SOURCE

PART II

POLICIES AND PROCEDURES

for

Services Options Using Resources in Community Environments

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: April 1, 2016

Policy Revisions Record

Part II Policies and Procedures Manual for SOURCE Services

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)	Reason for change
1/2016	904	**Routine Reevaluations/ Reassessments** **plete Re Evaluation Packets)** ***r the sentence that states:*** "Source members are evaluated for continued eligibility at least annually, and more often as necessary (e.g. improvements, as directed by GMCF, as directed by DCH). " *Transfers excluded from this statement*	D	N/A	Consistency in policy
1/2016	905 Modified Reevaluation/ Readmission into SOURCE	Members with a greater than 3 month LOC do not have to have an evaluation packet submitted to GMCF. If a transfer, submit appendix X	A A	N/A	Relieve burden on CM agency
1/2016	905 Modified Reevaluation/ Readmission into SOURCE	Members who meet certain requirements, may qualify for a modified evaluation packet.	A	N/A	As above
1/2016	Section 904 and Appendix QQ	New form/ form requirements for Modified reevaluation	A	N/A	Assist in clarification of new policy
1/2016	1406 Right to appeal	If agency discharges a member, and member appeals, GMCF requires the evaluation packet to be uploaded to GMCF to extend the LOC thru the hearing process. Clearly ID packet as agency denied	A	N/A	GMCF requirement
4/2016	701. Eligible Members	Need to determine eligibility factors annually or more often	A	N/A	Clarification
4/2016	1404	Removed all references to notify DCH with an appendix F for member discharges…	D	N/A	No longer applicable
4/2016	Appendix F Provisional Level of Care	Provisional Level of Care removed. This process no longer applicable with newly implemented PA Service process	D	N/A	N/A for program
4/2016	Appendix Z (pages 6 and 7)	Forms updated for discharge planning and any References in manual to Appendix Z specific pages updated to reflect new documents	M/A	N/A	update
4/2016	Appendix Z page 6	Form needed for legal updated	M	N/A	update
4/2016	1404.Member Discharge	*Discharge **Planning** Policy Statement added and*	A	N/A	Consistency

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4/2016	1404 Member Discharge	Reinforcement of steps for discharge planning: Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix - 8 to be filed in the member's chart.	A	N/A	
4/2016	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 b) Complete / Review Discharge Planning (see Appendices) for new members, reassessed and discharging members	A	N/A	
4/2016	Appendix H	New SOP for provision of resources to members with an involuntary discharge and follow up with member	A	N/A	Continuity
4/2016	Appendix BB	Discharge planning information added	A	N/A	Consistency
4/2016	1405 SOURCE MEMBER INVOLUNTARY DISCHARGE	2 The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program	A	N/A	Member help
4/2016	1406. Right to Appeal	**Procedures after decision of non-eligibility :** a 2nd level review option will be present in the GMCF letter to members. How it works is described.	A	N/A	Member help
4/2016	Appendix MM	**How to attach the new information to GMCF in a 2nd level appeal**	A	N/A	Member help
4/2016	APPENDIX LL GMCF	*Provider Workspace User Manual* that will show SOURCE Providers how to submit Second Level Reviews/ Reconsiderations. How providers should submit additional documentation for Second Level Review/ Reconsideration via the Reconsideration Link ONLY.	A	N/A	Program advance

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PREFACE

Policies and procedures in this manual apply to all SOURCE Case Management Providers. All service 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 Providers 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.

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.**

Rev. 10/09

DON-R- The Screening tool entitled Determination of Need- Revised**.**

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.

GMCF- Georgia Medical Care Foundation, medical management vendor, subcontractor of DCH.

MDS-HC – Minimum Data Set Health Care – A Home and Community standardized assessment tool 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 service 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 ensuring proper implementation of 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.**

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01/12

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

EPCCM – abbreviation for Enhanced Primary Care Case Management

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

601. Introduction to SOURCE

SOURCE operates under authority of the Elderly and Disabled 1915-c Home and Community Based Services (HCBSS) Medicaid Waiver approved by the Centers for Medicare and Medicaid Services (CMS). Individuals eligible for enrollment in SOURCE must be eligible for full Medicaid (this excludes SLMB, QMB, and QI). 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 Case Management Provider is enrolled 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 coordination of medical and long term support services
d) Increasing the cost-efficiency and value of Medicaid Long Term Care (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 implements 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.

b) 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 Provider 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.

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 DCH address problems for chronic care populations

605. Partnership with DCH

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 due on the 15th of the month following the reporting period
c) Compliance with quality assurance protocols for waiver programs developed for CMS by DCH

DCH maintains oversight of all program components and reserves the right to give final approval of all aspects of the program including determination of eligibility and ILOC.

606. Enrolling as a SOURCE Enhanced Case Management Provider

Due to the complex nature of SOURCE and the fragility of the population, only established businesses with a history of providing case management may enroll. Other stipulations are as follow below and in Appendix FF

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.

Enrollment for EPCCM requires completion of the Medicaid enrollment application located at the HP web portal www.mmis.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.

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 HP website: mmis.georgia.gov

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- 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) that the Department of Community Health (DCH) has denied the application.
- DCH will conduct site visits, if applicable. If the site visit results in unsatisfactory review, DCH will deny the enrollment application.
- 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.

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

607. Expansion Procedures

Rev 04/08

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)

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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.

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 07/13

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. Letter of Intent is no longer required.

C. Providers must complete the following enrollment steps:

- Complete the Facility Enrollment Application located on the HP website: mmis.georgia.gov

- Attach the following documentation with the Facility enrollment application:

--**See checklist in Appendix II for needed documentation**

- Mail the completed provider enrollment application to 2 Peachtree Street N.W.
- 37th floor c/o SOURCE Program
- Atlanta, GA 30017
- Or scan and email to tunderwood@dch.ga.gov or lstewart@dch.ga.gov (SOURCE enrollment in subject line)

B. DCH will review the SOURCE Provider application**s** 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.

C. DCH will distribute the Community Service Provider's information to appropriate SOURCE agencies in applicable counties to be placed on their rotation log.
D. Once Community Service Providers have a SOURCE member, the provider must attend regular conferencing with SOURCE and other contract expectations as outlined in this manual and CCSP.
E. Non-compliance maybe associated with suspension or removal from the rotation log/list

701. Eligible Members

Rev. 07/16

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SOURCE operates under authority of the Georgia Elderly and Disabled 1915c Medicaid Waiver. For core waiver requirements see section 801.3-- The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home Level of Care (LOC). Eligibility factors must be met annually or more often per guidelines in this manual, referenced manuals and the federal Waiver.

a) Aged 65 and older, or under 65 and physically disabled
b) Receiving full Medicaid (this excludes SLMB, QMB, QI)
c) Eligible based on meeting criteria for Intermediate Nursing Home Level of Care
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)

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Member General Exclusions

- Members currently enrolled as members in the Georgia Families program (this is not the Georgia 360^0 program)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the PRTF program
- Members of a federally- recognized Indian Tribe
- Qualified Medicare Beneficiaries (QMBs) without SSI (or full Medicaid);
- SLMB or QI without SSI (or full Medicaid)
- Members Residing in an Institution
- Members not meeting eligibility requirements

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- Programs or Waivers that would cause duplication of services*

***Dual Waiver Enrollment Exclusions and Allowances**:

In some instances, SOURCE members are allowed to participate in more than one waiver or program. There are still some Waiver and program exclusions. In the instance where a member would need to choose, individuals have the option of transfer from one waiver to another, contingent upon eligibility and available funding.

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Exclusions from enrolling in two Waivers/Programs:

A member enrolled in SOURCE cannot receive duplicate services. Medicaid Waiver Programs that would cause duplication of services or excluded.

Waivers or programs where the member would need to be enrolled as an inpatient/ or in an institution are excluded from SOURCE.

All members considered for SOURCE must meet all SOURCE eligibility requirements.

Examples of 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 inpatient, intermediate care facilities for people with developmental disabilities, or correctional institutions
- CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs members are excluded

Allowances:

The SOURCE agency continues to assume full responsibility for the professional management of the individual's SOURCE care in accordance with the SOURCE manual. When an individual enrolled in SOURCE elects a second program or when an individual in another non excluded program elects SOURCE: See lists below for allowances:

- SOURCE dual enrollment in GAPP may be permitted
  Please refer to the GAPP manual for more information
- SOURCE dual enrollment in Hospice may be permitted without duplication of services.
  PSS services and Skilled Nursing are not a covered service from the SOURCE provider.
  An individual or a child currently enrolled in a Medicaid waiver program that is diagnosed with a terminal illness may elect to enroll in the Hospice program Please see Community Care Services General Manual section 901 Covered Services for more information

- Children Receiving Services under Title V/CMS without duplication of Services may be permitted

  Caution should be given for children in this category, member must demonstrate all eligibility requirements including a need for SOURCE services.

Procedure for Dual Enrollment:

If dual enrollment is desired by the member and meets the guidelines above (and of course all eligibility requirements) the agency should follow these procedures:

A) The member's SOURCE team and the 2nd program's case manager and member **must** communicate, establish, and agree upon a coordinated plan of care for both providers that prevents duplication of services. Distinct Case management services must be agreed upon to be given by each CM agency. Information on these areas is documented at the beginning of the relationship and quarterly. More frequent communication should be documented if the need arises.

B) Both companies must keep records that indicate: that multiple Medicaid plans of care have been coordinated. Failure to demonstrate this coordination will be considered a failure to comply with the terms of this policy. As such, lack of evidence of coordinated care in documentation will result in a terminated lock-in and any paid claims for services will be subject to recoupment.

C) If Hospice is the designated 2nd program, the hospice agency MUST be the provider of the skilled nursing and personal support services. SOURCE may provide extended personal support services (in-home respite).If SOURCE member is in a PCH, the PCH must continue to give all care and not designate the normal care of a member to the Waiver such as hospice

D) All hospice services must continue to be provided directly by hospice employees. The services cannot be delegated. When the member is in a waiver program residential facility (SOURCE Personal Care Home), the hospice agency may involve the facility staff in assisting the administration of prescribed therapies that are included in the plan of care; this is only to the extent that the hospice would routinely utilize the service of the patient's family/caregiver in implementing the plan of care.

E) When the member is a resident in a waiver program's residential facility, the facility must continue to offer the same services to the individual that elects the hospice benefit. The hospice member should not experience any lack of facility services because of his/her status as a hospice member.

Rev 04/09

The following activities are not allowed by SOURCE providers of any type:

SOLICITATION OF MEMBERS FOR THE SOURCE PROGRAM
This includes:

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

Neither SOURCE case management providers nor HBCS providers shall solicit Medicaid members for the purpose of SOURCE following the policy outlined in:
Part I, Policies and Procedures for Medicaid/Peachcare for Kids-- which all Medicaid providers agree to follow. The policy states:

> *106. General Conditions of Participation*
>
> *E) Not contact, provide gratuities or advertise "free" services to Medicaid or PeachCare for Kids members for the purpose of soliciting members' requests for services. Any activity such as obtaining a list of Medicaid or PeachCare for Kids members or canvassing neighborhoods (or offices) for direct contact with Medicaid or PeachCare for Kids members is prohibited. Any offer or payment of remuneration, whether direct, indirect, overt, covert, in cash or in kind, in return for the referral of a Medicaid or PeachCare for Kids member is also prohibited. It is not the intent of this provision to interfere with the normal pattern of quality medical care that results in follow-up treatment. Direct contact of patients for follow-up visits is not considered solicitation, nor is an acknowledgment that the provider accepts Medicaid/PeachCare for Kids patients.*

801 – Levels of Care

801.1 Carepath Levels

a) All members are assigned Carepath level I. Indicate if members has intensifying needs for medical monitoring and assistance in the carepath.
b) On the Care Path signature page, indicate if member has functional impairments due to physical disability and / or cognitive impairment. Give Prior Authorization dates, Disease Management information, and signatures as indicated

Note, members will be moved to single care path of Care Path Level I, upon full evaluations starting July 2015

801.2 Level Of Care Criteria

a) The Intermediate Level Of Care (LOC) determination for SOURCE is based on: the medical criteria used by Department of Community Health (DCH), Division of Medicaid to establish an individual's LOC certification for nursing facility placement. SOURCE members must meet the Level of Care criteria for Intermediate Nursing Home Placement (see 801.3). Level of care determination is a function of the assessment process which includes: the SOURCE RN/LPN, through the use of the MDS-HC (v-9), Level of Care criteria (Appendix I), and professional judgment, gives a preliminary determination of Level of Care (LOC) for members during the assessment process.
b) GMCF or DCH gives final approval on all members for an active Level of Care.
c) Assessments and re-assessments completed by the LPN **must** be signed and certified by the designated RN within 10 business days of completion.

Rev. 01/09

d) SOURCE services rendered to a member will be ordered by a physician and listed on the Carepath and Appendix F (level of care and placement instrument). The Primary Care Physician/Medical Director's signature orders the services listed on the Appendix F.

Rev. 07/13

e) 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), approved by GMCF(all members as of 9/30/2013), and affirmed by the completed MDS-HC (v9) assessment.

f) Members must meet all SOURCE eligibility criteria to participate in the program.

Rev. 04/15; 10/12 01/09,

g) Each qualifying SOURCE member is given an approved LOC certification for SOURCE program participation by GMCF. A LOC certification is approved for no more than 12 months (usually 365 days). Members approved for a length of stay less than one year require assessment at least 30 days prior to the expiration of the LOC in order to re-determine eligibility for the Program.

h) The GMCF Prior Authorization effective date is to be the LOS start date on the "Appendix F" LOC form, the GMCF expiration date is to be the LOS end date

Rev. 04/10, 07/10

As of 8/1/2012, approved LOC with enrollment date (Prior Authorization date) will be issued by GMCF for all newly admitted SOURCE members; as of 9/30/2013 approved LOC with enrollment date will be issued by GMCF for all reassessments/ re-evaluations.

Rev. 04/15

07/13

Note: DCH maintains oversight of all program components and reserves the right to give final approval on all aspects of the program including eligibility and ILOC. DCH may extend LOC with legal documents or provisional level of care document. This may be especially necessary during the months when transitioning from MMIS locks to Prior Approval system.

Rev. 10/11

801.3 For Source, the eligible individual will meet the target population guidelines and Intermediate Nursing Home LOC:

The target population for SOURCE is physically disabled individuals who are functionally impaired or who have acquired a cognitive loss that results in need of services to assist with the performance of the activities of daily living (ADLs). All individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE:

Summary for Intermediate Nursing home LEVEL OF CARE CRITERIA and SOURCE Program guidelines (use to interpret Appendix I):

1. Services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND either a mental/ cognitive (column B) and/or functional impairment that would prevent self-execution of the required nursing care (Column C Functional Status).

2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric or related to a developmental disability rather than medical need. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

Use the following table to assist with Appendix F and I for SOURCE clients:

To meet an intermediate nursing home level of care the individual must meet item # 1 in Column A AND one other item in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C)

Items in red are interpretive guidelines for SOURCE eligibility.

COLUMN A Medical Status	COLUMN B Mental Status (must include a cognitive loss) rev. 04/11 Mental Status impairment with etiologic diagnosis not related to a developmental disability or mental illness The mental status must be such that the cognitive loss is more than occasional forgetfulness	Column C Functional Status impairment with etiologic diagnosis not related to a developmental disability or mental illness
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the	1. Documented short or long-term memory deficits with etiologic diagnosis such that it interferes significantly with the activities of	1. Transfer and locomotion performance of resident requires limited/extensive assistance by

criteria listed immediately above, the patient's specific medical condition must require any of the following (2-8) plus one item from Column B or C. 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive 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 (less than five (5) times weekly for SOURCE). 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.	daily living. Cognitive loss must also be addressed on MDS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis as above for daily decision making such that it interferes significantly with the activities of daily living. 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 such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia such that it interferes significantly with the activities of daily living. Cognitive loss must also be addressed.	staff through help or one-person physical assist. 2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help 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).

Procedures once 'slot' is available for member:

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1) Complete MDS-HC with member
2) Obtain member signature on the SOURCE Level of Care and Placement Form (Appendix F)
3) Forward all material as requested by GMCF, to GMCF per web portal.
4) IF GMCF validates/confirms Level of Care then give the MDS-HC document, placement form and all assessment documents and member information to the multidisciplinary

team meeting with the Medical Director (physician) (see section 903 if ILOC is not confirmed).

5) If physician agrees that member meets the definition in section 801.3 including ILOC, physician signs SOURCE Level of Care and Placement Form
6) the agency RN certifies the definition in section 801.3 including ILOC by his/her signature on the SOURCE Level of Care Placement Form

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

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

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 Provider 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 Providers and CMs

e) Accessibility of PCP to case management staff, as needed

f) Reliance by Primary Care Provider 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 Provider 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. 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 the HCBS services ordered, frequency and duration as indicated by the MDS-HC assessment tool, signing the APPENDIX F form for new members, and reassessments, at least annually.
f) Confirm ongoing eligibility for members requiring reassessment to include continuation of level of care eligibility criteria.
g) Confirm and sign APPENDIX F when member fails to meet nursing home Level of Care and requires discharge

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h) Review service delivery issues
i) Review repeated hospital encounters for individual members
j) Review issues of chronic non-compliance
k) Review Carepath variances as requested by case management staff
l) Review discharges to nursing homes, prior to the date of discharge
m) Review utilization data
n) Review complex referrals

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804 <u>Case Management</u>

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 may 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.

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- 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).**

805 Case Management Supervision

In supporting 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 the 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

c) Review new admissions and confirm/verify the care path and need for HCBS services, along with service type, frequency and duration
d) Complete / Review Discharge Planning (see Appendices) for new members, reassessed and discharging members
e) Authorize service plans for ongoing members
f) Develop site-specific policies and procedures
g) Track and analyze repeated hospital encounters for individuals
h) Hear issues of non-compliance and involuntary discharge

i) Review chronic Carepath variances and potential nursing home discharges
j) Review provider or service delivery complications
k) Review discharges to nursing homes, prior to the date of discharge
l) Review utilization data
m) Review complex referrals

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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 member meets the definition in 801.3 for a new member's initial assessment 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 Providers

All community services providers must first be enrolled under CCSP and must comply with CCSP policies and procedures unless indicated otherwise in this manual. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Providers will need to enroll in SOURCE per directions found in section 608. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members. SOURCE emphasizes the provider role in achieving outcomes associated with community residence and optimal health status for SOURCE members. This is accomplished by working closely with the Care Management agency and remaining compliant with current policy. When contacted by the SOURCE Case Management Agency and a client is brokered, the provider must abide by all SOURCE rules and conditions, including maintaining current on CCSP policy.

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)

Community services primarily offer assistance to members in activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Self-care and informal sources are first maximized before accessing HCBS

in SOURCE. 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 HP Website: www.mmis.georgia.gov

Key characteristics of the SOURCE provider role (and used for provider compliance) :

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* (may use for other providers as desires)
k) External Care Coordination Complaint log will be maintained for all providers
l) Internal and External Complaint log will be maintained for the providers that don't receive score cards
m) Monthly Score and Complaint log will be used for Corrective Action
n) An active 24-hour on-call service that coordinates dependably with Case Manager and members/Caregiver

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

901. SCREENING

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Potential SOURCE members will be screened to determine likely eligibility using the Determination of Need – Revised (DON-R) screening tool. The tool was designed and validated for use in telephonic screening and provides a method for prioritizing SOURCE applicants for admission. SOURCE screening is performed by the SOURCE Enhanced Case Management agencies, usually at the time of applicant inquiry by telephone. Screening is conducted by phone or can be conducted face to face in the case of difficult to screen individuals (those with communication impairment, no telephone, or cognitive impairment). 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 documented using the DON-R tool along with the SOURCE screening form used for collection of demographic data (Appendix C).

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b) Medicaid Eligibility: Screening staff will access the GAMMIS 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.

c) Functional Eligibility: Full screening is 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). All telephone screening is only considered complete when performed using the Determination of Need – Revised assessment tool attached at Appendix KK.

d) Depending upon availability of SOURCE benefit funds, applicants who have been telephone screened and determined eligible for the Program may have to be placed on a waiting list for full assessment. When placed on a waiting list, an applicant will be advised of his right to be re-screened if his functional need or status changes. In the absence of applicant-initiated contact, applicants will be rescreened by the SOURCE EPCCM agency that conducted the first

screening using telephone contact and re-administration of the DON-R every 120 days if held on the waiting list.

e) In the case of wait lists for SOURCE admission, the EPCCM Agency sends the completed DON-R with legible demographic information to the DCH Program Specialist via facsimile or use of the www.source.dch.ga.gov e-mail address via secure method of transmission.

f) For those meeting SOURCE Medicaid eligibility criteria and wishing to pursue enrollment, information gathered from the screening will be used to determine admission priority and returned to the submitting EPCCM Agency to schedule assessment as program slots are available. In the case of a waiting list, those with the highest level of need as identified through use of the DON-R are admitted to the SOURCE Program.

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902. ASSESSMENT

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All persons who meet screening requirements for SOURCE, and program slots are available will be formally assessed in their homes by the EPCCM 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:

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.

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c) Gather data regarding the population served by the program, for Division of Medicaid 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.

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

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b) Member is currently residing in a nursing home

d) Some member assessments may go through Provisional Level of Care Policy/Procedures, See Appendix F section labeled DCH Issued Provisional Level of Care.

Procedures:

a) Following screening and slot allocations, within 30 days, the case management staff schedules the initial assessment.

b) A Case Manager or a nurse may complete the Assessment Addendum Form;

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c) Nurses will assess all potential members using the MDS-HC (v9) assessment tool and determine eligibility for the Program based on ILOC criteria and need for community-based services.

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

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e) Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment.

f) Applicants who meet ILOC but have all needs met by informal supporters are not appropriate for admission to SOURCE.

g) 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.

h) 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
Note: Individuals who are wards under legal guardianship procedures may not enroll themselves in the SOURCE Program nor sign program-related documents

i) 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.

j) The Case Manager or nurse will review the program's operations with the potential member following the assessment, including selection of the site as primary care provider.

k) 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.

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(2) Consent for Enrollment form signed at admission.

(3) Records Release Authorization signed at admission and at reassessment, at least annually. Rev. 10/09, 07/10

(4) SOURCE Level of Care and Placement form, formally selecting SOURCE as primary care provider under Medicaid at admission and level of care status.

l) The Case Manager will provide the member/caregiver with the names of participating Primary Care Providers. All members enrolling must select and agree to use a designated Primary Care Provider.

m) All new members, not currently an established patient of a SOURCE physician must have an initial visit with the program Primary Care Provider selected. The member/informal caregiver OR the Case Manager may schedule the initial visit.

n) The assessment process will be initiated within 30 business days of release from wait list for members who must go through the wait list process. 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

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o) 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.

p) Following completion of the admission assessment, the Case Manager will record all recommended services on the Services Recommended Form.

q) Case Manager will request and record member feedback and signatures from both member and Case Manager will be secured.

903. Program Admission Procedures

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SOURCE admission occurs with these steps following assessment:

1. Initial determination of eligibility using the definition in section 801.3 as recommended by the assessment nurse using the information gathered from the MDS-HC (v9) and compared to the Level of Care Criteria (Appendix I)

2. Submitting the assessment packet to Georgia Medical Care Foundation (GMCF), the Division of Medicaid's medical management vendor, for validation of level of care.

   Note: assessment packets are submitted only through the secure GMCF web portal for review. All correspondence related to admissions will be conducted through the secure web portal.

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3. Prepare information on Community Supports available to member that may be used to support the patient during their stay in SOURCE or information that can be used to support member at termination (prepare for Discharge at time of enrollment)
4. Receive confirmation of the level of care approval from GMCF
5. Review new/ reassessed members by a multidisciplinary team
6. Assignment of the Carepath . Admission is considered complete upon the MD order/signature on the Level of Care and Placement Instrument (Appendix F) which provides the physician order for HCBS services/confirms LOC and RN signature for certification of level of care. Care path completion is required within fourteen (14) days of this date
7. Upon completion of enrollment (synonymous with the PA approval/effective date) and initiation of services, case manager will:

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

- MDS-HC, SOURCE Assessment Addendum, and MDS-HC signature page (Appendix T) wiith 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~~ (no longer required)
- 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)
  - Prior Authorization numbers (may write on transfer or Carepath form, Appendix F or I)

Rev. 04/11 Note: All services ordered must be listed on Appendix F. The exception to this is if the member is not due for a reevaluation and the new service ordered does not require a reevaluation/ reassessment; in the case of new services ordered without full reassessment, the services are added on the Carepath and indicated as ordered by physician by signature and date on the Carepath.

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Rev B. Provide the following completed documents to the member:

- Member participation form
- Carepath-Member Version

Process for Routine admissions:

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For HCBS provider billing, SOURCE members are enrolled in the program after Prior Authorization LOC approval is given by GMCF. The Prior Authorization effective date is considered the date of GMCF approval and serves as the date of SOURCE lock in. However, services may not be reimbursed until the SOURCE physician signature authorizes approval of the HCBS services including enhanced case management. The R.N. signs the ILOC form after concurrence is provided by GMCF or DCH review.

Process for members who meet eligibility:

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Eligibility requires GMCF approval for any initial SOURCE clients or SOURCE member reassessments on or after 9/30/2013. Services may not be delivered until a GMCF approval and a valid Appendix F ordering HCBS services is in place.

Routine Admission Overview:

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g) The Case Management Agency makes an appointment with the member for a face to face interview.
h) The Case Manager may complete the Assessment Addendum
i) A nurse completes the MDS HC.
j) When the MDS-HC is completed by an LPN, within ten (10) business days from the date of the assessment, the RN reviews the MDS-HC, completes and signs Appendix T to indicate supervisory review.
k) Appendix T is a signature page that confirms all who are present and assisted in interview for the MDS-HC and that the MDS-HC received RN review and agreement. It must be signed within 10 business days of the MDS HC assessment by the RN. It is part of the member assessment.
l) 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) wiith 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
- 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)

m) 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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n) Case managers will provide the following completed documents to the member:

- Member Participation form
- Carepath-Member Version

o) The Case Manager submits documentation via the web portal to GMCF. Exceptions, if the member has a current Prior Authorization that is not expiring within 3 months, it is not necessary to submit to GMCF. GMCF reviews the assessment package and confirms Level of Care.
Documents to be submitted via web portal include:

- Appendix F: Level of Care and placement Form (filled out in entirety)
- Appendix I: LOC justification for Intermediate Nursing Facility Care
- MDS-HC form
- SOURCE Assessment Addendum
- Medication Record
- Case Notes (6 months of Case notes for reassessment including Appendix U)
- DON-R Screening Tool for initial assessments
- Current physician or PCP medical documentation that supports level of care such as history & physical, medical progress notes and/or office visit notes, specialist consult notes (or form approved by DCH for this purpose)

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- GMCF may request additional information if needed for confirmation of diagnosis or care level (ie dementia diagnosis that is not supported by documentation or suggestive of mental health issues).

p) Following level of care approval by GMCF, the member assessment and care path recommendation are reviewed by the multidisciplinary team.

q) Case Managers will use the following format in presenting newly eligible members to the weekly admissions meeting of the multidisciplinary team:

(1.) Member name, age and diagnoses
(2.) Caregiver information, if applicable
(3.) ADL/IADL impairments from MDS-HC Assessment
(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.) ADH level recommended

ADH LEVEL I. Client Profile:

2. Requires watchful oversight to ensure safety and/or
3. Requires medical monitoring on a weekly basis or more often.
4. Requires minimal to maximal assistance with activities of daily living (Refer to Section 1103.4C for a list of task).
5. 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).

ADH LEVEL 2. Client Profile:

1. Oversight needs to ensure safety.
2. Medical monitoring needs.
3. Level of Need for assistance with personal care such as transfers, ambulation, bathing, or eating.
4. Any Need for specialized therapy.
5. Need for specialized nursing services such as bowel or bladder retraining, catheter care, dressing changes, or complex medication management.
6. Disease Management Needs (if required due to poor outcomes on medical parameters and/ or variances

The team reviews information to ensure that:

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(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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r) Following discussion of information presented, the multidisciplinary team reviews the Level of Care, MDS-HC and other SOURCE approved assessment tools for development of the care path and service plan.

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s) The Medical Director and/or member's primary care physician confirms that the member meets eligibility requirements for the SOURCE Program and orders specific services on the SOURCE Level of Care and Placement Instrument (Appendix F) by signature. His/her signature on the Carepath confirms the service level. Medical Director or PCP must sign the Level of Care Placement form within 90 (90) calendar days of the member signature.

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t) Once the physician signature is on the level of care form, then a Service Prior Authorization can be created in the Medicaid information System.

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

v) GMCF communicates level of care approvals to DCH weekly for admission.

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Ineligible members

Ineligible Initial Clients (New Clients)

Process for new clients who do not meet admission criteria due to incomplete information / application (technical denial)

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- GMCF does not validate/does not confirm Level of Care and eligibility
- GMCF sends out a certified letter to the member (uses the address listed in the MMIS)
- GMCF notifies by email and sends a letter to the SOURCE agency
- The SOURCE agency notifies the member and makes sure any questions are answered
- The member does not have appeal rights with an incomplete application
- The agency Medical Director and R.N. DOES NOT sign Appendix F, Level of Care and
- SOURCE Agency reviews the discharge plan with community supports, adding information as needed, giving it to member when complete (See Discharge Appendix BB and Z7)

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- The SOURCE Case Manager follows the instructions on Appendix Z8 and ensures completion

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Process for established members who do not meet continued eligibility at reassessment

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a) If a member no longer meets Level of Care (and does not appeal) or is discharged for any other reason, the site will notify all service providers and end all lines on the service Prior Authorization.

b) Except in cases where member meets immediate discharge criteria (I.i.e. threatening behavior), the agency should attempt to determine if the member is going to appeal and give the member 30 days before ending the service Prior Authorization.

c) Service Prior Authorizations should be ended in 30 days by the Case Management agency if member has not appealed.

d) The appropriate forms should be placed in the member's chart.

904 Routine Reevaluations/ Reassessments (Complete Re Evaluation Packets)

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Source members are evaluated for continued eligibility at least annually, and more often as necessary (e.g. improvements, as directed by GMCF, as directed by DCH). 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 are sent to GMCF to obtain approval. The SOURCE case management agency confirms that the member continues to meet criteria for:

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- Eligibility using the definition in section 801.3 including Intermediate Level of Care for nursing home placement.

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- Continued eligibility, appropriateness, and need for SOURCE services
- Allows for adjustment of the CarePath goals and service plan

Note: All services ordered for member at the time of reevaluation must be listed on Appendix F, Line 23.

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 or if indicated possible ineligibility

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f) Initiate the development of a new CarePath with input from member/member representative

g) Obtain GMCF approval as of 9/30/2013 on all annual reassessments with MDS

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h) Present member information and documentation at multi-disciplinary team meeting

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i) Complete certification of LOC and continued participation in SOURCE

i) Provide copies of reassessment documents to community service providers before LOC certification end date. The following documents are maintained as part of the SOURCE member clinical record:

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- 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
- Member Version of the Carepath
- Member Referral Form
- Member Information Form (if applicable)
- Rights and Responsibilities
- 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 Section902, Procedures (k)

k) If member is not approved for SOURCE during the Reevaluation/Reassessment process, and the member appeals, a copy of the GMCF notice of appeal or the member's copy of DCH Legal Services Division acceptance of member's appeal, will extend the LOC currently in place

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

905 Modified Reevaluation/ Readmission into SOURCE

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Modified Reevaluation Process may be used for members with Current PA greater than 3 months from expiration. Such as:

- Members returning to SOURCE from Nursing Home
- Member returning to SOURCE from a Prolonged Institutional Stay
- Internal or External Case Management Agency transfer or
- Member has changes in functioning that significantly affects how care is delivered

This policy is for Medicaid members who have an active SOURCE Prior Authorization. That authorization must have an expiration date greater than 3 months or more into the future. This may be used for members who have been in Nursing Homes or have had hospital stays. Inappropriate use would be for members who have improved in their health and can care for self.

Interview of member for this process may be conducted by LPN, RN, or Case Manager. Cases involving complex wound care, complex equipment such as IV infusions, peritoneal dialysis, new insulin pumps or new insulin administration should be conducted by nurses. Cases involving children should be conducted by nursing staff.

Procedure:

Using the: "Modified Reevaluation Contact Sheet for Members with Active Prior Authorizations/Approvals" in Appendix QQ. (This form was developed to give all the information needed in a concise format.)

1. Complete: Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals (or see Box 1 if case note is preferred)
2. Complete for readmissions to SOURCE
    a. APPENDIX D CONSENT FOR ENROLLMENT/ RIGHTS AND RESPONSIBILITIES,
    b. APPENDIX E AUTHORIZATION FOR RELEASE (IF NOT PREVIOUSLY IN PLACE)
    c. APPENDIX F SOURCE LEVEL OF CARE and PLACEMENT INSTRUMENT
    d. Pull Sentinel Event (IF RELATED TO THIS REEVALUATION) and place with packet when in office.
3. Send to GMCF:
    a. If an internal or external agency transfer, a SOURCE Member Transfer Form (Appendix X) from admitting agency indicating who member transferred from and the new agency identification number. The PA number.
4. Send to DCH;
    a. DMA 59 if member is discharged from Nursing Home

RN reviews and Signs MODIFIED RE EVALUATION CONTACT SHEET FOR MEMBERS WITH ACTIVE PRIOR AUTHORIZATIONS/APPROVALS OR *MODIFIED READMISSION CASE NOTE* before services begin. RN supervisory review indicates that medications and treatments are consistent with diagnosis and appropriate to be given at home. RN checks box yes or no next to *need for Disease Management*. RN documents recommendation for home care, educational needs, and disease management. (or documents 'no recommendation") If a sentinel event led to this Nursing Home admission, RN reviews the sentinel, documents recommendations under action plan and/or process improvement and signs/dates the form. All urgent Information is directly communicated to Case Management staff and documented. The RN signs the appendix F.

Case Management and Case Management Supervisors: Assure that all documents are completed. Assure Care path is updated. Assure resources are in place for a smooth, safe transition home.

Review member during Team and Quarterly Case Management meetings. Assure that urgent needs were addressed. Update any sentinel event that lead to this admission under action plan and process improvement (with new dates and data). Resend Sentinel to DCH with UPDATE written on top.

Procedure for Community Service Providers:

COMMUNITY SERVICE PROVIDERS should receive this information for readmissions:

(Note! This is an amended list for these members)

1. SOURCE MODIFIED RE EVALUATION CONTACT SHEET FOR MEMBERS WITH ACTIVE PRIOR AUTHORIZATIONS/APPROVALS (or Case note with complete documentation from Box 1);
2. APPENDIX F; SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT; must contain required signatures (physician and RN) and dates;
3. Appendix F will have current PA expiration date as the end of LOS
4. APPENDIX I LEVEL OF CARE JUSTIFICATION form, with noted Readmission Reason written on bottom of form;
5. Source Updated Care Path with current dates;
6. Member Version of Care Path;
7. APPENDIX D Rights and Responsibilities; Consent for reenrollment
8. ~~APPENDIX E Authorization for Release of Medical Information~~; (no longer required)
9. APPENDIX W Member Information Form;
10. ADVANCE DIRECTIVES (if not previously acquired);
11. Directions to the member's home, starting from the local SOURCE site to the member's home address
12. SOURCE Member Transfer Form (Appendix X) if applicable;
13. Copy of this policy (optional if provider is familiar with policy)

Box 1: Information needed if Modified Readmission using Case Notes to capture information is desired (note, will also need to use Appendix C):

Member Information: Name, DOB, (and any agency specific information)

Purpose of this documentation: Readmission into SOURCE with current PA

Interviewer Info: Name and title of person conducting interview. Date time and location interview occurred.

Interview Contributors; who all was present during interview? Who gave information

Body of Documentation: Reason for Admission to Nursing Home or Discharge from SOURCE services

If reason for admission was due to a fall, head injury, overdose, accident, or suicide event, please document this information. This will be needed later in the process.

New diagnosis, any therapies, all medications.

Mobility: Has there been a significant decrease in mobility?

Has there been a significant change in ability to care for self?

New equipment: what member needs or will be going home with (continued)

Medications can be listed on agency specific sheet or print off of home medications from Institution. RN signs and dates when reviewed.

Next scheduled visit for: Specialist, PCP, and any therapists

Will skilled nursing visits be needed? If so list why.

Will prolonged skilled nursing care be needed?

Case manager or Nurse Interviewer: Signs and date:

2) Complete Appendix C1-6. AND Appendix T: Note on Appendix C6 and T that this is an MODIFIED REEVALUATION per policy guidelines (this does not replace annual full re assessment.)

3) Complete
   b. **APPENDIX D** RIGHTS AND RESPONSIBILITIES, CONSENT FOR ENROLLMENT
   c. **APPENDIX E** AUTHORIZATION FOR RELEASE (if not previously in place)
   d. **APPENDIX F** SOURCE LEVEL OF CARE and PLACEMENT INSTRUMENT
   e. Pull sentinel event and place with packet when in office if related to stay

Follow Guidelines for RN'S, CASE MANAGERS AND COMMUNITY SERVICE PROVIDERS UNDER SECTION 905.

906 SOURCE Member External Transfers:

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Transfers from one case management agency to a different case management agency do not require a DON-R Score. As of Oct 1 2015 a complete re-evaluation is only necessary by the receiving agency within 10 business days, if the GMCF Level of Care is expiring in 3 months or less. Otherwise only a modified reevaluation is necessary within 10 days.

If a complete reassessment is needed, submit to GMCF to confirm Level of Care. Clearly indicate that this is a transfer with an expiring Level of Care through contact us or an agency note GMCF will issue a new Level of Care or denial.

The transfer agency will work with the admission agency to set the service Prior Authorization end dates so that the member has a seamless transfer process with minimal interruption in service.

Appendix F submission to DCH for SOURCE admission by the receiving agency is no longer required.

DCH reserves the right to request the evaluation packet and determine LOC.

Agencies should work together for a transition that allows time for GMCF approval.

Members transferring to another SOURCE EPCCM provider will be provided informed choice of providers/program prior to request for admission. One method used to secure informed choice is to involve the member, the previous agency/program staff, and the new agency to admit the member via conference call in order that all parties hear the member's choice directly.

Please note the information below:

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—it's preferable at the end of a calendar month. SOURCE screening staff is responsible for review of member program participation through the HP 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.

1001. Carepaths

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SOURCE utilizes Carepaths for a standardized sets of goals and expected outcomes, to develop a plan of care for SOURCE members. Carepaths, designed around indicators associated with chronic illness and impairment, are individualized plans written and implemented for each member. Carepaths, while not disease-specific, address risk factors held in common by people at the SOURCE Nursing Home Level of Care. 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 Provider 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. Agencies are to create their disease management profiles to meet member's needs.

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 hFis/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:

- Determine member formal and informal support, availability and reliability (Whenever possible, nurses/CM's will meet with informal caregivers to discuss care planning)
- Add to SOURCE Carepath profiles when information is obtained from the member/family during the assessment
- Effective date and expiration date of the Carepath will be taken from the Prior Authorization dates given by GMCF.
- A new Effective date that services were restarted may be documented by a Case Management agency on the carepath if service is interrupted during an active Prior Authorization.
- Short term hospitalizations (less than 2 weeks), temporary moves, member initiated internal transfers, member need for different services, may be documented with a Carepath update and case note. Document service change on the Carepath with Physician Signatures
- A prolonged Span for hospitalization, nursing home stay, rehab stay, may meet requirements for a modified reevaluation. See section 905 Modified Reevaluation/ Readmmission into SOURCE
- Prior Authorization expiration dates are only given by GMCF
- Complete the Carepath within fourteen (14) days of the completion of the enrollment process which includes determination of level of care, physician signature, and is finalized by the RN signature. 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
- Case management or Physician may add or delete services (with explanation) for the member on the carepath. Physician must indicate approval with signature and date.

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

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 Provider 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

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- Information on community services that will enhance member's wellbeing are provided as available and included on Care Path.

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 /re evaluation. CM documents in case notes PCP recommendations. Subsequent PCP conferences will include review of variances of carepath goals .

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.

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1004. <u>Carepath Formal Review</u>

Case Managers formally review Carepaths each quarter with members and with Primary Care Providers. Formal reviews are conducted face to face. Based on Case Manager's observation and information received from members or caregivers, Primary Care Providers, 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. <u>Member Version</u>

Each SOURCE Carepath is accompanied by an abbreviated Member Version that lists desired outcomes and the plan for achieving them. The member version includes formal/informal support caregivers. The document serves as an educational tool for members/informal caregivers throughout their participation in

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SOURCE. Case Manager/LPN/RN will complete the member version carepath within (14) days of completion of the enrollment process.

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.

The member version carepath is reviewed with the newly admitted member at the first face-to-face visit. During that visit, the member signs this version, acknowledging understanding and agreement. Case manager signs to indicate explanation of the document and its contents.

Instructions for completion of Carepath document:

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1. Complete member name and the effective date of the carepath. Effective date of the Carepath is the effective date of the PA.
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

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.

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.

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Procedures:

a) The Case Manager will follow rotation procedures as outlined in Appendix HH.

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b) 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:

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- 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 (unsigned version maybe sent initially, CM must send signed version within 10 days of signature procurement)
- Rights and Responsibilities
- ~~Authorization for Release~~

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

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

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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 Provider

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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).

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All HCBS 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.

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:

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 Provider
- Increasing service levels or changing service categories
- Coordinating with provider on service delivery issues

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.

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

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

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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) The Case Manager will discuss and document variances with the PCP on the quarterly contact form and other service providers as applicable

f) 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.

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 Providers, 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 Providers:	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 Providers, 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 Providers 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. <u>Procedures for Scheduled Contacts</u>:

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.
   (6) Monthly contacts will be documented by the Case Manager on the contact sheet, appended by case note entries if required for complete

documentation of service quality, progress toward goals and any other issues impacting care.

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 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.

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(7) Following the home visit, the Case Manager will review additional information from Primary Care Providers, providers, etc., on Carepath variances for individual members. It is recommended at the 3rd quarterly visit the Case manager works with member and PCP to have a functional assessment exam scheduled, completed and documented. Submit to GMCF for annual re evaluations.
(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 Provider
- All Providers

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d) **Re-evaluations:** A formal re-evaluation will be completed for all members annually at minimum. These will be submitted to GMCF following instructions in section 904 :

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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.

(4) The level of care will be reviewed by the Case Manager and confirmed by the Primary Care Provider or the Medical Director signature on the new Carepath, attesting to the member's current health and functional status. A new Level of Care form is initiated for the new member and member's who are due reevaluation (annually or more often as needed) 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) GMCF or DCH will validate Level of Care with the complete assessment package submitted by the Case Management Agency as of 9/30/2013.

(6) 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.

(7) The R.N. and Medical director signature on the Level of Care form (Appendix F) should follow (as of 9.30.2013) after GMCF validation) with multidisciplinary team review and confirmation

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(8)

8. Note: an APPENDIX F must be completed, at least annually, to verify continued Level of Care eligibility; unless a legal notice is given to extend the expiration date.

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

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

It is strongly recommended that at the Case Management 3rd quarter F2F visit, the Member is assisted to make a functional assessment appoint with their PCP. The functional assessment document should be given with explanation to the PCP for this visit and upon completion, submitted to GMCF. See appendix NN for approved form.

Rev. 10/15

(11) Annual evaluation packets on members determined by the RN and the multidisciplinary team NOT to meet LOC do not have to be submitted to GMCF. An Appendix Z Reduction… termination and denial form should be sent as soon as possible and if no legal action is taken. All service Prior Authorization lines should be ended if no legal action is taken. As always, the SOURCE Case Manager follows the instructions in Appendix Z and ensures completion, the SOURCE agency notifies the member and makes sure any questions are answered

1303. Scheduled Contacts with Primary Care Provider

Rev. 09/12

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.

Rev. 10/14

Areas discussed and PCP recommendations are to be documented on the contact form or in the case notes. Special attention should be given to any problems, variances and all sentinel events the member may have had since the last quarterly meeting. If the member has an Annual reevaluation scheduled in the next 3 months, concurrence with diagnosis, medications, and functionality should be discussed and documented with the PCP.

Procedures

Rev. 10/12

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 but may in the case of member compliance problems as a strategy to improve compliance with the medical or HCBS care plan.

Rev. 07/10

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

A. 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.

B. The Primary Care Provider office will have patient charts pulled for the conference and will have ancillary staff (typically nursing staff) attend.

C. For established members review the following, noted by PCP or Case Manager or RN/LPN since last conference, as applicable:

- Changes in health or functional status (including LOC changes)
- Sentinel events with PCP recommendations documented
- Carepath variances, with corrective actions discussed
- Changes in Carepath since last conference
- Equipment/supply needs
- Other factors jeopardizing continued community residence
- Repeated hospital encounters, inpatient or emergency department
- Administration of flu or pneumonia vaccines, when applicable
- PCP concurrence with level of care within 3 months of annual reevaluation

D. For new members: Review Carepath and significant findings from the initial PCP visit.

E. PCP will sign and date new member Carepaths.

F. 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.

G. Variances noted will be marked by circling the appropriate goal in the

1. Primary Care Provider Conference section of the Contact Sheet / sentinel events that have occurred since the last discussion with the PCP will be reviewed and documented.

H. The Primary Care Provider and the Case Manager will sign and date the

i. Contact Sheet in the PCP Conference section for all members.

I. Participating Primary Care Provider, PA, NP, or RN will attend conferences in person; additional PCP office staff (typically nursing personnel) may attend as indicated.

Rev. 7/10

J. 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.

K. The Case Manager designated will review all PCP recommendations with appropriate case management staff, following the conference.

L. 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 for Scheduled Contacts with Direct Service Providers

Member initial referrals, discrepancies, discharges:

a) **Initial Referrals**: see SOURCE-Reimbursed Services.

b) All providers with members will submit to the site monthly reports of actual services delivered.

Rev. 07/13

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).

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g) The provider will copy the Adjustment Request Form to the SOURCE Enhanced Case Management.

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, . Monthly conferences will take place with new services providers (as listed below)rendering services to a SOURCE agency's members for less than or equal to 6 months and who actively provide the following services to a member:

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

Rev 01/09

j) Quarterly conferences will take place with providers serving a site's members for greater than 6 months of service delivery, unless otherwise specified on the SOURCE Case Management Internal/External Complaint Log , for these services

- Adult Day Health
- Personal Support/Extended Personal Support
- Alternative Living Services

NOTE: With the agreement of both the SOURCE Site (EPCCM) and the provider, conferences may take place either face to face or by a mutually agreed upon electronic method. .Provider conferences will include for members served by the agency, efforts to resolve:

- Member Carepath variances and sentinel events
- 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

j) 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.

k) 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 Provider a referral for behavioral care for an ALS resident, etc.)

l) 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.

m) 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.

Rev. 07/13

n) For discharge of a member 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 high risk 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

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b) The site will maintain written minutes from the conferences. Minutes will be maintained in one central location and site may document on the individual member's charts.

c) 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.

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(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 team's agreement that the member does not meet LOC.

d) 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).

e) The Case Management Supervisor will sign the Contact Sheet within thirty days following the quarterly home visit.

1309. PRN Contacts

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.

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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.

Access to Primary Care Providers – as needed to manage clinical or behavioral complications of members – is a cornerstone of the program. Effective Primary Care Provider 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 Provider 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 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

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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.

1310. Disease State Management

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

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1400. Provider Performance Monitoring

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 Providers and HCBS agencies.

Procedures:

***SOURCE CASE MANAGEMENT* SITES**

DCH LONG TERM CARE UNIT MAY REQUIRE A CORRECTIVE ACTION PLAN (CAP) FOR NON-COMPLIANCE IN THE FOLLOWING AREAS. PLEASE SEE THE REFERENCED SECTIONS FOR COMPLIANCE REQUIREMENTS:

- Source Programmatic Report (See Appendix JJ). (monthly)
- SOURCE Case Management Team Meetings Documentation (See section 806)
- Management of Community Service Provider Performance (See section 807)
- Program admission procedures: submitting all documentation to GMCF (See section 903)
- Program admission procedures: documents submitted to providers (See section 903)
- Care Path Formal Review Documentation (See section 1004)
- Member Forms in Chart; forms present and documentation complete (See section 1300)
- Scheduled Contacts with Primary Care Providers (See section 1305)
- Disease State Management Initiation and Tracking and Intervention Logs (See section 1308)
- Maintaining 24 hour call system: documentation and maintaining system (See section 1402)
- Hospital tracking and intervention Logs (See section 1308 and 1403)
- Utilization Management oversight documentation (See section 1401)
- Standards of Promptness (See Appendix H)
  Including submissions to GMCF are prior to level of care expirations (timely)
- Discharge planning documents: Complete and Comprehensive discharge planning documentation (See appendix Z6-8 and section 806)
- Guardian notification occurs as outlined (See 902 Procedures (d) and 1406 Right to Appeal)

DCH may require a Corrective Action Plan (CAP) for non-compliance. Sites must submit a CAP within 14 calendar days of notice of non-compliance and Corrective Action Plan. If an approved CAP is not properly applied or executed, DCH may impose additional sanctions ranging from new member suspensions up to suspension of participation as a Case Management Agency. The areas listed above are frequently requested areas, SOURCE Case Management Companies are still required to follow all SOURCE policy.

***HCBS PROVIDERS (HOME AND COMMUNITY BASED SERVICES PROVIDERS)* WILL BE MONITORED BY SOURCE CASE MANAGEMENT FOR THE FOLLOWING (INCLUDING INFORMATION FOUND IN APPENDIX HH AS OF 7.01.2013):**

- 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

Note: More Information on Provider Performance Monitoring and Corrective Action by CM agency to HCBS providers including removal or suspension from the rotation list can be found in Appendix II

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Monitoring methodologies for HCBS providers include but are not limited to the PSS/EPS service delivery score, the Case Management Complaint log 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.

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10. Upon completion of enrollment and initiation of services, case manager will provide the following documents to all community service providers:

- The MDS-HC with Medication List, and Appendix T
- SOURCE Assessment Addendum C1-5,
- SOURCE Level of Care and Placement Instrument (must contain required signatures and date of signature)
- Level of Care Justification (Appendix I)
- The SOURCE Carepath detail (Appendix J, L, or N)
- Member Version of the Carepath (initial paperwork may be an unsigned version, signed versions must be sent after member signature procurement)
- Rights and Responsibilities
- 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))

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- Consent for Enrollment (Appendix C7) for initial and annual enrollment
- Referral Form (Appendix V) for initial and annual enrollment and when member has notable changes
- SOURCE Member Information Form (MIF) (only when member has notable changes)

1402. 24-Hour On Call

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

- 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.

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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 Provider or designated qualified medical professional
   (3) Assistance in resolving service delivery complications, after hours
   (4) Authorization of medical services

d) Authorization of community services including increase or decrease in service (also using the site specific SOURCE number) must be approved by 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 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:**

- Exploration of all possible routes to a community-based plan
- Primary Care Provider 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.

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e) Hospitals coordinating with SOURCE are requested to communicate with the SOURCE site relative to hospitalized members for collaboration in discharge planning.

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 Providers
   (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.

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 Provider, if he or she agrees to perform the functions described under "SOURCE Primary Medical Care" and in the Scheduled Contacts – Primary Care Providers and Policy, PRN Contacts.

1404. Member Discharge

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*Discharge **Planning** Policy Statement*:

Discharge planning is instituted at the beginning of the SOURCE participation to assist a client in making the transition from one service environment to another

Discharge planning is conducted to: Plan for continuity of an individual's health care; Maintain the individual's level of functioning; Lower an individual's readmission rates to medical facilities (for example: hand rails in bathroom to prevent falls)

Process for Discharge **Planning**:

Complete the following activities at enrollment to ease planning at discharge:

Begin to develop the discharge plan during the initial assessment (document what the member will need if discharged)

Reflect discharge planning in care plans by utilizing the steps in 1401 that ensure maximize funding (i.e. keep family resources in place, use community resources)

Coordinate discharge planning in consultation with the client's physician, other involved service agencies, and other local resources available to assist in the development and implementation of the individual's discharge plan. (Track key providers in member's well-being, consult with them as necessary)

.

See Appendix BB and Z6 and Z7-8 for more Information on operationalization of discharge planning.

Discharge Policy Statement:

SOURCE Members can be discharged for a variety of reasons. Voluntarily or Involuntarily. SOURCE supports and when possible improves the member's functioning. If evaluation or occurrences support discharge, SOURCE will work to make the transition as smooth as possible.

Process for 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

- Managing non-compliance is a core function of the CM/Primary Care Provider 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 enters a facility or institution
- Member does not meet eligibility using the definition in section 801.3 disability and Intermediate Nursing Home Level of Care Criteria

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- Member is no longer eligible for full Medicaid
- Member death

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- Member transfers to another waiver program
- Member is admitted to a nursing home (with expectation of Medicaid reimbursement for the nursing facility services.)
- Member Choice
- Member is chronically non-compliant
- Member health and safety needs cannot be met in the community
- Member's health and functionality is not confirmed by the Primary Care Provider's documentation or other appropriate physician specialist

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:

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(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 Provider 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.

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(7) Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix Z (7) to be filed in the member's chart.

1405 SOURCE MEMBER INVOLUNTARY DISCHARGE

Involuntary Discharge

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.

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:

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- Failure to keep scheduled Primary Care Provider 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. DCH Program Integrity staff recommend in writing that a member be discharged from service

3. Member/member's representative consistently refuses service(s)

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

5. Member enters a nursing facility. The provider must send the notice of discharge immediately upon the member's placement in a nursing facility in the case of nursing facility admission expected to be of a long term nature (greater than 21 days) or if the member has no payor source other than Medicaid for nursing facility services.

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

6. 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.

7. 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.

8. 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)

9. Member expires.

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10. Provider can no longer provide services ordered on the Carepath. (see also section 1306 Discharge… initiated by the provider)

11. Member is non compliant. Examples of non-compliance includes:
    - Failure to keep scheduled Primary Care Provider 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

Procedures:

(1) The assigned Case Manager will communicate clearly at admission the program's expectations of members/caregiver.

(2) The Case Manager will state that program eligibility requirements and reevaluation is needed to remain on the SOURCE program

(3) 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.

(4) 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).

(5) Issues of non-compliance and efforts at resolution will be documented in the member's case notes, on the Carepath, in Variance Reports, etc.

(6) The multidisciplinary team staffing the admissions process will be the entity to hear, explore and decide issues of pending discharge due to non-compliance.

(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 dis-enrolling member so requests.

(13) The Case Manager will facilitate the transition to other agencies in all ways possible.

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(14) Members will be informed in writing of the formal date of discharge from SOURCE.

(15) Members may further seek to appeal an involuntary discharge through the Department of Community Health's appeal process.

(16) Members may be involuntarily discharged immediately from SOURCE by the site's multidisciplinary staff group for criminal activities by member or in the home, and physical aggression toward providers, CM or PCPs, by member or in the home environment bypassing procedures 3 through 13.

(17) Upon discharging the member, the CM will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB) and Appendix Z(7-8), to be filed in the member's chart.

1406. Right to Appeal

The DON-R Score, Failure to meet eligibility including **Nursing Home Level of Care, Reduction in Services or other SOURCE Terminations**

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

- The DON-R score (but may not appeal agency 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)

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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. Agencies are not to reassess a client while the client is under an appeal request or Request for Fair Hearing (RFH) unless;

A) Greater than 9 months since last assessment (waiver requires annual assessment)

a. Notify GMCF and submit with information on circumstances in contact us

B) Reassessment has been approved by DCH.

a. Notify GMCF and submit with information on circumstances in contact us

Sites should note that this policy applies only to SOURCE-reimbursed services.

Procedures for Issuing Discharge Notice from Case management Agency:

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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. SOURCE sites will involve the primary care physician and/or Medical Director in all decisions resulting in adverse action.

Members who fail to meet the eligibility criteria including Nursing Home Level of Care 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 eligibility, the Medical Director and/or PCP will indicate same in item 34 of Appendix F and sign his/her name as required.

1. Following discussion of an action falling into any of the categories described above, the site will inform the member clearly of the action to be taken.

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2. Unless GMCF issues the written notice, 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. The form will be dated the day the form is mailed.

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3. Sites are not to issue a discharge letter (Appendix Z form) if GMCF has issued the decision. Sites may download GMCF's written notice from the GMCF web portal and take to client if client is not aware of notice, or has not received notice through mail.

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. 4. 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.

After conferring to the member Appendix Z 7 is completed. A copy is kept in the SOURCE chart.

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5. For members concurring with the intended action, the Appendix Z-1 letter and the Appendix Z-2 and Z-7 form will also be completed and provided to members as described above.

6. 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 thirty days of the Appendix Z-1 letter's date. Services remain in place pending the outcome of the Administrative Hearing.

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(*Discharge to nursing home requires immediate discharge of without Thirty day (30) waiting period. Refer to Section 1405-Involuntary Discharges*)

7. 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. (See Step 3 if member has not received notice)

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8. If the member wishes to appeal, the case manager should assist with their request for a hearing as appropriate.

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9. If the discharge was agency issued and the member appeals, a complete assessment packet is uploaded to GMCF to maintain the Prior Authorization and maintain member services. The packet should be clearly identified as involuntary termination with appeal. (if GMCF concurs, no new discharge notice is issued.)

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).

11. The Case Manager will check with the member and/or family representative regarding the notice of adverse action and whether a hearing request has been filed with DCH before formally discharging the member from the program.

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12. Members requesting discharge from SOURCE are exempt from the 30-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.

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13. 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.

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

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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 throughout the thirty-day notification period

15.. 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.

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NOTE: Prior to review by the Interdisciplinary team, the nurse (R.N. or L.P.N.) shall review the member's diagnoses, medications, treatments with the member's PCP to ensure concurrence with Member's health and functional status as documented on the MDS-HC .

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Procedures after decision of non-eligibility:

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1. SOURCE assessment nurse (R.N. or LPN) will carry out the MDS HC assessment and the RN will make a preliminary determination if the member meets eligibility. If determined by the Case Management agency or GMCF that the member does not meet eligibility, an appendix Z form will be sent to the member by the denial agency. 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. Discharge planning information/resources are sent to the member within 15 days of denial.

3. As of April 2016, GMCF will reference a 2nd level review option on the discharge Appendix Z letter to members who have a GMCF issued denial. This means that:

    a. If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter.
    b. The member will have 10 business days to provide new information to GMCF through their Case Management agency.
    c. If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter.
    d. If the member does not give new information, no new denial letter will be issued from GMCF. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter

4. If the member requests a hearing, the member will send his/her hearing request to DCH Legal Services.

5. Upon receipt of the hearing request, DCH Legal Services will decide to accept or reject the request for hearing. If accepted DCH will:

6. Send the member a confirmation letter that the hearing will be granted and

7. Contact the SOURCE Program Site and /or GMCF to request a copy of the file/records used to make the eligibility determination.

8. Documentation of paperwork from steps 4 or 5, GMCF confirmation, or a memo from DCH SOURCE confirming the hearing request was granted will confirm that Level of Care is to be continued under the DCH Legal Services authority (and services are to continue) for Utilization Review or Program Integrity.

9. SOURCE Program site or GMCF will provide a copy of the records to DCH Legal Services.

10. The benefits must continue.

11. If member's Prior Authorization has expired, GMCF will extend the LOC PA if they have denied the member. If this is an agency denial, Agency must upload reassessment packet to GMCF with explanation that member is in appeal and needs a Prior Authorization number to continue benefits.

12. Upon receipt of the records, DCH Legal will assign the case to an attorney

and transmit the case to OSAH for a hearing.OSAH will issue a notice of hearing setting a specific hearing date, time, and location.

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11. While waiting for the hearing to occur, the benefits must continue, and reevaluations/ reassessments should occur if:

a. Greater than 9 months since last assessment
b. Approved by DCH.

12. 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 And 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.

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13. 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.
14. 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. Keep ruling with member file.
15. If the judge rules in favor of the member, the benefits will continue and DCH can appeal to the next level. Maintain a copy of the ruling with the most current Appendix F. Reference on the appendix F the court ruling. Annual Reassessment following an appeal

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is determined by the Prior Authorization dates. The time spent in hearing will count to the annual review.

Note: In the case of SOURCE terminations upheld through hearing, or in the case of voluntary terminations, SOURCE case management agencies notify all HCBS provider agencies involved in the provision of services to the member in order to avoid continuation of services not reimbursable under Medicaid.

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.

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.

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 for SOURCE HCBS providers

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SOURCE providers have the right to an Administrative Review should they be removed from a SOURCE Enhanced Case Management's rotation list of 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.

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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.

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding removal from the SOURCE rotation list will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the 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.

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.

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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 SOURCE 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.

1410. HIPAA 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 HIPAA 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 physical, financial or emotional 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. These are not events that occur in a hospital or rehabilitation facility.

Reportable Sentinel events include:

:

- Falls
- Significant physical injuries
- Alleged criminal acts by staff against a member
- Alleged criminal acts which are reported to the police by a person who receives services
- Member missing without authority or permission and without others' knowledge of whereabouts
- Financial exploitation or mismanagement of client funds
- The intentional or willful damage to property by a client that would severely impact operational activities or the health and safety of the client or others
- Whether by a member or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a member
- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)
- Isolating member from member's representative, family, friends, or activities
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Leaving member alone for long periods of time
- Failure to provide basic care or seek medical care

Procedures:

1. In the event of a sentinel event, the Case Manager will complete the Sentinel Event Report (see Appendix for form), 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.

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1412. Transfers between SOURCE Case Management Agencies

Transfers between SOURCE Enhanced Case Management can happen for a variety of reasons that may be member initiated or agency initiated. 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 site or 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.

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A. MEMBER Chooses to TRANSER TO A Different CASE MANAGEMENT AGENCY within same Community (External Transfer)

Procedures:

1. The new agency will notify the existing agency 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 a different 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. Original agency is responsible for providing one year of copied records to the receiving agency.

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3. The new site may assess the member at any point during the month.

4. The new agency will not be responsible for case management until the member is discharged from the existing site..

5. Until discharge, the existing agency is responsible for all aspects of case management.

6. With the member's permission and a signed release, the existing site forwards a copy of the member's chart or the most current year's documentation to the new agency. (Original agency is responsible for providing one year of copied records to the receiving agency.)

7. Receiving agency uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness

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8. The new agency will submit a SOURCE Member Transfer Form (Appendix X) to GMCF if a modified reevaluation is completed. If a full evaluation is needed, submit complete packet to GMCF and indicate that is an external agency transfer.

9. With physician signature on the appendix F and a service PA start date the member is considered enrolled with the new agency

10. As SOURCE is a voluntary program, the existing CM agency will discharge the member according to the date requested by the member.

11. ~~Members transferring to another site will be subject to existing SOURCE lock-in procedures for HCBS.~~ (Lock in are scheduled to end 10/1/2015 and SOURCE moves to Prior Authorizations for service.

Rev. 07/11

B. MEMBER must RE-LOCATE or TRANSFER to different Case Management Agency

Procedures:

When a member needs to transfer CM agencies (for instance, the member is relocating to an area that is not served by the existing case management company, or the existing case management company cannot serve the member and must transfer the member), the existing Case Manager (CM) and the existing Case Management Supervisor (CMS) will begin the transfer process.

Note: If this is a case management company initiated transfer, DCH must be notified and give approval.

1. The Case Manager or supervisor will offer the member a list of case management agencies that provide service in the area (use Appendix Z-12 in the SOURCE DCH manual).

2. The member will select a site and notify the Case Manager of their choice.

3. The Case Manager will notify the CMS, who will contact the new agency to make a referral, give the new agency an anticipated relocation or transfer date if possible and coordinate discharge and admissions processes to best serve the member.

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4. Members will be counseled by case management staff to plan moves (and discharge from the existing site), in order to lessen the member's time without HCBS.

5. With the member's permission and a signed release, the existing agency forwards a copy of the member's chart or the most current year's documentation to the new agency. (Original agency is responsible for providing one year of copied records to the receiving agency.)

6. Receiving agency uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness

7. Upon moving, the new agency 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. Assessment (may use Modified Reevaluation as directed in section 905) is required within 10 days in the case of a change of address that impacts caregiver availability, environmental issues related to service delivery, or needs of the member.

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8. The new agency will submit a SOURCE Member Transfer Form (Appendix X)to GMCF if a modified reevaluation is completed. If a full evaluation is needed, submit complete packet to GMCF and indicate that is an external agency transfer. .

9. Members transferring to another agency will be subject to existing SOURCE procedures for HCBS.

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C. MEMBER TRANSFER TO ANOTHER SOURCE Site Location within Same CASE MANAGEMENT AGENCY (Internal Transfer)

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Procedures:

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1. Original site notifies the new site of member's upcoming transfer.

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2. Original site is responsible for providing one year of copied records to the receiving site.

3. The new site may determine a need to reassess the member. Modified reassessment (see section 905) is required within 10 days in the case of any of the following changes:

- circumstances that impact caregiver availability
- environmental issues related to service delivery
- Changes in the needs of the member.

4. Complete Reassessment is required if Level of Care Expires within 90 days. .A complete Packet is uploaded to GMCF
5. If the LOC does not expire within 90 days, the new agency may complete a modified reevaluation and will submit only a SOURCE Member Transfer Form (Appendix X) to GMCF

6. Until transfer, the existing site is responsible for all aspects of case management.

7. Receiving site uses copied records for historical reference and picks up monthly contacts, service, and care plan reviews from the previous dates and related standards of promptness

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1413. Case Management Reimbursement Hierarchy

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Note: Duplication of Case Management Services

Federal policy and the Department of Community Health (DCH) prohibit the reimbursement for repetitive case management services to more than one agency or Medicaid provider that renders case management services to an individual. (Guidelines for dual enrollment in SOURCE and acceptable non-repetitive Case Management are in section 701 Member Exclusions)

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- 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
  2. COS 851 – SOURCE CM (COS 851 ends 10/1/2015)
  3. COS 680 - MRWP/NOW
  4. COS 681 - CHSS/COMP
  5. COS 660 – ICWP
  6. COS 590 – CCSP
  7. COS 764 – Child Protective Services Targeted Case management
  8. COS 800 – Early Intervention Case Management

9. COS 765 – Adult Protective Services Targeted Case Management
10. COS 763 – At Risk of Incarceration Targeted Case Management
11. COS 762 - Adults with AIDS Targeted Case Management
12. COS 790 – Rehab Services/DSPS
13. COS 100 – Dedicated Case Management – Non-Waiver Members
14. COS 840 – Children's Intervention Service

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:

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- 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.

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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

_____
PERSON

_____
TELEPHONE NUMBER

4. _____
PROVIDER AGENCY

_____CONTACT
CONTACT PERSON

_____
TELEPHONE NUMBER

AS A PARTICIPANT IN THE SOURCE PROGRAM:

YOU WILL NOT LOSE ANY MEDICAL ASSISTANCE BENEFITS THAT YOU ARE CURRENTLY RECEIVING BY PARTICIPATING IN THE SOURCE PROGRAM.

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? _____

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

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: _____

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

___ Bed Rail ___ Hospital Bed ___ Incontinence pads
___ Catheter ___ High toilet seat ___ Glasses
___ Brace (back) ___ Prosthesis _____ ___ Cane/walker
___ Blood glucose monitor ___ Adaptive eating equipment ___ Grab bars
___ Bathing equipment ___ Bedside commode ___ Other vision
___ Lift (manual/electric) ___ Wheelchair (manual/electric) ___ Dentures
___ Other _____

_____ _____

Care Manager Signature_____Date _____

APPENDIX C
SOURCE ASSESSMENT ADDENDUM

Member: _____ Date: _____

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SOURCE SERVICES RECOMMENDED

Issues Noted	**Services Recommended**	**Provider Assigned**	Member Choice, PCP Choice, Rotation List	**Frequency**	**Participant Feedback**
			MC PC RL		
			MC PC RL		
			MC PC RL		
			MC PC RL		
			MC PC RL		

_____ _____

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

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

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 Level of Care

Admit Discharge Transfer Other

LOC PA Number: **Effective/End Dates**_____/_____

Georgia Department of Community Health
SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT

1. **SOURCE TEAM NAME & ADDRESS** Telephone: Provider ID#	2. Patient's Name (Last, First, Middle Initial): 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. ☐ Initial 2. ☐ 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 and the Department of Human Resources with necessary information including medical data.

16. Signed _____(Patient, Spouse, Parent or other Relative or Legal Representative) 17 Date_____

Section ***B. Physician's Examination Report, Recommendation, and Nursing Care Needed***	1. ICD 10	2. ICD10	3. ICD10
18. Diagnosis on Admission to SOURCE 1. Primary _____ 2. Secondary _____ 3. Other _____ 19. Is Patient free of communicable disease? 1. ☐ Yes 2 ☐ No			

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

22. SOURCE SERVICES ORDERED: ECMS, _____

23. **Diet**	24. **Hours Out of Bed Per Day**	25. **Overall Condition**	26 **Restorative**	27. **Mental and Behavioral Status**
☐ Regular ☐ Diabetic ☐ Formula ☐ Low Sodium ☐ Tube Feeding ☐ Other	☐ Intake ☐ IV ☐ Output ☐ Bedfast ☐ Catheter Care ☐ Colostomy Care ☐ Sterile Dressings ☐ Suctioning	☐ Improving ☐ Stable ☐ Fluctuating ☐ Deteriorating ☐ Critical ☐ Terminal	☐ Good ☐ Fair ☐ Poor ☐ ☐ None	☐ Agitated ☐ Noisy ☐ Dependent ☐Confused ☐ Nonresponsive ☐ Independent ☐ Cooperative ☐ Vacillating ☐ Anxious ☐ Depressed ☐ Violent ☐ Well Adjusted ☐ Forgetful ☐ Wanders ☐ Disoriented ☐ Alert ☐ Withdrawn ☐ Inappropriate Reaction

28. **Decubiti**	29, **Bowel**	30. **Bladder**	31. **Indicate Frequency Per Week of the following services:**						
			Physical Therapy	Occupational Therapy	Restorative Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
☐ Yes ☐ No ☐ Infected ☐ On Admission Surgery Date_____	☐ Continent ☐ Occas Incontinent ☐ Incontinent ☐ Colostomy	☐ Continent ☐ Occas Incontinent ☐ Incontinent ☐ Catheter							

32. Record Appropriate Legend	**IMPAIRMENT**				
1. Severe 2. Moderate 3. Mild 4. None	Sight ☐_____	Hearing ☐ __	Speech ☐ ___	Ltd Motion ☐ ____	**Paralysis** ☐ _____

Record Appropriate Legend	**Activities of Daily Living**					
1. Dependent 2. Needs Asst 3 Independent 4. Not App	Eats ☐ ___	Wheel-Chair ☐ ____	Transfers ☐ ___	Bathing ☐ ____	Ambulation ☐ ____	Dressing ☐ ____

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

ASSESSMENT TEAM USE ONLY

42. **Nursing Facility Level of Care?** ☐ Yes ☐ No	43. **L.O.S.**	**Certified Through Date**	44. Signed by person certifying LOC:	Title	Date Signed	Phone

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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 waivered services provided by SOURCE.

Who Completes Form: Initial assessments are completed by a licensed nurse (RN or LPN), case manager. The LOC is always signed 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, and transfers from one SOURCE site to another. Include the transfer date.

Instructions:

Indicate whether this is an initial admit, discharge, or transfer and date agency would like change to occur. May write any other helpful information in the box or at top of page.

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, and Medicaid provider identification number 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 (□) 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.

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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 waivered services ordered by case management team.

Please designate ADH level 10/14

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, confirming the GMCF review and LOC determination.
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.**

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NOTE: Physician or nurse practitioner signs within 60* days of 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

42. 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.
43. 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.

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44. Licensed person certifying level of care signs in this space, indicates title (R.N.), date of signature, and contact information.

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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.

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For SOURCE : LOS Certified Through Date = Expiration on PA
* For SOURCE "Date of Signature" for the Physician and RN is extended to 90 days

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

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SOURCE Care Path Level (OPTIONAL)

Note: If services are ordered between annual reviews and at such a level that it does not require the member to have a reassessment, the service(s) can be documented on the Care Path, and the physician signs and dates the Carepath. As of July 1, 2015 members who have a complete reassessment will all be on SOURCE Level I carepath.

SOURCE Level I	CRITERIA: Based on GA Nursing Home ICF and SNF Levels
All patients must have a medical condition which requires physician monitoring. Check what the patient Requires. ☐ Patient requires skilled nursing services daily Yes No ☐ Patient requires assistance with a documented mental problem (cognitive loss) Yes No ☐ Patient requires assistance with a documented physical problem Yes No AND if there is another problem that contributes to member's care: ☐ Other _____ Circle any problems below that require medical monitoring: Nutritional status; skin care; catheter use; therapy services; clinical indicators/lab studies; restorative nursing care; or medication management.	

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Rev. 10/12 , Rev. 07/13
Rev. 10/13, Rev. 01/13
Rev. 10/14

APPENDIX H
Standards of Promptness

Case Managers complete SOURCE activities within the standards of promptness guidelines

Standard of Promptness for Care Coordination	
IF ACTIVITY IS	**THEN STANDARD OF PROMPTNESS IS WITHIN**
Responding to telephone inquiry regarding SOURCE admission	3 business days after telephone inquiry
SCREENING	
Screening a referral	3 business days after telephone inquiry
Notifying client referral source of client denial/ineligibility determination at screening	Within 3 business days after decision of non-eligibility
INITIAL ASSESSMENT	
Nurse completion of face to face assessment for new admissions	within 30 business days of notification of slot availability
RN review of the assessment	10 business days following the assessment visit
Sending assessment /reassessment package to GMCF for LOC review	No later than 60 days from assessment completion date
REASSESSMENT	
Send Reassessment package to GMCF for LOC review	At least 45 days before expiration of the current Level of Care and no sooner than 89 days before LOC expiration
RN review of the assessment	10 business days following the assessment visit
Medical Director/PCP signature confirming LOC	Within 90 days of member signature on LOC* See Section 1406
Completing reassessments when requested by: • SOURCE service provider • Utilization Review analyst • Legal Services Office • Administrative Law Judge • Member	10 business days after reassessment request
Brokering services for new client	Within 5 business days of SOURCE admission or confirmation of lock in
Telephone follow-up with a client after service brokered to assess service compliance, client satisfaction	10 business days after service initiation
Sending member a Participation Form and Member Care Path	5 business days after service initiation

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APPENDIX H
Standards of Promptness

IF ACTIVITY IS (cont'd.)	THEN STANDARD OF PROMPTNESS IS WITHIN (cont'd.)
Sending referral packet to provider	Before service provider begins services
Completing and returning Member Information Form (MIF) to provider	3 business days after receipt from provider 2 business days if involving a sentinel event
Telephone contact with member	Monthly
Face to Face Care Path review	Quarterly
Provider meeting for the coordination of care (Applies to all ALS, ADH, and PSS providers)	Monthly Note: may be conducted face to face, telephone or electronically
Reporting Sentinel events to DCH, Adult Protective Services, local law enforcement, and Long Term Care Ombudsman	Within 1 business day of the notification or discovery of the event
Transfer of client record when client moves to another SOURCE site with the same provider (copy of records is acceptable)	5 business days after notification of transfer
Submitting Monthly Statistical Reports to DCH	By the 15th of the month following the month subject to report
Involuntary Discharge	
Complete and provide a copy of the discharge plan with specific resources to the member	No later than 15 days following a SOURCE involuntarily discharge (day of notification by GMCF or date the CM agency issued letter to member)
Follow up call or visit to member and or family to confirm understands information on discharge and discharge planning resources	7 to 10 work days after discharge plan is given

Appendix I: Intermediate Nursing Home Level of Care

Rev. 07/11 **USE SECTION 801.3 FOR INTERPRETIVE GUIDELINES AND USE INSTRUCTION /GUIDE** (FOLLOWING PAGE).

To meet an intermediate nursing home level of care the individual must meet:

Item # 1 in Column A AND one other item (2-8) in Column A,

PLUS at least one item from Column B or C (with the exception of #5, Column C)

Column A		Column B		Column C
Medical Status **(If #1 is circled, please document etiology)**		**Mental Status** **(If #1-4 is circled, please document etiology)**		**Functional Status** **(If #1-5 is circled, please document etiology)**
In addition to the criteria in # 1 below, the patient's specific medical condition must require any of the following plus one item from Column B or C		*The mental status must be such that the cognitive loss is more than occasional forgetfulness*		*Functional Status* *One of the following conditions must exist (with the exception of #5)*
1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician		1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement		1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist.
2. Nutritional management; which may include therapeutic diets or maintenance of hydration status		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.		2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.
3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions or healing decubiti (continued)		3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention (continued)		3. Requires direct assistance of another person to maintain continence.
4. Catheter care such as catheter change and irrigation		4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia		4. Documented communication deficits in making self-understood or understanding others.

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

INSTRUCTIONS/GUIDE for Determination of ILOC

Intermediate Level of Care Criteria: SOURCE Applications

Rev. 07/11

The target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE and all other eligibility requirements listed in 801.3. The Intermediate Level of Care Criteria is recommended by the Site's Registered Nurse, using assessment information reported via the MDS-HC assessment, case notes, physician notes, history & physical, and other assessment tools. The R.N. circles all relevant items from Column A, B & C to support the level of care. If additional notes such as related diagnoses are required, such information is noted on the document.

Specific criteria as below:

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, Phenobarbitol, 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 that includes cognitive loss. Must Satisfy one of #1 through #4

(NOTE: ALWAYS INVOLVES COGNITIVE LOSS WITH ETIOLOGIC DIAGNOSIS NOT RELATED TO A DEVELOPMENTAL DISABILITY OR MENTAL ILLNESS FOR SOURCE WAIVER ELIGIBILITY)

SOURCE LOC CRITERIA	PRIMARY LOC APPLICATIONS
1. "Documented short or long-term memory deficits . . . "	Linked to a diagnosis (CVA, TBI, dementia, Alzheimer's, 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)

(NOTE: ALWAYS INVOLVES IMPAIRMENT WITH ETIOLOGIC DIAGNOSIS NOT RELATED TO A DEVELOPMENTAL DISABILITY OR MENTAL ILLNESS FOR SOURCE WAIVER ELIGIBILITY)

APPENDIX I
Level of Care

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 . . . "	Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement.
5. "Assistance . . . dressing/personal hygiene"	Self-explanatory. See "another deficit" requirement described.

APPENDIX I

To meet an intermediate nursing home level of care the individual must meet:
Item # 1 in Column A AND one other item (2-8) in Column A, PLUS at least one item from Column B or C (with the exception of #5, Column C).

Column A Medical Status

Medical Status
(If #1-8 is circled, please document etiology/cause/diagnosis)

1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician
*Etiology*_____
2. Nutritional management; which may include therapeutic diets or maintenance of hydration status
*Etiology*_____
3. Maintenance and preventative skin care and treatment of skin conditions, such as cuts, abrasions or healing decubiti
*Etiology*_____
4. Catheter care such as catheter change and irrigation
*Etiology*_____
5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (3 times per week or less)
*Etiology*_____
6. Restorative nursing services such as range of motion exercises and bowel and bladder training
*Etiology*_____
7. Monitoring of vital signs and laboratory studies or weights
*Etiology*_____
8. Management and administration of medications including injections
*Etiology*_____

Column B Mental Status

The mental status for this column must be cognitive loss and more than occasional forgetfulness

Mental Status
(If #1-4 is circled, please document etiology)

1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement
*Etiology*_____
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.
*Etiology*__ _____
3. Problem behavior, i.e. wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention
*Etiology*_____
4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia
*Etiology*_____

Note!: Etiologies not covered in SOURCE are those due to a mental health (i.e. Schizophrenia, mental retardation, developmental delay etc)

However, cognitive loss (traumatic brain injury, dementia, Alzheimer's) can be covered under SOURCE.

Column C Functional Status

The Functional Status impairment must not be related to a developmental disability or mental illness

Functional Status
(If #1-5 is circled, please document functional etiology. Circle where supported on MDS (Optional).

1. Transfer and locomotion performance of resident requires limited/extensive *assistance by staff* through help or one-person physical assist.
*Functional Etiology of movement deficit*_____

G2F; 3 4 5 6 G2g 3 4 5 6
G3c; 0 G3d 0
*J3a; 1 2 3 4 *J3b 1 2 3 4
*IF J3a-b is circled, is this compensated by walker, cane, slower movements, or use of furniture? y n If so, this is not enough for NH level.

2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.
Functional Etiology of feeding assist need _____
G2J 3 4 5 6

3. Requires direct assistance of another person to maintain continence.
Functional Etiology of incontinence
_____
G2g 3 4 5 6 G2h 3 4 5

4. Documented communication deficits in making self-understood or understanding others.
Functional Etiology of communication deficit
_____
D1 3 4 D2 3 4

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).
*Functional Etiology*_____
G2a 3 4 5 6 G2b 3 4 5 6
G2c 3 4 5 6 G2d 3 4 5 6

Signature of R.N. _____ Date _____
(Must be present)

Signature of Other_____ Date _____
title_

This is a preliminary review of patient. Final determination is made with the Level of Care and Placement Instrument (Appendix F).

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

Service Options Using Resources In Community Environments

Rev. 10/15

LEVEL I – CAREPATH

Circle what the patient has:

1) a documented mental problem (with cognitive loss)–
2) a documented physical problem

Prior Authorization Dates: _____ to _____ PA #_____

Disease (s) that require DM Plan? _____

SOURCE Case Manager _____Signature _____ Date_____

SOURCE Case Mgmt Sprvsr_____Signature_____ Date_____

SOURCE PCP _____Signature _____ _ Date_____

SOURCE Medical Director _____Signature _____Date_____

Care Path additions: Document Reason for Care Path changes and signatures as needed below for members who have Care Path changes but don't require a full reevaluation.

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

07/12

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member resides in community, maintaining maximum control possible over daily schedule and decisions. **Sentinel events are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action.** **GOALS:** **A. Member/caregiver contributes to the design and implementation of community-based services plan.** **Key member responsibilities:** • **Accept services as planned with manager;** • **Provide accurate information on health status and service delivery; and** • **Maintain scheduled contact with case manager.** **B. Member keeps scheduled medical appointments.**	**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. PCP: _____Case Mgr._____ *SOURCE PCP role:* Evaluate and treat episodic /acute illness Manage chronic disease, including: 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 Refer/coordinate/authorize specialist visits, hospitalizations and ancillary services Promote wellness, including immunizations, health screenings, etc. *SOURCE Case Manager role:*	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 2nd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 3rd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 4th review period (__/__/__): A. __met __not met

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

C. Support services are delivered in a manner satisfactory to SOURCE members, informal caregivers and Case Managers. **Key provider performance areas:** • **Reliability of service** • **Competency and compatibility of staffing;** • **Responsiveness to member concerns and issues; and** • **Coordination with Case Manager.**	Maintain contact with member, for ongoing evaluation: Monthly by phone or visit (minimum) Quarterly by visit (minimum) PRN as needed Educate members on patient responsibilities Encourage/assist member in keeping all medical appointments Conference/communicate regularly with PCP; assist patients in carrying out PCP orders Encourage/assist member in obtaining routine immunizations, preventive screenings, diagnostic studies and lab work Coordinate with informal caregivers and paid providers of support services Educate or facilitate education on chronic conditions Assist members in ALL issues jeopardizing health status or community residence NOTES: _____ _____ _____ (Providers and units/schedules listed on Member Version)	B. __met __not met C. __met __not met Sentinel events? _____

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
A member's diet will be balanced and appropriate for maintaining a healthy body mass and for dietary management of chronic conditions **GOALS:** **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).** **B. Meals are generally balanced and follow appropriate diet recommended by PCP (observed by Case Manager or provider, self- or caregiver report).**	**MEMBER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other _____ **MEAL PREPARATION:** ___self-care (total) ___assistance by informal caregiver(s)_____ _____ _____ ___home delivered meals ___ALS (alternative living service) ___ PSS aide (includes G-tube) **MEAL PREPARATION SCHEDULE: (Indicate SELF, INF, HDM, PSS or ALS):**	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met 2nd review period (__/__/__): A. __met __not met B. __met __not met 3rd review period (__/__/__): A. __met __not met B. __met __not met 4th review period (__/__/__): A. __met

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

	Mon _____B _____L _____S Thurs ____B_____L_____S Tues _____B_____L_____S Fri _____B_____L_____S Wed _____B_____L_____S Sat _____B_____L_____S Sun _____B_____L_____S NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	__not met B. __met __not met

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member's skin will be maintained in healthy condition, avoiding breakdowns and decubiti. **GOALS:** **Member has no skin breakdowns or decubiti requiring clinical intervention/wound care.**	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ___SOURCE educational material ___other _____ **MONITOR SKIN for integrity:** ___SOURCE PCP ___self care ___informal caregiver _____ ___ADH ___specialist _____ ___PSS aide/PSS RN every 62 days ___ALS ___skilled nursing provider:_____ Dates of Service:	**GOALS:** 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Member _____ Medicaid # _____Date:_____

	Assistance required: ___turning/repositioning (see page_____) ___continence (see page _____) ___nutrition (see page____) NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	

APPENDIX J
Level 1 Carepath Rev. 10/2015

Rev. 07/12

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Key clinical indicators and lab values will regularly fall within parameters acceptable to SOURCE PCP or treating specialist. **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.** **The PCP will advise on any additional monitoring required for each member.** **Additional monitoring required, if applicable:** **___blood glucose** **___blood pressure**	**MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP/PCP staff ____SOURCE educational material ___other_____ **MONITOR CLINICAL INDICATORS:** ____SOURCE PCP (OV) **ADDITIONAL MONITORING REQUIRED:** ___self care ___ASSISTANCE REQUIRED ___informal caregiver_____ ___ADH ___PSS aide ___ALS ___RN provider: _____	**GOALS:** 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

___weight (as indicator of illness, for CHF patients, etc.) **___labs** **___other_____** **_____ LMP_____** **last menses for women of child bearing age**	___other _____ _____ NOTES:_____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	

07/12

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Member/caregiver understands and adheres to medication regimen (self- or caregiver report, physician/RN report or observation by Case Manager). **Sentinel events around medications are discussed with appropriate responsible parties.**	**MEMBER/CAREGIVER EDUCATION**: ___SOURCE PCP/PCP staff ___SOURCE educational material ___other_____ **MEDICATION ADMINISTRATION/MANAGEMENT:** ___self care ___informal caregiver _____ ___ADH/DHC ___ALS ___PSS aides (cueing) ___RN provider_____ Dates of Service: **OBTAINING MEDICATIONS:** ___self care ___informal caregiver ___pharmacy delivery _____ ___other_____ **PHARMACY**:_____ NOTES: _____	**GOALS:** 1st review period (___/___/___): _ met _ not met Sentinel events? _____ 2nd review period (___/___/___): _ met _ not met Sentinel events? _____ 3rd review period (___/___/___): _ met _ not met Sentinel events? _____

Member _____ Medicaid # _____Date:_____

	_____ _____ _____ (Providers and units/schedules listed on Member Version)	4th review period (___/___/___): _ met _ not met Sentinel events? _____

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Regular performance of ADLs and IADLs is not interrupted due to cognitive or functional impairments. **GOALS:** **No observations by Case Managers or reports from mbr. /caregiver/other providers (including SOURCE PCP) identifying problems with ADLs, IADLs and/or patient safety.** **Sentinel events are discussed with appropriate parties (exclude falls).**	___**ASSISTANCE REQUIRED:** (S=SELF; INF=informal support; PSS=PSS aide; HDM=home delivered meals; ALS=alternative living service): _____bathing _____dressing _____eating _____transferring _____toileting/continence _____turning/repositioning _____errands _____chores _____financial mgt. _____meal prep. __**informal caregiver(s)** providing assistance: _____ _____ ___**home delivered meals** ___**ADH** ___**ALS** ___**ERS** ___**incontinence Carepath** ___**PSS aide** Total hours/week: _____ Indicate no. of hours:	**GOALS:** 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

Member _____ Medicaid # _____Date:_____

	Monday _____AM _____PM Thursday _____AM _____PM Tuesday _____AM _____PM Friday _____AM _____PM Wednesday _____AM _____PM Saturday _____AM _____PM Sunday _____AM _____PM NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

Rev 7/1/03

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Problem behavior will not place the Member at risk of social isolation, neglect or physical injury to themselves or others. Diagnosis: _depression __ _substance abuse ___bi-polar disorder ___schizophrenia ___Alzheimer's ___ other dementia ___other _____ **GOALS:** **A. Residential arrangements remain stable.** **B. Mental health conditions or cognitive impairment will be adequately managed by informal or paid caregivers. Indicators of inadequately managed behavior include:** • **hospitalization for condition** • **discussion of potential institutionalization** • **increased level of caregiver stress** • **physical danger to self or others posed by behavior** • **discharge from a program or service due to behavior** **Examples of problem or symptomatic behavior:**	**ROUTINE AND PRN MONITORING AND EVALUATION** by SOURCE PCP for signs of changes in mental status **MEMBER/CAREGIVER EDUCATION:** ___SOURCE PCP ___other_____ __**ongoing management of condition** by mental health professional provider: _____schedule_____ ___**supervision** by informal caregiver(s): _____ ___**ALS** for supervision and monitoring ___**PSS** aides for supervision and monitoring ___**day program** for supervision and monitoring of mental status when or if informal support is unavailable	**GOALS:** 1st review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 2nd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 3rd review period (__/__/__): A. __met __not met B. __met __not met C. __met __not met Sentinel events? _____ 4th review period (__/__/__): A. __met __not met

Member _____ Medicaid # _____Date:_____

wandering impaired memory substance abuse **profoundly impaired judgment** **physical aggression** **suicide attempts or threats** **C. Sentinel events around behavior are discussed with appropriate parties and process improvement that will assist member to reside safely are documented and put into action.**	provider: _____ schedule: M T W Th F NOTES: _____ _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	B. __met __not met C. __met __not met Sentinel events? _____

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Transfers and mobility will occur safely. **GOALS:** **Member has no falls due to unsuccessful attempts to transfer.** **Sentinel events around falls are discussed with responsible parties.**	**MEMBER/CAREGIVER EDUCATION:** __SOURCE PCP/PCP staff __SOURCE educational material __PCP is notified. Member gait, balance assessed, medication reviewed. __other_____ **ASSISTANCE REQUIRED:** ___**informal caregiver(s)** to provide assistance with transfers and mobility: _____ _____ ___**PSS aide** for assistance if/when informal support is unavailable ___**ALS** ___**ADH program** for assistance if/when informal support is unavailable ___**Adaptive equipment** as indicated, with training as required (specify): _____ _____ _____ ___**Home modifications** as indicated (specify): _____	**GOALS:** 1st review period (___/___/___): _ met _ not met Sentinel events? _____ 2nd review period (___/___/___): _ met _ not met Sentinel events? _____ 3rd review period (___/___/___): _ met _ not met Sentinel events?

Member _____ Medicaid # _____Date:_____

	_____ NOTES: _____ _____ _____ _____ (Providers and units/schedules listed on Member Version)	_____ 4th review period (___/___/___): _ met _ not met Sentinel events? _____

APPENDIX J
Level 1 Carepath Rev. 10/2015

Member _____ Medicaid # _____Date:_____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	QUARTERLY REVIEWS
Informal caregivers will maintain a supportive role in the continued community residence of the SOURCE pt. **GOALS:** **No reports or other indicators of caregiver exhaustion (self-report, observed by case manager, etc.).**	___**Ongoing SOURCE case management/support service plan** ___**Referral to support group** _____ ___**In-home respite** Extended Personal Support (EPS) schedule: _____ ___**Out-of-home respite** provider: _____ schedule: _____ ___**ADH** for respite purposes for informal caregiver NOTES:_____ _____ _____ (Providers and units/schedules listed on Member Version)	GOALS: 1st review period (__/__/__): __met __not met 2nd review period (__/__/__): __met __not met 3rd review period (__/__/__): __met __not met 4th review period (__/__/__): __met __not met

APPENDIX J
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Member _____ Medicaid # _____Date:_____

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

Member _____ Medicaid # _____Date:_____

GOALS:		1st review period (___/___/___): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met 4th review period (___/___/___): _ met _ not met

Member: _____ 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.

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_____

Member: _____ Date: _____

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_____ **DATE** _____

APPENDIX L

SOURCE

HOUSING, INCONTINENCE CAREPATHS

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in housing that is safe, affordable and accessible. Issues identified: ___substandard physical structure ___unaffordable ___not accessible ___geographic isolation ___family/household dynamics ___other _____ **GOALS:**	___Member preference is to explore relocating to a new home. ___Member preference is to remain in existing home and explore repair options as feasible. ___**SOURCE RELOCATION ASSISTANCE:** ___Assess Member's own circumstances, preferences and financial resources for housing. ___Identify a contact person – if available – to explore housing options on behalf of the Member, if applicable. ___Offer list of housing resources maintained by ___For Members with inadequate informal support, review available options. ___Complete application process (gathering necessary documentation).		**MEASURES:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____ **DATE** _____

No reports or observations of the above. .	___Follow-up on application once submitted (review waiting list if applicable, contact regularly to check) ___Relocation checklist: ___security deposit ___utilities ___transfer ___new service (deposit) ___change of address with Social Security, DFCS, etc. ___notification of providers		

HOUSING Page 1

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in housing that is safe, affordable and accessible. (CONT'D, Page 2)	Moving arrangements: ___family/informal support ___PSS aide; provider _____ Date moved: _____ Date refused to relocate: _____ **___HOME REPAIR, renter:** ___Broadly describe nature of repairs needed: ___structural ___electrical ___plumbing ___infestation ___heating/cooling ___major accessibility modifications ___other_____		**MEASURES:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____ **DATE** _____

	___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.		

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 3)	___Identify and contact landlord, describing nature of need repairs. ___One-month follow-up ___repairs acceptable ____/____/____ ___repairs in progress ____/____/____ ___no repairs initiated ____/____/____ ___Notify appropriate authority: ___City Inspection Department ___/___/___ (structural, plumbing, wiring) ___Health Department ___/___/___ (infestation, sewage) ___Fire Department ___/___/___ (electrical, wiring, smoke alarms) ___One month follow-up with Member ___repairs in progress/completed ___repairs not initiated ___Re-contact appropriate authority		**MEASURES:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____ **DATE** _____

	Final disposition: ___ repairs made ___ repairs not made ___ Member preference is to relocate (see relocate plan)__ ___ Member preference is to remain in home under present conditions		

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	QUARTERLY REVIEWS
Member will reside in safe, affordable and accessible housing. (CONT'D, page 4)	___**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_____		**MEASURES:** 1st review period (___/___/____): _ met _ not met 2nd review period (___/___/___): _ met _ not met 3rd review period (___/___/___): _ met _ not met

MEMBER_____ **DATE** _____

	___Explore available funding from other sources: _____		

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE PARTY	FUNDING	Quarterly Reviews
Member will reside in safe, affordable and accessible housing. (CONTD, page 5)	__One month follow-up ___repairs acceptable __/__/__ ___ repairs in progress __/__/__ ___no repairs initiated __/__/__ ___Re-contact appropriate funding source __Final disposition: __repairs made __ repairs not made ___Member preference is to relocate (see "Relocation" section) ___ Member preference is to remain in home under present conditions		**MEASURES:** 1st review period (_/_/_) : __met __not met 2nd review period (_/_/_): __met __not met 3rd review period (_/_/_) : __met __not met

APPENDIX L HOUSING, INCONTINENCE CAREPATHS

MEMBER_____ **DATE** _____

KEY MEMBER OUTCOMES	PLAN/RESPONSIBLE	FUNDING	QUARTERLY REVIEWS
Member's incontinence will be managed to promote skin integrity and adequate personal hygiene. **GOALS:** **A. Member has no skin breakdowns or decubiti requiring clinical intervention/wound care** **B. Member maintains acceptable personal hygiene (no perceptible odor, etc., and no reports by Member or caregiver/provider/PCP).** **C. Member has no infections/complications OR frequency of infections decreased for persons with catheter.**	___**paper continence products** supplier: ___Member/informal caregiver ___Community Benefits ___assistance by informal caregiver ___assistance by PSS aide provider: schedule: ___**catheterization** ___in-and-out ___assistance by informal caregiver ___assistance by LPN/RN provider: schedule: ___in-dwelling ___assistance by informal caregiver ___assistance by RN/LPN provider: schedule: ___external ___assistance by informal caregiver		**MEASURES:** 1st review period (___/___/___):_ A. A. __met _ not met B. __met _ not met C _ met _ not met 2nd review period (___/___/___):_ A. __met _ not met B. _ met _ not met C. _ met _ not met 3rd review period (___/___/___): A.

MEMBER_____ **DATE** _____

	___assistance by PSS aide provider: schedule: ___ostomy ___Member/caregiver education ___SOURCE PCP ___SOURCE RN ___self-care Assistance required: ___assistance by informal caregiver ___assistance by PSS aide provider: schedule: ___assistance by LPN/RN provider: schedule:		__ met _ not met B. __ met _ not met C. __ met _ not met 4th review period (___/___/___): A. __ met _ not met B. __ met _ not met C. __ met _ not met

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: _____

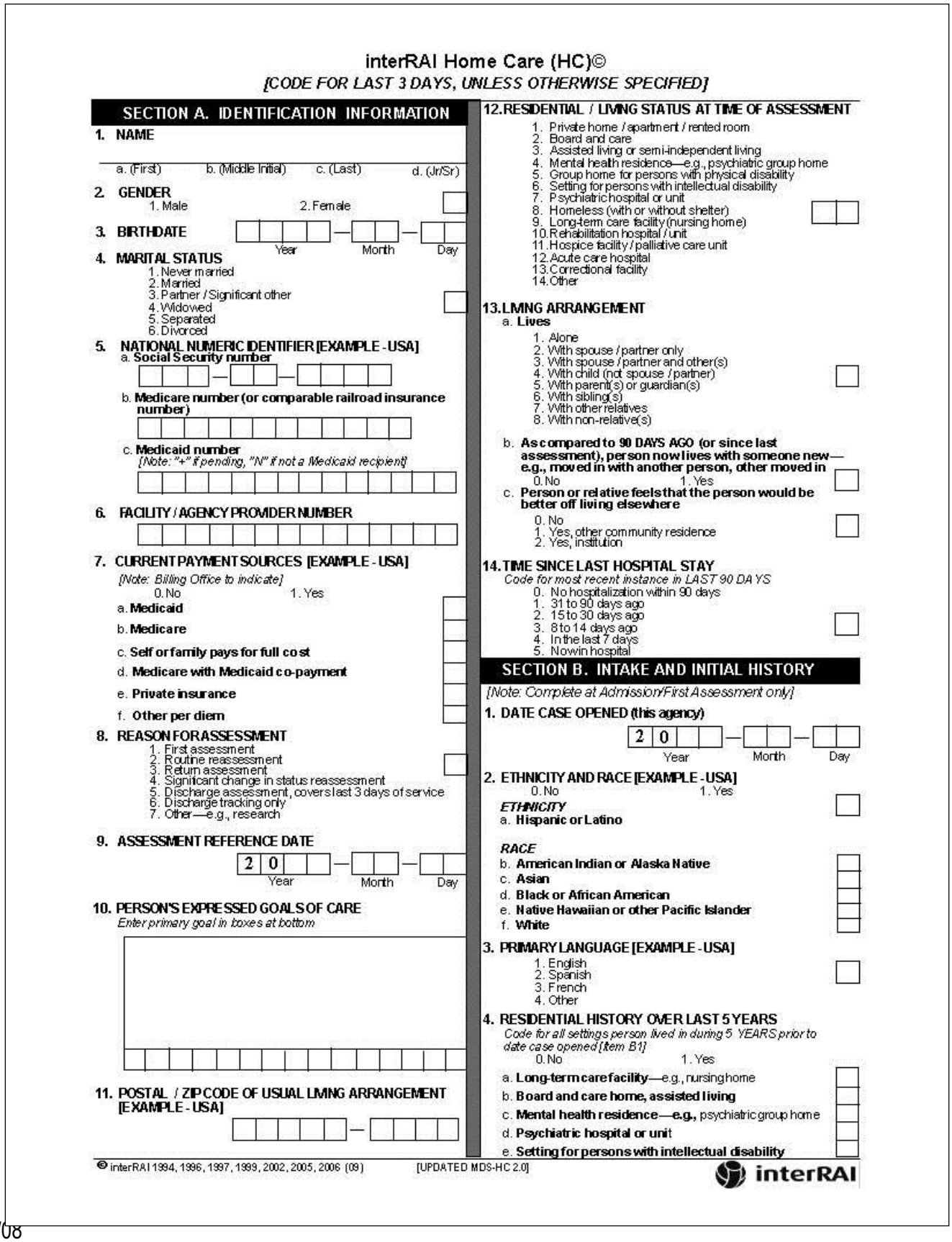
__Comm __Skin __Clin __Meds __I/ADLs __Trans/MOB

__Nutr'n __Behavior __Inf Support __Incontinence

Corrective Action Taken:

Rev. 04/11 Note: Remember when assessing LOC with the Multi Data Set – Home Care (MDS-HC) that the target population for SOURCE are physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance in the performance of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs); these individuals must meet the Definition for Intermediate Nursing Home LEVEL OF CARE.)

Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER
1. Male 2. Female

3. BIRTHDATE
Year Month Day

4. MARITAL STATUS
1. Never married
2. Married
3. Partner / Significant other
4. Widowed
5. Separated
6. Divorced

5. NATIONAL NUMERIC IDENTIFIER [EXAMPLE - USA]
a. **Social Security number**

b. **Medicare number (or comparable railroad insurance number)**

c. **Medicaid number**
[Note: "+" if pending, "N" if not a Medicaid recipient]

6. FACILITY / AGENCY PROVIDER NUMBER

7. CURRENT PAYMENT SOURCES [EXAMPLE - USA]
[Note: Billing Office to indicate]
0. No 1. Yes
a. **Medicaid**
b. **Medicare**
c. **Self or family pays for full cost**
d. **Medicare with Medicaid co-payment**
e. **Private insurance**
f. **Other per diem**

8. REASON FOR ASSESSMENT
1. First assessment
2. Routine reassessment
3. Return assessment
4. Significant change in status reassessment
5. Discharge assessment, covers last 3 days of service
6. Discharge tracking only
7. Other—e.g., research

9. ASSESSMENT REFERENCE DATE
2 0 — — —
Year Month Day

10. PERSON'S EXPRESSED GOALS OF CARE
Enter primary goal in boxes at bottom

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - USA]

12. 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

13. LIVING ARRANGEMENT
a. **Lives**
1. Alone
2. With spouse / partner only
3. With spouse / partner and other(s)
4. With child (not spouse / partner)
5. With parent(s) or guardian(s)
6. With sibling(s)
7. With other relatives
8. With non-relative(s)

b. **As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new—e.g., moved in with another person, other moved in**
0. No 1. Yes

c. **Person or relative feels that the person would be better off living elsewhere**
0. No
1. Yes, other community residence
2. Yes, institution

14. TIME SINCE LAST HOSPITAL STAY
Code for most recent instance in LAST 90 DAYS
0. No hospitalization within 90 days
1. 31 to 90 days ago
2. 15 to 30 days ago
3. 8 to 14 days ago
4. In the last 7 days
5. Now in hospital

SECTION B. INTAKE AND INITIAL HISTORY

[Note: Complete at Admission/First Assessment only]

1. DATE CASE OPENED (this agency)
2 0 — — —
Year Month Day

2. ETHNICITY AND RACE [EXAMPLE - USA]
0. No 1. Yes

ETHNICITY
a. **Hispanic or Latino**

RACE
b. **American Indian or Alaska Native**
c. **Asian**
d. **Black or African American**
e. **Native Hawaiian or other Pacific Islander**
f. **White**

3. PRIMARY LANGUAGE [EXAMPLE - USA]
1. English
2. Spanish
3. French
4. Other

4. RESIDENTIAL HISTORY OVER LAST 5 YEARS
Code for all settings person lived in during 5 YEARS prior to date case opened [Item B1]
0. No 1. Yes
a. **Long-term care facility**—e.g., nursing home
b. **Board and care home, assisted living**
c. **Mental health residence—e.g.,** psychiatric group home
d. **Psychiatric hospital or unit**
e. **Setting for persons with intellectual disability**

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Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance

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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 (bedroom, 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 8. 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 let 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 other's belongings
e. **Inappropriate public sexual behavior or public disrobing**
f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

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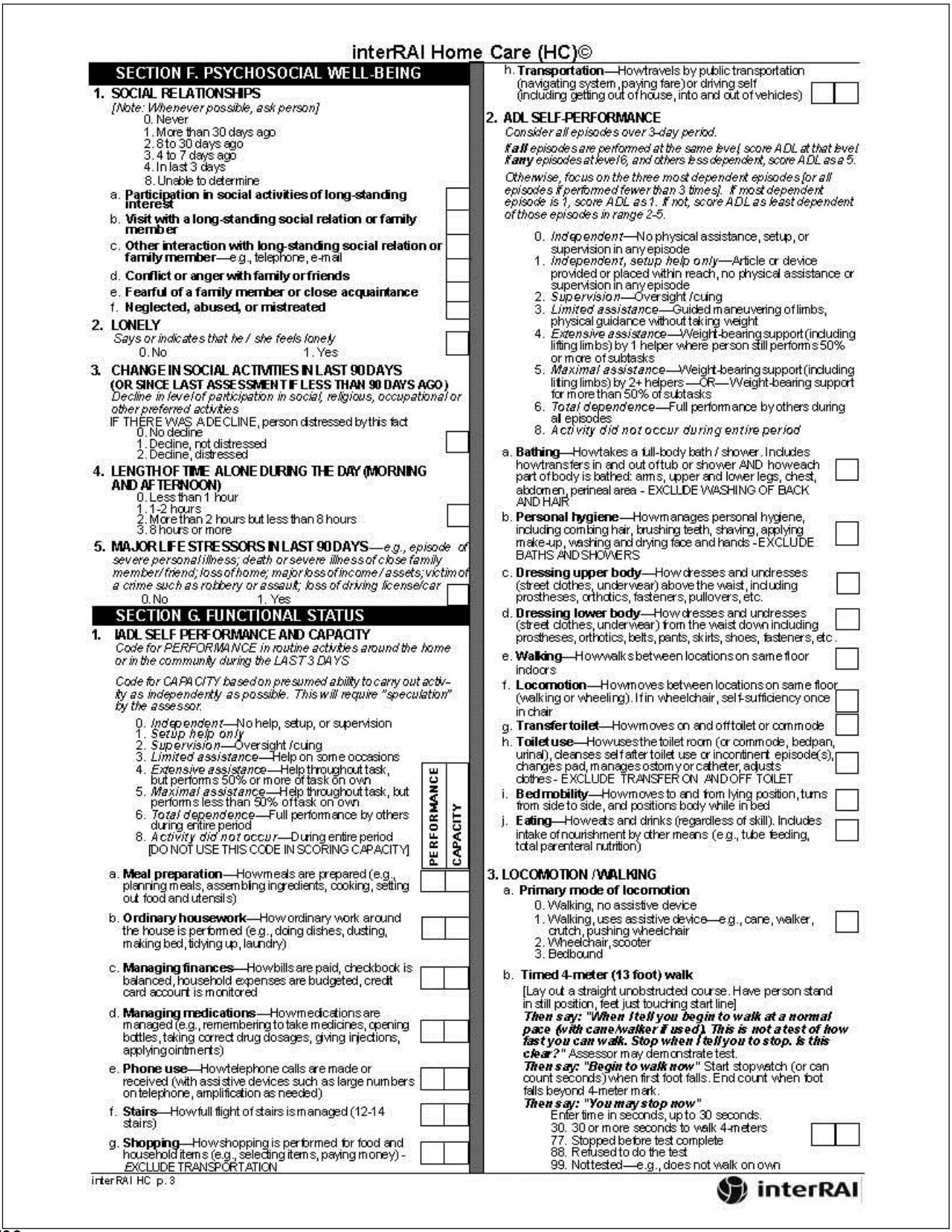
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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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]

	PERFORMANCE	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 [or 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 and 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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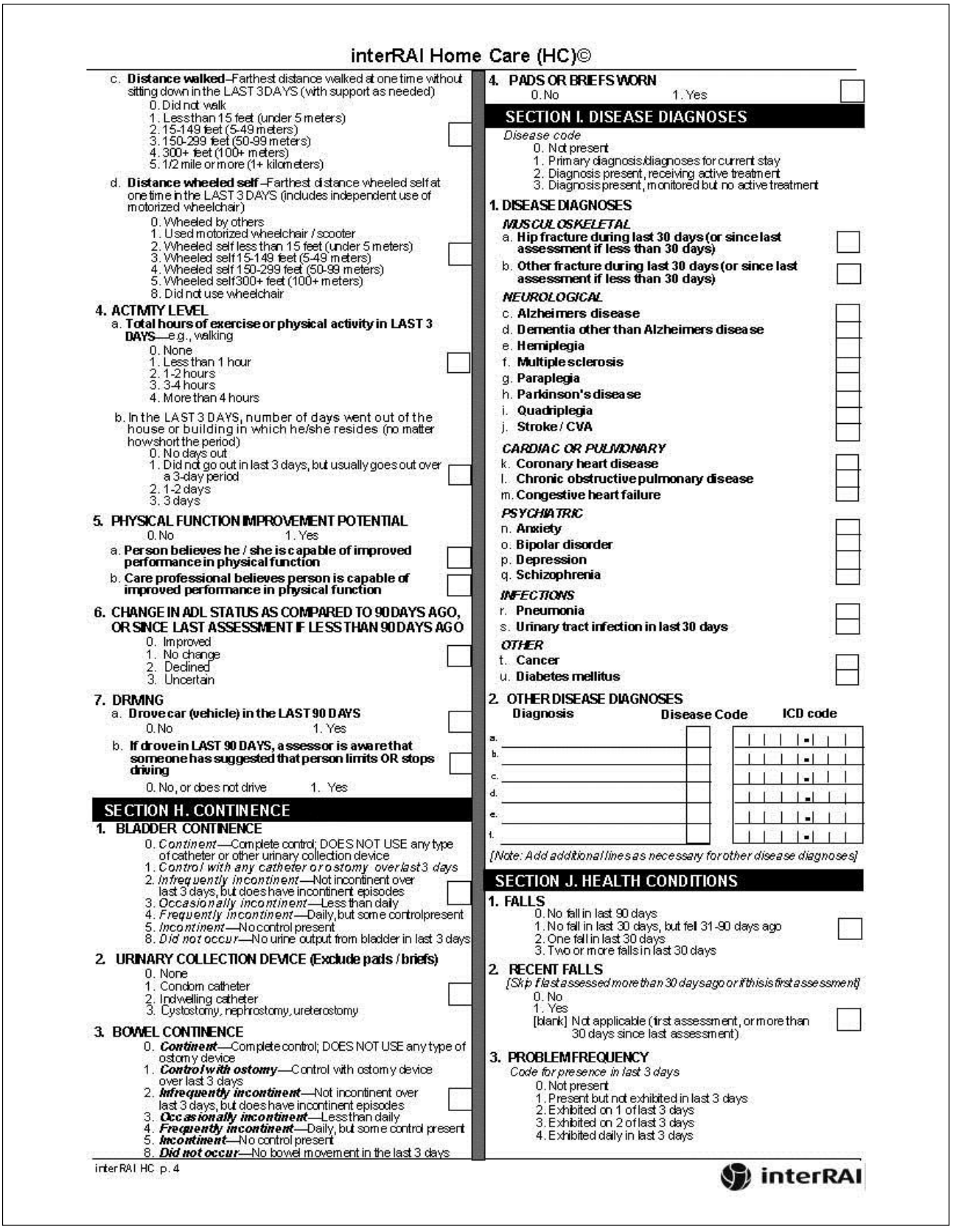
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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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, a 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

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 if last 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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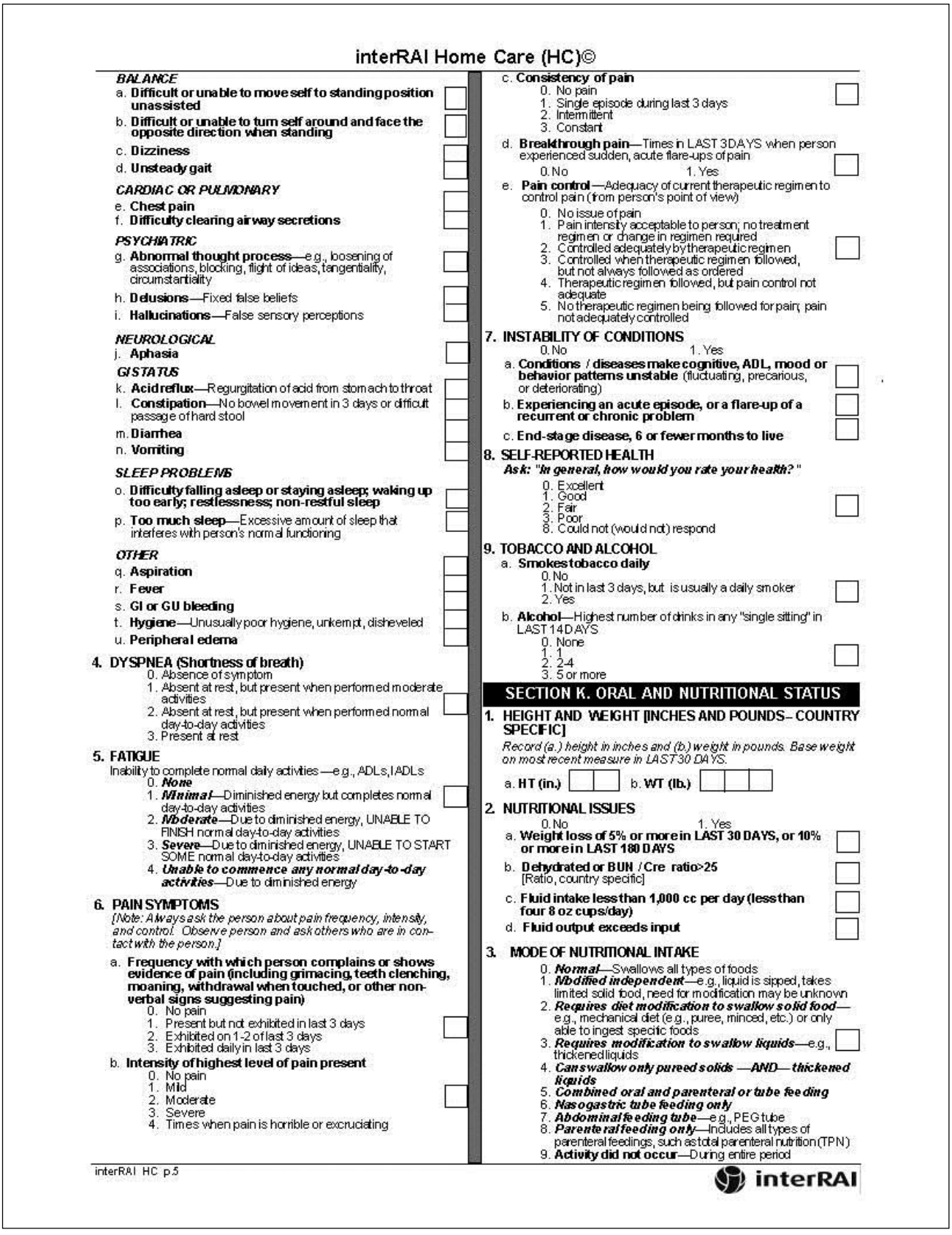
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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BALANCE
a. **Difficult or unable to move self to standing position unassisted**
b. **Difficult or unable to turn self around and face the opposite direction when standing**
c. **Dizziness**
d. **Unsteady gait**

CARDIAC OR PULMONARY
e. **Chest pain**
f. **Difficulty clearing airway secretions**

PSYCHIATRIC
g. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
h. **Delusions**—Fixed false beliefs
i. **Hallucinations**—False sensory perceptions

NEUROLOGICAL
j. **Aphasia**

GI STATUS
k. **Acid reflux**—Regurgitation of acid from stomach to throat
l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
m. **Diarrhea**
n. **Vomiting**

SLEEP PROBLEMS
o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**
p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning

OTHER
q. **Aspiration**
r. **Fever**
s. **GI or GU bleeding**
t. **Hygiene**—Unusually poor hygiene, unkempt, disheveled
u. **Peripheral edema**

4. DYSPNEA (Shortness of breath)
0. Absence of symptom
1. Absent at rest, but present when performed moderate activities
2. Absent at rest, but present when performed normal day-to-day activities
3. Present at rest

5. FATIGUE
Inability to complete normal daily activities—e.g., ADLs, IADLs
0. ***None***
1. ***Minimal***—Diminished energy but completes normal day-to-day activities
2. ***Moderate***—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3. ***Severe***—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4. ***Unable to commence any normal day-to-day activities***—Due to diminished energy

6. PAIN SYMPTOMS
[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

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)**
0. No pain
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

b. **Intensity of highest level of pain present**
0. No pain
1. Mild
2. Moderate
3. Severe
4. Times when pain is horrible or excruciating

c. **Consistency of pain**
0. No pain
1. Single episode during last 3 days
2. Intermittent
3. Constant

d. **Breakthrough pain**—Times in LAST 3DAYS when person experienced sudden, acute flare-ups of pain
0. No 1. Yes

e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
0. No issue of pain
1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
2. Controlled adequately by therapeutic regimen
3. Controlled when therapeutic regimen followed, but not always followed as ordered
4. Therapeutic regimen followed, but pain control not adequate
5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS
0. No 1. Yes
a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating)
b. **Experiencing an acute episode, or a flare-up of a recurrent or chronic problem**
c. **End-stage disease, 6 or fewer months to live**

8. SELF-REPORTED HEALTH
Ask: "In general, how would you rate your health?"
0. Excellent
1. Good
2. Fair
3. Poor
8. Could not (would not) respond

9. TOBACCO AND ALCOHOL
a. **Smokes tobacco daily**
0. No
1. Not in last 3 days, but is usually a daily smoker
2. Yes

b. **Alcohol**—Highest number of drinks in any "single sitting" in LAST 14 DAYS
0. None
1. 1
2. 2-4
3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT [INCHES AND POUNDS– COUNTRY SPECIFIC]
Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.
a. **HT (in.)** ☐☐ b. **WT (lb.)** ☐☐☐

2. NUTRITIONAL ISSUES
0. No 1. Yes
a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**
b. **Dehydrated or BUN / Cre ratio>25** [Ratio, country specific]
c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)**
d. **Fluid output exceeds input**

3. MODE OF NUTRITIONAL INTAKE
0. ***Normal***—Swallows all types of foods
1. ***Modified independent***—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
2. ***Requires diet modification to swallow solid food***—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
3. ***Requires modification to swallow liquids***—e.g., thickened liquids
4. ***Can swallow only pureed solids —AND— thickened liquids***
5. ***Combined oral and parenteral or tube feeding***
6. ***Nasogastric tube feeding only***
7. ***Abdominal feeding tube***—e.g., PEG tube
8. ***Parenteral feeding only***—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
9. **Activity did not occur**—During entire period

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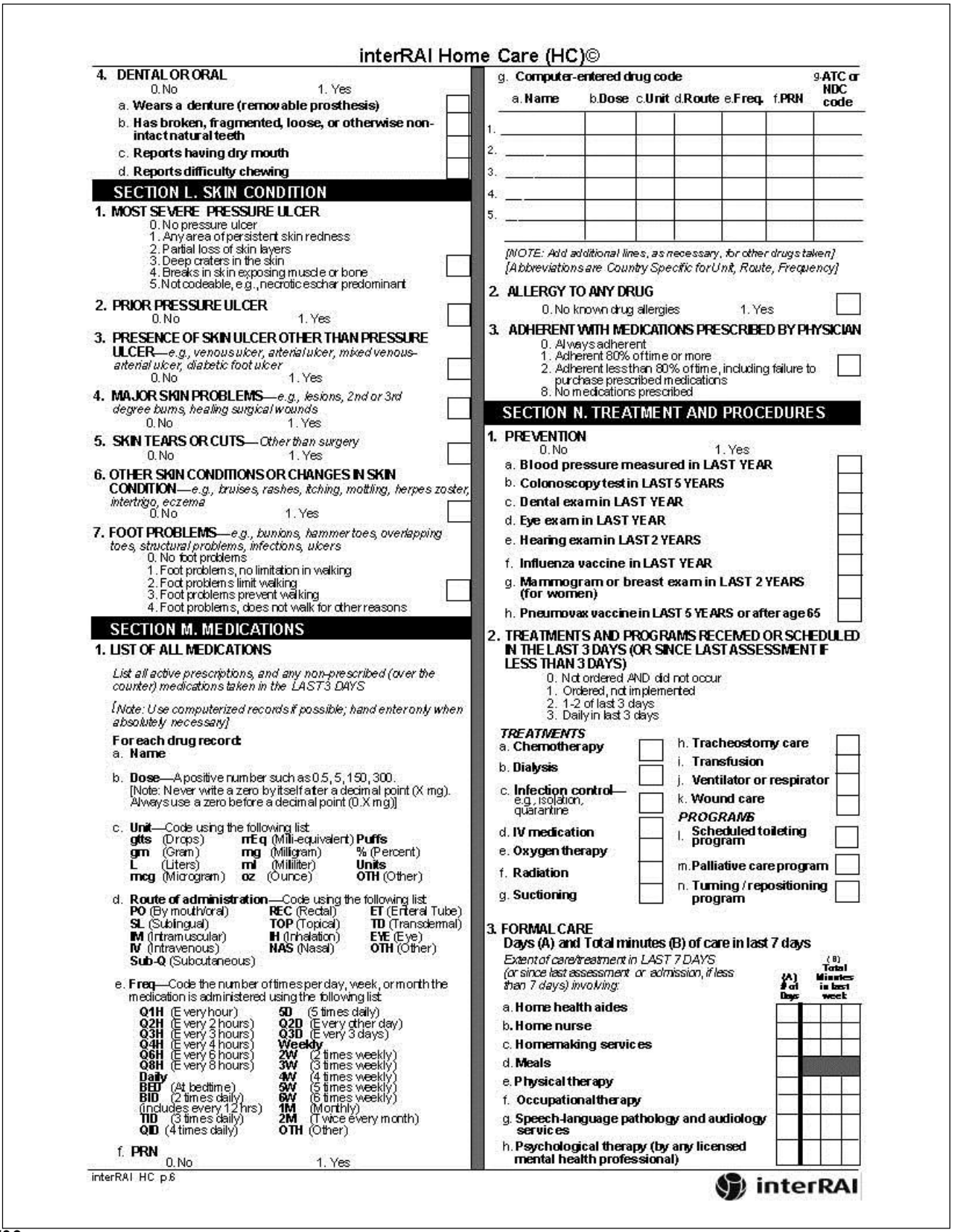
Look for physically disabled individuals who are functionally impaired, or who have acquired a cognitive loss, that results in the need for assistance



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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, mottling, 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:
gtts (Drops) **mEq** (Mili-equivalent) **Puffs**
gm (Gram) **mg** (Miligram) **%** (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** (Enteral 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)
BED (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** (Twice every month)
QID (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
8. 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**
b. **Dialysis**
c. **Infection control**—e.g., isolation, quarantine
d. **IV medication**
e. **Oxygen therapy**
f. **Radiation**
g. **Suctioning**
h. **Tracheostomy care**
i. **Transfusion**
j. **Ventilator or respirator**
k. **Wound care**

PROGRAMS
l. **Scheduled toileting program**
m. **Palliative care program**
n. **Turning / repositioning program**

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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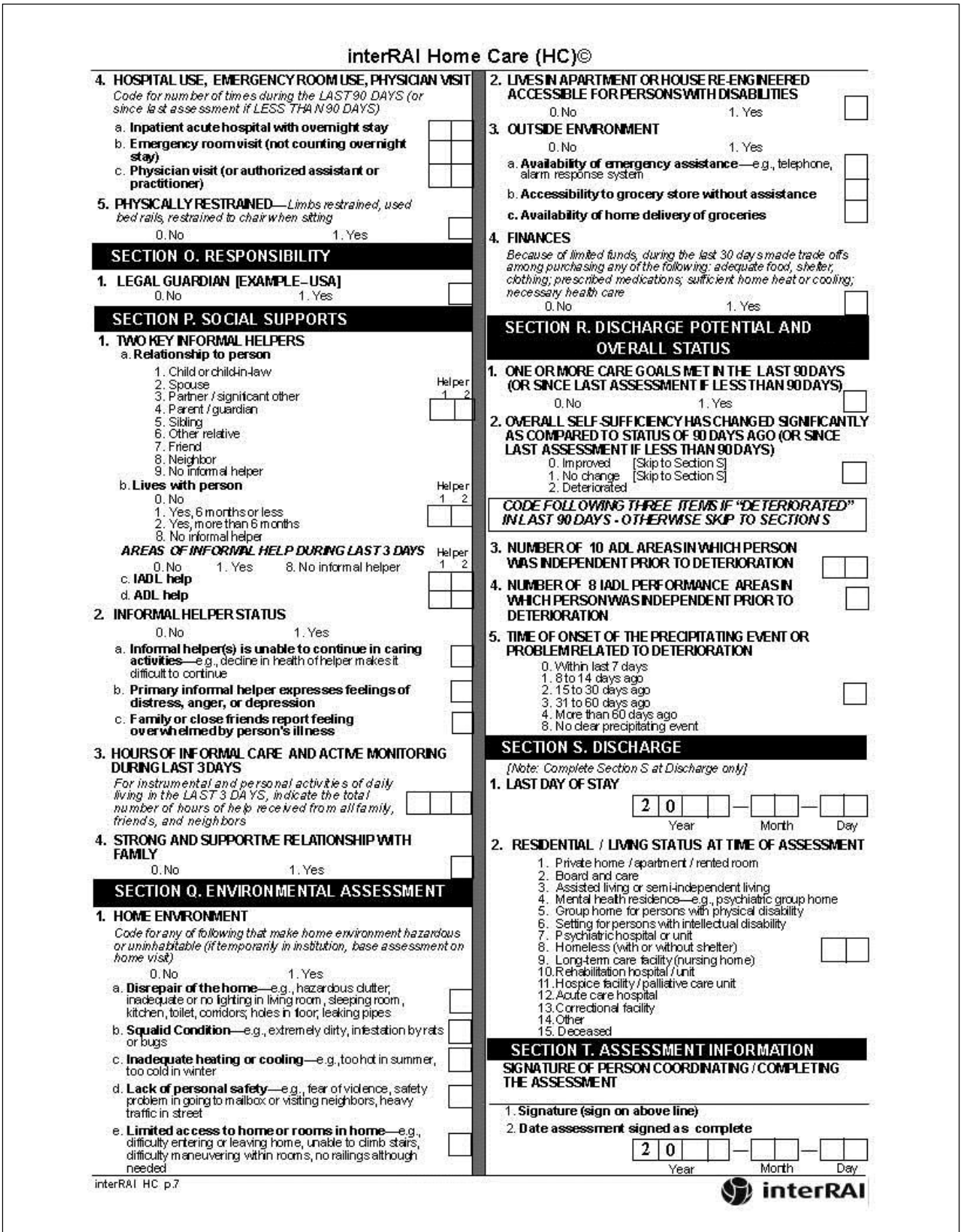

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4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)
a. **Inpatient acute hospital with overnight stay**
b. **Emergency room visit (not counting overnight 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
2. Spouse
3. Partner / significant other
4. Parent / guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper
Helper 1 2

b. **Lives with person**
0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper
Helper 1 2

AREAS OF INFORMAL HELP DURING LAST 3 DAYS
0. No 1. Yes 8. No informal helper
Helper 1 2
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

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
2 0 — — —
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**
2 0 — — —
Year Month Day

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APPENDIX T

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MDS-HC Participants
SOURCE Program

Participant	Agency	Relationship to Applicant	Date

RN Who Reviewed MDS HC for Completeness: (Printed) :	RN signature	Date:

Appendix T needs to be signed and dated by R.N. SOP is within 10 business days of completion of the MDS-HC.

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APPENDIX U1

SOURCE MONTHLY CONTACT SHEET

Use this form for Case management **Monthly Contact Sheet.** May use this form **or** U2 for **quarterly reviews**. Review these areas with member or member's caregiver each month. See section 1302. Summarize this info with PCP during quarterly visits by transferring information to PCP contact sheet.

Member's Name:_____ Level:_____ PCP:_____

Date of Birth

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Services Ordered: _____ Significant Diagnosis:_____

Column A	Column B	Column C
PROCESS See Policy 1302	**1st 2nd 3rd 4th (circle quarter) QUARTERLY OBJECTIVES Circle Variances**	**MONITORING/CASENOTES √: if GM goals met. CN: see case notes. NA: not applicable**
Monthly Contacts (Minimum) **Circle Specifics below:**	**I have Reviewed with the member:** **Community Services:**	*Quality Service Level provided? Complaints?*
	Medical Appts and Dates: ☐ **PCP or** ☐ **Specialist**	Document reason and outcome of appt i.e. new diagnosis, meds, referrals etc. or NO APPTs
	Emergency Room Visit or Hospitalizations	*Document number, reason , outcome if any of these occurred*
Month 1 _____ DATE **Month 2_____** DATE **Other _____**	**Diet and Nutrition Goals:**	*Weight stable, feeding problems, following diet*
	Skin Integrity Goals:	*Details for any skin openings or decubiti: ie stable, worsening, new*
	Clinical Goals	*Is blood pressure, blood sugar or other within goal?*
	ADL/IADL Goals	*Any disruptions in ADL or IADL maintenance?*
Home Visit or Phone or Other_____	**Transfer and Mobility Goals**	*Any falls or concerns with Transfers or Mobility?*
_____ Copies of Advance Directives received, if applicable	**Behavioral Goals:**	*Any problem behaviors?*
	Care Giver Support Goals	*Informal caregivers maintained in member's life?*
Any Variances Yes No Document # of Variances (In Quarter) ___	**Incontinence Goals:** ☐ **Ostomy or** ☐ **Catheter**	*Incontinence issues including supplies*
	Medications (update list from chart)	*Adherence issue? Problems?*
Disease Management Tracking Log Reviewed Yes No N/A	**Disease Management (DM)** (Does member Have or Need DM)	*Is Intervention needed? What will be done?*
Any Sentinels this month/Quarter? Yes No # of Sentinels	**Notes (***include resolution of last month's variances, if any, teaching done on DM***):**	
	Appropriate follow up actions/ interventions needed:	

CM Signature and Date	Member Signature and Date (if face to face)
CM Supervisor Signature and Date (quarterly)	

Section D

Tips for Appendix U1

Tips for completing Appendix U for Monthly Reviews

Before calling member: fill out Column A, Review chart for any phone calls, notes, variances, sentinel events, service problems. Make notes of any follow up information you may need from the member. Pull most recent medication record. Move back and forth between columns Band C while speaking with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Tips for completing Appendix U for Quarterly Reviews:

Before visiting member fill out Column A. Review member's chart for any phone calls, notes, variances, sentinel events, service problems. Make notes of any follow up information you may need from the member. Review Carepath and use columns B and C for short summaries. Take copy of Medication Record to confirm with member.

Complete section D with thoughtful review on conversation with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines

Per Policy: **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 Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.**

APPENDIX U2

SOURCE QUARTERLY ALTERNATE /ANNUAL CONTACT SHEET

Document on this form before and during Carepath review with member. See Policy 1302.

Member's Name:_____ Level:_____ PCP:_____

Date of Birth: _____ Significant Diagnosis:_____

PROCESS	1st 2nd 3rd 4th **QUARTERLY/ ANNUAL OBJECTIVES** √: if GM goals met, Circle Variance, NA: not applicable	**MONITORING/CASE NOTES** (Date and CM Signature required each contact)
Quarterly Review OR Annual Re-evaluation	_____COMM ___NUTR'N _____SKIN _____CLIN ____MEDS _____I/ADL _____BEH ____TRANS ____INF SUPP (√ = goals met, circle variances) No. of Emergency Room visits: No. of Hospitalizations: Sentinel Events this quarter? Yes No Or Number of Sentinels this year# _____	_____ See member chart for additional information **on**: _____ Copies of Advance Directives received, if applicable
Phone, Face to Face Other ____		

Does member have / need **Disease Management** (see policy section 1310)? Yes No

If so, information given/ reviewed with patient:_____ OR

Is skilled nursing, RN or PCP care, or other intervention needed for DM and will be recommended at team meeting? Yes No

(Circle appropriate intervention if needed)

Notes/Additional Follow-up actions indicated by this review:_____

_____

Δ Confirm/ List medications for Annual Visit:

Name	Dosage	Who ordered?	Member Compliant?	Notes

Δ For Annual Evaluation: **Member Stated Goals** for year: _____

Member Signature and **Date**

Case Management Signature and **Date**

Case Management Supervisor Signature (quarterly) **Date**

Tips for Appendix U2

U2 can be used instead of appendix U for quarterly visits. Always use U2 for Annual contact with members

Quarterly visits:

Before speaking with member, Fill out Column labeled *Process* and Pull/ copy a recent medication list.

.Review chart for any phone calls, notes, variances, sentinel events, service problems. Pull Carepath to review with member. Make notes of any information you may need from the member.

Complete quarterly objectives with member while reviewing Carepath. Complete monitoring notes with thoughtful review with member taking into consideration variances/ sentinels. Review non-urgent issues including new medications during Case Management supervisory review. Escalate problems to PCP conferences as needed. Urgent matters should be discussed and handled per individual agency guidelines.

Per Policy: **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 Providers, program supervisors, and if applicable, providers; Carepaths provide guidance and formal structure for the concurrent review process.**

Δ **Annual visits:**

See guidelines above for quarterly visits and also complete the areas marked with triangle symbol.

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APPENDIX U3

SOURCE QUARTERLY ALTERNATE /ANNUAL CONTACT SHEET

PCP CONFERENCE

Date:

Member's Name:_____ Level:_____ PCP:_____

Date of Birth: _____ Significant Diagnosis:_____

Current Services: _____ER Visits/ Hospitalizations? Yes NO Why?_____

PCP recommendations for prevention_____

Does member need a SOURCE Disease Management Tracking Log? **Y N** If so, was it reviewed? **Y N**

Document all member deficits

Case Management or RN: prepare as much as possible ahead of time to present to PCP.

✓ Use Check if Goal is met for Area, Circle if not met, N/A if not applicable. Comments from Agency and PCP are encouraged.

☐ Keeping PCP Appointments _____
PCP _____

☐ Diet/Weight_____
PCP_____

☐ Behavior Issues _____
PCP _____

☐ ADL/IADL Needs _____
PCP_____

☐ Medication Compliance _____
PCP _____

☐ Falls/Mobility Issues _____
PCP _____

☐ Clinical Indicators – list and give current range (lab, v/s) _____
PCP _____
Is Flu/Pneumonia/ Other Vaccine Due? Y N

☐ Skin Care/Breakdowns_____
PCP _____

☐ Caregiver Issues_____
PCP _____

☐ Continence Issues _____
PCP _____

New Diagnoses! _____

Variances (goals not met): Y N what is problem_____
SENTINEL Events this Quarter? Y N _____
PCP is Medical appt or Referral needed to address Sentinel/ Variances?

Review Carepath, record any changes made. _____

Confirm/ List medications with PCP office Quarterly. * = new medications:

Member Health complaints/ risks that may be due to Medication actions, list here so PCP may assess. Such as Fall/ER/ weakness/Dizziness, other._____

✓ **PCP Notes/Comments/Goals for member at any visit**:

✓ Major Changes/Concerns in Functional Status: Yes No *Physical or cognitive?*_____ _____

_____ _____ _____
PCP Signature MD/PA/NP Date

_____ _____
CM Signature Date Case Management Supervisor Signature Date

CM received H&P, notes, labs needed _____
PCP Signed Care path _____

PCP Signed Contact Sheet _____
Other_____

Tips for Appendix U3 PCP Conference

Use this form to prepare and summarize before visit with PCP case management areas of interest to medical providers (quarterly visit go back to the beginning of the quarter) (with annual visits go back one year) such as:

1. Circle which quarterly visit or is this the closest date to the member's Annual visit where member will be reassessed for the program?
2. Document which home and community services member receives (case management is a given)
3. Does the member have or now need disease management tracking? See Policy section 1310.
4. Were the majority of appointments with the PCP kept? Were the majority of appointments with the specialist kept? (Write in N/A if no specialist visits needed).
5. Review member chart and estimate number of emergency department visits and hospitalizations.
6. Review member chart to see if variances occurred. Circle the section and write a brief note on variance (ie. resolved, in progress, etc) under the correct areas.

   Were diet goals met? Were there any variance? Short note to indicate progress if a variance was reported (ie resolved or ongoing?)

   Are there any skin breakdowns or poorly healing wounds? Locations and variances are self explanatory.

   Clinical Goals: if any routine medical tests are followed by the member for health conditions, are they within acceptable ranges for the re-evaluation time period? (BP stands for blood pressure, FSBS stands for fasting blood sugar, O2 is oxygen management) These are common tests followed. Enter tests you and PCP feel are critical.

   ADL /IADL goals for transfers and mobility. Fill out as indicated.

   Behavioral Issues: Complete as indicated.

   Caregiver Support Issues. Fill out as indicated.
7. Please list all current medications.
   a. If member has medications, are they taking them as indicated?
8. Any significant sentinel events this year? If yes, just indicate type ie abuse, fall, neglect etc

II. When meeting with PCP, please encourage provider to jot comments, notes, and goals on form.

9. If any areas not reviewed, document why it was not reviewed.
10. PCP and Case management signs form.
11. If there is an annual re evaluation due for the member within 3 months, go over information in black box with PCP.

    ❖ It's very important to confirm if PCP agrees that member has ADL and/or IADL deficits and the etiology or diagnosis that is causing the deficits.

    ❖ You may inform the PCP that for SOURCE, those deficits must be due to a physical deficit or a cognitive loss, and rise to Nursing Home Level of Care which is determined by standardized assessment tools, and team review of all pertinent information on the member.

    If PCP has questions, have an agency R.N. or supervisor speak to PCP

APPENDIX V

SOURCE Referral Form

Rev. 01/09

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_____

Appendix F is good through date:_____

Member is under administrative review. Please continue services until: _____

APPENDIX V

SOURCE Referral Form

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:

SOURCE Site _____

Signature_____ Date_____

Title_____

APPENDIX W
MIF

SOURCE Member Information Form

_Provider to Case Manager _Case Manager to Provider

Rev. 10/2015 04/10

_Initial _Change _Discharge _FYI Response required? _YES _NO

Provider Name _____

Member Name _____ 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 mbr's. Health/functional status
_Hospitalization
_Service not delivered
_Change in frequency/units by case manager
_Change of physician/CM
_Other
_FYI

Explanation: _____

_____

_____ Effective date of change: _____

Discharge

Discharge Reason _____

_____

Date of Discharge _____

COMMENTS: _____
Prior Authorization Dates: ---------- to _____ PA #_____
_____

Signature _____Date _____
Title _____Phone_____
Signature _____Date _____
Title _____Phone_____

APPENDIX W
MIF

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.

Rev 07/09

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

Rev. 10/15 **SOURCE MEMBER TRANSFER FORM**

SOURCE Program: Prior LOC Authorization Number: _____
Expiration Date: _____

1. Member name
_____DOB:_____
(Last, First, M.I.)

2. Social Security number _____
Medicaid number _____

3b. Other Contact Information:_____

3. Member transfer from:
SOURCE Agency Name and Provider ID#: _____

County _____

Care coordinator / Contact person _____

Telephone ( ) _____

Last service day _____

Member's previous address _____

City _____ State _____ Zip _____

5. Member transfer to:

SOURCE Agency Name and Provider ID#: _____

County _____

Case Manager/Contact person _____

Telephone _____

Member's new address _____

City _____State___ _____ Zip _____

Telephone ( ) _____
Rev. 07/11

Instructions

SOURCE MEMBER TRANSFERS

Purpose: The member transfer form is used to transfer case records and to notify GMCF of transfer.

Who Completes/When Completed: The case manager completes the member transfer form. It accompanies the original case record of the last year of service to the receiving agency.
Original agency is responsible for providing one year of copied records to the receiving agency.
Receiving agency uses those records for historical reference and picks up monthly contacts, service, and care path reviews from the previous dates and related standards of promptness
Full reassessment is required within 10 days in the case of a change of address that impacts caregiver availability, environmental issues related to service delivery, or needs of the member.

Instructions:

1. Enter member's name (last name, first, and middle initial) and Date of Birth.

2. Enter member's social security number.

3. Enter member's Medicaid number.

4. Enter SOURCE Agency and county member is transferring from.

    - Enter the name, area code, and telephone number of the case manager/contact person transferring the case record.

    - Enter member's last date of service.

    - Enter member's prior address.

5. Enter SOURCE AGENCY and county member is transferring to.

    - Enter the name, area code, and telephone number of the case manager/contact person receiving the case record. If the new case manager's name is not known default to the new agency/SOURCE site.

    - Enter member's new address.

APPENDIX X SOURCE MEMBER TRANSFERS

Distribution: The original Member Transfer accompanies the original member case record to the receiving SOURCE agency. A copy is filed in the duplicate case record maintained at the transferring SOURCE agency.
NOTE: This form or a copy of this form is used by the case manager to ensure care continuity.

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. SUPPOR
___ INCONTINENCE

APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

Rev. 7/16

1. To _____ SSN xxx-xxx-_____Date: _____

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:

☐ 2.Decision to **Reduce Services**: you have been determined to require fewer services because _____

OR

☐ 3.Decision to **Terminate or Deny Services**: You **do not meet** the **eligibility** requirements as found in the Elderly and Disabled 1915-c Home and Community Based Services Medicaid Waiver as outlined in Section 701 in the Georgia Department of Community Health Manual, Part II Policies and Procedures for Service Options Using Resources in Community Environments (SOURCE).

You do not meet the eligibility requirements because (check as many as apply)

- ☐ a) You don't Receive full Medicaid (this excludes SLMB, QMB, or QI Medicaid)/ or full Medicaid under SSI or Public Law categories
  Contact your local DFCS and ask if you are eligible for waiver Medicaid
- ☐ b) You did not have SSI. You must contact Social Security at 1-800-772-1213
- ☐ c) You are an excluded member of Medicaid because you are, at the time of application or enrollment you are:
  - ☐ A Member with retroactive eligibility only or presumptive eligibility
  - ☐ A Member in an institution, including skilled nursing facilities, hospital swing bed units, in patient hospice, intermediate care facilities for people with developmental disabilities, or correctional institutions in the Georgia Families program
  - ☐ A Child enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Children's Medical Services) or receiving services under Title V (CMS funding)
  - ☐ A Member in another waiver program (CCSP, Independent Care Waiver, the NOW and COMP Waiver Programs or the Georgia Pediatric Program (GAPP)
  - ☐ A Child whose care is coordinated under the PRTF program
  - ☐ A member of a federally- recognized Indian Tribe
- ☐ d) You did not Meet the 1915-c Waiver target population guidelines see- section 801.3 of the SOURCE manual: Your primary diagnosis or your primary needs are psychiatric or related to a developmental disability rather than medical needs
- ☐ e) You don't meet **criteria for Intermediate Nursing Home Level of Care** (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I
  (Assessment indicates it is NOT necessary for you to reside in a Nursing Home for the elderly or physically disabled)

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Last revision 7/13/2013 Continue onto next page

APPENDIX Z (continued)

To _____

- ☐ f) Your cost of medically necessary services that can be provided by SOURCE is higher than the Medicaid cost of nursing facility care
- ☐ g) You are not cooperative with enrollment in SOURCE (Member did not (have/do/ complete/ refuses etc.) _____
- ☐ h)You don't live in / or have moved from a SOURCE Enhanced Case Management's designated service area
- ☐ i) You don't have the capability, 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)
- ☐ j) You are an applicant who has all needs met by your informal support
- ☐ k) You failed to meet requirements at initial screening :
  - ☐ Your DON-R (determination of need-revised) score was too low to meet admission requirements
  - ☐ You don't have unmet needs_____
- ☐ l) Other

  _____

If you 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

4. Call your SOURCE Case Manager or Care Agency if you do not understand this letter. Call:

Name of Case Manager /Other	Agency	Phone

5. Appendix I in table format enclosed? Yes No

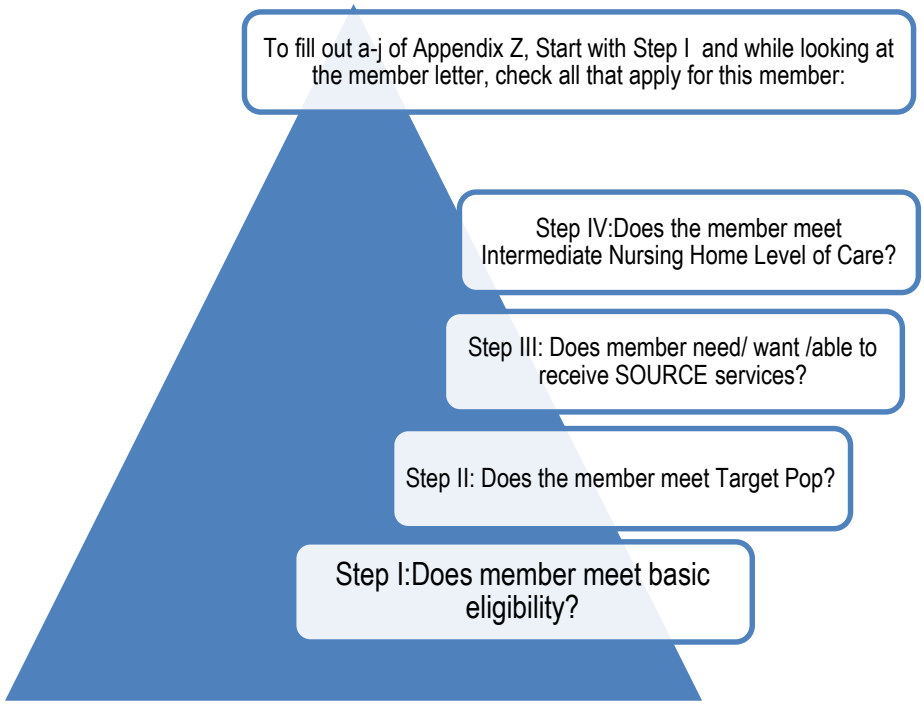
APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

Instructions for agency completion of Appendix Z

Agency Use ONLY

Appendix Z is a mandatory form that must be used as formatted by DCH.

1. Fill in member's name, last 4 digits of Social security number, and date
2. Check this option if you are reducing services. Write in the reason for the reduction in services.
    i. Then: Skip to #4 and give the member contact information
3. Check this option if denying or terminating services. Then see pyramid to complete a-j.
4. Always complete #4.
5. Indicate whether Appendix I is enclosed (must be table format)



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07/13

I. Basic eligibility choices:

Check a-c if any of these apply for the member:

a) You do not receive full **Medicaid or Full Medicaid** under SSI or Public Law categories
b) You did not have SSI. You must contact Social Security at 1-800-772-1213
c) You are an excluded member of Medicaid (check why the member is excluded)

II. Target population choice:

Did the member not meet criteria for SOURCE because they are not the target population for this waiver—i.e.:

Go to and check #d if the member is under age 65 years and their primary diagnoses that are causing problems is mental illness or mental retardation.

Step III Other choices:

Check f-l if any of these applies to the member.

Note: Detail the reason for non-compliance if #g is selected.

Note: Fill in the details for l if any other reasons apply.

Step IV Intermediate Nursing Home level of care:

Check if this applies to the member

For every member denied or terminated services, decide if the member meets the definition to enter a Medicaid Nursing home facility i.e. if the member presented to a Nursing Home today, would they be accepted? (This is not a facility for the mentally retarded or with developmental disability) If the answer is no, check this box and send out a clean Appendix I in table format to send to client. Table I worksheet is recommended.

☐ e) Meet criteria for Intermediate Nursing Home Level of Care (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I

Appendix I in **table format** must be sent to member if completed in the course of assessment work for denial or terminations. A final "worksheet "version may be sent to member. Detail Column A with all applicable diagnoses. If Column B has any etiologies written in, indicate why the member does not meet. Column C should not appear to indicate nursing home level of care.

Appendix Z notice pages 1-2 must be sent to member as shown in this manual.

APPENDIX Z
NOTICE OF DENIAL, TERMINATION or REDUCTION in SOURCE Services

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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:

1. **Georgia Legal Services Program**
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. **Georgia Advocacy Office**
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

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)

4. **State Ombudsman Office**
   1-888-454-5826
   (Nursing Home or Personal Care Home)

APPENDIX Z
SOURCE PCP Concurrence Form for Discharge Planning

This form is Only completed for Discharged Members that Did Not Meet" Level of Care".

The purpose of this form is to document PCP concurrence and Discharge Planning for members denied admission or continued enrollment and received an "Appendix Z" for not meeting Intermediate Nursing Home Level of Care. Documentation must include current services and community resources available to assist with the member's needs. The R.N./L.P.N. must sign and confirm PCP concurrence of the current assessment.

Member: _____**Medicaid ID**: _____DOB:_____

Diagnoses_____

Case Management Agency:_____

Document the date that the nurse reviewed the member's functionality and health with the member's PCP to ensure concurrence with MDS HC data.

- PCP Name and date of contact: _____
- Member's functionality and health of member confirmed with PCP □ Yes and □concurs with data on MDS HC □No not confirmed or does not concur (include supportive documentation below)
  _____
  _____
  _____
- Diagnosis, Medications, Treatments confirmed? □ Yes □No
- Referrals in last 3 months? □ Yes □ No If yes, provide additional information?
  _____
  _____
  _____
- R.N. /L.P.N. Name and Phone:
  _____
- Additional information (if applicable):
  _____
  _____
  _____
  _____

APPENDIX Z

Case Management Discharge Planning for SOURCE

Complete and provide a copy to the member no later than 15 days following a SOURCE involuntarily discharge

Section A:
Member's Name: _____ Medicaid number: _____ Today's Date: _____
Member's Address: _____

Discharge Planning Received by (name/relationship): _____Date: ___/___/____
Mail _____ In Person _____ (check or circle)
Follow-up Date: ____/___/____ Mail _____ In Person _____ Phone _____ (check or circle)

Case Manager's name/title (print):_____
Case Manager's Signature: _____

SOURCE Agency Name and phone number/extension: _____

SECTION I Formal Info– Services Received or Recommended (Circle/Select all that apply or enter N/A)

Service	Frequency/Units	Provider Contact Information (Name/Phone Number)	Availability/cost of service after discharge from SOURCE
Personal Support			
Home Delivered Meals			
Emergency Response System			
Adult Day Health			
Alternative Living Services			
Skilled Nursing Services			

SECTION II Community Resources – Plan must include additional Community Resources specific to member needs. Select all that apply, complete contact information and include any special conditions or availability. Suggestions are given in the () brackets but be creative and specific for member. "See Attachment" with a copied list of general resources can be given in addition to, but will not substitute for this form if member has needs.

Service	Contact Information (Name/Phone Number)	Special Conditions/ Comments
☐ **Personal Support (DAS, Churches, Family)** ☐ **Home Delivered Meals (food banks, stamps, senior services)** ☐ **Emergency Response System (Cell phone, local discounted company, Walmart, Splash)** ☐ **Adult Day Health (Senior Day Activities)** ☐ **Alternative Living Services**		

APPENDIX Z

Case Management Discharge Planning for SOURCE

Complete and provide a copy to the member no later than 15 days following a SOURCE involuntarily discharge

☐ **Skilled Nursing Service (set up with Medicaid through PCP)** ☐ **Transportation (Disabled County specific transport)** ☐ **NOW/COMP if member has MR or Developmental Delay** ☐ **DFCS if losing eligibility** ☐ **GAPP/ Local Health Dept programs if child in need**		
☐ **DBHDD if mental health issues** ☐ **APS as needed** ☐ **Pharmacy /Medication set up needs** ☐ **Other specify (i.e. energy assistance)**		

Instructions: Discharge planning is required for all members with involuntary discharge from SOURCE services. SOURCE requires appropriate and specific plan be given to member or member's family. Source requires Case Management give assistance with applications for other services. The process is as follows:

- ☐ Notify member and ascertain what the member needs after discharge. Complete Section A of form.
- ☐ If member does not have any needs, document the information in Section I and give a general list of community resources for Section II (only appropriate if member does not have any needs).
- ☐ If member has specific needs, give formal (Section I) and community support specific information (Section II). Document on this form.
- ☐ After form is completed: Make copy for member records. Mail to member or present in person.
- ☐ Follow up in 7 to 10 work days to make sure member and or family understands information and questions are answered. Document all contacts to family on discharge planning.
- ☐ Special attention and tracking of this process is imperative when member must apply for other services; assist and document assistance to member with this process.

Present this form and all discharge information to the Department of Community Health (DCH) with DCH request for member records or upon notification from the DCH staff or attorney.

Rev. 04/13

Checklist for SOURCE Request for Hearing

Case Management Agency: please provide the following forms to DCH upon notification of a hearing request:

If GMCF gave LOC denial:

- ☐ Discharge Planning information:
  - ☐ Appendix Z6 SOURCE PCP Concurrence and
  - ☐ Appendix Z7 Case Management form for Discharge planning
  - ☐ Case Notes that document discharge planning support
- ☐ Recent Physician visits or ER visits
- ☐ If member has unknown cognitive deficits work with attorneys to resolve

If Agency issued Denial

- ☐ Appendix Z Reduction in service, Termination and Denial
  - ☐ Discharge Planning Information (as listed above)
- ☐ Appendix Z Administrative Hearing Information (as a cover sheet)
- ☐ Appendix I Level of Care with etiology for any items circled
- ☐ Appendix I Level of Care in table format sent to member
- ☐ Appendix C SOURCE assessment and addendum
- ☐ Appendix S Minimum Data set (MDS-HC)
- ☐ Medication List
- ☐ Annual Case management notes and 1-3 Quarterly Case management notes
- ☐ Annual physical examination (NN form) from PCP and/or appropriate “H&P” (history and physical) notes from 1-2 most recent visits with PCP
- ☐ Recent Physician visits or ER visits
- ☐ Document and send (if possible) any specialty physician visit information from the past 3 months
- ☐ If member has unknown cognitive deficits work with attorneys to resolve

APPENDIX AA

DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

() Death () Head Injury () Hip Fracture () Suicide () APS Referred () Fall () Accident

(TYPE IF POSSIBLE)

Report Date:	Member Name:	Member Medicaid ID:
Member's DOB/Age:	Significant Diagnosis:	Phone Number:
Address Where Member Resides:	City:	County
SOURCE CM Agency Name:	SOURCE Manager:	Office Hours Contact Phone:
CM Address:	Which Agency Involved? Name & Address:	Type of Provider:
Provider #:	Location Where Event Occurred:	Date Event Occurred:
Name of Supervisor/Manager:	Contact Phone:	Date CM Agency Notified:

Type of Death, Injury or Incident: (see Table AA)	Place Occurred:	Name of Person Discovering Event:
Cause: (i.e. push, fall)	Address: (if different from residence)	
Description: (i.e. fracture)		

CONTRIBUTING FACTORS: **INITIAL RESPONSE**:

Lack of Supervision:	Paralysis:	Balance Deficit:	Incontinence:	Family Involved:	
Cognitive Impairment:	Medication:	Illness:	Pain:	Hospital:	ER:
Progressive Muscular Disease:		Poor Vision:	Gait Deficit:	Police:	MD Visit:
Progressive Neurological Disease:		Failed to use assistive device:		Mental Health Eval:	
Other:				Family Notified:	

CARE COORDINATION INTERVENTIONS:

Add New Services:	MD/PCP Review Meds:	Notified MD:	Family Notified: (*in notes)*
Eye Exam Referral:	Case Conference:	Family Involved:	
Safety Assessment:	Request Therapy Order:	Reassessment:	Other:

Order/Repair Assistive Device:	Temp Services Increase:	Safety Ed:	

OUTCOME OF EVENT: ***ONLY*** *when the final outcome is known*

Member Name and Medicaid ID:

Date Follow-up Requested:		Date Follow-up Received:
SOURCE Manager Notes:	Follow-up Notes:	SOURCE Manager Name:
Detailed summary including information helpful to understand event, adverse outcomes & follow-up of event:		

ACTION PLAN and PROCESS IMPROVEMENT:

How to prevent in the future?
What processes were instituted to evaluate the effectiveness of the action plan?

MEDIA EVENT?

If so, name of media and contact person and phone:

OTHER PERSON OR SERVICES NOTIFIED:

Title	Yes	No	Name	Date	Time
Supervisor:					

Primary Physician:					
Family/or Guardian:					
APS/ Police report number (non mandatory to add this line to your form until 1/1/2015)					
DCH:					
Other:					

Signature of Case Manager: _____ **Phone:** _____ **Date:** _____

Report Sentinel Events by:

Mailing or faxing the Sentinel Event Report upon completion and phone call if indicated to:

SOURCE Program Sentinel Event

2 Peachtree Street NW, 37th Floor

Atlanta, GA 30303

Phone: 404-463-6570

Fax: 404-656-8366

Reminder, if member has an APS referral, a sentinel event and police reporting is needed.

APPENDIX AA
DEATH, SIGNIFICANT INJURY OR CRITICAL INCIDENT REPORT
SOURCE SENTINEL EVENTS

Sentinel Event REPORT
Instructions

Revised: 04/11 Purpose: The care coordinator uses the Sentinel Report in the SOURCE program to report Significant Injury, Unexpected Death or other critical incidents involving SOURCE members

Note: Reporting Sentinel events to DCH, Adult Protective Services, local law enforcement, and Long Term Care Ombudsman is needed within 1 business day of the notification of the event.

Table AA

Sentinel events include (see Section 1411 of SOURCE manual):

- Significant physical injuries / unexpected death
- Alleged criminal acts by staff against a member
- Alleged criminal acts which are reported to the police by a person who receives services
- Elopement or Member missing without authority or permission and without others' knowledge of whereabouts
- Financial exploitation or mismanagement of member funds
- The intentional or willful damage to property by a member that would severely impact operational activities or the health and safety of the member or others
- Whether by a member or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a member
- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)
- Isolating member from member's representative, family, friends, or activities
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Leaving member alone for long periods of time (when inappropriate for member's mental/physical well-being)
- Failure to provide basic care or seek medical care

Purpose: The care manager uses the Sentinel Report in the SOURCE program to report Serious Injury, Unexpected Death or other critical incidents involving SOURCE members.

Note: Unless the incident occurs in a hospital or rehab centers, all other incidents as outlined below are to be reported.

Incidents that result in serious injury or unexpected death are to be reported.

Emotional/ financial/ sexual abuse and criminal acts are to be reported.

Report these incidents in case notes:

Incidents that occur in hospitals or rehab centers are to be documented in the case notes only

Who Completes/When completed: The SOURCE Care Management care coordinator completes the form within **one** business day of event notification. All reports received the previous month shall be completed with additional information and known outcomes no later than the 15th of the following month (Police/ Forensic follow-up information may take longer).

Provider Incident Reports: The SOURCE Case Management Agency is responsible for obtaining these reports for all critical incidents that occur in ALS or ADH facilities or where provider staff is present at the time of the incident. The incident report identifies member appropriate interventions to decrease the risk of a recurrent incident that may result in serious injury or unexpected death.

Instructions:

- Give date report is filled out, member name, Medicaid number, Date of Birth, Age and any significant related diagnosis.
- Give Member resident address including city and state, county and phone number of member.

- Identify SOURCE Case Management (CM)agency name address and provider ID in the box. Add SOURCE Case manager name and contact information. Include location where event occurred (if different address there will be a place later for this address), date event occurred and date that the SOURCE Case Management agency was notified. If a provider service agency is involved give name and address, check type of provider, a contact phone and supervisor/manager name***.***

- ***Death, Significant Injury, Critical Incident***: Type of Death, Significant Injury, Critical event: Use wording from table AA to identify the event (i.e. fall, significant physical injury, unexpected death, alleged criminal acts-- police report filed by family etc).
  Death, injury or incident is for a short definition of the event (i.e. broken leg, minor injury, elopement, abuse, stolen jewelry, house fire etc.)
  Cause may be accident, pushed, etc.
  Place where Death, Injury or Incident Occurred: this is the location where event occurred*:* Be specific where event occurred if possible, i.e. "*member's house, bedroom"* "*Other-- see Case management notes"* can also be used.
  Address: Give address if different from home address***.***
  Name of person discovering problem: give name of service personnel or SOURCE provider agency (and their title) that discovered, witnessed or first reported the member's event.

- ***Contributing Factors***: Identify all that may be applicable with regard to the incident being reported. *Cognitive Impairment* applies to members with dementia, traumatic brain injury, brain tumors or any other diseases/injuries that impairs cognition. *Progressive Muscular Disease* refers to diseases such as Multiple Sclerosis, Parkinson's Disease, Muscular Dystrophy, Huntington's Disease etc. *Progressive Neurological Diseases* include ALS, Post-

Polio Syndrome, Progressive Spinal or Muscular Atrophy etc., Other, please specify (may give details in Case management notes if needed).

- ***Initial Response***: Check all that apply. *Family Involvement* means the family took responsibility for seeking medical care, staying with the member after the incident etc. Family notified, indicates family was called. Other, please specify in CM notes on 2nd page.

- ***SOURCE Care Coordination Interventions****:* This should relate to what the SOURCE case manager identified as contributing factors. *Family involvement* should be indicated if the support system increases its responsibility in the care of the member for ADLs and/or IADLs. In the case of safety education the notes should include what education was provided and who was educated. If other is checked documentation should specify what other intervention was initiated.

- ***Outcome****:* Update the incident record by identifying outcome ***only*** when the final outcome is known.

- ***Date Follow Up Requested****:* Enter date provider incident report or other items requested as a follow up to the incident. Document in incident report notes what was requested and from whom. ***Date Follow Up Received***: Record date requested item was received.

SOURCE Manger Notes: List in narrative form the incident and injuries sustained by the member. Documentation should include the specific area of the body affected. Documentation of Who, What, Where, How will give the most concise accounting of the incident. Document information about events leading up to the incident.
Update: Document in narrative format follow up activities/findings and resolution to the ***critical incident.*** Include results of the member record review and provide information
Witness: Include the full name of the witness (es), relationship to member and contact information in narrative if not listed elsewhere.
Action Plan and Process Improvement: Define process to reduce risk here if not already documented and follow-up time frames for evaluati***ng eff***ectiveness of processes used to reduce risk.
Media Event: fill out if news services involved.

- ***Other services/ persons notified of Incident***: Document, here or in the SOUR***CE manag***er notes, the date SOURCE notified individuals such as physician, nurse, family or agencies/organizations including DCH. Document notification of Area Agency on Aging immediately or no later than one business day upon learning of the incident as appropriate.

Rev. 04/14

Note: The Georgia Department of Community Health, Healthcare Facilities

Regulations services (HFR) and local Long Term Care Ombudsman (LTCO) are notified when the critical incident occurs in a PCH/ALS facility. For members not living in long term care facilities, Adult Protective Services is notified of critical incidents when the suspected cause of the incident may be the result of abuse, neglect or exploitation. As of 2013, there is a legislative change where Police must be concurrently notified. Others are contacted as appropriate.

APPENDIX BB

SOURCE Discharge Summary

(Rev. 10/15)

SOURCE Member: _____Date of Discharge: _____

Discharging Agency: _____

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 <u>not met</u> at time of discharge (refers to Carepath):

___COMM ___SKIN ___MEDS ___I/ADLs ___TRANS/MOB

___NUTR'N ___CLIN ___BEHAVIOR ___INF. SUPPORT

APPENDIX BB
SOURCE Discharge Summary

*Discharge **Planning** Policy Statement*

Upon discharging the member, the Case Manager will complete the SOURCE Discharge Summary Form in its entirety (Appendix BB), and Appendix Z (7-8) to be filed in the member's chart.

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

Rev. 4/12

Provider Billing

The Hewlett Packard is the third-party administrator for Georgia's Medicaid and PeachCare for Kids programs. Providers should begin submitting claims and other transactions to HP as of November 1st, 2010.

Provider claims will be entered via the web at http://mmis.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: HP, P.O. Box 105200, Tucker, GA 30085**-5200**

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) provider number in the first Referring ID 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 HP provider Enrollment Unit in writing of address changes.

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is.* The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers.

Also, the National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

  Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

  Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

*For COS 930 this would be the NPI of the provider who signs the Appendix F

APPENDIX DD
SOURCE National Codes and Rates

Rev.
07.13

Effective 10/1/2005 Rev. Effective 10/2014

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 (51st unit of service)
~~Y3802~~	Home Delivered Services; Physical Therapy	S9131	Physical therapy, in home, per diem		Provider Specific (51st unit of service)
~~Y3803~~	Home Delivered Services; Speech Therapy	S9128	Speech therapy, in the home, per diem		Provider Specific (51st unit of service)
~~Y3804~~	Home Delivered Services; Occupational Therapy	S9129	Occupational therapy, in the home, per diem		Provider Specific (51st unit of service)
~~Y3805~~	Home Delivered Services; Medical Social Services	S9127	Social work visit, in the home, per diem		Provider Specific (51st unit of service)
~~Y3806~~	Home Delivered Services; Home Health Aide	T1021	Home health aide or certified nurse assistant, per visit		Provider Specific (51st 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	GN	$44.15 per visit

SOURCE National Codes and Rates

Old Code	Description	National Code	Description	Modifier	Rate
			an outpatient speech therapy plan of care		
~~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
~~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	$37.38 per day

APPENDIX DD

SOURCE National Codes and Rates

Old Code	Description	National Code	Description	Modifier	Rate
~~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	$37.38 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	$10.10 per 30 minutes units. 30 minutes equal 1 unit. (not to exceed 5 units or 2.5 hours per visit)

APPENDIX DD

SOURCE National Codes and Rates

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	$8.98 per 30 minutes equal 1 unit. (Not to exceed 48units a day) Not to exceed 720 units/ Month (360 hours/15 days)
~~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	Nursing care, in the home by a registered nurse per diem		$65.00 per visit
~~Y2851~~	Skilled Nursing Services LPN	T1031	Nursing care in home, by licensed practical nurse per diem		$50.00 per visit
	SOURCE CM fee	T2022		SE	$186.67. per month

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APPENDIX EE
Case management Provider Main Offices

Rev. 10/15
04/11
Rev. 10/11

Albany ARC

Contact Person: Grace Williams, Program Director, BSW, MS or
Shon Houston, Asst. Program Director, BHS, MS
(229) 883-2334 Fax: (229) 883-2710
1105 Old Dawson Road, Albany, Georgia 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, RN (706) 571-1946
Fax: (706) 660-6279
1900 10th Avenue, Columbus GA, 31901
Counties: Chattahoochee, Harris, Marion, Muscogee, Talbot, Stewart, Meriwether, Upson, Pike, Taylor, Troup

Crisp Care Management

Contact Person: Tony Dickerson, RN Program Manager
Office: (229) 276-2126 Fax: 229-271-4669
910 North 5th Street, Cordele, GA 31015
Counties: Crisp, Dooly, Macon, Pulaski, Sumter, Wilcox

Corners of Care SOURCE

Contact Person: Juanita Benjamin, Owner/Administrator
803-226-0236 or 1-800-811-7534
Fax: 803-226-0335 or 1-888-316-9859
3050 Whiskey Road
Aiken, South Carolina 29803
P. O. Box 5569
Augusta, Georgia 30906
County: Burke, Columbia, Richmond

Crossroads Community SOURCE

Contact person: Laura Phillippi, RN, BSN, Program Manager
Office: (478)224-6677
Fax: (478)988-0093
1211-D Macon Road Perry, GA 31069
Counties: Bibb, Bleckley, Crawford, Dooly, Houston, Peach, Pulaski, Twiggs, 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 of GA Inc.

Contact: Faith Vickerie- Morgan, RN (678) 624-1646
Fax: 678-624-1696
P.O. Box 2063, Alpharetta, GA 30023
Counties: Fulton, Cobb, Clayton, Dekalb, Forsyth, Gwinnett, Rockdale

Legacy Link Inc

Contact: Amy Allen (770) 538-2668
Contact: Dianne Dodgins (770) 538-2669
4080 Mundy Mill Road, Oakwood, GA 30566
Counties: Banks, Barrow, Cherokee, Clark, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Rabun, , Stephens, Towns, Union, White

Next Step Care

Corporate Office
15 Merritt Street P.O. Box 952 Hawkinsville, GA 31036
Christie Shaw, MHSA, Director of Operations
Ph: 478-621-2070

APPENDIX EE
Case management Provider Main Offices

Referral Intake
10 South Broad Street, P.O. Box 25 Butler, GA 31006
Lou Ann Moulton, Assistant Director of Referral Intake
Ph: 478-862-5886
Alt Number: 888-762-2420
Fax: (478) 862-9111
E-mail: info@nextstepcare.org

Next Step Care Offices

Albany
Administrator: Gladys Bussey, LPN
Ph: 229-431-0523
Fax: 229-431-0525
507 N Jefferson St, Albany, GA 31701 Counties:
Crisp, Dooly, Lee, Sumter, Terrell, Turner, Wilcox, Worth, Ben Hill, Irwin, Dougherty

Augusta
Administrator: Edwina Wright
Ph: 706-737-0705
Fax: 706-737-0250
2100 Central Avenue Suite #5, Augusta 30904
Counties: Burke, Columbia, Richmond

Athens
Administrator: Steven Johnston, BS
Ph: 706-543-8460
Fax: 706-543-8293
405 Gaines School Rd., Athens, GA 30605
Counties: Barrow, Clark, Elbert, Franklin, Hart, Jackson, Madison, Oconee, Oglethorpe, Banks, Stephens

Butler
Administrator: Claire Locke, MFS
Ph: 478-862-4840
Fax: 478-862-4844
12 South Broad Street, P.O.Box 89 Butler, GA 31006
Counties: Crawford, Macon, Marion, Schley, Talbot, Taylor, Upson, Spalding, Pike

Columbus
Administrator: Claire Locke, MFS
Ph: 706-562-2340
Fax: 706-257-1006
6531 Effingham Way, Suite K , Columbus, GA 31909
Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster

APPENDIX EE
Case management Provider Main Offices

Covington
Administrator: Shanika Warren
Phone: 404-832-4225
Fax: 770- 388 - 7539
2120 Lee Street SW, Covington, GA 30014
Counties: Rockdale, Walton, Newton, Henry, Dekalb

Duluth
Administrator: Steven Johnston, BS
Ph: 770-717-2690
Fax: 770-717-2692
2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096
Counties: Gwinnett, Fannin, Gilmer, Pickens, Cherokee, Union, Lumpkin, Dawson, Forsyth, Towns, White, Hall, Habersham, Rabun

Eatonton
Administrator: Michael Barton (Interim)
Ph: 706-485-4128
Fax: 706- 485-4159
951 Harmony Rd, Suite 104, Eatonton, GA 31024
Counties: Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes

Macon
Administrator: Steven Johnston, BS (Interim)
Ph: 478-471-0782
Fax: 478-621-7538
2000 A Northside Crossing Macon, GA 31210
Counties: Bibb, Jones, Monroe, Butts, Lamar

Metter
Administrator: Melinda Howell, LPN
Ph: 478-314-1573
Fax: 912- 685-7640
58 SE Broad Street, P.O. Box 631 Metter, GA 30439
Counties: Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, , Tattnall, Telfair, Toombs, Treutlen, Wheeler, Appling, Atkinson, Bacon, Brantley, Bryan, Camden, Charlton, Chatham, Clinch, Coffee, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Ware, Wayne

Perry
Administrator: Claire Locke, MFS
Phone: 478-314-1573
Fax: 478- 218 - 0378
Address: 107 Woodlawn Drive, Perry, GA 31069
Counties: Peach, Bleckley, Twiggs, Houston, Dodge, Pulaski

APPENDIX EE
Case management Provider Main Offices

Rome
Administrator: Michael Barton, BS
Ph: 706-378-1270
Fax: 706-378-1330
413 Shorter Avenue , Suite 111, Rome, GA 30165
Counties: Bartow, Catoosa, Chattooga, Cobb, Dade, Floyd, Gordon, Haralson, Murray, Paulding, Polk, Walker, Whitfield

Thomasville
Administrator: Shonell Rogers
Ph: 229-227-6430
Fax: 229- 227- 6156
14004 Hwy. 19 S. Suite 101, Thomasville, GA 31757
Counties: Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas, Tift, Berrien, Cook, Lanier, Lowndes, Echols

Tyrone
Administrator: Brenda Nelson, RN, BSHA
Ph: 770-629-2197
Fax: 770-742-0913
602 Dogwood Trail, Suite A, Tyrone, GA 30290
Counties: Carroll, Coweta, Douglas, Fayette, Heard, Meriwether, Troup, Fulton, Clayton

Wrightsville
Administrator: Olivia Humphrey
Ph: 478-864-3126
Fax: 478- 864-9423
8647 South Marcus Street, P.O. Box 64, Wrightsville, GA 31096
Counties: Glascock, Jefferson, Johnson, Laurens, Washington, Wilkinson

St. Joseph's/Candler Health System
Contact Person: Terri Davis 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, Liberty

Baxley Office
Contact Person: Jilda Brown (866) 835-0709 or (912) 367-6108
Fax (912) 367-0392
68 North Oak St. Suite E Street, Baxley, GA 31513
Counties: Appling, Bacon, Evans, Jeff Davis, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne

SOURCE Partners Atlanta –VNHS

Fax 404-527-0606
5775 Glenridge Drive, NE Suite E375

Atlanta, GA 30328
Tel (404) 581-4782
Counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale

Trinity Case Management Source

Contact Person: Administrator: Sonja Lockett, BS

(706) 507-5510 or (706) 507-5517

Fax: (706) 507-5550

5510 Veterans Parkway Suite 103

Columbus, Ga. 31904

Counties: Chattahoochee, Clay, Harris, Muscogee, Meriwether, Marion, Quitman, Randolph, Stewart, Talbot, and Webster

PruittHealth Home First (Formerly Unihealth)

Patricia Walker, Vice President (770)331-7954

1626 Jeurgens Court. Norcross, GA 30093

PruittHealth Home First -Corporate Office

Patricia Walker, Vice President (770) 331-7954

1626 Jeurgens Court. Norcross, GA 30093

Athens

Contact Person: Kristie Dorsey , Administrator (706) 549-3315
Fax: 706 543-3841
435 Hawthorne Ave., Suite 300, Athens, GA 30606
Counties: Banks, Barrow, Clarke, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Stephens, Walton

Atlanta

Contact Person: Charles Teasley, Administrator (770) 925-1143
Contact Person: Terry Bates, Administrator (770) 925-1143
Fax: 678 533-6488
1626 Jeurgens Court, Norcross GA 30093
Counties: Clayton, DeKalb, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Rockdale Coweta, Fayette, Fulton (30291 only) , Harris, Heard, Meriwether, Muscogee, Spaulding, Talbot, Troup

APPENDIX EE
Case management Provider Main Offices

Augusta

Contact Person: Brenda Braddock , Administrator (706) 651-1535
620 Ponder Place, Evans, GA 30809
Fax: 706 863-9401
Counties: Burke, Columbia, , Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes Emmanuel

North Georgia Mountain/Blueridge

Contact Person: Jane Addison, RN, Administrator (706) 258-5300
Fax (706) 632-0028
5004 Appalachian Hwy, Suite 4, Blueridge, GA 30513
Counties: Cherokee, Dawson, Fannin, Gilmer, Lumpkin, Pickens, Rabun, Towns, White, Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haraleson Murray, Polk, Walker, Whitfield

(Cobb -- CLOSED Consolidated)

Contact Person: Ann Noles, Acting Administrator (770) 916-4502
Fax: 770 916-4505
1676 Mulkey Road, Austell, GA 30106
Counties: Carroll, Cobb, ,Douglas, Paulding,

Cordele

Contact Person: Jennifer Harris , Administrator (229) 273-2570
Fax: 229 273-4750
208 4th Avenue East, Cordele, GA 31015
Counties: Chattahoochee, Marion, Quitman, Stewart, Webster , Ben Hill, Bleckley, Clay, Crisp, Dodge, Dooly, Dougherty, Irwin, Lee, Macon, , Pulaski, Randolph, Schley, Sumter, Telfair, Tift, Turner, Wilcox, Worth

Jesup (consolidated 7.13)

Macon

Contact Person: Mildred O'Neal , Administrator (478) 474-0979 or (800) 913-0134
Fax: (478) 474-2068
6060 Lakeside Commons Drive, Box 9, Macon, GA 31210
Counties: Baldwin, Bibb, Butts, Putnam, Taylor, Twiggs, Upson, Wilkinson, Laurens, Jasper, Jones, Monroe, Lamar, Pike, Crawford, , Peach, Houston, Johnson, Montgomery Treutlen, Wheeler

(Newnan -- CLOSED - Consolidated)

Contact Person: Diana Davis, RN , Administrator 770 254-1545
Fax: (770) 254-8605

APPENDIX EE
Case management Provider Main Offices

7345 Red Oak Road Building 26
Union City, Georgia 30291
Counties: Coweta, Fayette, Fulton (30291 only) , Harris, Heard, Meriwether, Muscogee, Spaulding, Talbot, Troup

(Rome -- CLOSED Consolidated)

Contact Person: Debbie Faulkner, Administrator (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

Swainsboro -- CONSOLIDATED 7/15

Contact Person: Mona Williamson Rushing, RN Administrator (478) 237- 7270
Fax (770-237-7290
667 South Main Street, Swainsboro, GA 30401
Counties: Bulloch, Chandler, Emmanuel, Evans, Johnson, Montgomery, Tattnall, Tombs, Treutlen, Wheeler

Valdosta

Contact Person: Trina Still Valdosta , Administrator, (229) 241-8750
Fax: 229 241-8940
312 Canna Drive
Valdosta, Georgia 31602
Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Echols, Lanier, Lowndes,Thomas, Ware , Jeff Davis

Savannah

Contact Person: Mary Cuff , Administrator- 912 925-9181

Fax: 912 925 9340
9100 White Bluff Road suite 303
Savannah, Georgia 31406
Counties: Appling, Bacon, Brantley, Camden, Charleton, Glynn, Pierce, Wayne , Bryan, Chatham, Effingham, Liberty, Long, McIntosh Bulloch, Chandler Evans

Rev. 10/15

Application For Enhanced Primary Care Case Management Applicants

I. Applicant Basic Information

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: (Only Established Companies will be considered)

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:

APPENDIX FF

Enhanced Primary Care Case Management Application

Title

Telephone Number: Fax Number:

II. General Directions:

A. To ensure that applications are given appropriate consideration, responses to the SOURCE Provider Enrollment Application must be typed or computer-generated, concise and relate to the Policies and Procedures of SOURCE. Attachments should clearly identify which specific question is being addressed. Failure to submit a clear, well organized, complete application may delay enrollment and the application will be returned to the applicant.

—

III. Company Background Information:

Business Experience – All applicant's companies must have experience in case management and disease management for a minimum of twenty-four months prior to making application for enrollment in SOURCE. Example ICWP Case management Agency.

All applicants must have business management experience, managing 5 or more employees, in the health care field, for a minimum of twelve (12) consecutive months prior to making application for enrollment in SOURCE.

Applicants must give assurance of conflict free case management. Details will be provided by DCH. Email to Lstewart@dch.ga.gov

In order to be a SOURCE Case Mangement Agency, please document the following:

1. A minimum of two years experience providing case management and disease management services and oversight

A) Briefly summarize your company's experience with case management, home and community based services, and disease management programs. More in-depth questions will be asked below. Include types of services provided, fund sources for the services, and the dates during which the services were provided.

Next, please give a comprehensive documentation of:

aa. **CASE MANAGEMENT EXPERIENCE:**

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 services and oversite. 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
- Working with other service agencies
- Financial responsibilities

bb. DISEASE MANAGEMENT EXPERIENCE:

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 and oversight. Applicant should describe the following:

- Disease management stratification and intervention process
- Tracking mechanism associated with the stratification process.
- How improvement or decline is tracked and followed

Provide names, addresses, and telephone numbers of three references who are familiar with your professional experience.

2) Document your company's 12 months background of business experience and oversight of 5 or more employees in the health care field.

Include what the business does, employees managed, type of services provided, financial obligations, and date the business opened.

3) The ability to meet the State's electronic data reporting requirements

Document the ability to file electronically and submit data electronically.

—

IV. Network Development:

Proposed Service Area

List the counties you are proposing to serve in the table below. Your network coverage must be appropriate for the demographics of each county. For example, Medicaid Transit has a set one way mileage limit, so it would not be appropriate to expect a large county like Gwinnett to have only one service provider. Choice for the member must also be considered.

Primary Care Providers:

List your Primary Care Providers by Name and office. There must be at least two Primary Care Provider agreeing to work in each rural county that is proposed- situated to assure choice and access; An appropriate network (to assure choice and access for members) of Primary Care Provider is needed in urban areas, consider logistics in your choice.

List all Primary Care Providers proposed to be enrolled in the program. Indicate which counties each will serve in table below.

1. List the proposed days and counties the physicians will be responsible for covering in a table format. Include the physical address (es) the provider will use to service the clients in each county.
2. Provide written confirmation from each physician attesting that s/he will act in this capacity* and for the specified day and counties if the program is approved. *Use detailed information from sections 802, 1302, and Appendix NN so that duties and responsibilities are clearly documented. Confirm with Physician that PCP for member will meet on specified day/ time with Case Manager quarterly. Detail how SOURCE Case Managers can assist in meeting health care goals.

Acute Care Provider

List all hospitals that will provide acute care services for members enrolled with the program. The must be at least one hospital that will serve each county in the proposed service area.

1. Please list the name of County matched to the Hospital(s) in a table format below.

2. You must provide written confirmation from each hospital attesting that it will act to coordinate care with your agency and members and for the counties specified if the program is approved. See Section 1403 in this manual for language to include in the attestation.
   ii. From this discussion with the Acute Care provider, describe how the program will work with Acute Care Providers admission and/or discharge departments and
   iii. How will the company track emergency room visits and hospitalizations

County	Physician	Address	Days for client appointments	Acute Care Hospital with Contract

V. Program Structure

a. 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.

b. Attach job descriptions for all positions related to the program and resumes, if available.

c. Document the number of people in each position you will hire per member.

d. 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.

VI. 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. Describe how timeliness to calls and response to problems is documented and reviewed. Assigned personnel for this task must be appropriate for the health fragile clientele population served.

VII. Service Provider Network Development

A. Home and Community Based Services (HCBS) Providers

1. As of July 1st, 2013, SOURCE opened enrollment to all current CCSP HCBS providers in good standing. Compliance with increased performance expectations is expected for all SOURCE providers to achieve optimal health states for SOURCE members.

   Document how a multitude of providers will be used in a rotation pattern for your agency.
   Document how conflict of interest could occur and will be avoided with the Service Provider Community.

VIII. Forms/Documentation

Forms that must be used are referenced in the SOURCE Manual. Attach copies of all other 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. Do not send copies of the SOURCE manual mandatory forms.

Screening

Assessment

Program Admission

Developing and Implementing EPCCM Carepaths

Robust Disease Management tools

Referrals for all Medicaid reimbursed HCBS

PCP Contacts

Provider Contacts, monitoring

Case Manager Hire and Training

Case Manager Supervisor Hire and Training

RN / LPN Hire and Training

Robust Community Resources for Discharged members

Community Resource list for non-Medicaid reimbursed services

IX. 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.

X. 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.

Describe how the program will correct and monitor deficiencies in services and variances in Carepath goals.

Provide all forms that will be used to organize and complete this task.

XI. Billing

Describe who will be responsible for billing Medicaid for the case management fee and the process for oversight of billing. Give assurance that billing provider has read and will keep current with PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS

XII. 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 Providers. Describe how poor quality or performance will be handled and documented, including provider termination and member notification and reassignment. Describe how member satisfaction surveys will be carried out. Provide copies of tools that will be used in this process.

_____ _____

Signature and Title Date Submitted

Mail completed application and a copy of the completed Provider Enrollment Application located on the Hewlett Packard website(mmis.georgia.gov) to:

APPENDIX FF

Enhanced Primary Care Case Management Application

Department of Community Health

2 Peachtree Street NW

37th floor, c/o SOURCE Program Specialist

Atlanta, GA 30017

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 Providers 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 Providers, 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.

Rev. 07/13

REFERRAL SYSTEM/ ROTATION LOG WHEN MULTIPLE SERVICE PROVIDERS EXIST FOR CLIENT (THIS IS THE SAME AS CCSP)

A. When Client is able to choose

Where more than one SOURCE provider offers the same major service within a given geographic area, a choice of these providers is presented to the client. The client or client representative indicates the preferred provider.

Factors affecting the client's choice are:

3. Physician's recommendation for service

If the client's physician specifies a preference for a particular SOURCE provider to render services to the client, the client will be informed of the physician's recommendation, and whether or not the particular services needed are provided by the recommended provider. The client makes the final choice regarding the service provider.

2.Availability of services

If the client is in need of immediate (emergency) services and the SOURCE provider chosen by the client is unable to render the immediate service, an alternate provider may be utilized.

If the service dates/ times the client needs is not offered by the SOURCE agency chosen, an alternate provider may be utilized.

If the SOURCE provider chosen does not provide the comprehensive services needed (i.e., O.T.) the client may be referred to an alternate provider.

B. When Client is unable to choose

If, for any reason (unfamiliarity with service providers, confused mental state, etc.), a client is unable to choose from among multiple providers of the same service, the SOURCE agency utilizes the rotation procedure for that Planning and Service Area.

APPENDIX HH
HCBS PROVIDERS REFERRAL / MONITORING SYSTEM

SOURCE PROVIDER ROTATION LOG

SERVICE _____ **COUNTY** _____

PROVIDER NAME	**PROVIDER ID NUMBER**	**CLIENT NAME**	**DATE SERVICE BROKERED**	**REFERRAL ACCEPTED/ DECLINED**

Instructions

SOURCE PROVIDER ROTATION LOG INSTRUCTIONS

Purpose: This form is used when a client does not choose a provider. New providers are added to the rotation log within three business days of the notification of the provider number from the Dept of Community Health or its operating agencies.

NOTE: There is one log, per county, per service.

Who Completes/When Completed: The nurse or case manager selects a provider from the top of the rotation log when the client does not select a provider. If the provider refuses to accept a client for any reason they are placed at the bottom of the rotation list for that complete rotation.

Instructions:

Service: Enter the service provided on this rotation log (e.g., Alternative Living Services, Adult Day Health).

County: Enter the county where this service is provided.

Provider Name: Enter each provider name as they are approved to provide SOURCE services.

Provider ID

Number: Enter each provider's ID number

Client Name: Enter the name of the client assigned to a provider by the rotation system.

Date Service Brokered: Enter the date the service was brokered and accepted by the provider.

Accepted or Declined: Enter A if the provider accepted the referral and enter D if the provider declined.

NOTE: If the provider declines the referral after accepting it, enter D and the date the referral was declined.

Distribution: This is an interoffice form and not distributed for any reason.

PROVIDER CORRECTIVE ACTION

Corrective Action by Case Management (CM) Agency

A. Removal from Rotation List/Suspension of Referrals as Corrective Action

 The CM agency may remove providers from the rotation list and have referrals suspended when appropriate documentation supports this action. DCH will review the notice before it is sent to the provider, however, new members can be with held during this review period.

B. Reasons for Removing a Provider From the Rotation List/ Suspending Referrals

A provider may be removed from the rotation list and have referrals suspended for reasons including, but not limited to:

- Provider fails to accept referrals
- Provider fails to provide services as required by the comprehensive care plan
- Provider refuses to accept member because one or more of other needed services are brokered to another provider
- Provider overcharges members for services
- Provider fails to refund fees
- Provider has a documented history of confirmed complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
- Provider fails to submit requested plan of correction.
- Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit
- Provider fails to attend 2 or more meetings in a year.

C. Definition of Removal from Rotation List/Suspension of Member Referrals

When a provider agency is removed from the rotation list, Case Management agencies will not broker any SOURCE members to the provider agency and will not refer new SOURCE referrals to the provider agency for a specific period of time. The provider agency may continue providing services to SOURCE members currently brokered to the agency.

D. Procedure for Removing a Provider From the Rotation List/Suspension of referrals

The SOURCE Case Management will notify the provider in writing that the provider agency has been removed from the rotation list and that all referrals have been suspended and the reason(s) for the corrective action. The written notice will include the effective date of the removal from the rotation list/suspension of referrals, the duration of the corrective action, and the appeal process should the

provider disagree with the corrective action imposed. DCH will work with the provider on the written plan of corrective action.

The duration of the removal from the rotation list/suspension of referrals will be imposed for a specific time period. For the first offense, a minimum of three (3) months will be imposed; for subsequent offenses, a minimum of six (6) months will be imposed.

Note: DCH may request a written plan of correction from the service provider. DCH may shorten or lengthen the duration of the corrective action, depending upon the reason for the action.

E. Due Process (See also section 1409)

The provider shall have ten (10) days from the date of the written notice of removal from the rotation list/suspension of referrals to submit a written request for an Administrative Review. All requests for reviews must be submitted to

2 Peachtree Street NW
37th floor SOURCE; Aging and Special Populations Unit
Atlanta, GA 30303
this address should be specified in the corrective action notice to the provider

NOTICE OF REMOVAL FROM PROVIDER ROTATION LOG

Date of Notice: _____

Dear Provider _____ (provider name)

Provider address and phone number _____

Provider billing ID / Service type for removal: _____

This letter is to notify you that your agency is being removed /suspended from the provider rotation list for _____ (case management agency name),

In these counties: _____

You can continue to serve the members you were authorized to service prior to the date of this notification.

All new referrals have been suspended for the duration of _____months (3 months for first offense, or up to 6 months for subsequent offenses) and will end on _____. This will be effective 10 days from the date of this written notice._____ Date takes effect

The reason for this corrective action is due to the following: (check as many as apply)

- ☐ Provider fails to accept referrals
- ☐ Provider fails to provide services as required by the comprehensive care plan
- ☐ Provider refuses to accept member because one or more of other needed services are brokered to another provider.
- ☐ Provider overcharges members for services
- ☐ Provider fails to refund fees
- ☐ Provider has a documented history of confirmed complaints related to member care/issues
- ☐ Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- ☐ Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction or revocation of the license/permit.
- ☐ Provider fails to submit requested plan of correction

Continued to Next Page

- ☐ Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit.
- ☐ Provider fails to attend 2 or more meetings in a year.
- ☐ OTHER _____

These are a summary of the grievances. Please see attachment for specific incidents, dates and details.

DCH Note for Provider:

If you disagree with this decision, you may request a Policy Review. You have ten days (10) from the date of this letter to request a review in writing. All requests for reviews must be submitted, with a copy of this letter, to

Department of Community Health
SOURCE Policy Services Section, 37th floor
2 Peachtree Street, NW
Atlanta, GA 30303-3159

Please contact the SOURCE Administrator for this location if you have any questions or concerns in regards to this letter. The Administrator is _____

and can be reached at _____ phone number.

- ☐ Copy to Provider
- ☐ Copy to DCH

CC: Copy of letter and attachments sent to DCH, ATTN: SOURCE Program, 2 Peachtree Street NW, Floor 37, Atlanta GA 30303

Rev. 10/13

Instruction for Notice of Removal from Provider Rotation Log:

Date of Notice: _____

APPENDIX HH
HCBS PROVIDERS REFERRAL / MONITORING SYSTEM

Leave this date bland until approval from DCH.

Dear Provider _____ *(provider name)*

Provider address and phone number _____

Provider billing ID / Service type for removal: _____

Use all of providers names that describe the company who provides the service being reviewed IE LaLa House ADH
At this address and phone number
Provider billing id xxxxxA/ adult day health

(Do not include other names and services the provider may offer such as PSS or home delivered meals.)

Place your agency name i.e.

This letter is to notify you that your agency is being removed /suspended from the provider rotation list for

____*SourceWaiver 's of Atlanta*_____ (case management agency name),

In these counties: ____Dekalb, Fulton_____

Fill in the number of months and date when referrals will resume.
All new referrals have been suspended for the duration of _____ *and will end on* _____. *This will be effective*

Don't fill this date in in until approval from DCH
*10 days from the date of this written notice.*_____ *Date takes effect*

Check as many reasons as apply and attach detailed supporting evidence:

The reason for this corrective action is due to the following: (check as many as apply)

☐ *Provider fails to accept referrals etc etc*

These are a summary of the grievances. Please see attachment for specific incidents, dates and details.

Give contact information and check appropriate boxes. Send to Dch for review/approval and comment. If approved, fill in current dates and send certified mail to the provider.

Please contact the SOURCE Administrator for this location if you have any questions or concerns in regards to this letter. The Administrator is _____ *and can be reached at* _____ *phone number*

HCBS Name:

Month/Year

Case Management External Complaint Log For SOURCE

Complaint Log Categories

1.Abuse/neglect/exploitation

2.Missed visit(s) (professional judgment when to start)

3.Task not performed/ not adequate

4.Aide late

5.Aide not staying time ordered

6.No RN supervision

7.Lack of communication from provider

8.Other

Category Totals

1. ____ 4. ____ 7. ____
2. ____ 5. ____ 8. ____
3. ____ 6. ____ Total: _____

HCBS Name:

Month/Year

Case Management Internal Complaint/Review Log FOR SOURCE

Date	Prov. Name/#	Nature of Complaint	Cat.	Client	Caller	CM	CM Intervention/Comments	DCH Intervention	Outcome/date

APPENDIX HH-HCBS Monitor Log

(Internal)Category Totals

9. ____	12. ____	15. ____	18. __
10. ____	13. ____	16. ____	19.____
11. ____	14. ____	17. ____	20. __

Total_____

9 Provider fails to accept referrals
10 Provider fails to provide services as required by the comprehensive care plan
11 Provider refuses to accept member because one or more of other needed services are brokered to another provider
12 Provider overcharges members for services
13 Provider fails to refund fees
14 Provider has a documented history of confirmed complaints related to member care/issues
15 Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
16 Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
17 Provider fails to submit requested plan of correction.
18 Failure of the provider to comply with Utilization Review or failure of the provider to correct deficiencies cited as the result of an audit
19 Provider fails to attend 2 or more meetings in a year.
20 Other____

CM: Initials Signatures

Date	Nature of Complaint/ Problem	CAT	Client	CM	CM Interventions/ Comments	DCH Interventions	Outcomes

SCM Initials Signature

Date of Review

Internal/ External Complaint Log Alternate

SOURCE Case Management Internal/External Complaint Log

HCBS Name: _____ Month/Year: _____

External Complaints	Internal Complaints
1.Abuse/Neglect/Exploitation	9. Provider fails to accept referrals
2. Missed visit(s) - (professional judgment when to start)	10. Provider fails to provide services as required by the comprehensive care plan
3. Task not performed/not adequate	11. Provider refuses to accept member because one or more of other needed services are brokered to another provider
4. Aide late	12. Provider overcharges members for services
5. Aide not staying time ordered	13. Provider fails to refund fees
6. No RN supervision	14. Provider has a documented history of confirmed complaints related to member care/issues
7. Lack of communication from provider	15. Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
8. Other	16. Healthcare facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction or revocation of the license/permit
	17. Provider fails to submit requested plan of correction
	18. Failure of the provider to comply with UR or to correct deficiencies cited in an audit
	19. Provider fails to attend 2 or more meetings in a year
	20. Other

Internal Category Totals					
1	2	3	4	5	6
7	8	Total			

External Category Totals					
9	10	11	12	13	14
15	16	17	18	19	20
Total					

Date	Internal/ External	Provider Name/Number	Nature of Compliant/Problem	Category	Client	Caller	CM	CM Interventions/Comments	DCH Interventions	Outcomes

CM initial:_____ Signature/date:_____CMS initial: _____ Signature/date:_____

CM initial:_____ Signature/date: _____

Instructions

SOURCE Program

Case manager External and Internal COMPLAINT LOG

Purpose: Case Management Agencies for SOURCE are responsible for follow up on provider complaints (External Complaint Log); and for monitoring provider performance (Internal complaint Log). The logs have been developed as an assistant quality improvement tool to assess timely follow up and resolution of complaints and problems with HCBS providers. It is not mandatory to use the Internal Log if a score Card is being kept for the HCBS provider. The external log can be redesigned to incorporate several months or several providers.

Who completes/When completed:

Case Manager enters information. The Case Manager Supervisor reviews logs monthly to assess for trends in complaints or providers.

Instructions:

1. HCBS Name: Enter the name of the Home and Community Based Services Provider Agency and Service Type.
2. Month/Year: Enter the month and year.
3. Category Totals: Enter the total for each category of complaints and the total number of all complaints.
4. Date: Enter the date the complaint was received/given.
5. Provider Name/Phone Number: Enter the name of the provider the complaint is being made against and the phone number of the person contacted regarding the complaint.
6. Nature of Complaint: State briefly the details concerning the complaint. Use professional judgment if first missed service call.
7. Category: Using the prescribed legend, enter the number that corresponds to the category of complaint.
8. Client Name: Enter client's name.
9. Caller: Enter name of person making complaint and relationship to client.
10. CM: Enter the initials of the assigned Case Manager

11. CM Intervention/Comments: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed from Rotation Log, or you may specify another intervention in the space. Enter information about follow up activities.

12. DCH Interventions: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed Provider from Rotation Log, Address(ed) at Network Meeting or you may specify another intervention in the space.

13. Outcome/Date: Enter resolution and date.

NOTE: Record detailed information about follow up and interventions in case notes.

Distribution: Maintain in central location. Indicate when there are no new for a month complaints, no complaints pending resolution, and no complaints resolved during the report period.

NOTE: Indicate "no complaints" in the comments section of the log. Include the name of the Provider Company, month, and year.

SOURCE
Provider Application Checklist

Provider Name _____

Base Rendering Provider ID*_____
Payee ID**_____

NOTE: Forms listed in bold type can be accessed at www.mmis.georgia.gov by clicking on "Provider Enrollment" at the top of the page.

1. _____ **DCH Facility Enrollment Application (June 2012 version or later)**
2. _____ Current state license issued by GA Dept of Community Health, Healthcare Facility Regulation Division (HFRD)
3. _____ Letter from HFRD that lists the counties you are licensed to serve (***private home care provider agencies only***)
4. _____ Current business license issued by your city or county
5. _____ **Statement of Participation**
6. _____ **Disclosure of Ownership Form** (Make sure you complete Section III!)
7. _____ Approved CCSP Provider (6 mos or more)
8. _____ Proof of liability and worker's comp insurance coverage
9. _____ Completed **SOURCE Application Checklist** (This form!)

* This is the provider ID you use to Medicaid.

** This is the number that is associated with your bank account and tax ID.

Scan and send the completed application packet to tunderwood@dch.ga.gov. Use "SOURCE application packet for (your agency name)" as the title of the e-mail when you transmit the packet.

NOTES:
_____
_____
_____
_____

Rev. July 2013

Instructions:

APPENDIX II
HCBS SERVICE PROVIDER ENROLLMENT

To apply for a Medicaid Provider Number under the SOURCE Contract (930), go to www.mmis.georgia.gov, and access the following forms by clicking directly on "Provider Enrollment" at the top of the page. Complete the following forms:

- **Facility Enrollment Application** – Use the June 2012 version and complete all sections, including at least one entry in Sections K and L.
- **Statement of Participation** – Write the name of your agency as the "Printed Name of Enrolling Provider" on the last page.
- **Disclosure of Ownership Form** - Make sure you complete Section III to list all owners of your company.
- **SOURCE Provider Application Checklist**.

Enter your Medicaid payee number on the application form. This will be used to route automatic deposit of payment of SOURCE claims to the bank account you specified when you applied for a CCSP provider number. Use the same legal and DBA names that you used when you applied to be a CCSP provider.

Include the following attachments with the completed forms as part of the packet:

- **A copy of your current license that's issued by the State of Georgia** (Health Facilities Regulation Division of the GA Dept of Community Health) if you are applying as a Group model Alternative Living Services (Specialty 010), Personal Support Services and/or Skilled Nursing Services Provider (Specialties 197, 243 or 249) or Home Delivered Services (Specialty 087) provider.
- ***If you are a personal support services/skilled nursing provider*, a copy of the letter from HFRD that lists the counties you are licensed to serve.**
- **A copy of your current local business license** if required by your city or county.
- **A copy of your insurance declarations page**, showing **proof of general liability and worker's compensation** coverage for your agency.

Scan and send all the above in PDFor TIF format to tunderwood@dch.ga.gov or lstewart@dch.ga.gov

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APPENDIX JJ

Case Management Agency Monthly Report

1. Agency Name: _____ **2. Report Month:** _____

2. Submitted by: _____ **4. Today's Date/ Year:**_____

Provide member counts for the report month as follows:

5. Previous Month Total Members: _____
6. Members Admitted during report month: _____
7. Members Discharged during report month:_____
8. Current Active Members: _____ **8a.**
8a. Unduplicated Members with 2014-2015 "Flu Shot" _____
8b Total members 2014-2015 who received "flu shot" (add 8a + any members from previous months as applicable. _____
9. Unduplicated total _____
10. Reason(s) Discharged (include number for each)-

Nursing Facility: _____
Deceased: _____
Moved out of Service Area: _____
Hospice: _____
Member Choice: _____
Non-Compliance: _____
Lost SSI/Related Eligibility: _____
Lost Level Of Care _____
Other (specify):

Wait List Data:

11. Total Number on the Wait List: _____
12. Wait List Report by DON-R Score:

DON-R Score	# Members on WL	DON-R Score	# Members on WL

Programmatic report is due to: Department of Community Health, Division of Medicaid, SOURCE Program Specialist no later than the 15th of the month following the report month. EPCMM agencies with multiple locations will complete one programmatic report for purpose of management of the waiting list.

Instructions for SOURCE monthly report:

The purpose of the report is to keep track of how many active members your SOURCE site currently serves (members locked into your site), how many unduplicated members the Site has served to date, track the reason why members discharge from the program, and track the number of members in process to receive service.

Instructions:

1. **Agency Name**

   Insert the SOURCE case agency name here.

2. **Report month.**

   The month the data gathered and submitted for the report. Member information gathered in April would equal an April Report Month.

3. **Submitted by**

   Who is responsible for this data or who compiled the report.

4. **Today's Date and Year**

   The date the report is submitted.

5. **Previous month total**

   Represents the current number of members active on the previous month report.

6. Members Admitted during report month

Number of new members who became locked into your site during the month. (This includes anyone locked in during the report month who were retro locked back to a previous month.)

7. Members Discharged during report month

If you sent in a discharge and DCH closed the span.

8. **Current Active Members**

Active members equal #5 + #6 - #7. (Number of members locked into your site as of the last day of the report month)

8a. Members unduplicated who received 2014-2015 influenza vaccine the month of the report

8b. All members who received influenza vaccine for this season. Season starts July of the calendar year to June 30th of next calendar year.

9. Unduplicated total equals #5 (previous month total) + #6 (members admitted during report month)

10. Reason(s) Discharged (include number for each

Self explanatory. Numbers must equal number discharged.

Wait List Data (WL)

11. Total Number on Wait List:

Anyone screened during the report month and any members pending lock in from previous months. If score is less than 15, there is no need to put on the waiting list.

12. Wait List Report by DON-R Score

The agency may devise a span of scores to group member data on this list or report by individual score.

APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

Date:		**Member Name** **Important Diagnosis:** **Caregiver (CG) name:**	
	Column A	**Column B**	**Comments:**
Function	**Level of Impairment**	**Unmet Need for Care**	**If scores 1-3 explain why client needs assistance ie bad leg, weak arm, dementia etc**
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			

Column A Functional Impairment

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

● No significant impairment of function remains; ● Activity is not required by the client ● Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who: ● Experience minor, intermittent fatigue in performing the activity; or ● Take longer than would be required for an unimpaired person; ● Require some verbal prompting to complete the task

Score 2 - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity. This includes clients who:

● Experience frequent fatigue or minor exertion in performing the activity; ● Take an excessive amount of time to perform the activity; ● Must perform the activity much more frequently than an unimpaired person● Require frequent verbal prompting to complete the task.

3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant physical assistance.

Column B: Unmet Need for Care

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

			Member's Name:
Function	**Column A** **LOI**	**Column B** **Unmet Need**	**Comments:** **If scores 1-3 give reason why client needs assistance ie bad leg, weak arm, dementia etc**
7. Managing Money			
8. Telephoning			
9. Preparing Meals			
10. Laundry			
11. Housework			
12. Outside Home			
13. Routine Health			
14. Special Health			
15. Being Alo ne			
Total 1-6 (ADL)			
Total 7-15 (IADL)			
Total 1-15 (ADL+ IADL)			

Column A Functional Impairment

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

● No significant impairment of function remains; ● Activity is not required by the client ● Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who: ● Experience minor, intermittent fatigue in performing the activity; or ● Take longer than would be required for an unimpaired person; ● Require some verbal prompting to complete the task

Score 2 - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity. This includes clients who:

● Experience frequent fatigue or minor exertion in performing the activity; ● Take an excessive amount of time to perform the activity; ● Must perform the activity much more frequently than an unimpaired person● Require frequent verbal prompting to complete the task.

3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant physical assistance.

Column B: Unmet Need for Care

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

Tool to determine appropriateness for services based on the applicant's medical and financial status.

Rev. 01/12

When Completed: The screening and intake is completed within three business days of receiving the referral or inquiry.

Inform applicant of screening process before you begin.

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED - REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person's functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants.

A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column B, before a client is referred for assessment. If the Level of Impairment score is less than 15 refer client to other available services through the Area Agency on Aging or other resource.

The central question to determining the level of need for care is whether a person can perform activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: BASIC AND INSTRUMENTAL.

Table 1 - Activities of Daily Living Included in the Determination of Need (DON)

BASIC ACTIVITIES OF DAILY LIVING (BADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money

Bathing	Telephone
Grooming	Preparing Meals
Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

ITEM DEFINITIONS

1. EATING:

A. Is the client able to feed himself/herself?

Assess the client's ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see "preparing meals" and "routine health" items).

B. Is someone available to assist the client at mealtimes?

If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. BATHING

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client's circumstances?

Assess the client's ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client's ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?
If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?
Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?
If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?
Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?
If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.

NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client's ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions?
If the client scores at least (1) in Column A, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs?
Assess the client's ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client's home. (Note: the use of an emergency response system device should not be considered.

B. Is some available to assist the client with telephone use?
If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?
Assess the client's ability to plan and prepare routine hot and/cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to plan therapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client?
If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later.

LAUNDRY

A. Is the client able to do his/her laundry?
Assess the client's ability to do laundry including sorting, carrying, and loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.

B. Is someone available to assist with the performing or supervising the laundry needs of the client?
If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

A. Is the client able to do routine housework?
Assess the client's ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client's health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

B. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards?
If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home?
Assess the client's ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations?
If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundramats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the MDS-HC question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care?
Assess the client's ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning,

monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care , and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

14. SPECIAL HEALTH CARE

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score "0" for clients who have no specialized health care needs.

B. Is someone available to assist with or provide specialized health care for the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

15. BEING ALONE

A. Can the client be left alone?

Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

B. Is someone available to assist or supervise the client when the client cannot be left alone?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

BADL's refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for his or her own physical needs.

IADL's are the more complex activities associated with daily life. (They are applications of the BADL's.) Information regarding both BADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in

scores in subscales for BADL's and IADL's and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in BADL's, IADL's and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

Rev. 04/14

1. If answer is "no", inform applicant of CCSP/SOURCE ineligibility and right to appeal. If applicant agrees, refer client to other resources as appropriate. (If client appeals, please complete the case management form under Appendix Z6) Attempt to give member/ family **county** specific resources as well as state offerings. Gather resources through contacts, from internet, the local health department https://dhs.georgia.gov/ and others as appropriate. Focus resources on what the member identifies as the reason for the application to the program i.e. if needs monitoring refer to ADH or churches/ similar programs; if member needs food, refer to food banks, food stamps, meals on wheels etc; if family needs respite, search for respite offerings in community. https://dhs.georgia.gov/

2. If applicant's answer is yes, continue screening process answering each area with appropriate number (0-3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The "Case Comments" space to the right of Column B in the functional status section is used to:

- Note special reasons for impairment or unmet need.
- Describe the type of service, caregiver support or assistive devices that decreases the client's unmet need.
- Record the primary care giver's name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.
2. If Column A, "level of impairment" is scored "0", score Column B "0".
3. If Column A is scored greater than "0", ask Column B, Unmet Need for Care.

Column A: Level of Impairment

APPENDIX KK
DETERMINATION OF NEED- REVISED (DON-R)

Each one of the BADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?
- How much difficulty do you have in doing...?

NOTE: If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON-R. The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task

Score 2 - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or

- Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care
In scoring this column, the idea is both to obtain information from the applicant about his or her perceptions regarding need for care and to use observational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.
Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zarit burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.
Questions that might be asked of applicants and caregivers are:

- Do you feel burdened by providing care to your family member or friend?
- How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly?
- How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:

- Can you tell me if you are getting enough help in meeting your needs with...?
- Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. Observe the applicant's mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

Comments - Ask applicant "If you are not able to get these services, what will happen" and record the answer in applicant's own words

APPENDIX LL
GMCF

FAQs

SOURCE program admission now includes GMCF review for initial admission assessment, 6 month reassessment, and a designated number of annual reviews.

Information on their services and how to access their services is now available to Providers via the Provider Workspace/Education and Training link.

To access the training resources referenced in the SOURCE Webinar, please follow these instructions:

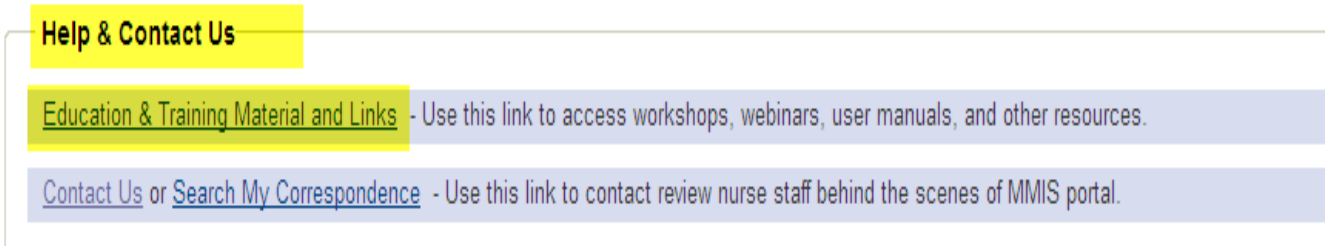
Open the web portal at www.mmis.georgia.gov

Log in using your assigned credentials to open the *Secure Home* Page

Click the ***Prior Authorization*** link

Click ***Provider Workspace*** from the drop list

Go to the bottom of the workspace page, and under the Help & Contact Us section, click ***Education and Training Material and Links***



If GMCF gives a final denial to the member it is the responsibility of the SOURCE Case Management Agency to follow up with the member per section 901 under Procedures/ Medicaid Eligibility: Screening staff will access the GAMMIS 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.

2nd level Reviews:

The 2nd level review option is only for members who have an evaluation denial from GMCF

- The member receives this information in their denial letter and will have 10 business days to provide new information to GMCF through their Case Management agency.
- Please do not use the contact us system. Use the Reconsideration Link only (page 39 of the Provider Workspace User Manual).
- If the member provides new information in the 10 days, they will either be accepted by GMCF for LOC, or they will receive a 2nd and final denial letter. (see attached SOURCE Second Denial Notification)
- If the member does not give new information, no new denial letter will be issued from GMCF. The member continues to have the right to ask for an appeal 30 days from issuance of the original denial letter.

APPENDIX MM
Claims, Billing (See Part I for ICD 9, and 10 information)

The Affordable Care Act (ACA)

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid**.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

NEW CMS 1500 Claim Form (version 02/12) & ZFLD Locator Instructions

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

- The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/HP:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/HP: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or

	Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/HP:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/HP:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. F **FOR DCH/HP**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

APPENDIX NN
Non-mandatory Forms for October 2014 Quarter

ANNUAL MEDICAL EXAM & REPORT FOR **SOURCE WAIVER** APPLICANT DETERMINATION OF **FUNCTIONAL/COGNITIVE IMPAIRMENTS** Version 9/2014 do not alter

SECTION I – IDENTIFICATION (To Be Completed by Submitting Agency)

AGENCY'S NAME & ADDRESS Phone and Fax	MEMBER'S NAME	MCD #	
	MEMBER'S ADDRESS	SEX □ MALE □ FEMALE	DOB
	CITY, STATE, ZIP		

SECTION II – MEDICAL REPORT

NOTICE TO PHYSICIAN: This member has made application or reapplication for Service Options Using Resources in Community Environments (SOURCE) which requires nursing home level of care. Your cooperation in completing this form to show the patient's current condition, focusing on both limitations and remaining capabilities, is requested. Your promptness will insure a timely decision on the patient's application. Please return completed form to the agency in Section I above.

DATE OF EXAMINATION:		ACTIVE/IMPORTANT DIAGNOSIS(ES):		
CURRENT MEDICATIONS AND USES:				
3. GENERAL FINDINGS: HEIGHT: _____Ft. _____In.	WEIGHT: _____Lbs.	BP:	HGB A1C:	Other pertinent labs:

PATIENT COMPLIANCE – Has patient demonstrated compliance with medical treatment? □ YES □ NO
If "No", please state reason:
_____
_____
_____

BODY SYSTEMS – Please indicate if the systems listed below are "normal"/"abnormal" or "present"/"absent." ("Abnormal" or "present" means applicant's complaint, objective physical finding or atypical diagnostic test.) Where "abnormal"/present" body systems are indicated, please complete the appropriate body system section in detail or submit a summary of your records which contain the required information. Please include operative notes if surgical procedures have been performed.

BODY SYSTEM	NORMAL	ABNORMAL	IMPAIRMENT	PRESENT	ABSENT
Musculoskeletal			Mental Disorder		
Hearing, Vision or Speech			Developmental Disorder		
Respiratory			Moderate to Severe Cognitive Disorder		

APPENDIX NN
Non-mandatory Forms for October 2014 Quarter

(BODY SYSTEM	NORMAL	ABNORMAL	IMPAIRMENT	PRESENT	ABSENT)
Cardiovascular			Requires mobility aides		
Digestive			Enteral feedings		
Genito-Urinary			Stage III or IV ESRD		
Blood & Lymphatic			Stage III or IV Decubiti		
Skin			Driving Restrictions		
Endocrine			Uncontrolled Seizures		
Neurological			Severe SOB with exertion requiring continuous 02		
Gait & Balance Disorder			Frequent Falls		
			Limited ROM		

DURATION – Has the impairment(s) described above lasted, or can it/they be expected to last for 1 year, or more? □ YES □ NO If "No", how long?_____

□ Summary of "abnormal/present" related to member's complaint, objective physical finding or atypical diagnostic test (ie. neuro exam) which supports nursing home level of care criteria:

_____

_____

General Questions (only describe if you check the box and functional status is affected):

□ Does the SOURCE member have any IADL/ADL functional impairments/limitations which require(s) nursing home level of care? If so, please describe:

_____

_____

□ Does the SOURCE member have any comorbid medical conditions(s) that contribute to the patient's functional impairments?

_____

_____□ Has the SOURCE member experienced or will have in the near future any medical or surgical procedures that have contributed to the need for nursing home level of care? If so, please document the date (actual/expected) of the procedure, procedure type and expected recovery time.

_____

_____

Give graded strength on a scale of 1-5/5:

1. Flaccid, Paralysis
2. Severe Weakness (no movement against gravity)
3. Moderate Weakness (movement against gravity but not resistance)
4. Mild Weakness (move against resistance)
5. Normal Strength

	UPPER EXTREMITIES		LOWER EXTREMITIES	
	Right	Left	Right	Left
A. Proximal	____	____	____	_____
B. Distal	____	____	____	_____

I attest that this SOURCE applicant meets the requirements for admission into a nursing home if SOURCE was not available.
□ Yes □ No

_____ _____ _____
Physician Name/Title Phone Number Date

This form is in concurrence with DCH SOURCE Policy 1303. Scheduled Contacts with Primary Care Provider:
If the member has an Annual reevaluation scheduled in the next 3 months, concurrence with diagnosis, medications, and functionality should be discussed and documented with the PCP (by the Case Manager). (May also be requested by DCH)

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name _____ Age _____

Is patient alert? _____ Level of education _____

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car

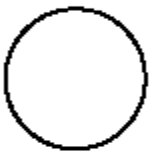
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
(1) **How much did you spend?**
__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember?** 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
__/2 (0) 87 (1) 649 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay
__/4 (2) Time correct

__/2 (1) **10. Please place an X in the triangle.**

(1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.
Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

(2) **What was the female's name?** (2) **What work did she do?**
__/8 (2) **When did she go back to work?** (2) **What state did she live in?**

_____ **TOTAL SCORE**

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

Scoring		
High School Education		Less than High School Education
27-30	Normal	25-30
21-26	MNCD*	20-24
1-20	Dementia	1-19

* Mild Neurocognitive Disorder

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impairment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. J am Geriatri Psych (in press).

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time. This is a non proprietary exam instead of the MMSE. Use this link for training.
http://aging.slu.edu/index.php?page=assessment_videos
http://www.elderguru.com/slums-dementia-test-available-in-various-languages/

VAMC Saint Louis University Mental Status Examination Form Details

Who Can Complete the Form: Social Services, Reflections/Passages Program Coordinators, Licensed Nurses, MDs, NPs, OTs, PTs, Residence Supervisors and Other Qualified Healthcare Professional who have been trained (and retrained annually) by viewing the VA-produced DVD (available upon request to tumosan@slu.edu).

Purpose of the Form: To screen individuals to look for the presence of cognitive deficits, and to identify changes in cognition over time.

Instructions for Use:

1. Complete resident demographics at the top of the page.
2. We recommend that you put the date and the name of the evaluator on the bottom of the page as well (see #19).
3. Administration should be conducted privately and in the examinee's primary language. Be prepared with the items you need to complete the exam. You will need a watch with a second hand on it.
4. Record the number of years the patient attended school. If the patient obtained an Associates, Bachelor's, Master's or Doctorate degree, note the degree achieved instead of actual years of school attended.
5. Determine if the patient is alert. Do not answer "yes" or "no", but indicate level of alertness. Alert indicates that the individual is fully awake and able to focus. Other descriptors include: drowsy, confused, distractible, inattentive, preoccupied.
6. Begin by asking the patient the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?"
   Then proceed with the exam questions.
7. Read the questions aloud clearly and slowly to the examinee. It is not usually necessary to speak loudly but it is necessary to speak slowly.
8. Begin by asking the patient something similar to the following:
   "Do you have any trouble with your memory?" "May I ask you some questions about your memory?" "I'd like to see how good your memory is by asking you some questions." You may need to reassure patients by telling them that this is not a test that they can fail but merely a tool much like a thermometer that takes temperature is a tool. What this does is checks for the amount of memory they have.
   Then begin to administer the exam questions.
9. Score the questions as indicated on the examination.
10. On question #4, read the statement as listed on the exam. Ask the patient to repeat each of the five objects (Apple, Pen, Tie, House, Car) that you recite to make sure that the patient heard and understood what you said. Repeat them as many times as it takes for the patient to repeat them back to you correctly.

09/03/09

LEGAL MEDICAL RECORD STANDARDS FOR SOURCE

PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet basic legal standards. To give guidance on electronic/ paper documentation with more hybrid medical records evolving.

All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name, and another unique identifier. Each page of a double-sided or multi-page forms must be marked with member identification, since single pages may be photocopied, faxed or imaged and separated from the whole.

Documentation requires the signature and professional title of staff, and the date of documentation..

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, unless that recording was incorrectly assigned to the wrong member.

Handwritten entries should be made with permanent black or blue ink. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed.

Copy and Paste Guidelines

Copying for re-use of data: A clinician may copy and paste entries as long as care is taken to ensure that the information actually applies to the current patient condition and visit, that applicable changes are made to variable data, and that any new information is recorded.

Appendix QQ:

Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

Section A. Identification
Case Management Agency _____ Date of Visit: _____
Member's Name: _____DOB:_____
Place of Assessment: ☐ Home ☐ Nursing Home Other _____

Section B. Reason for Re Evaluation:
Significant change: (circle) Mobility ADL's IADL's Other
Explain: _____
Nursing Home Return ☐ Yes ☐ No Hospitalization ☐ Yes ☐ No
List equipment, supplies, home modifications needed at this time?
_____
Nursing Home Stay related to Sentinel Event? ☐ Yes ☐ No

Section C. Communication
Speech clear ☐ Yes ☐ No or ☐ No Speech
Hearing problem ☐ Yes ☐ No Vision problem ☐ Yes ☐ No
Able to make needs known ☐ Yes ☐ No

Section D. Behaviors/ Cognition
Memory Loss ☐ Yes ☐ No Confusion ☐ Yes ☐ No
Wandering ☐ Yes ☐ No Resists Care ☐ Yes ☐ No
Inappropriate/other behaviors ☐ Yes ☐ No Specify: _____
Dementia ☐ Yes ☐ No

Section E. Continence
Bowel Continent ☐ Yes ☐ No ☐ At times
Bladder Continent ☐ Yes ☐ No ☐ At times
☐ Colostomy ☐ Catheter
Other Device _____

SectionF. Other
Pain ☐ Yes ☐ No Location: _____
Swelling ☐ Yes ☐ No Location: _____
Fatigue ☐ Yes ☐ No
Short of breath ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Infection in last 90 days ☐ Yes ☐ No
Other _____
Has member received vaccines? If yes, when? Flu_____
Shingles _____
Pneumonia _____
Other _____

Section G. Current Diagnoses
Diagnoses/Conditions leading to Nursing Home Stay

Other diagnoses
a. _____
b. _____
c. _____
d. _____
e. _____

Section H. Hospitalizations/ER Visits/PCP appointments
Nursing Home Admission Date_____ Nursing Home Discharge Date_____
Hospitalizations last 90 days ☐ Yes ☐ No
Admit/Discharge Dates_____
Diagnoses _____
ER visits last 90 days ☐ Yes ☐ No
ER Diagnoses_____
PCP name _____
Specialist _____
Next office Visit (dates) _____
New Referrals _____

Section I. Assistance Needed with ADLs/IADLs

Task	Help Needed (Yes) – who provides assist.	Help Needed (No)	Decline in member's Performance Y/N	
Meal Prep				
Housework				
Managing Money				
Managing Meds				
Phone Use				
Stairs				
Shopping				
Transportation				
Bathing				
Hygiene				
Dressing				
Walking				
Locomotion				
Toilet Use				
Bed Mobility				
Eating				

Fall in last 90 days ☐ Yes ☐ No
Uses assistive device for ambulation/locomotion
☐ Yes ☐ No Unsteady Gait ☐ Yes ☐ No

Appendix QQ:

Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

Member's Name: _____ **D.O.B.** _____ **Date of Contact**: _____

Section J. Equipment and Devices (CIRCLE)

Cane Walker Wheelchair Scooter Hospital bed Bedside Commode Oxygen Grab Bars
Adaptive eating equipment Prosthetics Lift (manual/electric) Braces Bathing equipment Other _____
_____

Section K. Diet and Weight

Specify Diet Ordered _____ Is this a new diet? ☐ Yes ☐ No Height _____Weight_____

☐ Weight Loss ☐ Weight Gain ☐ No Change Feeding Tube ☐ Yes ☐ No ☐ G-tube? ☐ Yes ☐ No Other:_____

Section L. Treatments (Yes / No)

Chemotherapy		Scheduled Toileting	
Radiation			
Dialysis		Turning and Repositioning	
Suctioning			
IV medication		Other	

Home Monitoring ☐ Blood Sugar ☐ BP
☐ Weight ☐ Other _____

Section M. Skin

Condition	Location	Other Information
Pressure Ulcer		Stage -
Other Ulcer		Type -
Skin Tear		
Rash		
Surgical Site		
Infusion, feeding, or Dialysis access		Specify -

Wound care/dressing change ☐ Yes ☐ No
Provider _____

Section N. Formal and Informal Support

Who does member live with? Name/relationship _____
If member lives alone, list name of primary support person: _____
Legal Guardian ☐ Yes ☐ No Name/contact information: _____
Support Services Needed: Indicate increase/decrease or new

Service	New Service Y/N	Provider Assigned	MC, PCP, RL	Frequency
PSS				
HDM				
ERS				
SNS				
PT				
OT				
ST				
ALS				
ADH				

Section O. Medications ☐ **See Medication List for more medications** **Pharmacy name/number:** _____

Medication	Dose	Route	Frequency	Diagnosis	New Med Y/N

Appendix QQ:

Modified Re Evaluation Contact Sheet for Members with Active Prior Authorizations/Approvals

Member's Name: _____ **D.O.B.** _____ **Date of Contact**: _____

Present During or Contributing to Member's Assessment	Agency	How related to Member	Date

Additional Notes: Teaching/ training needed for new diagnosis, diet, equipment, labs, treatments, medications etc.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
___

Interviewer Print Name _____Title_____

Interviewer Signature/date _____Date: _____

Case Manager Supervisor Printed Name_____ Sign _____Date:_____

R.N. Print Name _____Sign_____Date:_____

R.N. Assessment: Disease Management Needed? □ Yes □ No