkbox"/> |
| d. IV medication <input type="checkbox"/> | k. Wound care <input type="checkbox"/> |
| e. Oxygen therapy <input type="checkbox"/> | PROGRAMS |
| f. Radiation <input type="checkbox"/> | l. Scheduled toileting program <input type="checkbox"/> |
| g. Suctioning <input type="checkbox"/> | m. Palliative care program <input type="checkbox"/> |
| | n. Turning / repositioning program <input type="checkbox"/> |

- 3. FORMAL CARE**
- Days (A) and Total minutes (B) of care in last 7 days

Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in last week
a. Home health aides		
b. Home nurse		
c. Homemaking services		
d. Meals		
e. Physical therapy		
f. Occupational therapy		
g. Speech-language pathology and audiology services		
h. Psychological therapy (by any licensed mental health professional)		

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- 4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT**
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)
- a. Inpatient acute hospital with overnight stay
- b. Emergency room visit (not counting overnight stay)
- c. Physician visit (or authorized assistant or practitioner)
- 5. PHYSICALLY RESTRAINED**—Limbs restrained, used bed rails, restrained to chair when sitting
0. No 1. Yes

SECTION O. RESPONSIBILITY

- 1. LEGAL GUARDIAN [EXAMPLE-USA]**
0. No 1. Yes

SECTION P. SOCIAL SUPPORTS

- 1. TWO KEY INFORMAL HELPERS**
- a. Relationship to person
1. Child or child-in-law Helper 1 2
2. Spouse
3. Partner / significant other
4. Parent / guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper
- b. Lives with person Helper 1 2
0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper
- AREAS OF INFORMAL HELP DURING LAST 3 DAYS** Helper 1 2
0. No 1. Yes 8. No informal helper
- c. IADL help
- d. ADL help

- 2. INFORMAL HELPER STATUS**
0. No 1. Yes
- a. Informal helper(s) is unable to continue in caring activities—e.g., decline in health of helper makes it difficult to continue
- b. Primary informal helper expresses feelings of distress, anger, or depression
- c. Family or close friends report feeling overwhelmed by person's illness
- 3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS**
- For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors*
-
- 4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY**
0. No 1. Yes

SECTION Q. ENVIRONMENTAL ASSESSMENT

- 1. HOME ENVIRONMENT**
- Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)*
0. No 1. Yes
- a. Disrepair of the home—e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
- b. Squalid Condition—e.g., extremely dirty, infestation by rats or bugs
- c. Inadequate heating or cooling—e.g., too hot in summer, too cold in winter
- d. Lack of personal safety—e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
- e. Limited access to home or rooms in home—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed

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- 2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES**
0. No 1. Yes
- 3. OUTSIDE ENVIRONMENT**
0. No 1. Yes
- a. Availability of emergency assistance—e.g., telephone, alarm response system
- b. Accessibility to grocery store without assistance
- c. Availability of home delivery of groceries
- 4. FINANCES**
- Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care*
0. No 1. Yes

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

- 1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)**
0. No 1. Yes
- 2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)**
0. Improved [Skip to Section S]
1. No change [Skip to Section S]
2. Deteriorated

CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION S

- 3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION**
- 4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION**
- 5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION**
0. Within last 7 days
1. 8 to 14 days ago
2. 15 to 30 days ago
3. 31 to 60 days ago
4. More than 60 days ago
8. No clear precipitating event

SECTION S. DISCHARGE

[Note: Complete Section S at Discharge only]

- 1. LAST DAY OF STAY**
- —
- Year Month Day
- 2. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT**
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other
15. Deceased

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. Signature (sign on above line)
2. Date assessment signed as complete
- —
- Year Month Day



APPENDIX U
SOURCE Contact Sheet

Rev. 07/10

Member	Level	PCP
PROCESS	1 st 2 nd 3 rd 4 th QUARTERLY OBJECTIVES	MONITORING/CASE NOTES (Date and CM signature required each contact)
Monthly Contacts (minimum) Month 1 Month 2	___ phone ___ HV ___ other ___ COMM ___ NUTR'N ___ SKIN ___ CLIN ___ MEDS ___ I/ADL ___ BEH ___ TRANS ___ INF SUPP (√ = goals met; circle variances) ----- ___ phone ___ HV ___ other ___ COMM ___ NUTR'N ___ SKIN ___ CLIN ___ MEDS ___ I/ADL ___ BEH ___ TRANS ___ INF SUPP (√ = goal met; circle variances)	_____ _ See member chart. ----- _____ _ See member chart.
Quarterly Review OR Annual Re-evaluation (circle one)	___ COMM ___ NUTR'N ___ SKIN ___ CLIN ___ MEDS ___ I/ADL ___ BEH ___ TRANS ___ INF SUPP (√ = goals met; circle variances) _____ Member Signature _____ Case Manager Signature _____ CM Supervisor Signature	_____ _ See member chart.
PCP Conference	___ COMM ___ NUTR'N ___ SKIN ___ CLIN ___ MEDS ___ I/ADL ___ BEH ___ TRANS ___ INF SUPP (√ = goals met; circle variances) _____ PA Signature _____ Date _____ PCP Signature* _____ Date _____ Case Manager Signature _____ Date (*Includes review of SOURCE Disease Management Tracking Logs, as applicable.)	_____ _ See member chart.

SOURCE Contact Sheets record scheduled contacts between Case Managers and key players in the program. Additional documentation between scheduled contacts or requiring additional space may be recorded in the member's case notes.

APPENDIX V

SOURCE Referral Form

SOURCE Member _____ Date _____

Social Security No. _____ Medicaid No. _____

Address _____ Phone No. _____

_____ Medicare No. _____

SOURCE Level _____ Diagnosis Code _____

SOURCE Enhanced Case Management Authorization

No. _____

Directions to home _____

Primary Contact and Relationship _____

Primary Contact Phone Number(s) _____

Address _____

Service Requested:

Adult Day Health _____ Frequency _____

Level 1 Full Day _____

Level II Full Day _____

Level 1 Partial Day _____

Level II Partial Day _____

Physical Therapy _____

Speech Therapy _____

Provider _____

Alternative Living Service _____

Provider _____

Group Model _____

Family Model _____

Respite Services _____

Frequency _____

Out of Home Respite (12 hours) _____

Out of Home Respite (8 hours maximum, 3 hours minimum) _____

Provider _____

Personal Support Services _____

Frequency _____

Extended Personal Support Services _____ (may also be used for in-home respite 2-3 times per week) _____

Frequency _____

Provider _____

Emergency Response System _____

Provider _____

Installment _____

Monitoring Monthly _____

Home Delivered Meals _____

Provider _____

Frequency _____

Medicaid Home Health (75 units of service) _____

Skilled Nursing Visit _____

Physical Therapy Visit _____

Occupational Therapy Visit _____

Medical Social Services _____

Home Health Aide _____

Provider _____

Services to Begin: _____

Comments:

Signature _____

Date _____

Title _____

APPENDIX W
SOURCE Member Information Form

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Provider to Case Manager

Case Manager to Provider

Initial Change Discharge FYI

Response required? YES NO

Provider Name _____

MemberName _____ Medicaid No. _____

Service type: ADH ALS ERS HDM HDS PSS EPS

Initial

Service offered? _____
_____ No – Reason _____
_____ Yes - Date services initiated _____
_____ Frequency/Units _____

Change/FYI

Recommendation for change in service Change in frequency/units by case manager
 Change in mbr's. Health/functional status Change of physician/CM
 Hospitalization Other
 Service not delivered FYI

Explanation: _____

_____ Effective date of change: _____

Discharge

Discharge Reason _____

Date of Discharge _____

COMMENTS: _____

Signature _____ Date _____

Title _____ Phone _____

Signature _____ Date _____

Title _____ Phone _____

SOURCE Member Information Form

The SOURCE Member Information Form (MIF) conveys information between the site and participating service providers. The form serves as documentation of interactions on behalf of individual SOURCE members, and may be initiated by either case management or service provider staff. The form confirms key exchanges (new admissions, service level changes, hospitalizations, etc.) but also should be used to identify issues that potentially jeopardize a SOURCE member's ability to continue living in the community.

MIF Instructions:

1. Indicate entity-initiating MIF (site or provider) with a checkmark.
2. Indicate nature of the communication with a checkmark (Initial, Change, FYI or Discharge)
3. Complete demographic and service type information as indicated.
4. INITIAL: Check either No or yes, with additional information requested.
 If yes, record frequency/units in space provided.
5. CHANGE/FYI: Indicate the nature of the communication with a checkmark.
 Explain and date ALL items checked in the space provided.
6. DISCHARGE: Never complete this section without first communicating by phone or in
 person with the site or provider to attempt to resolve the issue prompting
 discharge.
7. COMMENTS: Record any additional relevant information.
8. SIGNATURE: Indicate staff member sending the MIF, the date sent and staff member's
 title.

NOTE: The agency receiving the MIF must acknowledge receipt of the MIF in writing, sign, date and return the MIF to the agency which generated the MIF within three (3) business days.

APPENDIX X
Carepath Variance Report

SOURCE Member: _____

Year/Quarter: _____ Date: _____

Comm Skin Clin Meds I/ADLs Trans/MOB
 Nutr'n Behavior Inf Support Incontinence
Corrective Action Taken:

Year/Quarter _____ Date: _____
 Comm Skin Clin Meds I/ADLs Trans/MOB
 Nutr'n Behavior Inf Support Incontinence

Corrective Action Taken:

Year/Quarter _____ Date: _____
 Comm Skin Clin Meds I/ADLs Trans/MOB
 Nutr'n Behavior Inf Support Incontinence
Corrective Action Taken:

Year/Quarter _____ Date: _____
 Comm Skin Clin Meds I/ADLs Trans/MOB
 Nutr'n Behavior Inf Support Incontinence
Corrective Action Taken:

APPENDIX Y

SOURCE Hospitalization Tracking Form

Patient: _____ Date of admission: _____

Hospital _____ Date of discharge: _____

1. ___ Room no. _____ and Case Manager assigned

2. ___ Contact Case Manager (beeper or voice mail,
etc.)/date(s): _____

___ Date of actual contact with Case Manager

___ Follow-up with social worker if indicated/date _____

___ Admitting Diagnosis _____

___ Discharge diagnosis _____

___ Programed date of discharge _____

___ REQUEST NOTIFICATION PRIOR TO MEMBER DISCHARGE for
coordination

___ Fax current SOURCE services and PCP to Case Manager

___ Notify SOURCE PCP of hospitalization ____/____/____

3. ___ Contact additional Case Manager if Member
moves _____

4. ___ Contact family/informal support date: _____

5. ___ MIF(s) to all providers if indicated ___ ERS ___ PSS/skilled ___ HDM ___ HDS

6. ___ Attend Case Conference if indicated

NOTES:

___ Copy of discharge summary received

___ SOURCE notified prior to discharge

___ MIF sent to providers to resume services; ___ service plan adjusted

CHECK ANY "NOT MET" UPON HOSPITALIZATION:

___ COMM ___ SKIN ___ HOUSING ___ I/ADL ___ TRANS/MOB

___ NUTR'N ___ CLIN ___ MEDS ___ BEHAVIOR ___ INF. SUPPORT

___ INCONTINENCE

APPENDIX Z

Service Options Using Resources in Community Environments

NOTICE OF DENIAL, TERMINATION, REDUCTION IN SERVICE, OR DELAY IN STARTING SERVICES FROM THE SOURCE PROGRAM

To _____ Date _____
_____ SSN _____

Your participation in the SOURCE Program has been given careful consideration. In accordance with the Code of Federal Regulation, 42 CFR 441.301(b) (i) (ii) and 441.302(c) (2), the following determination has been made.

A DETERMINATION BASED ON INITIAL ASSESSMENT/SCREENING:

You have been determined inappropriate for SOURCE because

B DECISION OF TERMINATION:

You have been determined no longer appropriate for SOURCE because

C DECISION TO REDUCE SERVICES:

You have been determined to require fewer services because

D DECISION TO SEEK ALTERNATIVE PLACEMENT:

You have determined that you do not want personal care home placement; otherwise you are still eligible when you find suitable living arrangements.

E DECISION BASED ON NO SSI. YOU MUST CONTACT SOCIAL SECURITY AT 1800-772-1213

If you have SSI and disagree with this decision, you may request a fair hearing. You have thirty days (30) from the date of this letter to request a hearing in writing.

Department of Community Health
Legal Services Section
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

SOURCE Case Manager
(Print)

SOURCE Case Management Agency
(Print)

SOURCE Case Manager Signature

Telephone Number

NOTICE OF YOUR RIGHT TO A HEARING

To schedule a hearing, you must ask for one in writing. You must send a copy of the Appendix Z Notice of Denial letter from the SOURCE Enhanced Case Management within 30 days from the letter's date to the following address:

Department of Community Health
Legal Services Section
Department of Medical Assistance
2 Peachtree Street, NW
40th Floor
Atlanta, Georgia 30303-3159

If you want to keep your services, you must send a written request for a hearing within 15 days from the date of your Appendix Z Notice of Denial letter from SOURCE. If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.

Rev 7/03

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourselves or let a friend or family member speak for them. The member may also ask a lawyer for help. You may be able to get legal help at no cost. If you want a lawyer to help, they may call one of these numbers:

Georgia Legal Services Program

800-498-9469 (statewide legal services, except for the counties served by Legal Aid.

Georgia Advocacy Office

1800-537-2329 (statewide advocacy persons with disabilities or mental illness)

Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett counties) 770-528-2565 (Cobb County)
404-524-5811 (Fulton County) 404-669-0233 (S. Fulton/Clayton County)

State Ombudsman Office

1888-454-5826 (Nursing Homes or Personal Care Homes)

You may also ask for free mediation services by calling 404-657-2800. Mediation is another way to solve problems without a hearing. If you cannot solve the problem with mediation, you still have the right to a hearing.



NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing**. Your request for a hearing, along with a copy of the adverse action letter, must be *received* within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to:

**Department of Community Health
Legal Services Section
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159**

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

- | | |
|--|--|
| <p>1. Georgia Legal Services Program
1-800-498-9469
(Statewide legal services, EXCEPT
for the counties served by Atlanta
Legal Aid)</p> | <p>2. Georgia Advocacy Office
1-800-537-2329
(Statewide advocacy for persons
with disabilities or mental illness)</p> |
| <p>3. Atlanta Legal Aid
404-377-0701 (DeKalb/Gwinnett Counties)
770-528-2565 (Cobb County)
404-524-5811 (Fulton County)
404-669-0233 (So. Fulton/Clayton County)
678-376-4545 (Gwinnett County)</p> | <p>4. State Ombudsman Office
1-888-454-5826
(Nursing Home or Personal
Care Home)</p> |

Action Plan: (How can you prevent this from happening in the future?)

Process Improvement:

What processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the member?

Define follow-up time frames for evaluating effectiveness of processes.

Notification:

	Name	Date	Time
Supervisor Notified	_____	_____	_____
YES ۞ NO			
Physician Notified	_____	_____	_____
YES ۞ NO			
Guardian/or Family Notified	_____	_____	_____
YES ۞ NO			
DCH Notified	_____	_____	_____
YES ۞ NO			
Other Agencies Notified	_____	_____	_____
YES ۞ NO			

Signature of Case Manager: _____

Date: _____

*****Please keep a copy for your records and mail a copy to DCH SOURCE*****

Appendix BB

SOURCE Discharge Summary

SOURCE Member: _____ Date of Discharge: _____

Discharge due to:

death nursing home (facility) _____
 moved from service area lost eligibility member choice
 involuntary/non-compliance Hospice
 other _____

SOURCE member discharged from:

home hospital (_____) personal care home

Primary reason for nursing home placement (if applicable):

increased cognitive impairment increased physical impairment
 increased medical acuity informal support issue
 other _____

Referrals (if applicable):

CCSP ICWP Hospice home health MRWP
 other _____

Brief discharge summary:

Indicate all key outcomes not met at time of discharge (refers to Carepath):

COMM SKIN MEDS I/ADLs TRANS/MOB
 NUTR'N CLIN BEHAVIOR INF. SUPPORT

Appendix CC

SOURCE Billing

SOURCE Reimbursed Services

Adult Day Health
Personal Support (PSS)
Extended Personal Support
Alternative Living Services (ALS)
Home Delivered Meals (HDM)
Home Delivered Services (HDS)
Emergency Response Services (ERS)
Nursing Visits
Case Management

Provider Billing

The Georgia Health Partnership (GHP) is the third-party administrator for Georgia Medicaid and PeachCare for Kids programs. Providers should begin submitting claims and other transactions to GHP as of April 1, 2003.

Provider claims will be entered via the web at

<http://www.ghp.georgia.gov>.

Customer Interaction Center: 1-800-766-4456

Customer Service Representative Availability: 8am- 7pm Monday thru Friday

Interactive Voice Response System Availability: 24 hrs day, 7 days a week

Written Correspondence: GHP, P.O. Box 5000, McRae, GA 31055

Procedures for Completing CMS 1500 (Web Portal or WINASAP)

Completion of the CMS1500 (Items not required by Georgia DMA are not included in these instructions)

This section provides specific instructions for completing the CMS Insurance Claim Form (CMSHCFA-1500) [12-90]. A sample invoice is included for your reference.

- Health Insurance Coverage
- Check Medicaid box for the patient's coverage.
- Insured's I.D. Number
- Enter the Recipient Client Number exactly as it appears on the recipient's Patient's Name exactly as it appears on the patient's current Medical Assistance Eligibility Certification (last name first).
- Patient's Birth Date and Sex
- Patient relationship to insured
- Patient Status
- Other Insured's Name

- SOURCE Enhanced Case Management authorization number in Referring ID field and Refer to Provider field.

A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all providers.)

When a liable third party carrier is identified within the computer system, the services billed to Medicaid will be denied. The information necessary to bill the third party carrier will be provided as part of the Remittance Advice on the Third Party Carrier Page.

- Other Insured's Policy or Group~ Number
- If the recipient has other third party coverage for these services, enter the policy or group number.
- Name of Referring Physician
- Enter the name of the physician or other source that referred the patient. Leave blank if there is no referral.
- Enter the SOURCE Enhanced Case Management Authorization Number in fields Refer to Provider field and Referral ID field

Dates of Service (DOS) - CRITICAL ELEMENT FOR CORRECT PAYMENT

Enter period of time that procedure/service occurred. If billing a partial month of service, enter the first day of the service in the "FROM" space and the last day of service in the "TO" space.

If billing a full month of service, enter the first day of the month in the "FROM" space and the last day of the month in the "TO" space.

The date(s) in this box must contain month, day and year in MM/DD/YY format (e.g., enter February 1 to February 28, 2003, as 02/01/2003 to 02/28/2003).

Claims for dates of service spanning more than one calendar month MUST be billed on separate invoices so that the Capitation (MCP) rate will be paid correctly.

NOTE: Monthly Professional Capitation Billing

If you are billing for the full capitation fee, the date of service will be the first day of the month and the last day of the month.

If the patient was not under your care for the full month, you must bill only for the portion of the month the patient was under your care.

Place of Service (P.O.S.)

Type of Service (T.O.S.)

Procedures code

Diagnosis Code

Charges

Enter the product of your “usual and customary” charge for the procedure multiplied times the units of service.

Days or Units

A “1” must always be entered when billing for Capitation (MCP) rate. For other services, enter the number of times the service was performed.

Note:

If you are billing more than one (1) unit for the same procedure code on the same date of service, please use one (1) line on the CMS 1500 and infield G list your total units. If you use more than one line, the system will consider the subsequent lines a duplicate and will deny them.

Total Charge

Enter the total of the charges listed for each line.

Amount Paid

Enter the amount received from third party. If not applicable, leave blank.

Balance Due

Enter the submitted charge less any third party payment received.

Signature of Physician or Supplies Including Degrees or Credentials

The provider must sign or signature stamp each claim for services rendered and enter the date.

Unsigned invoice forms cannot be accepted for processing.

Name and Address of Facility Where Services Rendered

Enter the full name, location (city) and Medicaid Provider number (if Medicaid enrolled) of the facility where billed services were performed.

Physician’s Supplier’s Billing Name. Address. Zip-Code and Phone Number

- a. Enter the provider’s name and address. Providers must notify the ACS provider Enrollment Unit in writing of address changes.

Appendix DD
SOURCE NATIONAL CODES and RATES
Effective 10/1/2005

Old Code	Description	National Code	Description	Modifier	Rate
Y3801	Home Delivered Services; Nursing Visit	T1030	Nursing care, in home, by registered nurse	TD	Provider Specific (seventy-sixth unit of service)
Y3802	Home Delivered Services; Physical Therapy	S9131	Physical therapy, in home, per diem		Provider Specific (seventh-sixth unit of service)
Y3803	Home Delivered Services; Speech Therapy	S9128	Speech therapy, in the home, per diem		Provider Specific (seventy-sixth unit of service)
Y3804	Home Delivered Services; Occupational Therapy	S9129	Occupational therapy, in the home, per diem		Provider Specific (Seventy-sixth unit of service)
Y3805	Home Delivered Services; Medical Social Services	S9127	Social work visit, in the home, per diem		Provider Specific (Seventy-sixth unit of service)
Y3806	Home Delivered Services; Home Health Aide	T1021	Home health aide or certified nurse assistant, per visit		Provider Specific (seventy-sixth unit of service)
Y3725	Adult Day Health Level I Full Day	S5102	Day care services, adult, per diem		\$50.45 per day minimum 5 hours
Y3726	Adult day Health Level I Partial Day	S5101	Day care services, adult, per half day		\$30.27 per day minimum 3 hours
Y3740	Adult Day Health; Physical Therapy	S9131	Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care	GP	\$44.15 per visit
Y3750	Adult Day Health; Speech Therapy	S9128	Speech therapy, in the home, per diem; services delivered under an outpatient speech therapy plan of care	GN	\$44.15 per visit
Y3790	Adult Day Health; Occupational Therapy	S9129	Occupational therapy, in the home, per diem; services delivered under an outpatient occupational therapy plan	GO	\$44.15 per visit
Y3827	Adult Day Health Level II Full Day	S5102	Day care Services, adult, per diem: intermediate level of care	TF	\$63.07 per day
Y3828	Adult Day Health Level II Partial Day	S5101	Day care services, adult, per half day; intermediate level of care	TF	\$37.85 per day

Old Code	Description	National Code	Description	Modifier	Rate
Y3617	Alternative Living Services - Group Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Group Setting	HQ	\$35.04 per day
Y3625	Alternative Living Services – Family Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Individualized service provided to more than patient in same setting	TT	\$35.04 per day (payment to the individual model home must be no less than \$15.25 per day)
Y3600	Out of Home Respite (12 hours)	S5151	Unskilled respite care, not hospice, per diem; intermediate level of care	TF	\$42.57 per night minimum 12 hours
Y3715	Out of Home Respite (hourly)	S5150	Unskilled respite care, not hospice, per 15 minutes		\$3.00 per unit, 32 units (8 hours) maximum, 12 units minimum (3 hours)
Y3832	Personal Support Service	T1021	Personal care services, per 30 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	U-1	\$9.47 per 30 minutes units. 30 minutes equal 1 unit. (not to exceed 5 units or 2.5 hours per visit)

Old Code	Description	National Code	Description	Modifier	Rate
Y3840	Extended Personal Support	T1021	Personal care services. Per 30 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) intermediate level of care	TF	\$8.41 per 30 minutes equal 1 unit. (Not to exceed 375 hours or 730 units max a month.)
Y3823	Emergency Response Monitoring (Monthly)	S5161	Emergency response system; service fee, per month (excludes installation and testing)		\$31.53 per month
Y3824	Emergency Response Monitoring (Weekly)	T2025	Emergency response system; waiver services; not otherwise specified (NOS)	U9	\$7.88 per week
Y3825	Emergency Response Installment	S5160	Emergency response system; installation and testing		Up to \$94.60 one installment
Y3831	Home Delivered Meals	S5170	Home Delivered Meals		\$6.58 per meal maximum 21 per week,
Y3850	Skilled Nursing Services RN T1030	T1030	Nursing care, in the home by a registered nurse per diem		\$65.00 per visit
Y2851	Skilled Nursing Services LPN T1031	T1031	Nursing care in home, by licensed practical nurse per diem		\$50.00 per visit

Rev. 07/08

SOURCE Case Management T2022

SE \$175.00 per month

Appendix EE

SOURCE Case Management Provider Main Offices

Albany ARC

Contact Person: Grace Williams or Sahirah Hall(229) 883-2334

Fax: (229) 431-8534

1319 W Broad Street, Albany, GA 31707

Counties: Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell Thomas, Worth

Columbus Regional Healthcare System

Contact Person: Jenny Dowdy (706) 660-6356

Fax: (706) 660-6279

1900 10th Avenue, Columbus GA, 31901

Counties: Chattahoochee, Harris, Marion, Muscogee, Talbot

Crisp Regional Health Services, Inc. d/b/a

Crisp Care Management

Contact Person: Alicia McInvale, RN (229) 273-6282

Fax: 229-273-5990

910 North 5th Street, Cordele, GA 31015

Counties: Crisp, Dooley, Macon, Pulaski, Sumter, Wilcox

Diversified Resources Inc.

Contact Person: Owner/Administrators: Pat Albritton or Kathy Yarbrough (912) 285-3089 or 1800-283-0041

Case Manager Supervisor: Donna Robinson, RN, BSN

Fax: (912) 285-0367

147 Knight Avenue Circle

P. O. Box 1099 (31502)

Waycross, Georgia 31503

Counties: Atkinson, Clinch, Coffee, Pierce and Ware

Nahunta Office

Contact Person: Vickie Chesser, RN, CM Supervisor (912) 462-8449 or (866) 903-7473

179-A North Main Street, Nahunta, GA 31553

Counties: Brantley, Camden, Charlton, Glynn

Tifton Office

Contact Person: Robin Harris, RN, CM Supervisor (229) 386-9296 or (800) 575-7004

1411 US Highway 41 North

P.O. Box 7614

Tifton, Georgia 31793

Counties: Ben Hill, Irwin, Tift, Turner, Wilcox

Valdosta Office

Contact Person: Donna Robinson, Acting CM Supervisor (229)253-9995 or (800) 706-9674

124 N. Patterson St.

Valdosta, Ga. 31602

Counties: Berrien, Brooks, Cook, Echols, Lanier and Lowndes

Faith Health Services

Contact : Faith Vickerie- Morgan, RN (678) 624-1646
Fax: 770-442-3320
P.O. Box 2063, Alpharetta, GA 30023
Counties: Fulton, Cobb, Clayton, DeKalb, Forsyth, Gwinnett, Rockdale

Wesley Woods (Atlanta SOURCE)

Contact Person: Teresa Thompson or Sherry Watts (404) 728- 6555
Fax: (404) 728-4973
52 Executive Park South, N.E., Suite 5200, Atlanta, GA 30329
Counties: DeKalb, Fulton

Source Care Management LLC

108 South Broad Street
Butler, Georgia 31006
Contact Person: Caroline McDaniel, RN, BSN, Executive Director (478) 621-2070 ext. 2871
Kimberly Thomas, RN, BSN, Assistant Executive Director (478) 621-2070 ext. 2872
Lou Ann Moulton, Director of Administrative Services (478) 621-2070 ext. 2861
Ph: 478-621-2070
Fax: (478) 862-9111, 478-552-7280
Alt Number: (888)-762-2420
E-mail: info@source-ga.org

SCM OFFICES

Americus

Administrator: Alitha Hawkins, LPN
Ph: 478-621-2070 Extension 2981
Fax: 229-928-4485
104 International Blvd., Bldg. D, Americus, GA 31709
Counties: Crisp, Dodge, Dooly, Lee, Pulaski, Sumter, Terrell, Turner, Wilcox, Worth

Augusta

Administrator: Jan Parsons, RN, MSN
Ph: 478-621-2070 ext 2731
Fax: 706-737-0205
2531 Center West Parkway, Suite 130, Augusta 30909
Counties: Burke, Columbia, Richmond,

Athens

Administrator: Steven Johnston, BS
Ph: 478-621-2070ext 2882
Fax: 706-543-8293
405 Gaines School Rd., Athens, GA 30606
Counties: Banks, Barrow, Clark, Elbert, Franklin, Greene, Hart, Jackson, Madison, Oconee, Oglethorpe, Stephens

Butler

Administrator: Claire Locke, BA, MFS
Ph: 478-621-2070 Ext 2832
Fax: 478-862-4844
12 South Broad Street, Butler, GA 31006
Counties: Macon, Marion, Schley, Talbot, Taylor, Upson

Columbus

Administrator: Richard Morgan, LPN, BS, MS

Ph: (478) 621-2070 Extension 2861

Fax: 706-562-2342

3575 Macon Rd. Suite 18, Columbus, GA 31907

Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster

Douglas

Administrator: Sheri Boulet, RN

Ph: (478) 621-2070 Ext 2627

Fax: (912) 592-4630

114 North Peterson Avenue, Suite 205, Douglas, GA 31533

Counties: Atkinson, Bacon, Ben Hill, Berrien, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Tift, Ware

Duluth

Administrator: Dot Rodriguez, LPN

Ph: (478) 621-2070 Ext 2651

Fax: (770) 717-2692

2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096

Counties: Dawson, DeKalb, Fannin, Forsyth, Gwinnett, Habersham, Hall, Lumpkin, Newton, Rabun, Rockdale, Towns, Union, Walton, White

Eatonton

Administrator: Keith Estes, BA, MS, Administrator

Ph: (478) 621-2070 Ext. 2583

Fax: (706) 485-4159

951 Harmony Rd, Suite 104

Eatonton, GA 31024

Counties: Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes

Jesup

Administrator: Brittany Matthews, RN, BSN

Ph: (478) 621-2070 Ext 2951

Fax: 912-427-2672

248 NE Broad Street, Jesup, GA 31546

Counties: Appling, Brantley, Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Wayne

Macon

Administrator: Patty Duncan, LPN

Ph: 478-621-2070 Ext 2777

Fax: 478-471-0751

1760 Bass Road, Suite 203, Macon, GA 31210

Counties: Bibb, Bleckley, Butts, Crawford, Houston, Jones, Lamar, Monroe, Peach, Twiggs

Metter

Administrator: Linda Reigo, LPN

Ph: (478) 621-2070 Ext 2601

Fax: (912) 685-7640

58 SE Broad Street, Metter, GA 30439

Counties: Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, , Tattnall, Telfair, Toombs, Treutlen, Wheeler

Newnan

Administrator: Lucinda Melson, BS, MA

Ph: 478-621-2070 Ext 2812

Fax: 770-304-9521

772 Greison Trail, Suites H & I, Newnan, GA 30263

Counties: Carroll, Clayton, Coweta, Douglas, Fayette, Fulton, Heard, Henry, Meriwether, Pike, Spalding, Troup

Rome

Administrator: Scarlet Freelin, BSW

Ph: 478-621-2070 Ext 2757

Fax: 706-378-1330

701 Broad Street, Suite 201, Rome, GA 30161

Counties: Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield

Thomasville

Administrator: Terri Brinson, RN

Ph: (478) 621-2070 Ext 2902

Fax: (229) 227-6157

14004 Hwy. 19 S. Suite 101 & 102, Thomasville, GA 31757

Counties: Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas,

Wrightsville

Administrator: Sharon Jones

Ph.: (478) 621-2070 Ext 2926

Fax: (478) 864-9423

112 S. Marcus Street, Wrightsville, GA 31906

Counties: Glascock, Hancock, Jefferson, Johnson, Laurens, Washington, Wilkinson

Legacy Link, Inc.

Contact Person: Pat Freeman or Dianne Curran (770) 538-2650

Fax: (770) 538-2660

508 Oak Street, Suite 1, Gainesville, GA 30503

Counties: Banks, Barrow, Cherokee, Clark, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Rabun, , Stephens, Towns, Union, White

St. Joseph's/Candler Health System

Contact Person: Susan Earl or Betsy Boykin or Jackie Immel (912) 819-1520 or (866) 218-2259

Fax (912) 819-1548

1900 Abercorn Street, Savannah, GA 31401

Counties: Bryan, Bulloch, Candler, Chatham, Effingham, Evans

Baxley Office

Contact Person: Jilda Brown or Tonya Strickland (866) 835-0709 or (912) 367-6108

Fax (912) 367-0392

338 East Parker Street, Baxley, GA 31513

Counties: Appling, Bacon, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne

UniHealth Solutions SOURCE-Corporate Office

Juliette Simpson (770) 925-4788
1626 Jeurgens Court. Norcross, GA 30093

UniHealth Solutions Athens

Contact Person: Melissa Wilson, RN, BSN, CM Supervisor (706) 549-3315
Fax: (706) 543-3841
435 Hawthorne Ave., Suite 300, Athens, GA 30606
Counties: Banks, Barrow, Clark, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Stephens, Walton

UniHealth Solutions Atlanta

Contact Person: Peggy Stoneking Office Manager (770) 279-6200
Fax: (678) 533-6488
1626 Jeurgens Court. Norcross, GA 30093
Counties: Clayton, Dekalb, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Rockdale, Spalding

UniHealth Solutions Augusta

Contact Person: Sheila Warren RD (229) 561-3424
Fax: (706) 863-9401
620 Ponder Place, Evans, GA 30809
Counties: Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

UniHealth Solutions North Georgia Mountain/Blueridge

Contact Person: Jane Addison, CM Supervisor (706) 632-9263
Fax (706) 632-0028
5004 Appalachian Hwy, Suite 4, Blueridge, GA 30513
Counties: Cherokee, Dawson, Fannin, Gilmer, Lumpkin, Pickens, Rabun, Towns, White

UniHealth Solutions Cobb

Contact Person: Susan Farah, RN, BSN, CM Supervisor (770) 916-4502
Fax: (770) 916-4505
1676 Mulkey Road, Austell, GA 30106
Counties: Carroll, Cobb, Douglas, Paulding

UniHealth Solutions Columbus

Contact Person: Sylvette Walsh, RN, CM Supervisor (706) 322-7713
Fax: 706-322-7716
1133 13th Street, Columbus, GA 31901
Counties: Chattahoochee, Marion, Muscogee, Quitman, Stewart, Webster

UniHealth Solutions Cordele

Contact Person: Cathy Merritt, RN, CM Supervisor (229) 273-2570
208 4th Avenue East, Cordele, GA 31015
Fax: (229) 273-4750
Counties: Ben Hill, Bleckley, Clay, Crisp, Dodge, Dooly, Dougherty, Irwin, Lee, Macon, Marion, Pulaski, Randolph, Schley, Sumter, Telfair, Tift, Turner, Wilcox, Worth

UniHealth Solutions Jesup

Contact Person: Jacqueline Ray, RN, CM Supervisor (912) 530 7359
Fax: (912) 530-7362

151 East Cherry Street, Jesup, GA 31546
Counties: Appling, Bacon, Brantley, Camden, Charleton, Glynn, Peirce, Wayne

UniHealth Solutions Macon

Contact Person: Rita B. Davis RN, CM Supervisor (478) 474-0979 or (800) 913-0134
Fax: (478) 474-2068
6060 Lakeside Commons Drive, Box 9, Macon, GA 31210
Counties: Baldwin, Bibb, Butts, Crawford, Houston, Jasper, Jones, Lamar, Laurens, Monroe, Peach, Pike, Putnam, Taylor, Twiggs, Upson, Wilkinson

UniHealth Solutions Newnan

Contact Person: Diana Davis, RN, CM Supervisor (770) 254-1545
Fax: (770) 254-8605
772 Greison Trail, Suite E, Newnan, Georgia 30263
Counties: Coweta, Fayette, Fulton (Zip Code 30291), Harris, Heard, Meriwether, Pike, Spaulding, Talbot, Troup

UniHealth Solutions Rome

Contact Person: Nancy Green, CM Supervisor (706) 236- 4705
Fax: 706-232-5912
39 Three Rivers Drive, NE, Rome, GA 30161
Counties: Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haraleson, Murray, Polk, Walker, Whitfield

UniHealth Solutions Savannah

Contact Person: Nathalie Douglas, RN, CM Supervisor (912) 925- 9181
Fax: 912-925-9340
9100 White Bluff Road, Suite 303, Savannah, GA 31406
Counties: Bryan, Chatham, Effingham, Liberty, Long, McIntosh

UniHealth Solutions of Swainsboro

Contact Person: Mona Williamson, RN, CM Supervisor (478) 237- 7270
Fax (770-237-7290
667 South Main Street, Swainsboro, GA 30401
Counties: Bulloch, Chandler, Emmanuel, Evans, Johnson, Montgomery, Tattnall, Tombs, Treutlen, and Wheeler

UniHealth Solutions Valdosta

Contact Person: Trina Baker Still, RN, CM Supervisor, (229) 241-8750
Fax: 229-241-8940
312 Canna Drive, Valdosta, Georgia 31602
Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Echols, Jeff Davis, Lanier, Lowndes, Thomas, Ware

Georgia Corner of Care

Contact Person: Juanita Benjamin (803) 226-0236
Fax: (803) 226-0335 or 1- (888) 316-9859
3050 Whiskey Road
Aiken, SC 29803

SOURCE Partners Atlanta

Contact Person: Karen Bear (404) 463-3248
Fax: (404) 463-3264

40 Courtland Street, NE, Atlanta, GA 30303

Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett , Henry, Rockdale

Appendix FF

Application For Enhanced Primary Care Case Management Applicants

A. Applicant

1. Name of Company:
Street Address:

Mailing Address:

Telephone Number

Fax Number:

2. Type of Organization (please check):

Public

Private Non-Profit

Private for Profit

Other (please specify _____)

3. Date the organization was established: n/a

4. Location of proposed SOURCE program if different than above.

Street Address:

Mailing Address:

Telephone Number:

Fax Number:

5. Contact Person for this application.

Name:

Title

Telephone Number:

Fax Number:

B. Company Background Information:

In order to be a provider, the applicant must have the following:

- A documented network of primary care physicians, medical personnel, service providers, and hospital affiliations within the state, credentialed by the Department.

- A minimum of two years experience providing case management and disease management monitoring
- A history of working with enhanced primary care case management programs
- The ability to meet the State's electronic data reporting requirements

Describe any related experience you have had with managing case management, home and community based services, and disease management programs. Include types of services provided, fund sources for the services, and the dates during which the services were provided.

Provide names, addresses, and telephone numbers of three references who are familiar with your related experience.

CASE MANAGEMENT:

NOTE: Please read description of Case Management Components located in section 806 of the SOURCE manual. Applicant must have at least 2 years experience in providing case management service. Please describe your experience as it relates to the following key elements:

- **Assessment and Reassessment**
- **Development and periodic revision of specific care plan**
- **Referral and related activities**
- **Monitoring and Follow-up activities**

DISEASE MANAGEMENT:

NOTE: Please read description of Disease Management Monitoring located in section 1310 of the SOURCE manual. Applicant must have at least 2 years experience in providing Disease Management monitoring. Applicant should describe the following:

- **Disease management stratification and intervention process**
- **Tracking mechanism associated with the stratification process.**

C. Proposed Service Area

List the counties you are proposing to serve.

D. Program Structure

1. Attach organizational chart(s) for the organization and the program (if different). All positions related to the SOURCE program must be included (e.g., program

manager, case management supervisor, case managers, registered nurse, etc.). The lines of authority must be clear.

2. Attach job descriptions for all positions related to the program and resumes, if available.
3. Provide a written agreement with the person who will serve as the Medical Director of the program. Describe how the person will provide the clinical oversight required for the program. The Medical Director's resume must be included with those attached in response to item #2 above.

E. **Hours of Operation**

Provide the normal operating hours and days for the SOURCE office. Describe how a 24-hour a day/seven days per week/365 days per year on-call system will be maintained.

F. **Network Development**

Primary Care Physicians – List all primary care physicians proposed to be enrolled in the program. Indicate which counties each will serve. There must be at least one primary care physician agreeing to work with the program in each county in the proposed service area. Attach written confirmation from each physician attesting that s/he will act in this capacity and for the counties specified if the program is approved.

Home and Community Based Services (HCBS) Providers

List all providers of HCBS that will serve members enrolled in your program and the counties that each will serve. There must be at least one HCBS provider for each service that is offered under the SOURCE program as listed below. Personal Support Services must be available in every county. The SOURCE Case Management agency is encouraged, but not required, to have the remaining services available in every county.

Home Delivered Meals (HDM)
Home Delivered Services (HDS)
Assisted Living Services (ALS)
Emergency Response System (ERS)
Personal Support Services (PSS)
Adult Day Health (ADH)

—
Please list the names of Providers and show what service each provider will be providing.

Attach copies of written confirmation from each provider attesting that it will serve in this capacity and for the counties specified if the program is approved.

—
Acute Care Providers

List all hospitals that will provide acute care services for members enrolled with the program. There must be at least one hospital that will serve each county in the proposed service area. Attach written confirmation from each hospital attesting that it will act in this capacity and for the counties specified if the program is approved.

—
Describe how the program will work with admission and/or discharge departments. Provide methods for tracking emergency room visits and hospitalizations.

—
G. Forms/Documentation

Forms that must be used are referenced in the SOURCE Manual. Attach copies of all forms that will be used by the program for each of the functions listed below and any other forms that will be used that are not listed in the manual.

- Screening
- Assessment
- Program Admission
- Developing and Implementing EPCCM Carepaths
- Referrals for all Medicaid reimbursed HCBS
- PCP Contacts
- Provider Contacts

—
H. Policies and Procedures

Provide copies of site-specific policies and procedures for screening, assessment, admissions, Carepath development and implementation, referral for HCBS services, member contacts (scheduled and PRN), provider contacts (scheduled and PRN), disease management, HIPAA compliance, appeals, and measures to meet unfunded member needs.

Please Note: The policies and procedures must be agency specific. Do not submit copies of the policies in the SOURCE manual.

—

I. Provider and Service Oversight

Describe how the program will provide oversight to assure that members are receiving the services ordered and that Carepath goals are being monitored on a regular basis.

—

J. Billing

Describe who will be responsible for billing Medicaid for the case management fee and the process for oversight of billing.

—

K. Quality Assurance

Describe in writing how quality assurance and performance will be monitored and measured. Description of QA process should include but not limited to: monitoring roles and responsibilities of case managers; HCBS providers; and Primary Care Physicians. Provide copies of tools that will be used in this process.

—

Signature and Title

Date Submitted

Appendix GG EPCCM Expansion Application

The name and telephone number for the contact person for the application.

- The full address of the new office and telephone number for the new office, if available.
- Days and hours of operation for the new office
- Specification of the counties to be served by the new office.
- Demographics that support unmet need for SOURCE services in the area to be served.
- Documentation that the applicant has a written agreement with a physician to be the Medical Director for the new office. Include Medical Director Resume
- Documentation that the applicant has written agreements with primary care physicians sufficient to cover potential member enrollment throughout the geographic area to be served by the office. Provide the names of all physicians, a copy of their written agreements, and a delineation of counties to be served by each physician.
- Documentation that the applicant has a written agreement with a physician to serve as the medical director for the new office.
- Documentation that the applicant has written agreements with HCBS providers sufficient to cover potential member enrollment throughout the geographic area to be served by the office. There must be a written agreement for at least one provider for each SOURCE service.
- Documentation that the applicant has written agreements with acute care providers sufficient to cover the entire geographic area to be served by the office. Provide the names of all acute care facilities, a copy of their written agreements, and a delineation of counties to be served by each facility.
- A staffing plan, including an organization chart for the new office that documents adequate staffing to meet the requirements for the case manager and case management functions.
- Written job descriptions for all positions in the new office.
- An organization chart delineating the relationship of the new office to the approved SOURCE site that documents adequate oversight by the SOURCE site for the new office.
- Documentation of an after-hours on-call system for contacting case managers and primary care physicians, including a toll-free 24-hour phone number.
- Copies of site-specific policies and procedures for screening, assessment, admissions, Carepath development and implementation, referral for HCBS services, member contacts (scheduled and PRN), provider contacts (scheduled and PRN), disease management, HIPAA compliance, appeals, and measures to meet unfunded member needs.

Please Note: The policies and procedures must be site specific. Do not submit copies of the policies in the SOURCE manual. If the site has previously submitted all of the above policies and none has changed since the last submission, the site may state that and simply refer to its initial submission.

- Documentation that the SOURCE site has resolved, or has an approved corrective action plan in place, for resolving any cited deficiencies as a result of reviews conducted by DHR or DCH or their agents.

Appendix HH

Member Request Form

Member Name: _____ Member ID Number: _____
 Member Address: _____
 Member Telephone Number: _____

Georgia Enhanced Care (GEC)	SOURCE								
<p>Choice of PCP within Georgia Better Health Care</p> <table border="0"> <tr> <td><u>Type of Visit</u></td> <td><u>Acceptable Timeframe</u></td> </tr> <tr> <td>Urgent care hours</td> <td>Within 24 hours</td> </tr> <tr> <td>Routine sick patient care</td> <td>Within one week</td> </tr> <tr> <td>Well care</td> <td>Within one month</td> </tr> </table>	<u>Type of Visit</u>	<u>Acceptable Timeframe</u>	Urgent care hours	Within 24 hours	Routine sick patient care	Within one week	Well care	Within one month	<p>Required assignment to SOURCE PCP <i>(This may require changing doctors)</i></p> <p>Case Management Services: Service available through SOURCE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Twenty-four hour coverage, 7 days a week <input type="checkbox"/> RN/LPN face to face Assessment <input type="checkbox"/> Quarterly visits by case manager <input type="checkbox"/> Social Services <input type="checkbox"/> Care Coordination <input type="checkbox"/> Alternative Living Services <input type="checkbox"/> Personal Support Services <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Emergency Response <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Adult Day Health <input type="checkbox"/> Home Delivered Services (PT, OT, ST) <input type="checkbox"/> Transportation
<u>Type of Visit</u>	<u>Acceptable Timeframe</u>								
Urgent care hours	Within 24 hours								
Routine sick patient care	Within one week								
Well care	Within one month								
<p>Case Management Services: Services available through Georgia Enhanced Care:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Twenty-four Hour Call Nurse, 7 days a week <input type="checkbox"/> Education about your Condition <input type="checkbox"/> Care Coordination <ul style="list-style-type: none"> Meals Transportation Specialists Home health <input type="checkbox"/> RN Case Management (some face-to-face visits) <input type="checkbox"/> Social Services 									

**** I understand I may request to have my services ended in either program by calling the appropriate telephone number(s) listed on this form. I also understand that if I disenroll from the disease management program (GEC), I will not be able to enroll again.***

Date Telephone Case Conference Held: _____

I choose to participate in: Georgia Enhanced Care SOURCE

Member/Representative Signature: _____ Date: _____

Georgia Enhanced Care Vendor: _____

Telephone number: _____ GEC Case Manager: _____

SOURCE Site: _____ Telephone number: _____

SOURCE Case Manager: _____

FAX Numbers: APS Healthcare 1-866-220-2031
 United Health Care 770-300-4364

Member Request Form
Instructions

- 1) Complete Member Demographics
- 2) Educate member about services offered through GEC
- 3) Educate member about services offered by SOURCE
- 4) Use text boxes to indicate services
- 5) Contact appropriate GEC vendor to complete telephonic case conference
- 6) Document date form completed
- 7) Member indicates choice between GEC and SOURCE
- 8) If member selects GEC, CM stops the SOURCE admission process
- 9) Member signs and dates the document
- 10) CM documents GEC vendor information (APS Healthcare or United Health Care)
- 11) CM documents GEC vendor telephone number and GEC case manager, if known
- 12) CM documents name of SOURCE Case Management provider (site) and telephone contact number
- 13) CM documents his/her name

ev, 10/09

Upon completion of the document and all steps listed above, the case manager will:

- Leave a copy of the Member Request Form in the member's home
- Fax a copy of the document to the appropriate vendor (see fax contact numbers on form)
- Contact the GEC vendor within ten (10) business days of the member contact to confirm dis-enrollment from vendor services
- Fax APPENDIX F to DCH with cover sheet which indicates the dis-enrollment date from GEC services

NOTE: Prior to face to face intake/assessment, SOURCE case manager checks the Georgia Health Partnership portal to determine member participation in the Georgia Enhanced Care Program. It is the responsibility of the SOURCE case manager to follow the process through to confirmation of the member dis-enrollment from GEC.

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Appendix HH-1 must be completed per instructions to be considered a valid member request for dis-enrollment.

Clinical Information:

Fully describe:

Member functional deficit as relates to ADL performance:

and/or

Member cognitive impairment:

Document with specificity member resources (include **all** informal and formal support) and reasons member support system is not sufficient to provide adequate care:

Describe member situation and demonstrate imminent risk of institutionalization:

_____. Case Manager Signature _____ Date

Medical Information:

_____. Physician Signature _____ Date

Primary Care Physician or Medical Director

Refer to Chapter 600, Section 609 for urgent lock in criteria-Use additional pages if necessary

Rev 01/10 **SOURCE SITE MONTHLY ACTIVITY REPORT**
Service Options Using Resource in a Community Environment

Site Name : _____

Report Month: _____

Submitted by: _____

Date: _____

Provide member counts for the report month as follows:

Current Active Members: _____

Level I: _____

Level II-F: _____

Level II-C: _____

Members Admitted during report month: _____

Members Discharged during report month: _____

Reason(s) Discharged (include number for each)-

Nursing Facility: _____

Deceased: _____

Moved out of Service Area: _____

Hospice: _____

Member Choice: _____

Non-Compliance: _____

Lost SSI/Related Eligibility: _____

Other (specify):

Programmatic report is due to: Department of Community Health, Division of Medical Assistance, Long Term Care Section, SOURCE Program Specialist no later than the 15th of the month following the report month. EPCMM agencies with multiple locations will complete programmatic reports, by location, for Quality Assurance monitoring. The total number per agency will be reported to DCH.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health Care		
Statutory Service	Caregiver Temporary Support Service		
Statutory Service	Support Coordination		
Other Service	Assistive Devices and Medical Supplies (Assistive Technology)		
Other Service	Environmental Accessibility Adaptation		
Other Service	Home Delivered Meals		
Other Service	Non-Medical Transportation		
Other Service	Nursing		
Other Service	Personal Assistance Services (PAS)		
Other Service	Skilled Maintenance Therapy		
Other Service	Transition Intensive Support Coordination		
Other Service	Transition Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Services furnished as specified in the plan of care at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant.

Adult Day Health Care Services include:

- Meals - shall not constitute a "full nutritional regimen" (3 meals per day) but shall include a minimum of 2 snacks and a hot nutritious lunch.
- Transportation between the participant's place of residence and the ADHC in accordance with licensing standards;
- Assistance with activities of daily living;
- Health and nutrition counseling;
- Individualized exercise program;
- Individualized goal-directed recreation program;
- Health education classes; and
- Individualized health/nursing services.

The number of people included in the service per day depends on the licensed capacity and attendance at each facility; the average capacity is 49.

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--Community Choices Waiver Services--

Support Coordination

A service designed to assist participants in accessing and coordinating all needed services, regardless of the funding source. Services to be accessed and coordinated include but are not limited to: waiver services; state plan services; medical services; educational services; and housing. The support coordinator is also responsible for linking waiver participants to other federal, state and local programs; evaluation and re-evaluation of level of care eligibility; assessment and reassessment of the need for waiver services; development and/or review of the service plan; monitoring the participant's health and welfare; monitoring the provision of services included in the recipient's plan of care; addressing problems in service provision; responding to participant crises; and determining the cost neutrality of waiver services for an individual.

✦ Provider Enrollment Requirements

- Obtain initial certification from Health Standards
- Contact OAAS and complete the following OAAS requirements in the order listed below prior to enrolling with Medicaid:
 1. Provide to OAAS a copy of Health Standards Certification.
 2. Provide to OAAS the "OAAS Support Coordination Performance Agreement Signature Form" (*i.e.*, the original signed form)
 3. Purchase a Citrix Account at a cost of \$385.15 (price subject to change without notice). This account allows access to client assessment information. Initially, the agency will have access to a test site only. Full access will be made available after the agency has been approved as an enrolled provider. Call (225)342-6491 to purchase.
 4. One support coordinator supervisor and one support coordinator must complete and pass the Assessment and Care Planning Certification Training and attend orientation by the OAAS regional office. Information about the Assessment and Care Planning Training can be found at the OAAS website: <http://new.dhh.louisiana.gov/index.cfm/page/463>
 5. Submit support coordination agency brochure to OAAS for approval.
 6. Provide to OAAS the completed "OAAS Support Coordination Agency Key Personnel/Contact Information" form
- Obtain approval letter from OAAS indicating all requirements met
- Complete Medicaid enrollment process by completing both the basic and specific (Provider type 08: OAAS Case Management [Support Coordination) provider enrollment packets posted to the LA Medicaid website: <http://www.lamedicaid.com>
- Once OAAS is notified that the agency has completed the Medicaid provider enrollment process, the agency will be added to the freedom of choice list
- Once the newly enrolled agency has received first linkage (referral) the agency shall contact Statistical Resources, Inc. (SRI) at 225/767-0501 to complete Case Management Information System (CMIS) training.
- Prior & Post Authorization
- Unit of service – one (1) month
- Provisional or comprehensive POC is sent to SRI
- For the POC year, SRI issues two (2) PAs each for five (5) to seven (7) months.

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--Community Choices Waiver Services--

- One (1) unit is released for the previous month once requirements are met and documented in CMIS

Transition Intensive Support Coordination

A service designed to assist nursing facility residents in accessing and coordinating all services necessary for moving out of the nursing home, regardless of the funding source. This service can be provided for a maximum of six months prior to transition from the nursing facility. See the description of Support Coordination above for additional details on the support coordinator's responsibilities to participants transitioning from nursing facilities.

✦ Provider Enrollment Requirements

Same as for Support Coordination

✦ Prior and Post Authorization

- Unit of service – one (1) month
- Provisional or initial POC indicating the participant currently resides in a nursing home is sent to SRI
- SRI issues one (1) PA for a maximum of 6 months prior to transition from the nursing facility based on what is included in the POC
- One (1) unit is released for the previous month once requirements are met and documented in CMIS

Transition Services

These are time limited, non-recurring set-up expenses available for participants transitioning from nursing facilities. Allowable expenses are those necessary to enable the participant to establish a basic household and include the following: housing security deposits; specific set-up fees for telephone, electricity, gas, water and other such housing start-up fees or deposits; essential furnishings for the living room, dining room, kitchen and bedroom; and health and welfare assurances including pest control/eradication, fire extinguisher, smoke detector, and first aid supplies/kit. There is a \$1,500.00 lifetime maximum for these services.

✦ Provider Enrollment Requirements

Same as for Support Coordination

✦ Prior and Post Authorization

- After purchases are made, the "*Transition Service Expense and Planning Approval (TSEPA) Form*", the Provisional POC, POC or revised POC that includes Transition Services, and receipts are sent to SRI
- If information is complete, accurate, and everything matches, SRI simultaneously issues and releases one (1) PA to the authorizing Support Coordination agency
- Upon receipt of reimbursement, the Support Coordination agency is responsible for reimbursing the purchaser (family, provider, own agency, self...)

Environmental Accessibility Adaptations

These services are adaptations to the participant's home to reasonably assure health and welfare and to enable the participant to function with greater independence in the home.

✦ Provider Enrollment Requirements for EAA Assessor/Inspector/Approver

- Affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct

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- All EAA Assessor/Inspector/Approver services provided to Community Choice Waiver participants are prior authorized before services are rendered
- Have the following professionals on staff or under contract: licensed and registered Occupational Therapist, licensed Physical Therapist, and Rehabilitation Engineer credentialed as either an Assistive Technology Professional or a Registered Environmental Technician
- That professionals on staff or under contract have completed a minimum of 25 assessments in their particular area of service
- That professionals on staff or under contract have knowledge and experience to assess waiver participants and their home environments to determine whether or not there is a need for environmental adaptations to the home, provide a written report and recommendations, develop specifications for needed environmental adaptations, and perform mid-term and final inspections for environmental adaptations to the home.
- That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid
- Enroll as Medicaid provider type 15 (Environmental Accessibility Adaptation – Waiver) with provider sub-specialty of 8Q (EAA Assessor, Inspector, Approver)
- Provider Enrollment packet checklist instructions contain the following statement:
“Agencies enrolled to provide EAA Assessor/Inspector/Approver services for Community Choices Waiver recipients cannot enroll to perform Environmental Accessibility Adaptions for Community Choices Waiver recipients.”

OR

⚡ Provider Enrollment Requirements for EAA contractors

- Have license for one of the following building trade classifications: General Contractor, Home Improvement, Residential Building

OR

If currently enrolled in Louisiana Medicaid as a Durable Medical Equipment (DME) provider, documentation from the manufacturing company (on their company letterhead) that confirms this DME provider is an authorized distributor of a specific product that attaches to a building. The letter must specify the product and must state that this DME provider has been trained on its installation.

- Enroll as Medicaid provider type 15 (Environmental Accessibility Adaptation – Waiver) without a provider sub-specialty
- Provider Enrollment packet checklist instructions contain the following statement:
“Agencies enrolled to perform Environmental Accessibility Adaptions for Community Choices Waiver program recipients cannot enroll to provide EAA Assessor/Inspector/Approver services for OAS Community Choices Waiver recipients.”

⚡ Service Specifications & Limits

- Enrolled EAA Assessor/Inspector/Approver may not bill for providing environmental accessibility adaptations (ramps, lifts, bathroom modifications, other adaptations).
- Enrolled EAA contractors may not bill for EAA assessment, inspection and approval services.
- There is no longer a lifetime maximum
- This service cannot be used for basic home construction and repairs.

Office of Aging and Adult Services
--Community Choices Waiver Services--

✦ Prior Approval

- Until have enrolled EAA Assessor/Inspector/Approver, regional office retains responsibility for approval of EAA jobs.
- Once have enrolled EAA Assessor/Inspector/Approver this process is to be similar to the currently utilized process as authorized by the support coordination agency instead of regional office.
- An EAA job shall be authorized only if health and welfare can be reasonably assured for the duration of the POC year.

✦ Prior and Post Authorization

- A provisional POC or POC or revised POC including EAA assessment is sent to SRI
- SRI issues PA for the basic assessment and approval upon receipt of POC or revised POC
- Upon receipt of authorization that the assessment has been completed, SRI will release the PA for the basic assessment and approval service
- If EAA assessment indicates need for completion of EAA job, a revised POC is sent to SRI. The revised POC will include the complex assessment and approval service, and the EAA job
- SRI issues a PA for the complex assessment and approval service and a PA for the EAA job upon receipt of the revised POC
- SRI releases the PAs for the complex assessment and approval, and for the EAA job upon receipt of documentation that these tasks have been completed

✦ New Procedure Codes and Rates

- Environmental Accessibility Adaptation – Basic Assessment and Approval (Z0640)
\$600.00 per service
- Environmental Accessibility Adaptation – Complex Assessment and Approval (Z0642)
\$150.00 per service

Personal Assistance Services

These services include supervision or assistance with activities of daily living, instrumental activities of daily living and health related tasks; and protective supervision necessary for participants with functional limitations to remain safely in the community. Other services include escort assistance with community tasks and extension of therapy services.

✦ Provider Enrollment Requirements

- Waiver Personal Care Attendant agencies (provider type 82) must have PCA license from Health Standards
- Home Health Agencies (provider type 44) must have home health agency license from Health Standards
- Fiscal Agent (provider type 01) is used for participant directed services

✦ Service Specifications & Limits

- Additional/New delivery method:-PAS – a.m./p.m.:
 - Provided up to two (2) times per day at the beginning of the participant's day (e.g., the a.m. session) and/or at the end of the participant's day (e.g., the p.m. session)
 - The duration of each session is to be a minimum of one (1) hour and a maximum of two (2) hours
 - If both an a.m. and a p.m. session are provided, there is to be a minimum of a four (4) hour break between the two (2) sessions
 - The a.m. session is used to assist the participant to begin his/her day

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- The p.m. session is used to assist the participant to end his/her day
- It is permissible for a participant to receive only one session (either at the beginning of his/her day or at the end of his/her day)
- It is permissible for this method of delivery to be self directed
- This method of delivery is not intended to be shared
- Unit of reimbursement for PAS – a.m./p.m. is per visit (as opposed to 15 minute unit of reimbursement for regular PAS)
- PAS a.m./p.m. and regular PAS in 15 minute increments (shared and unshared) cannot be provided/received on the same day of service
- Home Health agency's PAS direct service worker must be a qualified Home Health Aide as specified in Louisiana's Minimum Licensing Standards for Home Health Agencies
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency
- PAS cannot be received at the same time of day as Caregiver Temporary Support or ADHC
- ✦ Prior and Post Authorization
 - Annual PA is issued based on what is included in the approved POC
 - Once the services are provided and documented in LAST, the PA is released on daily basis with weekly cap based on prior authorized week that begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m.
 - Unused portions of the prior authorized weekly allotment may not be saved or borrowed from one week for use in another week
- ✦ New Procedure Codes and Modifiers and Rates
 - Personal Assistance Services – a.m.-p.m. provided in the morning (S5126 – UF)
 - Personal Assistance Services – a.m.-p.m. provided in the evening (S5126 – UH)
 - \$30.00 per visit for each session

Adult Day Health Care

These services are provided at an Adult Day Health Care center, in a non-institutional, community-based setting and include health/medical and social services needed to ensure optimal functioning. Services include assistance with activities of daily living; health and nutrition counseling; individualized exercise program, individualized, goal-directed recreation program; health education classes; transportation to and from the ADHC; individualized health/nursing services; and meals to include 2 snacks or breakfast and 1 snack and a hot nutritious lunch.

- ✦ Provider Enrollment Requirements
 - Obtain Adult Day Health Care license from Health Standards
 - Enroll as Medicaid provider type 85 (Adult Day Health Care)
- ✦ Service Specifications & Limits
 - Unit of reimbursement is 15 minutes
 - Daily service maximum is 40 units (10 hours)
 - Weekly service maximum is 200 units (50 hours)
 - ADHC cannot be received at same time of day as PAS or Caregiver Temporary Support

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✚ Prior & Post Authorization

- Depending on the number of prior approved units of service, two (2) or more PAs will be issued for the POC year. Multiple PAs have to be issued because Molina's system limits each PA to a maximum of 9,999 units.
- PA is released for reimbursement once the services are provided and documented in LAST

Skilled Maintenance Therapies (SMTs) – Physical Therapy, Occupational Therapy, Speech/Language Therapy (Respiratory Therapy is pending further development)

These therapy services focus primarily on maintaining, improving, reducing decline in the participant's ability to perform activities of daily living. These services are not necessarily acute event focused as are Medicaid state plan services. These services may also be used for assessing a participant's need for assistive devices or home modifications; training the participant and caregivers in the use of purchased devices; performing in-home fall prevention assessments; and participation on the care planning team.

Physical Therapy services promote the maintenance of or reduction in the loss of gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities.

Occupational Therapy services promote the maintenance of or reduction in the loss of fine motor skills, coordination, sensory integration and/or facilitate the use of adaptive equipment or other assistive technology.

Speech/Language Therapy services preserve abilities for independent function in communication, eating and swallowing; facilitate use of assistive technology; and/or prevent progressive disabilities.

✚ Provider Enrollment Requirements

- Individual therapists must have professional license and enroll as applicable Medicaid provider type (PT) with applicable provider sub-specialty:
 - Physical Therapist – PT 35
 - Occupational Therapist – PT 37
 - Speech/Language Therapist – PT 39
- Home Health Agencies must have home health agency license from Health Standards and enroll as Medicaid provider type 44 (HH Agency) with applicable provider sub-specialty
- Rehabilitation Centers must have rehabilitation center license from Health Standards and enroll as Medicaid–provider type 65 (Rehab Center) with applicable provider sub-specialty
- All must affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct
 - That reimbursement can be received for services provided only to Community Choices Waiver participants
 - that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare
 - that failure to exhaust these above referenced third party payer sources may subject the Medicaid enrolled agency to recoupment of funds previously paid by Medicaid

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- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered
- that as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly
- That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid

✦ Service Specifications & Limits

- For physical therapy and occupational therapy: home care training for family and home care training for non-family are two separate services paid under two separate procedure codes so they are not payable on the same day of service. Training can be delivered to both at the same time, but the therapist will need to choose which code to use. This is not applicable to speech/language therapy because training is a part of the treatment service.
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

✦ Prior Approval

- If the support coordinator's assessment indicates a possible need for services, referral is made for an assessment to be completed by the participant's provider of choice
- If it is determined that therapy is needed, this will be included in the Provisional POC, POC or revised POC

✦ Prior & Post Authorization

- SRI will issue PA(s) for assessment and/or therapy upon receipt of a Provisional POC, POC or revised POC that includes these services
- These PAs are auto released at the time of issuance
- PAs will be issued for no more than 6 months
- If it is later determined that another source will pay for the services, a revised POC to remove the service will be sent to SRI. If SRI finds that the PA has not been used, the PA will be voided making the funds available for use by the participant.

✦ New Procedure Codes and Modifiers and Rates

- In-home Physical Therapy
 - Evaluation (97001 – GP) \$77.50 per service
 - Re-Evaluation (97002 – GP) \$77.50 per service
 - Physical Therapy (S9131) \$77.50 per visit
 - Home Care Training for Family (S5111 – GP) \$77.50 per visit
 - Home Care Training for Non-Family (S5116 – GP) \$77.50 per visit
- In-home Occupational Therapy
 - Evaluation (97003 – GO) \$77.50 per service
 - Re-Evaluation (97004 – GO) \$77.50 per service
 - Occupational Therapy (S9129) \$77.50 per visit
 - Home Care Training for Family (S5111 – GO) \$77.50 per visit
 - Home Care Training for Non-Family (S5116 – GO) \$77.50 per visit
- In-home Speech/Language Therapy
 - Speech/Language Hearing Evaluation (92506 – GN) \$77.50 per service
 - Swallowing Functioning Evaluation (92610 – GN) \$77.50 per service
 - Speech/Language Hearing Therapy (92507 – GN) \$77.50 per visit
 - Oral Function Therapy (92526 – GN) \$77.50 per visit

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Nursing Services

These are medically necessary services provided by a nurse practitioner, registered nurse or a licensed nurse within the scope of the Louisiana Statutes governing the practice of nursing. These services include periodic assessment of the participant's medical condition; evaluation of the need for medical intervention; monitoring and/or modifying medical treatment services provided by non-professional care providers; regular, ongoing monitoring of a participant's fragile or complex medical condition; monitoring of a participant with a history of non-compliance with medication or other medical treatment; assessing a participant's need for assistive devices or home modifications; training the participant and family in the use of purchased devices; and training the direct service workers in tasks necessary to carry out the plan of care.

↓ Provider Enrollment Requirements

- Nurse Practitioner must have professional license and enroll as Medicaid provider type 78 (Nurse Practitioner – Individual)
- Home Health Agencies must have home health agency license from Health Standards and enroll as Medicaid provider type 44 (HH Agency)
- Adult Day Health Care center must have Adult Day Health Care license from Health Standards and enroll as Medicaid provider type AL (Community Choices Waiver Nursing) with provider sub-specialty of 8K (ADHC HCBS)
- All must affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct
 - That reimbursement can be received for services provided only to Community Choices Waiver participants
 - that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare
 - that failure to exhaust these above referenced third party payer sources may subject the Medicaid enrolled agency to recoupment of funds previously paid by Medicaid
 - that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered
 - That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid

↓ Service Specifications & Limits

- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

↓ Prior Approval

- If the support coordinator's assessment indicates a possible need for services, referral is made for an assessment to be completed by the participant's provider of choice
- If it is determined that nursing services are needed, this will be included in the Provisional POC or POC or revised POC

↓ Prior & Post Authorization

- SRI will issue PA(s) for assessment and/or therapy upon receipt of a Provisional POC or POC or revised POC that includes these services

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- These PAs are auto released at the time of issuance
- PAs will be issued for no more than 6 months
- If it is later determined that another source will pay for the services, a revised POC to remove the service will be sent to SRI. If SRI finds that the PA has not been used, the PA will be voided making the funds available for use by the participant.
- ✦ New Procedure Codes and Modifiers and Rates for In-home Nursing:
 - Nursing assessment by Nurse Practitioner (T1001) \$65.22 per service
 - Nurse Practitioner visit(S0274) \$65.22 per visit
 - Nursing Assessment by RN (T1001 – TD) \$65.22 per service
 - Nursing Assessment by LPN (T1001 – TE) \$58.00 per service
 - Nursing Care by RN (T1030) \$65.22 per visit
 - Nursing Care by LPN (T1031) \$58.00 per visit

Home Delivered Meals

This service includes a maximum of two (2) nutritionally balanced home delivered meals per day. An eligible participant is unable to leave his/her home without assistance; unable to prepare his/her own meals, and/or has no responsible caregiver in the home.

✦ Provider Enrollment Requirements

- In-state providers must meet all Louisiana Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution
- Out-of-state providers must meet all USDA food preparation, processing, packaging, storage and out-of-state distribution requirements
- All must enroll as Home Delivered Meals provider type AM (Home Delivered Meals) with provider subspecialty of 8M (Community Choices Waiver – Home Delivered Meals)

✦ Service Specifications and Limits

- Each participant may receive a maximum of two (2) home delivered meals per day
- Meals may be shipped in bulk
- It is permissible for participants to have some meals delivered daily and others delivered in bulk by different providers as long as the two (2) meals per day maximum is not exceeded.
- Delivery of meals are to be suspended while the participant is hospitalized or temporarily in a nursing facility making it important for this information to be reported and acted upon immediately.
- Span date billing is allowed

✦ Prior & Post Authorization

- Unit of reimbursement is one (1) meal
- SRI will issue an annual PA for a maximum of two (2) meals per day and for a maximum of 14 meals per week according to what is on the POC
- These PAs are auto released at the time of issuance

✦ New Procedure Code and Rate

- Home Delivered Meals (S5170) maximum of \$7.00 per meal

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Personal Emergency Response System (PERS) – traditional

This service is a rented electronic device that enables the participant to secure help in an emergency. The unit is connected to the telephone line and is programmed to send an electronic message to a community-based 24-hour emergency response center when a “help” button is activated. This service is limited to participants who live alone, or are alone for significant parts of the day; who have no regular care giver for extended periods of time; who would otherwise require extensive, routine supervision; and who are cognitively and/or physically able to operate the system.

✚ Provider Enrollment Requirements

- Must be enrolled as provider type 16 (PERS-Waiver)

✚ Service Specifications & Limits

- A participant will not be able to simultaneously receive traditional PERS services and TeleCare Activity and Sensor Monitoring services

✚ Prior & Post Authorization

- One (1) PA is issued for one-time installation according to information on the POC
- An annual PA is issued for one (1) unit per month for a 13 month period for ongoing monitoring according to information on the POC
- These PAs are auto released at the time of issuance
- PAs are mailed to these providers rather than being issued electronically because these providers do not use LAST

Assistive Technology – TeleCare Activity & Sensor Monitoring

This service is a computerized system that monitors the participant’s in-home movement and activity for health, welfare and safety purposes. The system is individually set based on the participant’s typical in-home movements and activities. The provider agency is responsible for monitoring electronically generated information, for responding as needed, and for upkeep of the equipment. At a minimum, the system shall monitor the home’s points of egress and entrance; detect falls; detect movement or the lack of movement; detect whether doors are opened or closed; and provide a push-button emergency alert system. Some systems may also monitor the home’s temperature.

✚ Provider Enrollment Requirements

- Must be a home health agency with home health license from Health Standards and enroll as a Medicaid provider type 17 (Assistive Devices Waiver) with provider sub-specialty of 3U (Community Choices Waiver – Assistive Devices – Home Health)

✚ Service Specifications & Limits

- A participant will not be able to simultaneously receive TeleCare Activity and Sensor Monitoring services and traditional PERS services
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

✚ Prior & Post Authorization

- Same as for traditional PERS

✚ New Procedure Codes and Rates

- TeleCare – Activity & Sensor Monitoring – Equipment Installation & Removal (S5160) one (1) time \$200.00 at installation
- TeleCare – Activity & Sensor Monitoring – Monitoring, Routine Maintenance & Rental (S5161) \$130.00 monthly

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Caregiver Temporary Support

These services are provided on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the participant. The purpose of caregiver temporary support is to provide relief to unpaid caregivers to maintain the participant's informal support system. This service is provided in the participant's place of residence, an adult day health care center, an assisted living center, a nursing facility or a respite care center.

↓ **Provider Enrollment Requirements**

- Enroll as one of the following Medicaid provider types:
 - Personal Care Attendant – Waiver (provider type 82) with provider sub-specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) to provide in-home services
 - Caregiver Temporary Support (provider type AN) with provider specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) for:
 - Home Health agency with Home Health license from Health Standards with provider sub-specialty of 8F (Community Choices Waiver – Caregiver Temporary Support – Home Health) to provide in-home services
 - ADHC center with ADHC license from Health Standards with provider sub-specialty of 8H (Community Choices Waiver – Caregiver Temporary Support – ADHC) to provide center-based, non-overnight services
 - Assisted Living center with Assisted Living license from Health Standards with provider sub-specialty of 8G (Community Choices Waiver – Caregiver Temporary Support – Assisted Living) to provide center-based, overnight services
 - Nursing Facility with Nursing Facility license from Health Standards with provider sub-specialty of 8J (Community Choices Waiver – Caregiver Temporary Support – Nursing Facility) to provide center-based, overnight services
 - Respite Care Center (provider type 83) with provider sub-specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) to provide center-based, overnight services

↓ **Service Specifications & Limits**

- PCA and Home Health agencies will provide in-home services
 - Unit of reimbursement is 15 minutes
- ADHC centers will provide center-based, non-overnight services
 - Unit of reimbursement is 15 minutes
 - Daily service maximum is 40 units (10 hours)
- Assisted Living Centers, Nursing Facilities and Respite Care Centers will provide center-based, overnight services
 - Unit of reimbursement is daily
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency
- Caregiver Temporary Support cannot be received at the same time of day as PAS or ADHC
- POC year service maximum is 30 calendar days or 29 overnight stays
- Consecutive days of services/episodes maximum is 14 days or 13 overnight stays

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✦ Prior & Post Authorization

- SRI will issue PAs for no more than 30 calendar days or 29 overnight stays per POC year
- Each PA issued will be capped at 14 calendar days or 13 overnight stays
- No contiguous PAs will be issued
- PCA agencies, ADHC centers and Home Health agencies will use LAST to bill for Caregiver Temporary Support
 - PAs for these type agencies will be released for reimbursement once the services are provided and documented in LAST
- Assisted Living Centers, Nursing Facilities and Respite Care Centers will not use LAST to bill for Caregiver Temporary Support
 - PAs for these type providers are auto released at the time of issuance

✦ New Procedure Codes and Modifiers and Rates

- In-Home by PCA agency or Home Health agency (T1005) \$2.83 per 15 minute unit
- Center-Based, Not Overnight at ADHC ((T1005 – HQ) \$2.66 per 15 minute unit for maximum of 40 units or 10 hours per day
- Center-Based with Overnight stay:
 - at Assisted Living Center (H0045) \$95.00 per diem
 - at Nursing Facility (H0045 – HQ) \$148.31 per diem
 - at Respite Care Center (H0045 – HQ & UJ) \$148.31 per diem

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Community Choices Waiver Services Payable during Transition from a Nursing Facility

- ✦ Transition Intensive Support Coordination
- ✦ Transition Services
- ✦ Environmental Accessibility Adaptation – Ramp
- ✦ Environmental Accessibility Adaptation – Lift
- ✦ Environmental Accessibility Adaptation – Bathroom
- ✦ Environmental Accessibility Adaptation – Other Adaptations
- ✦ Environmental Accessibility Adaptation – Basic Assessment & Approval (Effective 10-1-11 in Molina’s system with description: “EAA Assessment”)
- ✦ Environmental Accessibility Adaptation – Complex Assessment and Approval (Effective 10-1-11 in Molina’s system with description: “EAA - Inspection and Final Approval”)
- ✦ Physical Therapy Evaluation
- ✦ Occupational Therapy Evaluation
- ✦ Speech Language Hearing Evaluation
- ✦ Swallowing Function Evaluation
- ✦ Nursing Service Assessment (by Nurse Practitioner, RN or LPN)

INTEND TO ADD:

- ✦ PERS Initial Installation
- ✦ TeleCare Activity and Sensor Monitoring – Equipment Installation

Community Choices Waiver Services Payable during Temporary stay in a Nursing Facility

- ✦ Support Coordination
- ✦ PERS Initial Installation
- ✦ PERS Monthly Maintenance
- ✦ Environmental Accessibility Adaptation – Ramp
- ✦ Environmental Accessibility Adaptation – Lift
- ✦ Environmental Accessibility Adaptation – Bathroom
- ✦ Environmental Accessibility Adaptation – Other Adaptations
- ✦ Environmental Accessibility Adaptation – Basic Assessment & Approval (Effective 10-1-11 in Molina’s system with description: “EAA Assessment”)
- ✦ Environmental Accessibility Adaptation – Complex Assessment and Approval (Effective 10-1-11 in Molina’s system with description: “EAA - Inspection and Final Approval”)
- ✦ Physical Therapy Evaluation
- ✦ Occupational Therapy Evaluation
- ✦ Speech Language Hearing Evaluation
- ✦ Swallowing Function Evaluation
- ✦ Nursing Service Assessment (by Nurse Practitioner, RN or LPN)

INTEND TO ADD:

- ✦ TeleCare Activity and Sensor Monitoring – Equipment Installation
- ✦ TeleCare Activity and Sensor Monitoring – (Monitoring,) Routine Maintenance & Rental

Regular Session, 2011

ACT No. 299

HOUSE BILL NO. 642 (Substitute for House Bill No. 440 by Representative Burford)

BY REPRESENTATIVES BURFORD, ARMES, HENRY BURNS, CHANDLER, CHANEY, GISCLAIR, HAZEL, HOFFMANN, HOWARD, MONTOUCET, NOWLIN, PUGH, GARY SMITH, JANE SMITH, TUCKER, WILLMOTT, AND WOOTON

AN ACT

To amend and reenact R.S. 37:1031(A)(introductory paragraph) and (D), 1033(A)(3) and (4), (B), (D)(1), (F), and (H), and 1034(3) and R.S. 40:2120.4(B)(1), 2120.5(D), and 2179(C), to enact R.S. 37:1031(A)(5) and (E) and R.S. 40:2119, and to repeal R.S. 37:1033(G), relative to home- and community-based providers; to provide for the applicability of statutory provisions governing direct service workers; to provide for appropriate training of direct service workers; to provide for the termination of authorization of direct service workers to perform certain procedures; to require the department to develop a comprehensive plan regarding the quality of services provided to individuals receiving home- and community-based services; to provide for licensure procedures and requirements applicable to granting deemed status to home- and community-based providers; to extend the application of state laws governing direct service workers to all direct service workers regardless of the type of compensation; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 37:1031(A)(introductory paragraph) and (D), 1033(A)(3) and (4), (B), (D)(1), (F), and (H), and 1034(3) are hereby amended and reenacted and R.S. 37:1031(A)(5) and (E) are hereby enacted to read as follows:

§1031. Applicability

A. The provisions of this Part shall not apply to gratuitous care provided by friends or members of the individual's family. The provisions of this Part shall apply to all direct service workers employed by a licensed agency, or employed as part of an authorized departmental self-directed program, and who attend to individuals

1 receiving ~~state or federally funded home~~ home- and community-based long-term
 2 services and who are not authorized to perform these tasks under other state laws or
 3 regulations. An individual being served shall meet the following criteria:

4 * * *

5 (5) Requires assistance with medication administration or other noncomplex
 6 medical tasks.

7 * * *

8 D. A registered nurse may delegate to a licensed practical nurse components
 9 of the training and supervision of the direct service worker provided that the
 10 registered nurse shall retain the responsibility and accountability for all acts of
 11 delegation and ensuring authorization and competency validation.

12 ~~D.~~ E. The Department of Health and Hospitals, in conjunction with the
 13 Louisiana State Board of Nursing, shall promulgate rules and regulations necessary
 14 to enable the implementation of this Part, and other rules and regulations concerning
 15 direct service workers consistent with this Part.

16 * * *

17 §1033. Required training; ~~registration~~

18 A. In order to be authorized to perform the procedures specified in R.S.
 19 37:1032, a direct service worker shall be employed by a licensed agency or
 20 employed as part of an authorized departmental self-directed program and shall
 21 receive the following training:

22 * * *

23 (3) In order to administer noncomplex tasks, complete didactic training, and
 24 demonstration of competency in accordance with guidelines established and
 25 approved by the Department of Health and Hospitals and the Louisiana Board of
 26 Nursing.

27 ~~(3)~~ (4) ~~At least six hours of~~ Appropriate person-specific training from a
 28 registered nurse who has assessed the health status of the individual ~~in the residence~~
 29 ~~where the receiving services are to be performed~~ and determined that the direct
 30 service worker can perform the tasks in a safe, appropriate manner, with additional

1 person-specific training by a registered nurse whenever the tasks to be performed or
 2 the types of medications to be administered are changed. Written documentation of
 3 training provided by the registered nurse shall be submitted to and maintained by the
 4 direct service worker's ~~employing agency~~ employer.

5 ~~(4) Current Cardio-Pulmonary Resuscitation certification:~~

6 B. Any unlicensed person performing the procedures authorized by this Part
 7 shall complete the training required by this Section no later than ~~thirty-six~~ twelve
 8 months after promulgation of the regulations required by this Part. Training
 9 specified in Subsection A of this Section shall be repeated if the registered nurse
 10 does not certify that the direct service worker has demonstrated a sufficient level of
 11 competency in the subject matter.

12 * * *

13 D.(1) Any ~~registered~~ licensed nurse who has properly trained and
 14 documented that a direct service worker can perform the prescribed tasks shall not
 15 be liable for any civil damages as a result of any act or omission of the direct service
 16 worker.

17 * * *

18 F. Direct service workers performing with a finding on the Department of
 19 Health and Hospital's Direct Service Worker Registry shall not perform tasks under
 20 pursuant to this Part, ~~shall maintain current registration with the Department of~~
 21 ~~Health and Hospital's Direct Service Worker Registry.~~

22 * * *

23 H. ~~During the thirty-six month training period required by Subsection B of~~
 24 ~~this Section, the~~ The Department of Health and Hospitals and the Louisiana State
 25 Board of Nursing shall meet ~~quarterly~~ at least annually to review data collected by
 26 the Department of Health and Hospitals that is relevant to the administration of
 27 health care tasks authorized by this Part. The Department of Health and Hospitals
 28 and the Louisiana State Board of Nursing shall use the data to evaluate the efficiency
 29 of this program and shall make joint recommendations to the secretary of the

1 Department of Health and Hospitals and the executive director of the Louisiana State
2 Board of Nursing for any needed revisions.

3 §1034. Termination of authorization

4 Authorization for a direct service worker to perform any of the tasks specified
5 in R.S. 37:1032 shall be terminated for any of the following reasons:

6 * * *

7 (3) The direct service worker ~~no longer maintains current registration in~~ has
8 a finding against him placed on the Direct Service Worker Registry.

9 * * *

10 Section 2. R.S. 40:2120.4(B)(1), 2120.5(D), and 2179(C) are hereby amended and
11 reenacted and R.S. 40:2119 is hereby enacted to read as follows:

12 §2119. Comprehensive plan

13 A. The Department of Health and Hospitals is hereby directed to develop a
14 comprehensive plan to address the delivery of quality services to a person receiving
15 home- and community-based services, and the department shall submit a written
16 report to the House Committee on Health and Welfare and the Senate Committee on
17 Health and Welfare by January 15, 2012.

18 B. The plan shall be developed with input from stakeholders and shall
19 include action steps, recommended time lines, and identified necessary resources for
20 implementation, and shall address the following:

21 (1) Accreditation - accreditation of home- and community-based service
22 providers.

23 (2) Compliance - assurance that all home- and community-based service
24 providers meet the standards for licensure and plan for monitoring to ensure ongoing
25 compliance.

26 (3) Billing - appropriate revisions to streamline the procedures for the billing
27 of home- and community-based services and the monitoring thereof to reduce fraud
28 and errors.

1 Aide Registry established under rules promulgated by the Department of Health and
2 Hospitals.

3 * * *

4 Section 3. R.S. 37:1033(G) is hereby repealed in its entirety.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____