

**FY 2016-2017  
SCOPE OF SERVICE**

**OPTIONS / CARE MANAGEMENT**

I. PURPOSE

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

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

II. DEFINITIONS

- A. Aging Program Directive (APD) is an official document issued by the Pennsylvania Department of Aging (PDA) in which detailed information is presented on the operation of specific aging service programs.
- B. Aging Services Policy and Procedure Manual sets forth guidelines and procedures for the 52 Area Agencies on Aging in the Commonwealth of Pennsylvania.
- C. Area Agency on Aging (ACDHS/AAA) is a program office of the Allegheny County Department of Human Services (DHS) that receives grant funds from the Pennsylvania Department of Aging (PDA) to provide programs and services that enable and empower adults who are 60 years of age and older and live in Allegheny County to maintain independent, safe and healthy lives.
- D. Care Manager works with participants and their caregivers in gaining access to the state's home- and community-based services and other medical, social and educational services regardless of funding source.

- E. Caregivers are family members, friends or neighbors who provide ongoing and frequent assistance to enable participants to live safely in their homes. The assistance is not limited to hands-on care, but must be critical to the well-being of participants. Within the Family Caregiver Support Program (FCSP), the assistance must be provided daily for functionally dependent adults.
- F. Care Plan is the detailed outline of the participant's needs and shows the coordination of services needed to address those needs. OPTIONS Care Plans are updated annually or when a participant's needs or level of care change.
- G. Cost Share / Co-Pay is required for OPTIONS participants in sharing the cost of their Care Plan based on their monthly countable income, determined by a sliding scale.
- H. Family Caregiver Support Program (FCSP) provides training and financial support to improve the quality of life, and address the emotional and financial burdens of eligible caregivers, 18 years of age and older, that look after a frail and/or dependent older adult without compensation. The FCSP serves caregivers, ages 55 and older, of related adults with disabilities, but not their own adult children with disabilities. FCSP also serves caregivers, ages 55 and older, who are caring for children, ages 18 and younger, who are related but not the biological or adopted children of the caregiver.
- I. Financial Summary Sheet. A detailed recording sheet used to help care managers show the assets/income of a participant and is used in conjunction with the cost share summary to explain the breakdown/eligibility of the individual for certain programs, services, and any costs they may have.
- J. Freedom of Choice Form. Form detailing that the participant has the right to receive services wherever they choose or to receive no services at all.
- K. Functional Needs Score (FNS) is a score used to prioritize assessments and care plans for ACDHS/AAA OPTIONS CM and FCSP participants. FNS is generated for a participant automatically in SAMS after a care manager completes a Needs Assessment Tool (NAT).
- L. Hard to Serve (HTS) List is a list of participants who have been authorized for service and a service plan has been completed but they are waiting for a worker. The HTS participants are waiting for a worker to provide Home Support, Personal Care, Home Health and/or Chore service. The HTS list is shared with the In-Home Service Providers on a weekly basis.
- M. Health Insurance Portability and Accountability Act (HIPAA) is a federal law that establishes privacy standards to protect patient medical records

and other health information provided by participants to health plans, doctors, hospitals and other health care providers.

- N. Home and Community-Based Services (HCBS) are aging services provided in non-institutional settings through AAAs and their contracted providers.
- O. Individual Service Plan (ISP) is a custom Care Plan to guide the implementation of services based on the needs and expressed preferences of participants and caregivers.
- P. Informal or Natural Supports are individuals or groups who voluntarily assist participants without payment.
- Q. Information & Assistance (I & A). ACDHS/AAA senior line representative acquires preliminary information on an interested participant.
- R. Level of Care Determination (LCD) is a clinical assessment tool used to determine level of care for participants. Completion of the LCD allows for classification of participants as Nursing Facility Clinically Eligible or Nursing Facility Ineligible. LCDs are required at initial assessment and whenever the level of care changes.
- S. Master Provider Enterprise Repository (MPER) a repository of key CONTRACTOR demographic data for all CONTRACTORS who provide services for DHS. DHS applications use MPER to validate AGREEMENT, services, facilities and rate information to facilitate documentation of services rendered information by CONTRACTORS. CONTRACTORS are required to keep all agency information including but not limited to contacts/agreements, facilities and service offering information up to date.
- T. Needs Assessment Tool (NAT) is an assessment tool developed by the PDA to compile information about the participant, their condition, situation and environment, and assist the care manager in developing the care plan and ongoing care management.
- U. NAT-E is a streamlined form required to assess participants requesting Non-Congregate / In-Home Meal Service (NCMS). This must be completed initially and thereafter annually for the participant to continue to receive home delivered meals.
- V. Nursing Facility Clinically Eligible (NFCE) participant who has been assessed and determined to be clinically eligible for nursing facility care.
- W. Nursing Facility Ineligible (NFI) participant who has been assessed and determined not to be clinically eligible for nursing facility care.

- X. Office of Long-Term Living (OLTL) is the unit of state government that funds and administers services for participants with disabilities and related health needs.
- Y. OPTIONS Home and community-based services funded primarily through the Aging Block Grant. The services in this program are provided to eligible participants aged 60+ to assist them in maintaining independence with the highest level of functioning in the community and delay the need for more costly care/services. OPTIONS services are not an entitlement. All other resources (individual, local, state and/or federal) must be considered and utilized before OPTIONS services are provided.
- Z. Participant is an individual who receives services under a PDA / OLTL and HCBS waiver, OPTIONS Program or Family Caregiver Support Program (FCSP).
- AA. Pennsylvania Department of Aging (PDA) coordinates and funds the aging service programs provided by the 52 area agencies on aging that serve older adults in the state.
- BB. Service Plan Agreement. Participant acknowledging a total understanding of their Care Plan and agrees to the services, providers, schedule, and any associated costs.
- CC. Service Provider Choice Form. This form records the participant's acknowledgement that they choose their provider and will be offered choice in the process. Also they have the right to receive a list of all providers who fit the services in their ISP, which they have a hand in developing.
- DD. Social Assistance Management System (SAMS) is software used to track all services provided to participants with Allegheny County Department of Human Services/Area Agency on Aging (ACDHS/AAA) funding.
- EE. Third-Party Payer (TPP) is one that makes payments for services, rather than having them paid by the ACDHS/AAA.
- FF. Waiting Lists (if in effect) will include participants who are waiting for an increase of services or a new service added to their plan according to the Function Needs Score (FNS).

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

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

Organizations providing services outlined in this Scope of Service shall comply with all federal and state directives listed below and any others that may be issued by the ACDHS/AAA.

- A. [Critical Incident Management Policy for Office of Long-Term Living Home and Community-Based Services Programs](#)
- B. [Pennsylvania Code, Title 6, Chapter 15: Protective Services for Older Adults](#)
- C. [Pennsylvania Department of Aging APD 10-01-02: Family Caregiver Support Program \(FCSP\)](#)
- D. [Pennsylvania Department of Aging APD 15-01-08: Aging Services Policy and Procedure Manual Aging Policy and Procedure Manual](#)

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

### IV. PERFORMANCE EVALUATION

Each AGREEMENT year the ACDHS/AAA will inform clear expectations of acceptable performance standards to the CONTRACTOR and hold the CONTRACTOR accountable to them. These standards relate to compliance with applicable policies, regulatory guidelines, AGREEMENT scopes, and Performance Based Contracting (PBC), where applicable, to support ongoing service quality and to best meet or exceed the participants' needs and to optimize service impact on its participants. The CONTRACTOR is responsible for adhering to the timelines in reporting its compliance to the scopes and using findings to build on its strengths and develop strategies on opportunities, through a continuous quality improvement process.

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

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

- A. CM Participants and caregivers will be effective partners in managing their needed supports.

- B. CM Participants will be able to remain safely at home or in a community setting of their choice.
- C. CM Participants will slow the decline in their health and/or functioning, thereby maintaining or improving their quality of life.
- D. Caregivers will maintain or improve their quality of life and be able to continue to provide care for a longer period of time.

Monitoring and Reporting: The ACDHS/AAA reserves the right to monitor all CM services and related information. CM CONTRACTORS must comply with the standards outlined in the OPTIONS Performance Matrix and those of the PDA.

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

#### V. SERVICE STANDARDS, REPORTING AND DOCUMENTATION REQUIREMENTS

- A. Components: The following are regarded as the essential components and requirements of the CM Program.
  - 1. Participant Referrals: ACDHS/AAA requires participant referrals in a timely and expeditious manner.
 

CM initiates contact with 100% of participants within three (3) business days after receiving the case assignment.
  - 2. Assessments. A comprehensive face-to-face assessment is conducted after intake with CM Participants and others of their choosing (e.g. family members, friends, etc.) to evaluate the medical, psycho-social, environmental and financial aspects of their situation. The Financial Summary and NAT are required initially and updated annually (semi-annually in the FCSP) or when the CM Participant's situation changes. CM participants also may request reassessments. The NAT is not required in the Grandparent program. A Caregiver Journal Note replaces the NAT in the Grandparent program.
    - a. 100% of assessments must be completed within 5 business days of referral; of these, 40% must be completed within 3 business days.

- b. 95% of assessments must demonstrate correct level of care determinations.
  - c. 95% of assessment must have acceptable substantiating documentation.
  - d. LCD assessments must be completed, signed, and the notification of level of care determination sent out within 15 days from the date of intake.
3. Resource Counseling and Support (Information and Assistance). Care managers assume a proactive role in counseling CM Participants on all available, appropriate ACDHS/AAA and non-ACDHS/AAA programs and services that address the CM Participants' unmet needs and help CM Participants to make informed decisions about their care. Counseling and support also are extended to caregivers, and may include referrals to community health, social service and other government programs. Care managers take a proactive role in informing, advising and connecting CM Participants and caregivers with CM services and resources available through the ACDHS/AAA, its CM CONTRACTORS and other human services organizations or community resources.
- 100% of CM Participants must receive ongoing resource counseling at least every 6 months. Resource counseling must be done a minimum of every three months with caregivers in the FCSP.
4. Individual Care Plans. Care managers work with CM Participants, caregivers and other persons in their support network to develop and implement a comprehensive, personalized care plan with services that are strengths-based and specific to the CM Participant's individual preferences, needs and desired outcomes. The plan draws on and coordinates informal supports, third-party payers and community organizations in a way that supports CM Participants, and protects their health and welfare. It does not replace informal supports with CM services, but may be used to assist these supports. Using a CM participant-centered and directed approach, care managers work with CM Participants to identify the most appropriate programs, CM services and strategies; develop back-up plans to mitigate risks; and enable CM Participants to live as they choose in their home or other setting of choice in the community.

At a minimum, CM CONTRACTORS must meet state standards, as indicated at

5. Service Initiation. CM CONTRACTORS must work collaboratively with CM Participants and caregivers to arrange for CM services, according to preferences for services, scheduling and CM CONTRACTORS.

No more than 5 business days from intake to face-to-face visit with CM Participant.

- a. 100% of referrals by CM CONTRACTOR to in-home providers must be completed within two (2) business days from the date when the participant is deemed eligible for services.
  - b. 90% CM Participant satisfaction with the CM service by the CM CONTRACTOR.
6. Regular CM Participant Contacts. Care managers work with CM Participants to establish and adhere to a regular schedule of contacts based on the CM Participants acuity, needs and level of support, but occurring not less than once a month. The contacts, which may be phone calls or personal visits, are conducted to check on the CM Participant's condition, assess the effectiveness of the care plan and allow for adjustments to the plan, as needed.
    - a. All CM Participants must receive a minimum of one monthly contact, either by telephone or face-to-face.
    - b. CM CONTRACTOR addresses participant initiated complaints and problems within two (2) business days and provides a reasonable response to ACDHS/AAA in writing within seven (7) business days.
    - c. All NFI CM Participants must receive at least one home visit every six months.
    - d. All NFCE CM Participants must receive at least one home visit every three months.
    - e. FCSP CM Participants and caregivers must receive at least one home visit every three months.
7. Service Utilization. Care managers monitor services to assure that they are delivered as prescribed, CM Participant needs and expectations are met, and problems or concerns are addressed effectively and promptly.

- a. 100% of CM Participants must receive a follow-up call no later than two weeks after referral to the in-home services provider.
  - b. 100% of qualifying incidents must be reported in compliance with incident management guidelines and to ACDHS/AAA Protective Services.
8. Emergency Situations. Care managers check on the well-being of CM Participants and caregivers, and provide additional CM services to those facing emergency situations in their homes, such as severe weather, property damage or utility issues. In addition to currently served CM Participants, CM CONTRACTORS are responsible for serving older adults affected by emergencies in the CM CONTRACTOR'S service area, or by special request of the ACDHS/AAA.
- a. At all times, the emergency plans of CM CONTRACTORS must be current, actionable, routinely updated, practiced, followed and, at a minimum, be in compliance with the ACDHS/AAA Emergency Response Plan.  
  
The ACDHS/AAA Emergency Plan can be found on the Allegheny Aging Portal:  
  
<https://allegheny.agingsupportportal.com/Login.aspx>  
  
Under Information Library > Department Manuals > All Users: Emergency Documents
  - b. At all times, CM CONTRACTORS must respond to public emergency situations affecting older adults in their community and deploy care managers as needed.
  - c. CM CONTRACTOR is expected to respond within 24 hours of notification by ACDHS/AAA of public emergency (24 hours a day / 7 days a week) in accordance with the ACDHS/AAA Emergency Plan.
  - d. All homebound CM Participants must be checked on in public emergency situations to assure their safety and mitigation of risk.
  - e. CM CONTRACTOR visits, assesses and appropriately intervenes the same day (available 24 hours a day / 7 days a week), on notification by ACDHS/AAA that an emergency situation affecting a participant exists, and reports back to

ACDHS/AAA within 48 hours. Notification by ACDHS/AAA will consist of entering an action in SAMS and following up with a phone call to the CM CONTRACTOR.

9. Documentation. CM CONTRACTORS are responsible for entering and updating all CM Participant data, on an ongoing basis, into SAMS, the mandated database required by the Pennsylvania Department of Aging.
  - a. CM CONTRACTORS are responsible for coordinating appropriate information management system training (SAMS), and the transfer of knowledge and information to current and new staff.
  - b. All CM Participant documentation must be entered into SAMS within three working days after a CM Participant contact or transaction.
  - c. CM CONTRACTORS are required to generate monthly reports on the data and its impact on CM Participants for submission to the ACDHS/AAA by the seventh working day of the month for the prior month's data.
  - d. FCSP monthly reimbursement data is accurately entered into SAMS by noon three business days after the 5<sup>th</sup> of the month.
  - e. FCSP monthly reports show no more than 10% of the reimbursement data by each CM CONTRACTOR contain errors which require correction.
  - f. CM CONTRACTORS must have the capacity to retrieve and submit data, information, reports and other communication through electronic Internet capabilities within one business day of receipt. Failure to receive or read ACDHS/AAA communications sent to CM CONTRACTOR MPER e-mail addresses the same day does not absolve CM CONTRACTORS from knowing, responding to or complying with the directives in the communication.
10. FCSP is a subsidiary program of the CM Program and is a required part of CM services. FCSP provides training and support to reduce the occurrence and level of stress among caregivers. Caregivers receive financial reimbursements for legitimate caregiving expenses, home modifications and assistive devices over their time in the CM Program.

- a. Care Managers must provide caregivers with quarterly resource counseling (Examples of acceptable resource counseling include support group lists, reading recommendations and community educational opportunities to support their caregiving role, and respite information). Resource counseling may be provided verbally or in writing (email / mail). In FCSP, resource counseling is only required with the caregiver.
- b. Care Managers must make monthly contact with 80% of caregivers via phone or e-mail.
- c. All FCSP care receivers and caregivers must receive a minimum of one monthly contact, either by telephone or face-to-face (If care receiver unable to communicate by phone, document).

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

100% of case conferences are held where appropriate and produce action plans to address the immediate needs of participants.

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

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

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

1. Strengths-Based Approach is the ability to respect and apply the personal strengths or assets acquired by CM Participants through

life experiences. The strengths-based approach is not license for care managers to abdicate responsibility for assisting CM Participants who are unable to act on their own behalf. It is the ability to encourage and empower CM Participants, caregivers and their informal supports to use their own strengths and assets to meet their responsibilities, secure their rights, and achieve positive change and balance in their lives.

2. Effective Communication is the ability to use effective oral and written communication. This includes interview and active listening skills to engage and negotiate with a diverse range of CM Participants, caregivers, and informal support groups and organizations.
3. Identification of Needs is the ability to work in partnership with CM Participants, caregivers and other professionals to assess CM Participants' circumstances; to identify CM Participant and caregiver needs, risks, gaps, opportunities; and to respond appropriately. Care managers must have the skills to deal with the various circumstances encountered in their work, including basic understanding of medical issues as they relate to normal and abnormal aging, mental health issues, substance abuse, physical or cognitive disabilities and other challenges. It is the ability to provide opportunities for CM Participants to function; participate and develop to their highest possible level of independence in their environments.
4. Service Coordination is the ability to arrange for and coordinate the CM services necessary for the CM Participants' appropriate levels of care and protection through the ACDHS/AAA and other community resources. It is the ability to follow, review and monitor established CM services to assure that they continue to meet CM participant needs and mitigate risk, and to amend CM services as needed.
5. Relationship Building is the ability to establish and maintain effective relationships built on a foundation of trust and respect with CM Participants and their caregivers.
6. Caregiver Support is the ability to engage and support caregivers with the goal of maintaining the highest level of functioning for caregivers so that they may continue to support their CM Participants.
7. Financial Stewardship is the ability to understand the financial context of CM services, to enable service CM Participants to make informed decisions within this context and to use only needed resources. Care managers also should be able to balance the need for ACDHS/AAA CM services as those of last resort while having a

positive outcome on CM Participants' lives.

8. Understanding Systems is the ability to comprehend, navigate and explain to CM Participants the aging services network and procedures across and within agencies, including issues related to formal and informal support systems. Care managers also should be able to guide and assist CM Participants with services outside of the ACDHS/AAA network, as needed.
9. Time Management is the ability to use time effectively and efficiently and to prioritize tasks accordingly.
10. Decision Making and Problem Solving is the ability to make sound decisions based on analysis, wisdom, experience and judgment. It also involves the use of logic and methods to solve complex problems.
11. Understanding of CM Participant Environment is the ability to think critically and apply knowledge to understand CM Participants and caregivers in the context of their environment. It is the ability to adapt behavior and opinions in light of the CM Participant's situation and remain flexible in responding to differences.
12. Evidence-based Approach is the ability to understand and practice evidence-based (i.e., reliable, objective data) techniques when working with CM Participants and caregivers.
13. Continuing Education is the ability and commitment to improve skills and knowledge by engaging care managers and supervisors in professional development opportunities, including appropriate certifications and trainings. It also involves the ability to impart aging-specific knowledge to care managers by which they may expand their expertise, performance and professional development over time.

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

1. All CM Participants and caregivers must be treated in a manner that is respectful of their individual rights, interests, needs and values.
2. All CM Participants and caregivers must be informed of all available, appropriate CM service alternatives and made aware of the conditions of service delivery.

3. All CM Participants and caregivers must be fully supported in the self-direction of their strengths-based care.
4. All CM Participants and caregivers must have the right to make final decisions about their CM services and to choose in-home providers from ACDHS/AAA lists of contracted providers, as mandated by the PDA.
5. Care managers must fully support responsible CM Participant and caregiver rights to commend, appeal decisions, file complaints or seek additional information about their CM services by explaining how, when and where to engage in the appropriate processes.

D. Cost Containment.

1. All participants who are seeking home and community-based services and who have been assessed and determined to be NFCE must apply for Aging Waiver by completing a PA-600L, which determines financial eligibility. For new NFCE participants, interim care plan cannot be initiated until the completed PA 600L is submitted to the CAO.
2. If the participant meets the criteria for Aging Waiver but refuses to apply, they are responsible for 100% of the cost of their Care Plan, including Care Management and associated administrative costs, which cannot exceed the cap set by PDA.
3. Applicants already enrolled in or new applicants for the Family Caregiver Support Program (FCSP) who are NOT interested in obtaining other services in conjunction with the FCSP are exempt.
4. Care managers can request an exceptional Care Plan by gaining approval from their supervisor and the local AAA OPTIONS Care Management Department, based on the guidelines from the OPTIONS Chapter. Following approval from the local AAA, the ACDHS/AAA Cost Sharing department will review approval and the participant pays 50% or their cost share percentage, whichever is greater. Participant's financial situation is taken into account with poverty protection. FCSP caregivers are reimbursed at the same reimbursement rate as prior to the care plan cap exception.
5. Cost Share/Copay will be completed on all OPTIONS participants except for those receiving a non-congregate in-home meal only service.

- E. Coordination of Service Delivery. The CM CONTRACTOR is responsible for coordinating the CM services necessary for the CM Participants' appropriate level of care and protection through the ACDHS/AAA and other community resources.

Coordination includes arranging for, reviewing and monitoring established CM services, and amending CM services as needed in order to meet CM participant changing needs, mitigate risks, and support the highest possible level of functioning and independence.

1. Ordering of Services

- a. Availability of service hours shall be determined prior to prescribing services.
- b. FCSP caregivers are responsible for coordination of services as per care plan.
- c. The participant's care manager will contact the participant's provider of choice with a service request.
  - i. The provider coordinator will notify the care manager within two business days regarding the availability of a worker. If the provider is unable to confirm a start date, the care manager will then phone the next provider and follow the same procedure until a provider is found or all providers are called. The care manager will document these contacts in the Journal. After the participant's Provider choice form has been exhausted then the Care Manager places the participant on the Hard to Serve list, as long as the participant is in agreement.
  - ii. Once the start date of service is determined, the care manager will immediately enter the provider, service information and start date into the Service Plan in SAMS. Note: The Service Plan must be completed prior to entering the Service Orders.
  - iii. Upon completion of the Service Plan, the care manager will enter service orders for the current care plan. In Special Instructions, the care manager will include the prescription and the specific days of the week the participant will receive services. The units should reflect the exact number of hours (units of service) the participant will receive each month.
  - iv. The In-Home service provider will then be able to access the participant from the Consumer List in SAMS and print

the service order. The provider shall not service a participant prior to viewing the Service Order in SAMS.

- v. The CM CONTRACTOR is responsible for communication with in-home providers on all assigned care management cases including but not limited to: missed services, service suspensions and termination of services.

F. Community Coordination

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

1. Coordination with I&A: OPTIONS care managers shall work with the ACDHS/AAA or CONTRACTOR'S I&A unit to identify formal and informal service providers within the geographic service area.
2. Coordination with ACDHS/AAA Senior Community Center Providers: An OPTIONS care manager is available at mutually agreed upon dates, at each Community Focal Point in their geographic service area at least quarterly to consult with Senior Community Center staff and participants about program services.

- G. Non-Congregate/In-Home Meal Service (NCMS) Only Participants. To be eligible for this service, the individual must be at nutritional risk, physically or mentally unable to obtain food or prepare meals and have no one willing or able to prepare meals for them as evinced by a completed NAT-E. Each meal shall adhere to the nutrition requirements as outlined in the most current PDA Nutrition Services APD and can be provided hot, frozen or in combination. These meals are provided to participants in their individual residences and not in a congregate setting.

This specific group of participants only receives the service of NCMS after the CM CONTRACTOR approves eligibility. The CM CONTRACTORS will continue to determine eligibility every four (4) months, complete an annual NAT-E and document a service delivery of the assessment. If there is change in status of the NCMS only participant the CM CONTRACTOR will handle accordingly. CM CONTRACTOR will also respond to any emergency situations for these participants.

H. Waiting Lists

1. When a waiting list is necessary, it will include participants who are waiting for an increase of services or a new service added to their plan.

2. Participants with the same FNS score will be ranked by the date of completion of their last LCD.
  3. Participants waiting for a Supplemental Service only cannot be served until all individuals on the Waiting List whom are waiting for a Core Service have been served.
  4. Core Services are Adult Day Service, Care Management, Consumer Reimbursement, NCMS and Personal Care.
  5. Supplemental Services are Home Support, Home Modifications/ Repairs, Medical Equipment and Assistive Devices and PERS.
- I. Reduction, Suspension and Termination of Services. CM services may be discontinued temporarily because CM Participants are in the hospital, CM participant needs are temporarily being met by another source of support, or CM Participants are temporarily out of town, or are placed in a personal care, nursing or rehabilitation facility. CM Participants whose CM services are suspended for more than forty-five (45) days need to be “terminated” and re-entered at the appropriate time. ACDHS/AAA wait list guidelines must be followed.

OPTIONS CM will follow the appeal process. The hearing and appeals chapter is outlined in the Aging Services Policy & Procedure Manual.

J. Involvement of Clients in Research

Individuals receiving services pursuant to this AGREEMENT may not be involved as subjects in any research associated with those services without the prior consent of the DHS Data and Research Privacy Board (hereafter known as Privacy Board). This includes research projects engaged in by CONTRACTORS as well as projects undertaken by CONTRACTOR sub-contractors and/or any entity (e.g., university, research organization) requesting client participation in such research. Any CONTRACTOR or entity wishing to engage in human subject research with DHS clients as subjects must submit a request to the Privacy Board at [DHS-Research@allegHENYcounty.us](mailto:DHS-Research@allegHENYcounty.us). More information and relevant forms can be found at <http://www.allegHENYcounty.us/dhs/research.aspx>.

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

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

L. Geographic Service Area.

Service shall be provided only to individuals residing within the contracted service area except in circumstances specified below.

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

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

1. At least one professional staff member shall be available in the office during the CM CONTRACTOR'S normal hours of operation.
2. After normal hours, a recorded phone message shall be in place to advise callers of emergency or crisis intervention procedures. In addition, building signage and contact information on the CM CONTRACTOR web site must be posted.
3. An administrative or professional staff person shall be available on call when the CM CONTRACTOR'S offices are closed.
4. CM CONTRACTORS must address the needs of caregivers and participants who are not able to consult with care managers during normal working hours.
5. CM CONTRACTORS shall submit annually to the ACDHS/AAA written documentation of their hours of operation and a list of holidays/closures.
6. CM CONTRACTORS shall develop and maintain a detailed, written contingency plan outlining emergency operation and closure procedures and submit an updated copy to the ACDHS/AAA by the last business day of August, during the term of any agreement with ACDHS/AAA. The contingency plans will include specific details about how communication between the CM CONTRACTORS and the ACDHS/AAA will occur with timelines and lines of responsibility

specified. The CM CONTRACTOR'S Emergency Plan is current, actionable, routinely updated, practiced, followed and in compliance with ACDHS/AAA Emergency Response Plan.

N. Contingency Funds.

1. Funds shall be budgeted for emergency placement, clothing, food, and health and safe environment, purchase of temporary service and needed reports of diagnostic assessments/evaluations for OPTIONS participants.
2. Allocation for funds is determined by ACDHS/AAA. ACDHS/AAA reserves the right to use these funds in emergency situations.
3. It is prohibited to use contingency funds for staff training and travel expenses.

O. Hard Copy Documentation. All financial records, supporting documents and other CM Participant records shall be retained for four years after case closures or until all litigation, claims or audits have been resolved and final actions taken. Records may be stored in hard copy or electronic storage media. Records must be available to ACDHS/AAA to view for monitoring or auditing purposes. All documents with original signatures must be available in hard copy upon request. All hard copy records must be destroyed when purged. Participant records are the property of ACDHS/AAA and must be returned to ACDHS/AAA within 5 days upon termination of the AGREEMENT. CONTRACTORS must have a written policy that hard or scanned copies of financial records, supporting documents and other participant records are kept on file for 4 years after case closure or until all litigation, claims or audits have been resolved and final actions taken. A hard copy of the following CM Participant documents must be kept on file.

1. Financial Summary Sheet
2. Individual Service Plan (ISP)
3. Voter Registration Form – 100% of participants are asked if they are registered to vote.
4. Provider Choice Form
5. HIPAA Form
6. Freedom of Choice Form
7. All correspondence to, from, or about the CM Participant

8. Follow-up documentation including written complaints and resolutions of service delivery problems
  9. Certification of Accountability with the caregiver signature for FCSP Participants
  10. All original receipts of reimbursed caregiving-related expenses for FCSP Participants
  11. Service Plan Agreement (FCSP only)
  12. Medical records or documentation, as needed
  13. PNC Debit Card Application form (FCSP only)
- P. Minimum Systems Requirements. The PDA mandates the use of SAMS as the CM Participant database for the CM Program. CM CONTRACTORS must utilize the SAMS database. A stand-alone installation installs a single instance of SAMS on a machine, with MSDE/SQL data base components, and requires the following:
1. Windows 7 or Windows 8
  2. PC Processor 2 Ghz or better
  3. 3 GB RAM (Minimum) 4GB RAM (Recommended)
  4. Internet Explorer 10, Internet Explorer 11 (Recommended)
  5. E-mail capability
  6. Latest version of Microsoft Silverlight (required for SAMS.net)
- Q. System Updates. CM CONTRACTORS must have the capability to respond to any changes in SAMS requirements indicated by the ACDHS/AAA or PDA during the term of the AGREEMENT.
- R. CM Organizational Changes.
- In cases where CM CONTRACTOR changes ownership or undergoes a major restructuring, including major changes to the submitted organizational chart or acquisition of another entity, such change must be reported in writing to the ACDHS/AAA 30 days prior to the change or in urgent circumstances within 48 hours of confirmation of the change. Major organizational changes may result in the ACDHS/AAA conducting a full on-site review to assess continued adherence to the terms of the AGREEMENT for CM services under the CM CONTRACTOR'S new structure. Continuation of the COUNTY AGREEMENT is contingent on a finding of the on-site review that the terms of the AGREEMENT will be

adhered to under the change or restructuring.

S. Personnel Requirements and Qualifications.

1. Care Managers: Care managers are members of multi-disciplinary teams that provide community-based services to CM Participants and caregivers within a defined geographic area. Care managers assess, plan, implement and evaluate needs and services. Care managers also assist CM Participants and caregivers in identifying, securing, negotiating and coordinating the application of resources. The primary function of care managers is to aid CM Participants in continuing to mitigate risk and live in their homes for as long as they are able and choose to do so. Care managers work with CM Participants and caregivers to cope with or resolve social, emotional, environmental and other problems or issues that may compromise their capacity to function as well as possible according to their preferences. In doing so, care managers mobilize and draw on the personal resources and strengths of CM Participants, caregivers and families, as well as those of the external community to help CM Participants achieve the outcomes that they have set for themselves.

Minimum qualifications for care managers include the following:

- i. Bachelor of Science or Arts degree.
  - ii. Ability to work independently.
  - iii. Ability to coordinate CM participant appointments and travel scheduling efficiently, and report allowable expenses and billable hours accurately.
  - iv. Proficiency in the use of a personal computer or laptop with MS Office Suite software, cell (smart) phone and the Internet.
  - v. Additional desired qualifications include at least one year of case management experience in human services, working knowledge of the provision of health care in various settings, and knowledge of community resources and care delivery systems.
2. Supervisors: CM supervisors lead multi-disciplinary teams that provide community-based services to CM Participants within defined geographic areas. Supervisors oversee care managers who assist CM Participants and caregivers in identifying, securing,

negotiating and coordinating the application of resources.

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

- a. Train and supervise new and current CM staff, and plan, assign, review and evaluate their work.
- b. Review, approve and sign off on case records and service plans.
- c. Assess the professional development, learning patterns and performance of subordinate staff, and assist them in developing social work skills.
- d. Assign work consistent with organizational policies and priorities, and the capabilities of subordinate staff.
- e. Determine procedures for resolving problems and issues according to sound case work practices and departmental policies.
- f. Confirm the eligibility for CM services of potential CM Participants, and take responsibility for final decisions to accept or terminate CM Participants from programs.
- g. Develop procedures and controls to accomplish work within the framework of established laws, policies and priorities.
- h. Conduct group and individual conferences with staff to discuss assignments, the status of current cases, rules, regulations, policies and laws.
- i. Maintain records on work quality and quantity.
- j. Coordinate staff scheduling (including emergency, on-call and back-up coverage) and work with other units, evaluate staff performance and administer corrective actions.
- k. Prepare reports, correspondence and other communications, and perform research.
- l. Represent the unit in relationships with other internal units and external organizations.

- m. Evaluate policies and procedures, and make recommendations to supervisors and administrators to improve programs.
- n. Participate in the development of community resources and CM services.
- o. The Care Management Direct Supervisor (to staff) carries no permanent caseload, or has three or fewer participants and has job responsibilities that are predominately within the CM unit only.

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

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

- 3. CM Personnel Changes. The ACDHS/AAA CM unit shall be notified within five working days of any changes for supervisors and changes to care managers can be reported in the monthly report.
- 4. Professional Consultation and Additional Expertise. Care Management CONTRACTORS must be able to call upon external professionals to provide consultation and services in areas beyond the expertise or experience of internal CM staff (e.g., nursing, community resources, physical and occupational therapy, behavioral health and intellectual disabilities, substance abuse, financial affairs, caregiving, physical medicine, etc.).

- T. Criminal History Information. CM CONTRACTORS must require all employees to submit the original criminal history clearance from the PA state police (PATCH/Act 31 clearance) before rendering service to a participant. The report must be dated within one year prior to the employees start date. IF PA residency is less than 2 consecutive years prior to the date of hire, an original FBI criminal history check, through the PA Department of Aging, is completed in addition to the PATCH. Substitute clearances are not acceptable. CM CONTRACTOR staff may not work directly with CM Participants until the appropriate criminal clearance is received and documented in the employee's personnel file

where it shall be maintained. Applicants must be notified in writing by the CM CONTRACTOR if they are not hired, in whole or in part, based on criminal history record information.

- U. SAMS Training. CM CONTRACTORS should have an adequate number of staff trained on SAMS so that service documentation is not disrupted in the event of the departure of SAMS-trained staff from the employment of CM CONTRACTORS.
- V. Staff Training. All new CM staff are expected to successfully complete ACDHS/AAA CM training (Tier 1 or 2) or equivalent (as determined by the ACDHS/AAA and CM CONTRACTOR) within the first six months of employment.
  - 1. Within three (3) months all new supervisors must complete the supervisor module or equivalent.
  - 2. CM CONTRACTORS are also expected to have active staff development programs in place.
  - 3. All CONTRACTOR staff who complete care management assessments or re-assessments must participate in state mandated semi-annual training on Voter Registration Procedures.
  - 4. All CONTRACTOR staff who complete care management assessments must complete necessary training and be LCD certified as required by PA Dept. of Aging.
  - 5. Complete annual required Protective Services (PS) training.

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

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

- A. Developing interim program policies and procedures to meet all Pennsylvania Department of Aging and local requirements during the life of this contract.
- B. Program Monitoring and evaluation to assure compliance with the specifications and terms of this contract.
- C. Developing all intake, assessment and reporting forms to be used for this contract.
- D. Specifying procedures for initiation and termination of service.

- E. Technical assistance as needed regarding program requirements.
- F. Technical assistance, direction and cooperation to assist the CONTRACTOR in satisfactorily recording program and service data into the appropriate information management system (SAMS).