FY 2023-24
SCOPE OF SERVICE

OPTIONS / CARE MANAGEMENT PROGRAM

I. PURPOSE

The Care Management (CM) Program offers a broad range of services tailored to the specific care needs and preferences of older adults (60 years old +) who choose to live in their own homes and communities. CM may be offered as either part of a continuum of services or a separate social work service. CM can also be provided to support caregivers.

The CM Program is a social work service that supports consumers and caregivers in achieving and sustaining their highest possible level of functioning. CM can be provided as a stand-alone CM service requiring only a few meetings between care managers, consumers and caregivers; or, CM can be provided as an ongoing CM service of indefinite duration. Care managers also can help consumers, caregivers and informal supports to identify needs and resources beyond those offered by the Allegheny County Department of Human Services/Area Agency on Aging (ACDHS/AAA). When provided as a stand-alone CM service, care managers can assist consumers and their families with decisions about home and community-based services, nursing facility admission or other long-term care issues.

II. DEFINITIONS

A. Aging & Disability (A & D) - See WellSky Aging & Disability

B. Aging Program Directive (APD) - is an official document issued by the Pennsylvania Department of Aging (PDA) in which detailed information is presented on the operation of specific aging service programs.

C. Area Agency on Aging (ACDHS/AAA) - is a program office of the Allegheny County Department of Human Services (DHS) that receives grant funds from the Pennsylvania Department of Aging (PDA) to provide programs and services that enable and empower adults who are 60 years of age and older and live in Allegheny County to maintain independent, safe and healthy lives.

D. Care Manager - works with consumers and their caregivers in gaining access to the state's home and community-based services and other medical, social and educational services regardless of funding source.

E. Care Plan - is the detailed outline of the consumer's needs and shows the coordination of services needed to address those needs. OPTIONS Care Plans are updated annually or when a consumer's needs or level of care change.

F. Caregiver Assessment Score (CAS) - is a score used to prioritize enrollment, home modifications and assistive devices when a wait list is implemented. The CAS is generated automatically in WellSky Aging & Disability after a care manager completes a Caregiver Assessment Tool (CAT).

G. Caregiver Assessment Tool (CAT) - is an assessment tool developed by the PDA to compile information about the caregiver, their needs, situation and environment, and assist the care manager in developing the Care Plan and ongoing CM in the CSP. The CAT is completed initially, every six (6) months, and if there is a change in the Caregiver / Care Receiver relationship.

H. Caregiver Support Program (CSP) - provides training and financial support to improve the quality of life, and address the physical, emotional and financial burdens of eligible caregivers, 18 years of age and older, that look after a frail and/or dependent older adult in the home. The CSP serves caregivers, ages 55 and older of related adults with disabilities. CSP also serves caregivers, ages 55 and older, who are caring for children, ages 18 and younger, who are related but not the biological children of the caregiver.

I. Caregivers - are the identified adult family or other responsible adult who has primary responsibility for the provision of care, including coordination of care and services, needed to maintain the physical and/or mental health of the care receiver. The caregiver may not receive compensation for personally providing caregiving services to the care receiver and shall be actively involved with various aspects of care on a regular basis.

J. Consumer - is an individual who receives services under PDA, OPTIONS Program or Caregiver Support Program (CSP). In CSP, the consumer is the caregiver.

K. Cost Share / Co-Pay - is required for OPTIONS consumers in sharing the cost of their Care Plan based on their monthly countable income, determined by a sliding scale. In CSP, the Co-Pay is based on the Care Receiver's household income determined by a sliding scale.

L. Department of Military Affairs (DMVA) Veterans Registry - a system created to provide veterans living in Pennsylvania with information on state, federal, and local programs, benefits and services to which they may be entitled. Act 69 of 2017 established the requirement for all state agencies to collaborate with the DMVA to identify and assist veterans with registration.

M. Freedom of Choice Form - Form detailing that the consumer has the right to receive services wherever they choose or to receive no services at all.

N. Functional Eligibility Determination (FED) - is an assessment tool used to determine level of care for consumers. Completion of the FED allows for classification of consumers as Nursing Facility Clinically Eligible or Nursing Facility Ineligible.

O. Health Insurance Portability and Accountability Act (HIPAA) - is a federal law that establishes privacy standards to protect patient medical records and other health information provided by consumers to health plans, doctors, hospitals and other health care providers.

P. Home and Community-Based Services (HCBS) - are aging services provided in non-institutional settings through AAAs and their contracted providers.

Q. Independent Enrollment Broker (IEB) – Processing information organization for enrollment into Community Health Choices and Life Programs.

R. Informal or Natural Supports - are individuals or groups who voluntarily assist consumers without payment.

S. Information & Assistance (I & A) - ACDHS/AAA senior line representative acquires preliminary information on an interested consumer.

T. Integrated Monitoring Tool (IMT) Application - Supporting improved quality, efficiency and collaboration of DHS monitoring efforts, the Integrated Monitoring Tool (IMT) captures key details and summary results from every monitoring visit and shares them across DHS offices. The application is built around administration, policy and procedure, staffing and personnel, environment, service delivery and outcomes.

U. MA LTSS - Medical Assistance Long-Term Services and Supports, also known as Community Health Choices (CHC).

V. Master Provider Enterprise Repository (MPER) - A repository of key CONTRACTORS' demographic data for all CONTRACTORS who provide services for DHS. DHS applications use MPER to validate AGREEMENT, services, facilities, rate information and document program funded budgets and invoices to facilitate documentation of services rendered and claims information by CONTRACTORS. CONTRACTORS are required to keep all agency information including but not limited to contacts, facilities and service offering information up to date.

W. Needs Assessment Score (NAS) – is a score used to prioritize consumers placement on a wait list for services and to determine if a cost cap exception care plan is warranted. NAS is generated for a consumer automatically in Aging and Disability after a care manager completes a Needs Assessment Tool (NAT).

X. Needs Assessment Tool (NAT) – is an assessment tool developed by the PDA to compile information about the consumer, their condition, situation and environment, and assist the care managers in developing the care plan and ongoing CM.

Y. Needs Assessment Tool-Express (NAT-E) – is a streamlined assessment tool developed to assess consumers requesting In-Home Meal Service and/or Care Management Only.

Z. Nursing Facility Clinically Eligible (NFCE) - consumer who has been assessed and determined to be clinically eligible for nursing facility care.

AA. Nursing Facility Ineligible (NFI) - consumer who has been assessed and determined not to be clinically eligible for nursing facility care.

BB. Office of Long-Term Living (OLTL) - the unit of state government that funds and administers services for consumers with disabilities and related health needs.

CC. OPTIONS - Home and community-based services funded primarily through the Aging Block Grant. The services in this program are provided to eligible consumers aged 60+ to assist them in maintaining independence with the highest level of functioning in the community and delay the need for more costly care/services. OPTIONS services are not an entitlement. All other resources (individual, local, state and/or federal) must be considered and utilized before OPTIONS services are provided.

DD. Pennsylvania Department of Aging (PDA) - coordinates and funds the aging service programs provided by the 52 area agencies on aging that serve older adults in the state.

EE. Pennsylvania Department of Aging Services Policy and Procedure Manual - sets forth guidelines and procedures for the 52 Area Agencies on Aging in the Commonwealth of Pennsylvania.

FF. Service Plan Agreement - a CSP form signed by the consumer acknowledging a total understanding of their Care Plan and agreeing to the services, providers, schedule, and any associated costs.

GG. Service Provider Choice Form - this form records the consumer's acknowledgement that they choose their provider and will be offered choice in the process.

HH. Third-Party Payer (TPP) - is an entity other than the consumer or the ACDHS/AAA that makes payments for services.

II. Waiting List - will include new consumers, existing consumers who are waiting for an increase of services or a new service added or waiting for a worker to provide Home Support/Personal Care/Home Health/Chore to their plan according to the Needs Assessment Score (NAS).

JJ. WellSky Aging & Disability (A & D) - The Pennsylvania Department of Aging's mandated information system used by ACDHS/AAA and CONTRACTORS to document and track specific services provided to consumers with ACDHS/AAA funding and demographics. The application is also known as Aging & Disability.

Also, see Aging Program Directive (APD) referenced below.

III. AGING PROGRAM DIRECTIVE (APD)/FEDERAL/STATE REGULATORY REFERENCE AND COMPLIANCE

A. Aging Policy and Procedure Manual

The primary source of requirements for the OPTIONS CM Program Scope of Services are established by the Pennsylvania Department of Aging and may be accessed by visiting the PDA Aging Policy and Procedure Manual Webpage. From this webpage, select the following chapters and all related documents.

1. Chapter II: Hearings and Appeals
2. Chapter III: Assessment
3. Chapter IV: OPTIONS Program
4. Chapter V: Care Management
5. Chapter VI: Caregiver Support Program
6. Chapter VII: Protective Services

B. Laws

- Military and Veterans Code (51 PA.C.S) – Veterans Registry; Act of Dec. 22, 2017, P.L. 1224, No. 69
- National Voter Registration Act of 1993
- Domiciliary Care Program

C. Aging Program Directives

- Aging Program Directive 19-29-01 Department of Military and Veterans Affairs (DMVA) Veterans Registry Enrollment and Reporting Policy and Procedures

This Scope of Service is subject to change based on changes to the above directives.

IV. PERFORMANCE EVALUATION

Each contract year the ACDHS/AAA will outline clear standards of acceptable performance to which the CONTRACTOR will be held. These standards relate to compliance with applicable policies, regulatory guidelines, Scopes of Service, Contract Workstatements, and Performance Based Contracting (PBC), where applicable. Standards are set to support quality service that meets or exceeds the needs of the consumer, and to optimize the impact of the service provided.

The CONTRACTOR is responsible for adhering to the timelines in reporting its compliance to the Scopes of Service and using findings to build on its strengths and develop strategies on opportunities, through a continuous quality improvement process.

Monitoring tools outlining acceptable evidence are used in evaluating compliance with regulatory requirements, service standards, documentation, and reporting requirements. The monitoring tool applicable to this Scope of Service is:

Allegheny County Department of Human Services
Area Agency on Aging
Care Management Services
Monitoring Tool

DHS Monitoring utilizes the Integrated Monitoring Tool (IMT). As such, for all monitoring visits, all service providers are required to access and upload documentation via the online application. For each monitoring visit, the county will utilize IMT to share important monitoring documents. Service providers are required to complete the monitoring process through IMT.

Monitoring and Reporting: The ACDHS/AAA reserves the right to monitor all CM services and related information. Providers must comply with the standards outlined in the acceptable evidence of the monitoring tool and those outlined by the PDA.

The ACDHS/AAA requires Providers to participate in and incorporate the results of Quality Management and Program Evaluation initiatives led by the ACDHS/AAA with the Provider. Provider has a designated representative who regularly serves on ACDHS/AAA performance / quality teams. The Provider maintains their own quality assurance program.

During FY 22-23, ACDHS/AAA will develop and work with CM provider network to implement procedures for measuring compliance with standard of 90% or better consumer satisfaction with CM services.

V. SERVICE STANDARDS, REPORTING AND DOCUMENTATION REQUIREMENTS

A. Components: The following are regarded as the essential components and requirements of the CM Program.

1. Consumer Referrals: ACDHS/AAA requires consumer referrals in a timely and expeditious manner.

   Care manager initiates contact with 100% of consumers within three (3) business days after receiving the case assignment.

2. Assessments: A comprehensive face-to-face assessment is conducted after intake with CM Consumers and others of their choosing (e.g. family members, friends, etc.) to evaluate the medical, psycho-social, environmental and financial aspects of their situation. Both the caregiver and care receiver must be present for the assessment process in CSP. In OPTIONS, the NAT/NAT-E is required initially and updated annually or when the CM Consumer's situation changes. In CSP, the CAT is required for the Caregiver initially and every six (6) months or when the Caregiver/Care Receiver's situation changes.

   a. 100% of NAT assessments must be completed within five (5) business days of referral; of these, 40% must be completed within three (3) business days and signed by CM Supervisor within ten (10) business days of assessment. This is required initially and annually to determine eligibility for OPTIONS consumers receiving In-Home Meal Service only.

   b. 95% of each assessment reviewed must have acceptable substantiating documentation supporting the level of care.

   c. 100% of NAT-E assessments must be completed within ten (10) business days of referral and signed by CM Supervisor within ten (10) business days of assessment. This is required initially and annually to determine eligibility for OPTIONS consumers receiving In-Home Meal Service only.

   d. In CSP, the CAT is required initially and every six (6) months. 100% of CAT assessments in CSP are completed within ten (10) business days of the referral. 100% of CAT are reviewed and signed by a CM supervisor within ten (10) business days of the home visit.

3. Resource Counseling and Support: Care managers assume a proactive role in counseling consumers on all available, appropriate ACDHS/AAA and non-ACDHS/AAA programs and services that address the consumers' unmet needs and help consumers to make informed decisions about their care. Counseling and support also are extended to caregivers, and may include referrals to community health, social service and other government programs. Care managers take a proactive role in informing, advising and connecting consumers and caregivers with services and resources available through the ACDHS/AAA, its Providers and other human services organizations or community resources.

   100% of CM Consumers and caregivers must receive ongoing resource counseling at least every six (6) months. All resource counseling must be documented in WellSky Aging & Disability.

4. Individual Care Plans: Care managers work with consumers, caregivers and other persons in their support network to develop and implement a comprehensive, personalized care plan with services that are strengths-based and specific to the consumer's individual preferences, needs and desired outcomes. The plan draws on and coordinates informal supports, third-party payers and community organizations in a way that supports consumers and protects their health and welfare. It does not replace informal supports with services but may be used to assist these supports. Using a consumer-centered and directed approach, care managers work with consumers to identify the most appropriate programs, CM services and strategies; develop back-up plans to mitigate risks; and enable consumers to live as they choose in their home or other setting of choice in the community.

5. Service Initiation: Care managers must work collaboratively with new consumers to arrange for CM services, according to preferences for services, scheduling and CM Providers.

6. Regular Consumer Contacts: Care managers work with consumers to establish and adhere to a regular schedule of contacts. The contacts are conducted to check on the consumer's condition, assess the effectiveness of the care plan and allow for adjustments to the plan, as needed. Specific journal types are required are outlined in the SAMS Care Management Manual and in OPTIONS Program, Appendix D, from PDA.

   a. OPTIONS

      i. All OPTIONS consumers, after the initial home visit, must receive a 3-month contact and a 9-month contact.
      ii. All OPTIONS consumers must receive a 6-month home visit.
      iii. All OPTIONS consumers must receive a 12 month-Annual Reassessment visit.

b. CSP

i. All caregivers, after the initial home visit, must receive a 3-month telephone contact and a 9-month telephone contact.
ii. The Care Manager must complete a 6 months-Home Visit-Reassessment at the Care Receiver's home with the Caregiver and Care Receiver present.
iii. The Care Manager must complete a 12 months-Home Visit-Reassessment at the Care Receiver's home with the Caregiver and Care Receiver present.

7. Consumer Complaints: CM will accurately complete provider complaint form and send it to the ACDHS/AAA within two (2) business days of contact with consumer. The In-Home provider gives a reasonable response to ACDHS/AAA in writing within seven (7) business days. The ACDHS/AAA will forward provider's response to the CM agency for next steps.

8. Service Utilization: Care managers monitor services to assure that they are delivered as prescribed, consumer needs and expectations are met, and problems or concerns are addressed effectively and promptly.

100% of consumers must receive a two-week telephone contact after the service is ordered and this is recorded by journal type entry.

9. Emergency Situations: Care managers check on the well-being of consumers and caregivers and provide additional CM services to those facing emergency situations in their homes, such as severe weather, property damage or utility issues. In addition to currently served consumers, CM Providers are responsible for serving older adults affected by emergencies in the CM Provider's service area, or by special request of the ACDHS/AAA.

100% benchmark requirement

a. At all times, the emergency plans of CM Providers must be current, actionable, routinely updated, practiced, followed and, at a minimum, be in compliance with the ACDHS/AAA Emergency Response Plan. The ACDHS/AAA Emergency Plan can be found on the Allegheny Aging Portal:

https://allegheny.agingsupportportal.com/Login.aspx

Under Information Library > Department Manuals > All Users: Emergency Documents

b. CM Providers must respond to public emergency situations affecting older adults in their community and deploy care managers as needed.

c. CM Provider is expected to respond within 24 hours of notification by ACDHS/AAA of public emergency in accordance with the ACDHS/AAA Emergency Plan.

d. All homebound consumers must be checked on in public emergency situations to assure their safety and mitigation of risk.

e. CM Provider visits, assesses and appropriately intervenes the same day, upon notification by ACDHS/AAA, that an emergency situation affecting a consumer exists. The care manager will document the consumer's record, within one (1) business day, that situation has been addressed. Notification by ACDHS/AAA will consist of entering an action in WellSky Aging & Disability and following up with a phone call to the CM Provider.

10. Documentation: CM Providers are responsible for entering and updating all consumer data, on an ongoing basis, into WellSky Aging & Disability.

a. CM Providers are responsible for coordinating appropriate information management system training (WellSky Aging & Disability), and the transfer of knowledge and information to current and new staff.

b. All consumer documentation must be entered into WellSky Aging & Disability within three business days after a consumer contact or transaction.

c. CM Providers are required to generate quarterly reports on the data and its impact on consumers for submission to the ACDHS/AAA.

d. CM Providers must have the capacity to retrieve and submit data, information, reports and other communication through electronic Internet capabilities within one business day of receipt. Failure to receive or read ACDHS/AAA communications sent to CM provider MPER email addresses the same day does not absolve CM Providers from knowing, responding to or complying with the directives in the communication.

e. Journal entries shall be entered for each contact with or related to the Care Management of an OPTIONS consumer. In addition to regular journal entries for each contact related to a consumer, specific Journal Entry Types shall be used and these are outlined in SAMS Care Management/CSP Manual or OPTIONS Program Appendix D from PDA.

11. Veteran's Registry: Care managers will complete required documentation to assist with Veteran's Registry inquiries, as outlined in Addendum 28 of the OPTIONS Care Management SAMS.net manual.

12. CSP: is an additional program for which OPTIONS Care Managers have responsibility. CSP provides training, respite, and support to reduce the occurrence and level of stress among caregivers. Caregivers receive financial reimbursements for legitimate caregiving expenses, home modifications and assistive devices over their time in the program. Care Managers are responsible for:
Processing monthly reimbursement data accurately into WellSky Aging & Disability by noon three business days after the 5th of the month.

    CSP monthly reports show 95% of the service deliveries and reimbursement data entered by each CM Provider is accurate.

13. Case Conferences: Case conferences are available to assist care managers, consumers, caregivers and community-based providers when appropriate, by convening a multi-disciplinary team of personnel from the ACDHS/AAA and CM Providers. Case conferences are coordinated by the ACDHS/AAA at the request of any involved party and can be conducted in a group setting or by conference call.

    100% of case conferences are held where appropriate and produce action plans to address the immediate needs of consumers and results are documented in WellSky Aging and Disability.

B. Competencies: As representatives of the ACDHS/AAA, CM Providers are expected to aspire to the highest ethical values, accountability and professionalism in all aspects of their work, beginning with the hiring of staff and through all interactions with consumers and caregivers. At the center of CM practice are three primary values:

- Build on the wisdom & strengths of older adults & those who care for them.
- Honor the individual choices made by those whom we serve.
- Respect individual diversity as it enriches the community and be inclusive in CM services.

These values are manifested through the following CM core competencies and reflect the fundamental ethics of the profession:

1. Strengths-Based Approach is the ability to respect and apply the personal strengths or assets acquired by consumers through life experiences. The strengths-based approach is not license for care managers to abdicate responsibility for assisting consumers who are unable to act on their own behalf. It is the ability to encourage and empower consumers, caregivers and their informal supports to use their own strengths and assets to meet their responsibilities, secure their rights, and achieve positive change and balance in their lives.

2. Effective Communication is the ability to use effective oral and written communication. This includes interview and active listening skills to engage and negotiate with a diverse range of consumers, caregivers, and informal support groups and organizations.

3. Identification of Needs is the ability to work in partnership with consumers, caregivers and other professionals to assess consumers' circumstances; to identify consumer and caregiver needs, risks, gaps, opportunities; and to respond appropriately. Care managers must have the skills to deal with the various circumstances encountered in their work, including basic understanding of medical issues as they relate to normal and abnormal aging, mental health issues, substance abuse, physical or cognitive disabilities and other challenges. It is the ability to provide opportunities for consumers to function; participate and develop to their highest possible level of independence in their environments.

4. Service Coordination is the ability to arrange for and coordinate the CM services necessary for the consumers' appropriate levels of care and protection through the ACDHS/AAA and other community resources. It is the ability to follow, review and monitor established CM services to assure that they continue to meet consumer needs and mitigate risk, and to amend CM services as needed.

5. Relationship Building is the ability to establish and maintain effective relationships built on a foundation of trust and respect with consumers and their caregivers.

6. Caregiver Support is the ability to engage and support caregivers with the goal of maintaining the highest level of functioning for caregivers so that they may continue to support their care receivers.

7. Financial Stewardship is the ability to understand the financial context of CM services, to enable consumers needing or receiving services to make informed decisions within this context and to use only needed resources. Care managers also should be able to balance the need for ACDHS/AAA CM services as those of last resort while having a positive outcome on consumers' lives.

8. Understanding Systems is the ability to comprehend, navigate and explain to consumers the aging services network and procedures across and within agencies, including issues related to formal and informal support systems. Care managers also should be able to guide and assist consumers with services outside of the ACDHS/AAA network, as needed.

9. Time Management is the ability to use time effectively and efficiently and to prioritize tasks accordingly.

10. Decision Making and Problem Solving is the ability to make sound decisions based on analysis, wisdom, experience and judgment. It also involves the use of logic and methods to solve complex problems.

11. Understanding of Consumer Environment is the ability to think critically and apply knowledge to understand consumers and caregivers in the context of their environment. It is the ability to adapt behavior and opinions in light of the consumer's situation and remain flexible in responding to differences.

12. Evidence-based Approach is the ability to understand and practice evidence-based (i.e., reliable, objective data) techniques when working with consumers and caregivers.

13. Continuing Education is the ability and commitment to improve skills and knowledge by engaging care managers and supervisors in professional development opportunities, including appropriate certifications and trainings. It also involves the ability to impart aging-specific knowledge to care managers by which they may expand their expertise, performance and professional development over time.

C. Consumer and Caregiver Rights: CM Providers are responsible to adhere to specific ethical standards during their interaction with consumers and caregivers. These include but are not limited to the following:

1. All consumers and caregivers must be treated in a manner that is respectful of their individual rights, interests, needs and values.

2. All consumers and caregivers must be informed of all available, appropriate CM service alternatives and made aware of the conditions of service delivery.

3. All consumers and caregivers must be fully supported in the self-direction of their strengths-based care.

4. All consumers must have the right to make final decisions about their CM services and to choose In-Home providers from ACDHS/AAA lists of contracted providers, as mandated by the PDA. In CSP, caregivers may choose any provider as long as the provider is not related to the care receiver by blood, marriage or adoption.

5. Care managers must fully support responsible consumer and caregiver rights to commend, appeal decisions, file complaints or seek additional information about their CM services by explaining how, when and where to engage in the appropriate processes.

D. Cost Containment

1. Consumers who are seeking home and community-based services and who have been assessed and determined to be NFCE and meet financial criteria must apply for MA LTSS and comply with the MA Eligibility Process by completing a PA-600L, which determines financial eligibility (not applicable to CSP).

2. If the consumer meets the criteria for MA LTSS but refuses to apply, they are responsible for 100% of the cost of their Care Plan.

3. Care Managers are to closely monitor consumers applying for CHC/Life by making monthly phone calls to the consumer following the referral to the IEB and utilizing specific Journal Types to assure that the appropriate follow-up has been made to the IEB for MA LTSS approval.

4. Care Managers can request a Cost Cap Exception Care Plan by gaining approval from their supervisor and the local AAA OPTIONS CM Department, based on the guidelines from the Chapter IV: OPTIONS. Consumer's financial situation is taken into account with poverty protection.

5. The monthly CSP Care Plan Cost Cap shall be justified and approved for all active Care Plans. Justification of the Care Plan Cost Cap shall be detailed by the care manager in the CSP Care Plan Cost Cap justification journal entry of the caregiver's consumer record.

6. Cost Share/Copay will be completed on all OPTIONS and CSP consumers except for those receiving CM only and/or In-Home Meal Service Only.

E. Coordination of Service Delivery: The CM Provider is responsible for coordinating the services necessary for the Consumers' appropriate level of care and protection through the ACDHS/AAA and other community resources. Coordination includes arranging for, reviewing and monitoring established In-Home Services, CM services and amending any services as needed in order to meet the consumers changing needs, mitigate risks and support the highest possible level of functioning and independence.

Ordering of Services

1. Availability of service hours shall be determined prior to prescribing services.

2. The consumer's care manager will contact the consumer's provider of choice with a service request.

a. For first time requests for Personal Care and Home Support, the CM Provider will enter an action into WellSky Aging & Disability. The provider coordinator will notify the care manager within three (3) business days regarding the availability of a worker. If the provider is unable to staff the prescription, the care managers will then contact the next provider and follow the same procedure until Provider Choice Form is exhausted.

b. After the consumer's Provider Choice Form selections have been exhausted then the care manager places the consumer on the Waiting List, as long as the consumer is in agreement.

c. Once the service Provider is able to service the consumer and start date of service is determined, the care managers will immediately enter the provider, service information and start date into the Service Plan in WellSky Aging & Disability. Note: The Service Plan must be completed prior to entering the Service Orders.

d. Upon completion of the Service Plan, the care managers will enter service orders. In Special Instructions, the care managers will enter the schedule of service, including specific days and units. In Comments, the care manager will outline the specific service or supply, schedule and tasks to be completed. The units should reflect the exact number of hours or number of supplies (units of service) the consumer will receive each month.

e. The CM Provider is responsible for communication with In-Home providers on all assigned CM cases including but not limited to: acknowledging missed services, entering service suspensions, timely modification of services and termination of services.

F. Community Coordination:

In order to promote and facilitate intra- and inter-agency coordination of aging services, OPTIONS CM shall include:

1. Coordination with I&A: OPTIONS care managers shall work with the ACDHS/AAA or provider's I&A unit to identify formal and informal service providers within the geographic service area.

2. Coordination with ACDHS/AAA Senior Community Center Providers: An OPTIONS care manager is available at mutually agreed upon dates, at each Community Focal Point in their geographic service area at least quarterly to consult with Senior Community Center staff and consumers about programs and services. 100% benchmark is required. This is recorded on quarterly reports from CM providers.

G. In-Home Meal Service: To be eligible for this service, an individual shall demonstrate a nutritional need and the need shall be documented in the NAT (or NAT-E for consumers who receive In-Home Meals only). The consumer may have nutritional needs such as, but not limited to, the inability to obtain food or prepare meals due to a physical or cognitive disability, lack of resources (money) for meals or absence of someone willing or able to prepare meals for them as evidenced by the completed NAT (or NAT-E).

For In-Home Meal Service-Only Consumers, the CM Provider approves eligibility, and the care manager will:

- Complete a NAT-E initially and annually.
- Care Manager will complete two-week follow-up (specific Journal Type) after the service has been ordered.
- All OPTIONS consumers, after the initial home visit, must receive a 3-month contact and a 9-month contact.
- All OPTIONS consumers must receive a 6-month home visit.
- All OPTIONS consumers must receive a 12 month-Annual Reassessment visit.
- Enter service orders through a Care Plan/Service Plan.
- Process changes in consumer's status accordingly.

CM provider will also respond to any emergency situations for these consumers.

H. Waiting List:

1. When a waiting list is necessary, it will include new consumers and existing consumers:

   a. Who are waiting for an increase of services and/or a new service added to their plan.

   b. When a consumer is eligible for personal care and/or home support and no contractual provider has an available worker.

2. Consumers with the same NAS score will be ranked by the date of completion of their last NAT.

3. In CSP, wait lists will apply to enrollment, home modification, assistive devices. Enrollment will be based on the CAS score generated by the CAT.

I. Reduction, Suspension and Termination of Services: CM services may be discontinued temporarily because consumers are in the hospital, consumer needs are temporarily being met by another source of support, consumers are temporarily out of town, or are placed in a personal care, nursing or

rehabilitation facility. Consumers whose CM services are suspended for more than forty-five (45) days "terminated" and re-entered at the appropriate time. For disputes, the OPTIONS care manager will follow the appeal process. The Hearings and Appeals chapter is outlined in the Aging Services Policy & Procedure Manual.

J. Involvement of Consumers in Research

Individuals receiving services pursuant to this contract may not be involved as subjects in any research associated with those services without the prior consent of the DHS Data and Research Privacy Board (hereafter known as Privacy Board). This includes research projects engaged in by DHS providers as well as projects undertaken by provider sub-contractors and/or any entity (e.g., university, research organization) requesting consumer participation in such research. Any provider or entity wishing to engage in human subject research with DHS clients as subjects must submit a request to the Privacy Board at DHS-Research@alleghenycounty.us. More information and relevant forms can be found at https://www.alleghenycountyanalytics.us/index.php/requesting-data/.

Research projects must adhere to all best practices in human subject research, including informed individual consent and confidentiality, as well as all applicable laws, and, in most cases, will require documentation of Institutional Review Board (IRB) or equivalent approval.

K. Confidentiality CM Providers are responsible for implementing all necessary procedures and safeguards to protect and maintain the integrity and confidentiality of all verbal, written and electronic consumer and caregiver data according to applicable federal HIPAA standards. CM Providers are liable to criminal or civil penalties for breaches of consumer confidentiality.

L. Geographic Service Area

Service shall be provided only to individuals residing within the contracted service area except in circumstances specified below. For CSP, the service area is where the care receiver resides.

ACDHS/AAA reserves the right to require the provider to serve individuals residing outside the contracted service area to meet special needs or circumstances. The provider may serve individuals residing outside the contracted service area to meet special needs or circumstances only with prior ACDHS/AAA approval.

M. Hours of Operation: CM Providers are required to submit to the AAA written protocols for contacting key personnel both during operating hours and after hours.

1. At least one professional staff member shall be available in the office during the CM Provider's normal hours of operation.

2. After normal hours, a recorded phone message shall be in place to advise callers of emergency or crisis intervention procedures. In addition, building signage and contact information on the CM Provider web site must be posted.

3. An administrative or professional staff person shall be available on call when the CM Provider's offices are closed.

4. CM Providers must address the needs of caregivers and consumers who are not able to consult with care managers during normal working hours.

5. CM Providers shall submit annually to the ACDHS/AAA written documentation of their hours of operation and a list of holidays/closures.

6. CM Providers shall develop and maintain a detailed, written contingency plan outlining emergency operation and closure procedures and submit an updated copy to the ACDHS/AAA by the last business day of August, during the term of any agreement with ACDHS/AAA. The contingency plans will include specific details about how communication between the CM Providers and the ACDHS/AAA will occur with timelines and lines of responsibility specified. The CM Providers Emergency Plan is current, actionable, routinely updated, practiced, followed and in compliance with ACDHS/AAA Emergency Response Plan.

N. Contingency Funds:

1. Funds shall be budgeted for emergency placement, clothing, food, and health and safe environment, purchase of temporary service and needed reports of diagnostic assessments/evaluations for OPTIONS consumers.

2. Allocation for funds is determined by ACDHS/AAA. ACDHS/AAA reserves the right to use these funds in emergency situations.

3. It is prohibited to use contingency funds for staff training and travel expenses.

O. Documentation (hard copy/scanned): All financial records, supporting documents and other consumer records shall be retained for four (4) years after case closures or until all litigation, claims or audits have been resolved and final actions taken. Records may be stored in hard copy or electronic storage media or scanned and attached to consumer records within WellSky

Aging & Disability. Records must be available to ACDHS/AAA to view for monitoring or auditing purposes. For CSP, all documents are now required to be scanned; therefore there is no need to also have hard copies. All hard copy records prior to July 1, 2018 must be destroyed when purged. Consumer records are the property of ACDHS/AAA and must be returned to ACDHS/AAA within 5 days upon termination of the contract. Providers must have a written policy that hard or scanned copies of financial records, supporting documents and other consumer records are kept on file for four (4) years after case closure or until all litigation, claims or audits have been resolved and final actions taken.

A hard copy or scanned attachment in WellSky Aging & Disability of the following CM Consumer documents must be kept on file:

1. All correspondence to, from, or about the CM Consumer

2. Follow-up documentation including written complaints and resolutions of service delivery problems

The following must be scanned and attached to a consumer record for OPTIONS cases:

1. Sign Care Plan Report/Notification of Right to Appeal

2. Voter Preference Form – 100% of consumers and caregivers are asked if they are registered to vote.

3. HIPAA Form

4. Provider Choice Form

5. Cost Share financial documentation

6. Home Modification Estimates (including Stair Ride installation)

7. Landlord Approval agreement for Home Modifications

8. Insurance Denials for Supplies, Nutritional Supplements and Home Health services

9. Physician’s scripts for Supplies and Nutritional Supplements

10. Power of Attorney

11. Release of Information form

In CSP, electronic copies of the following documents must be attached to the caregiver record in WellSky Aging & Disability, as well as any relevant documentation:

1. Financial verification.
2. Certification of Accountability with the caregiver signature for CSP Caregiver form.
3. Service Plan Agreement.
4. Notice of Appeal Rights.
5. Voter's Preference Form.
6. All receipts of reimbursed caregiving-related expenses for CSP Consumers.
7. Caregiver Reimbursement for Services and Supplies.
8. Caregiver Reimbursement for PC and In-Home Respite Services.
9. PNC Debit Card Application form.
10. Self-Employed/Independent Contractor declaration form.
11. Insurance denials, if applicable.
12. Acceptable bids for Home Modification and Landlord approval, if applicable.

P. Minimum Systems Requirements: The PDA mandates the use of WellSky Aging & Disability as the consumer database for the CM Program. CM Providers must utilize the WellSky Aging & Disability database. Workstations that access Aging & Disability must meet the minimum system requirements:

- Processor: 2.0 Ghz processing or better
- RAM: 4 GB (Minimum) / 8 GB (recommended)

  Note: The greater number of applications running concurrently on your workstation, the more RAM is required to ensure optimal performance.
- Screen Resolution: Minimum 1024x768 (1280x1024 is ideal)
- Internet Access: 40 -45 KB/s (kilobytes per second for each concurrent user)

  Note: WellSky does not support dial-up access
- Microsoft Silverlight: Silverlight version 5.1.30214.0 and higher
- Maximum Latency: 100ms or less round trip
- Other Add-Ons:
  - Adobe Reader: Required for viewing/printing PDF files
  - Adobe Flash Player: Required for On-Demand trainings

- Supported Internet Browsers:
    - Older versions of internet Explorer may function with WellSky products, but they will not receive updates from Microsoft. If a problem with a WellSky application is reported on an unsupported version of Internet Explorer, WellSky will make a best effort to address this issue, but if the problem is related to a documented browser or OS issue, we will recommend upgrading to Internet Explorer 11. Only compatible until June 15, 2022, when Internet Explorer end-of-life will occur.
    - Microsoft Edge browser configured to be in “IE Mode”
- E-mail capability

Q. System Updates: CM Providers must have the capability to respond to any changes in WellSky Aging & Disability requirements indicated by the ACDHS/AAA or PDA during the term of the contract.

R. Organizational Changes

In cases where CM agency changes ownership or undergoes a major restructuring, including major changes to the submitted organizational chart or acquisition of another entity, such change must be reported in writing to the ACDHS/AAA 30 days prior to the change or in urgent circumstances within 48 hours of confirmation of the change. Major organizational changes may result in the ACDHS/AAA conducting a full on-site review to assess continued adherence to the terms of the contract for CM services under the CM Providers new structure. Continuation of the contract with ACDHS/AAA is contingent on a finding of the on-site review that the terms of the contract will be adhered to under the change or restructuring.

S. Personnel Requirements and Qualifications

1. Care Managers are members of multi-disciplinary teams that provide community-based services to consumers and caregivers within a defined geographic area. Care managers assess, plan, implement and evaluate needs and services. Care managers also assist consumers and caregivers in identifying, securing, negotiating and coordinating the application of resources. The primary function of care managers is to aid consumers in continuing to mitigate risk and live in their homes for as long as they are able and choose to do so. Care managers work with consumers and caregivers to cope with or resolve social, emotional, environmental and other problems or issues that may compromise their capacity to function as well as possible according to their preferences.

In doing so, care managers mobilize and draw on the personal resources and strengths of consumers, caregivers and families, as well as those of the external community to help consumers achieve the outcomes that they have set for themselves.

Minimum qualifications for care managers include the following:

a. Bachelor of Science or Arts degree.

b. Ability to work independently.

c. Ability to coordinate consumer appointments and travel scheduling efficiently and report allowable expenses and billable hours accurately.

d. Proficiency in the use of a personal computer or laptop with MS Office Suite software, cell (smart) phone and the Internet.

e. Additional desired qualifications include at least one year of case management experience in human services, working knowledge of the provision of health care in various settings, and knowledge of community resources and care delivery systems.

2. CM Supervisors lead multi-disciplinary teams that provide community-based services to consumers within defined geographic areas. CM Supervisors oversee care managers who assist consumers and caregivers in identifying, securing, negotiating and coordinating the application of resources.

CM Supervisors perform a number of functions within CM teams. These functions include, but are not limited to the following:

a. Train and supervise new and current CM staff, and plan, assign, review and evaluate their work.

b. Review, approve and sign off on case records and service plans.

c. Assess the professional development, learning patterns and performance of subordinate staff, and assist them in developing social work skills.

d. Assign work consistent with organizational policies and priorities, and the capabilities of subordinate staff.

e. Determine procedures for resolving problems and issues according to sound case work practices and departmental policies.

f. Confirm the eligibility for services of potential Consumers and take responsibility for final decisions to accept or terminate Consumers from programs.

g. Develop procedures and controls to accomplish work within the framework of established laws, policies and priorities.

h. Conduct group and individual conferences with staff to discuss assignments, the status of current cases, rules, regulations, policies and laws.

i. Maintain records on work quality and quantity.

j. Coordinate staff scheduling (including emergency, on-call and back-up coverage) and work with other units, evaluate staff performance and administer corrective actions.

k. Prepare reports, correspondence and other communications, and perform research.

l. Represent the unit in relationships with other internal units and external organizations.

m. Evaluate policies and procedures and make recommendations to CM supervisors and administrators to improve programs.

n. Participate in the development of community resources and CM services.

o. The CM Direct Supervisor (to staff) carries no permanent caseload or has three or fewer consumers and has job responsibilities that are predominately within the CM unit only.

CM Supervisors must have all of the competencies required of care managers. They must demonstrate leadership qualities and abilities. In addition to the CM competencies indicated above, CM supervisors must possess the following minimum qualifications:

i. A Bachelor of Science or Arts degree and at least two years of CM experience.
ii. Additional desired qualifications include an advanced degree in social services, psychology, social work or a related discipline, and leadership training and experience in Continuous Quality Improvement or Quality Assurance programs.

3. <u>CM Personnel Changes</u>: The ACDHS/AAA CM unit shall be notified by email within five (5) business days of any changes for CM supervisors and changes to care managers can be reported in the quarterly report.

4. Professional Consultation and Additional Expertise: CM Providers must be able to call upon external professionals to provide consultation and services in areas beyond the expertise or experience of internal CM staff (e.g., nursing, community resources, physical and occupational therapy, behavioral health and intellectual disabilities, substance abuse, financial affairs, caregiving, physical medicine, etc.).

T. Criminal History Information

1. Provider will require applicants to submit to a Pennsylvania State Police background check using the PA Access to Criminal History at https://epatch.state.pa.us. Substitute clearances are not acceptable. The report must be dated within one (1) year prior to their employment start date.

2. Applicants applying for employment as a member of the office staff and owner/owners are also required to obtain a criminal history report.

3. If an applicant supplies their own Pennsylvania State Police background check, Provider must then access and print the report from https://epatch.state.pa.us, and place it into the personnel file. The report must be dated within one (1) year prior to their employment start date.

4. All requests for FBI background checks must be made directly through IdentoGO at www.identogo.com/locations/pennsylvania . In addition, applicants who have not been PA residents for two (2) consecutive years, without interruption and immediately preceding the date of application for employment, must obtain original PA Department of Aging FBI background check from IdentoGO in addition to the PSP background check from epatch.

5. Results from the FBI background check will be sent directly to the applicant with instructions to the applicant to show the results to the agency or facility at which they have applied for employment.

6. If either the epatch or the FBI background check result in positive findings, then the agency or facility must consider the following factors in the hiring decision:

   a. nature of the crime
   b. facts surrounding the conviction
   c. time elapsed since the conviction
   d. evidence of individual's rehabilitation
   e. nature and requirements of the job.

Documentation of consideration of these factors must be included in the employee's personnel file. The review must be dated and signed by both the Provider's Management staff representative and applicant confirming the completion and discussion of the analysis.

U. The agency or facility will make the final employment determination on all applicants.

Note: Staff may not directly work with Consumers until the appropriate criminal history clearance/clearances are received and documented in their personnel file.

V. Database Training: CM Providers should have an adequate number of staff trained on WellSky Aging & Disability so that service documentation is not disrupted in the event of the departure of WellSky Aging & Disability-trained staff from the employment of CM Providers.

W. Staff Training: All new CM staff are expected to successfully complete ACDHS/AAA CM training (Tier 1 or 2) or equivalent (as determined by the ACDHS/AAA and CM Provider) within the first six (6) months of employment.

1. Within three (3) months all new CM supervisors must complete the supervisor module or equivalent.

2. CM Providers are also expected to have active staff development programs in place.

3. All CM provider staff who complete CM assessments or reassessments must participate in state mandated semi-annual training on Voter Registration Procedures.

4. All service provider staff who complete CM assessments must complete necessary training as required by PA Dept. of Aging.

VI. RESPONSIBILITIES/EXPECTATIONS OF THE PROGRAM OFFICE (ACDHS/AAA)

ACDHS/AAA will support the service provider in meeting service standards and requirements by providing the following:

A. Developing interim program policies and procedures to meet all Pennsylvania Department of Aging and local requirements during the life of this contract.

B. Program Monitoring and evaluation to assure compliance with the specifications and terms of this contract.

C. Developing all intake, assessment and reporting forms to be used for this contract.

D. Specifying procedures for initiation and termination of service.

E. ACDHS/AAA Care Coordination Division provides an OPTIONS Care Management SAMS.net Procedure Manual.

F. Technical assistance as needed regarding program requirements.

G. Technical assistance, direction and cooperation to assist the service provider in satisfactorily recording program and service data into the appropriate information management system (WellSky Aging & Disability).