APPENDIX

APPENDIX A – JOB AID

- Job Aid Using Service Orders and Service Deliveries for CAE Screenings January 13,2010
- Job Aid Activities and Referrals for Short Term Approval July 1, 2010
- Job Aid G/AFC Determination by Coastline in SIMS June 8, 2011

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APPENDIX A – JOB AID

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Overview

This document describes how to record Service Orders and Service Deliveries for Clinical Assessment & Eligibility (CAE) services in SIMS. It also provides some sample settings for the production of standard CAE statistics using SIMS reports.

This is related to SIMS Support CCF-0069A.

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Revision History

Date	Version	Description	Author
February 1, 2008	1.0	Initial Draft for public distribution	Jim Ospenson
January 13, 2010	1.1	Updated to add requirement for Service order end date Updated list of CAE services.	

Why Require Service Orders for CAE Services?

There are three main reasons to require service orders for CAE screening services.

(1) Better quality measurement: the duration between the start of the screening (service order) and the completion of the screening (service delivery record) can be better measured.

(2) Better visibility of screenings-in-progress: a service order report will show work-in-progress and the age of incomplete screenings.

(3) Improved statistics on withdrawn screenings: a closed and voided service order represents a withdrawn screening; in the future a properly filtered service order report will enable reporting on withdrawn screenings.

The SIMS Steering Committee approved this change in September 2007.

Scenario 1: How to record CAE screenings using Service Orders

Agency learns that their clinical group needs to perform a CAE screen on a client.

Scenario 1: How to record CAE screenings using Service Orders			
#	**Who**	**Step**	**Notes**
1		Agency learns of client to be screened. • Note date of identified need for screening. • Identify appropriate CAE screening service. (See list of services below.)	**NOTE**: screenings for AFC or GAFC determinations involving Coastline must use a different process. See documentation distributed in October 2007.
2		Search for consumer record in SIMS	
3		If consumer record does *not* exist, then 1. Register client 2. Create CAE Enrollment. The Register screen enables the creation of a CAE Enrollment. Proceed to Step 6, and set enrollment details as described there.	
4		If consumer record exists, determine if you have access to the client record. 1. Identify consumer's Default Agency. 2. If you are the Default Agency or have served the client in the past (for any service), you have access to the client record. Proceed to Step 6. 3. Attempt to create CAE enrollment. Look for an active [Add Care Enrollment] button on the Care Enrollment screen. If you can create an enrollment, then you have access to the client record. Proceed to Step 6. 4. The client may have an existing active CAE enrollment from another agency. If so, then attempt to create service order. Look for an active [Add Order] button on the Service Order screen. If you can create and save a service order, then you have access to the client record. Proceed to Step 7. 5. If you cannot create an enrollment or service order, then you do *not* have access to the consumer record.	Identification of Default Agency: see screenshots 1 & 2 below.

Scenario 1: How to record CAE screenings using Service Orders			
#	**Who**	**Step**	**Notes**
5		If you do *not* have access to the consumer record, then you must take steps to share the consumer record. 1. You will need to contact a representative of the client's Default Agency, and request that (a) a Consumer Provider element for your agency is added to the client record, and (b) a recent CDS, if any, is shared with your agency. 2. After the Default Agency responds to your sharing request, you have access to the client record. Proceed to Step 6.	**NOTE**: See documentation for Client Sharing via Consumer Provider, Scenario 1.
6		Create active CAE enrollment (if one does not exist). 1. Set **Level of Care** = Clinical Assessment & Eligibility, and set **Care Program** = Clinical Assessment & Eligibility. Service Program will set automatically. 2. Verify that Application Date, Received Date, and Start Date is set to the date from the identified need for screening (from Step 1 above), or earlier. 3. Set **Status Date** = [date of the data entry]. 4. Save.	See screenshot 3 below. Note: the Service Order date cannot be earlier than the enrollment start date.
7		**Create Service Order.** The Service Order represents the beginning of the work that your agency does to screen the client. (Left hand pane) 1. Set **Level of Care** = Clinical Assessment & Eligibility 2. Set **Care Program** = Clinical Assessment & Eligibility 3. Set Service **Agency** = [your agency] 4. Set Service **Provider** = [your agency] 5. Set **Effective Date** = [date of identified need for screening from Step 1] 6. **Set Expiration Date** = ninety (90) days after the Effective Date. (Right hand pane) 7. Set **Service** = [the screening service identified in Step 1]. This must be one of the services listed below. Service Category will fill in automatically after you select the Service. 8. **Status** will be automatically set to "Open". 9. Set **Ordered Units** = 1 (the number of screenings you will perform. The system defaults to this value when you add a new service order.) 10. Apply & Close the Service Order.	See screenshots 4 & 5 below. The Service Order Effective Date cannot precede the Care Enrollment's Start Date. New: The presence of an Expiration Date makes it easier to close consumers. We suggest ninety (90) days from the Effective Date.
8		**Save** the Consumer Record.	

Scenario 1: How to record CAE screenings using Service Orders			
#	**Who**	**Step**	**Notes**
9		Conduct all appropriate and required screening activities, including but not limited to the following: 1. Arrangements to examine the client 2. Arrangements to get documentation from physicians or other medical personnel. 3. Review of medical records 4. Discussions with case manager, the client, family, or caregivers. 5. Assess the client 6. Review SIMS data 7. Record data in CDS. 8. Create documentation: SIMS journal entries or other 9. Transmit determination information, make notifications as required.	See Consumer Sharing documentation for info on how to share CDS information with the client's Default or Home Care Agency.
10		**Withdrawn Screens**: If a screening is withdrawn at client or family request, then **close and void** the Service Order. 1. Edit the Service Order. View the left-hand pane. 2. Set the **Expiration Date** = [date of withdrawal]. 3. Edit the Service Order Item (see Screenshot 6). View the right-hand (order item) side of the Service Order screen. 4. Set **Status** = Closed 5. Set **Reason** = Order Item Voided 6. Set **Status Date** = [date of withdrawal] 7. [Apply and Close] the Service Order. Save the consumer record. 8. Note: A Service Delivery record is not created for a withdrawn screen. 9. Skip to Step 12.	See Screenshot 6
11		**Create Service Delivery record.** When all work related to the screening is complete, create a Service Delivery Record. The Service Delivery represents the completion of the work that your agency performed in screening the client. 1. Set **Care Program** = CAE 2. Set Service **Agency** = [Agency performing the screen] 3. Set Service **Provider** = [Agency performing the screen]	See Screenshots 7 & 8 The Service Delivery must exactly match the open Service Order, or it will not be able to be saved. The Daily Unit Details cannot precede the Service Order's Effective Date.

Scenario 1: How to record CAE screenings using Service Orders			
#	**Who**	**Step**	**Notes**
		4. Set **Service** = [screening service identified in Step 1]. Service Category will fill in automatically after you select the Service. 5. Set **Daily Unit Details** = 1 unit on the date of completion. **NOTE**: When you [Apply and Close] or [Save] the Service Delivery record, SAMS automatically closes the related Service Order. If you examine the Service Order after creating the Service Delivery, you will see that ▪ **Service Order Item Status** = closed, and ▪ **Service order Item Reason** = Order Item - Fulfilled	
12		Terminate the client's CAE enrollment, if appropriate. Termination or End dates for the enrollment must be on or after the dates of service for all service deliveries.	Reasons *not* to terminate this enrollment: • The client received a short-term approval and will be reassessed by your agency in a short time. • The enrollment was created by another agency.
13		End.	

Scenario 2: Reporting on Screenings-in-progress

Run Service Order Report, filtered by open Service Orders in Care Program CAE.

Scenario 2: Reporting on Screenings-in-progress			
#	**Who**	**Step**	**Notes**
1		View **Reports > Consumer**	
2		Select the **Consumer Service Order Report**	Top pane
3		Select a saved Report Definition, if you have one. • Consult with someone at your agency who is comfortable with reports, if desired, to help build a standard report definition that saves your settings.	Bottom pane
4		Set sample report criteria below in Screenshot 9. Filter by • Service Agency: [Agency screening the client]	Note: make sure your filter is by Service Order Agency, and *not* by Default Agency. It may be misleading to filter by Consumer's Default Agency,

Scenario 2: Reporting on Screenings-in-progress			
#	Who	Step	Notes
		• Service Order Item Status: Open It is unnecessary to filter this report by date, you want to see all open service orders regardless of the create date.	especially if the client has been shared with your agency via the Consumer Provider element.
5		View and Print the Report 1. Click [Print Preview] to view report 2. If desired, adjust filters and criteria. Return to Step 1. 3. Click [Print Report] to send to printer	

Scenario 3: Reporting on Withdrawn Screens

Scenario 3: Reporting on Withdrawn Screens			
#	Who	Step	Notes
1		View **Reports > Consumer**	
2		Select the **Consumer Service Order Report**	Top pane
3		Select a saved Report Definition, if you have one. • Consult with someone at your agency who is comfortable with reports, if desired, to help build a standard report definition that saves your settings.	Bottom pane
4		Set sample report criteria below in Screenshot 10. This report must be filtered to show a date range. Scenario 1 above demonstrated the use of • Service Order Item Status = Closed, and Service Order Item Reason = Order Item Voided to indicate a withdrawn screening, and • Service Order Expiration Date to contain the withdrawal date of a screening. Therefore, we will filter this report by • Service Order Item Status = Closed • Service Order Item Reason = Order Item Voided • Expiration Date on or after: [start date] • Expiration Date on or before: [end date]	Each time you run this report, you will want to change the dates. Note: make sure your filter is by Service Order Agency, and *not* by Default Agency.
5		View and Print the Report 1. Click [Print Preview] to view report 2. If desired, adjust filters and criteria. Return	

Scenario 3: Reporting on Withdrawn Screens			
#	**Who**	**Step**	**Notes**
		to Step 1. 3. Click [Print Report] to send to printer	

Scenario 4: Generating Monthly Statistics

Scenario 4: Generating Monthly Stats			
#	**Who**	**Step**	**Notes**
1		View **Reports > Services**	
2		Select the **Agency Summary Report** or **Consumer Services List report.** Both of these reports look at Service Delivery records, not Service Orders.	Top pane Both reports accept similar criteria and will give you the information you need.
3		Select a saved Report Definition, if you have one. • Consult with someone at your agency who is comfortable with reports, if desired, to help build a standard report definition that saves your settings.	Bottom pane
4		Set sample report criteria below in Screenshot 11. This report must be filtered to show a date range. Filter this report by • **Service Agency** = [Agency performing screenings] • **Service Program** = Clinical Assessment & Eligibility (CAE) • **Service Start Date** on or after: [start of reporting period] • **Service End Date** on or before: [end of reporting period] There are numerous options available to display consumer details or not, and group/subtotal by various data elements.	Each time you run this report, you will want to change the dates to reflect the desired month. Note: make sure your filter is by Service Order Agency, and *not* by Default Agency.
5		View and Print the Report 1. Click [Print Preview] to view report 2. If desired, adjust filters and criteria. Return to Step 1. 3. Click [Print Report] to send to printer	

List of Services under Clinical Assessment & Eligibility

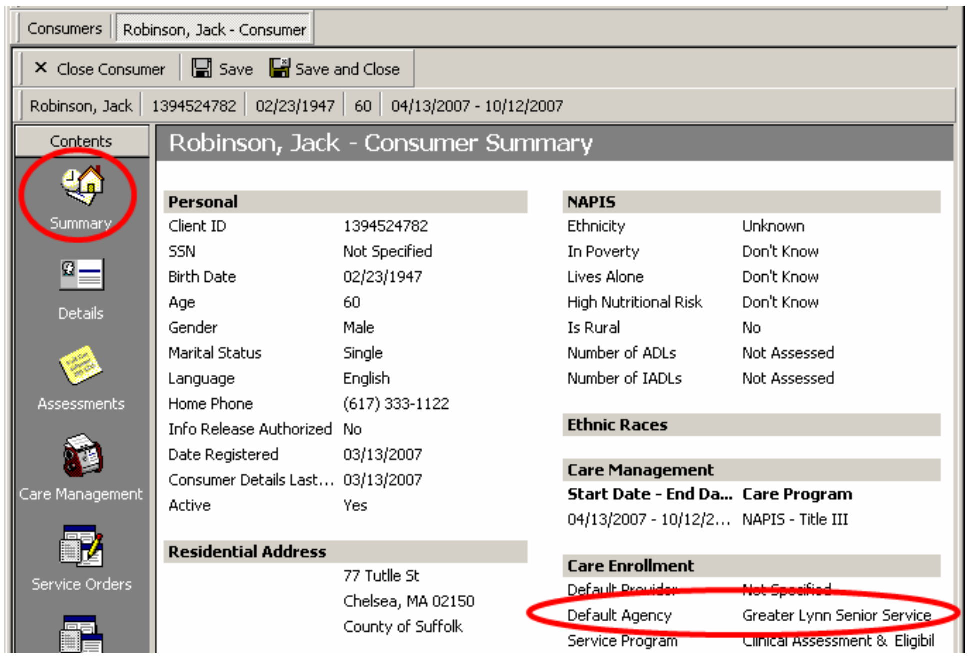
#	Service	Service Order Required?	Notes
1	ADH Initial Determination	yes	
2	AFC Initial Determination	yes	Use separate AFC process
3	Caring Homes Initial Determination	yes	
4	Caring Homes Re-Determination	yes	
5	ECOP - NW Initial Determination	yes	
6	ECOP - NW Re-Determination	yes	
7	GAFC Initial Determination	yes	Use separate GAFC process
8	NF AIH Initial Determination	yes	
9	NF Community Initial Determination	yes	
10	NF Continuation of Stay Determination	yes	
11	NF Conversion Initial Determination	yes	
12	NF Non-AIH Initial Determination	yes	
13	NF Retrospective Initial Determination	yes	
14	NF Short Term Review Determination	yes	
15	NF Transfer (NF to NF) Determination	yes	
16	PACE Initial Determination	yes	
17	PERS Prior Authorization	yes	
18	Waiver Initial Determination	yes	
19	Waiver Re-determination	yes	

NOTE: the two services for AFC or GAFC Determination screenings must use a different process, described in documentation that was distributed in October 2007 and re-issued in March 2008.

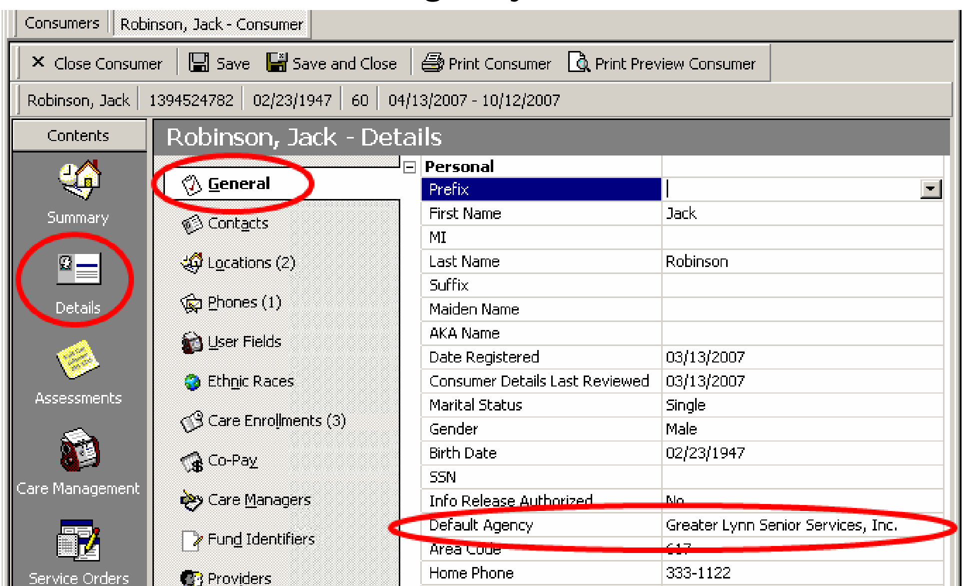
Jan 2010: updated list of CAE services.

Screenshots

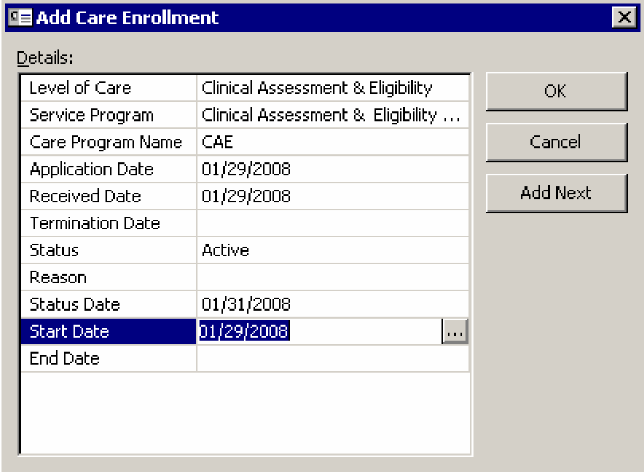
Screenshot 1: Default Agency on Summary



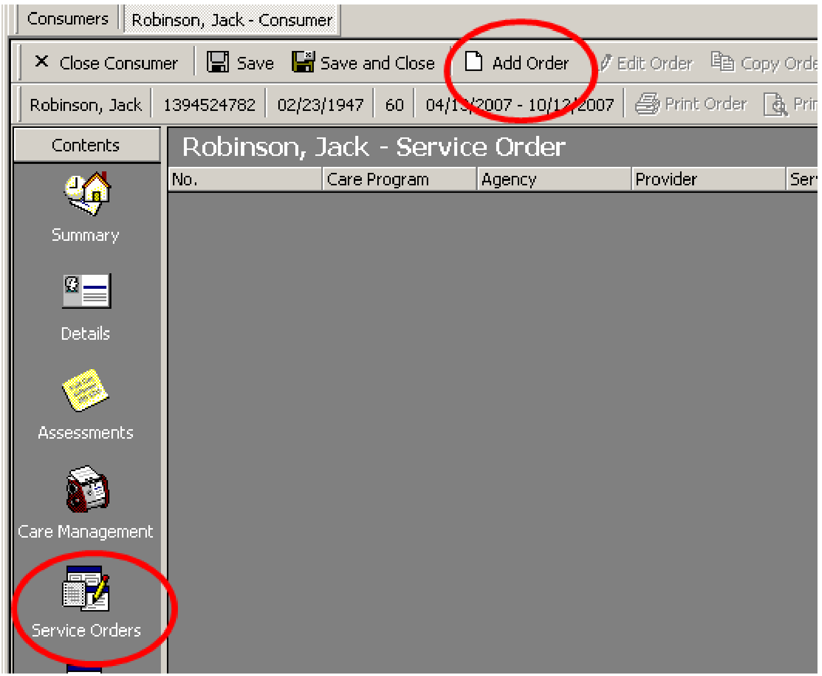
Screenshot 2: Default Agency on Details > General



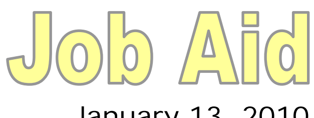
Screenshot 3: Enrollment

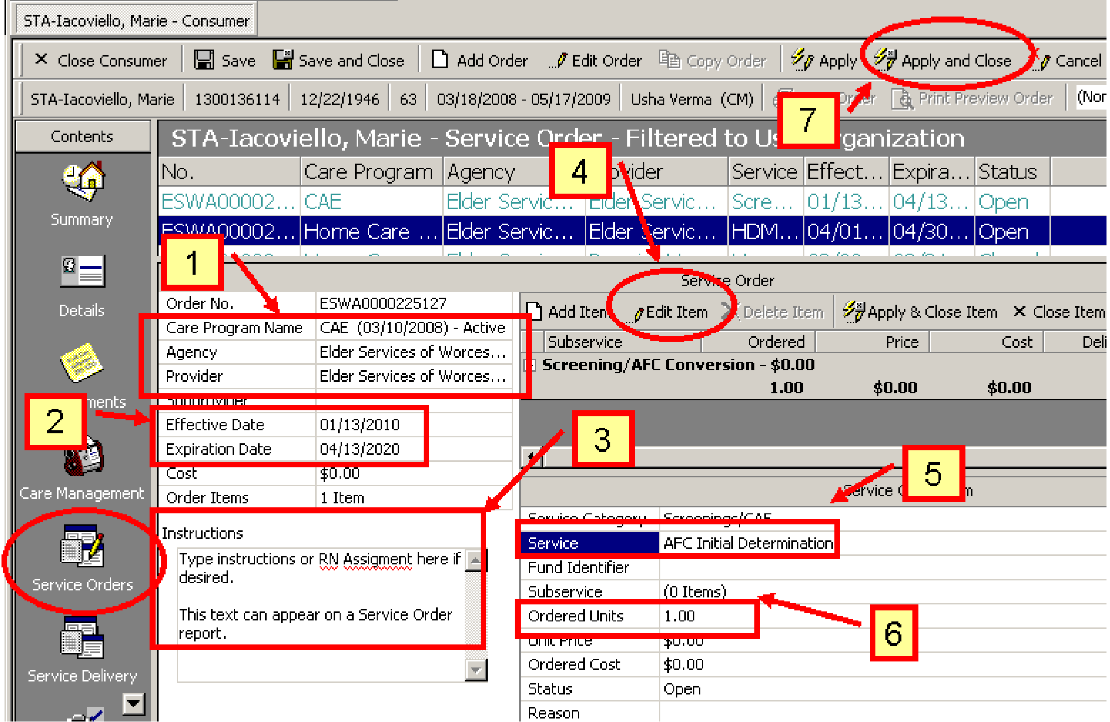


Screenshot 4: Add service Order



Screenshot 5: Create Service Order

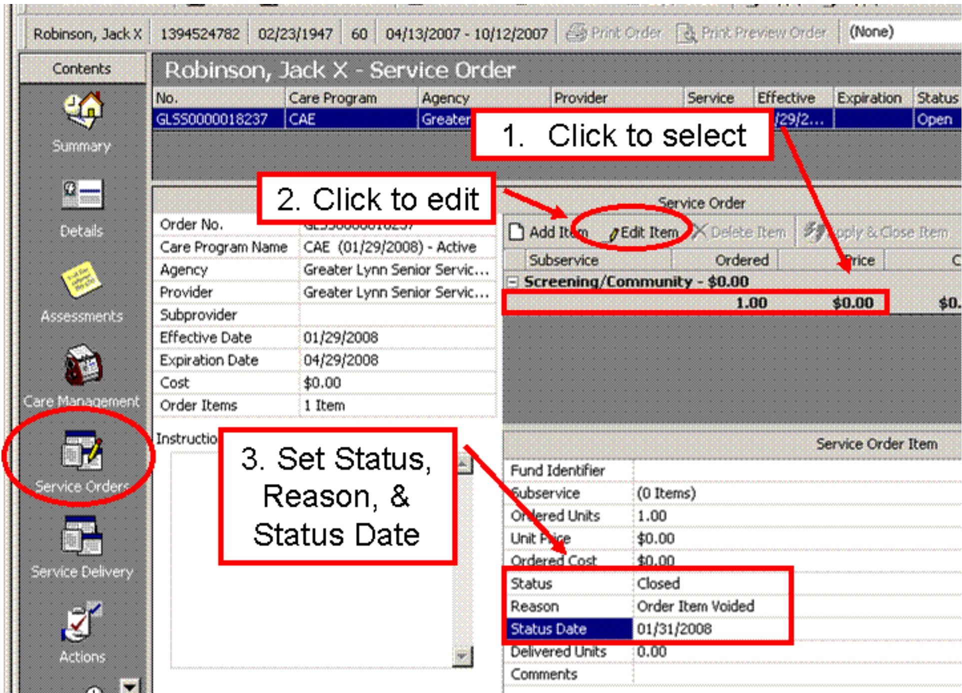




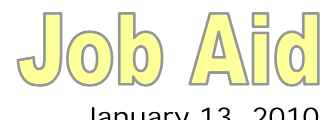
1. Set **Care Program** to CAE, **Service Agency** = [Agency performing the Screening], **Service Provider** = [Agency performing the Screening]
2. Set **Effective Date** = date of Identified need for screening. This date cannot be earlier than the enrollment start date.
   Set **Expiration Date** to 90 days after the Effective Date
3. (*optional*) Instruction text can appear on Service Order Report. This can be used to indicate an RN assignment.
4. Click [Add item]
5. Set **Service**. Ignore Service Category, it will fill automatically.
6. Set **Ordered Units** to 1. This is the number of screenings you will perform.
7. [Apply and Close] to save the service order.

(Screenshot updated to show addition of Expiration Date).

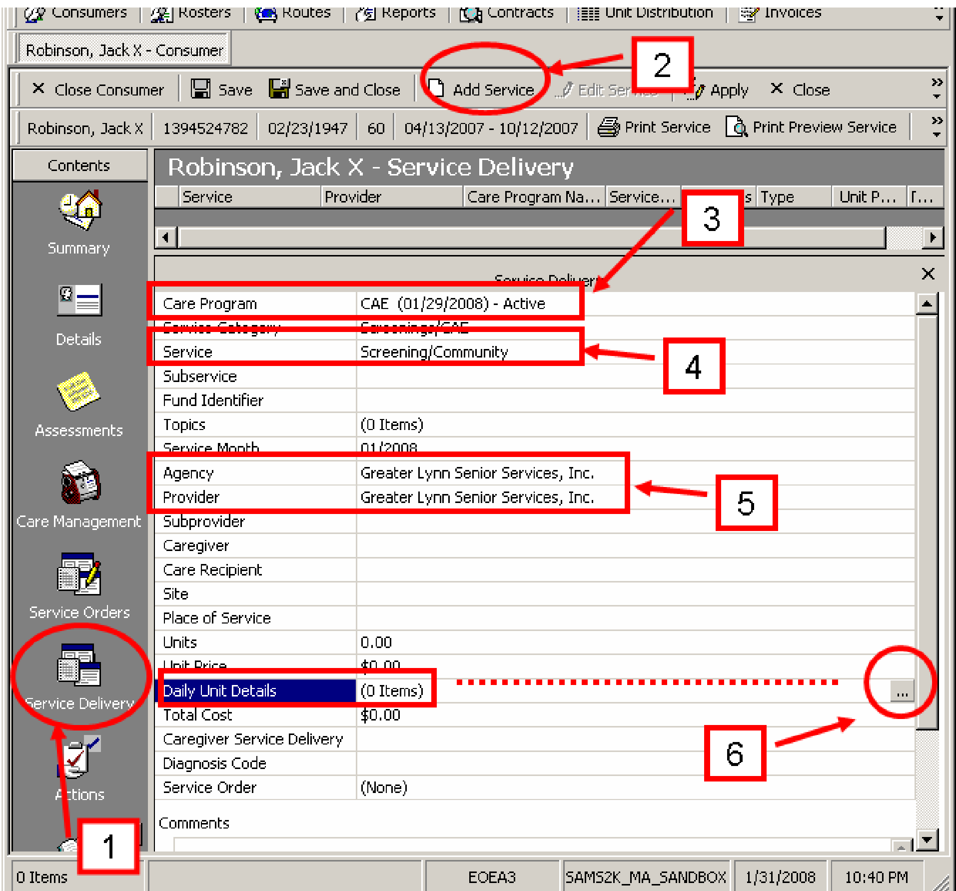
Screenshot 6: Edit Service Order for Withdrawal



Follow steps in the order shown.

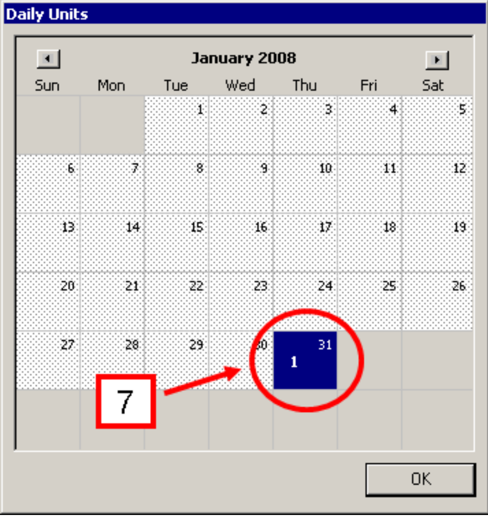


Screenshot 7: Create Service Delivery record



1. Open Consumer's Service Delivery screen
2. Click [Add Service]
3. Set Care Program = CAE
4. Set Service = [CAE Service]. Ignore Service Category: it will set automatically, based on the service.
5. Set **Service Agency** = [Agency performing the Screening], **Service Provider** = [Agency performing the Screening]
6. Click to open **Daily Unit Details**. A small calendar will popup (continued).

Screenshot 8: Service Delivery, set date of service and units



7. Identify completion date of the screening. Click on the date to select it and enter 1 as the number of completed units.
8. Click [OK] to return to the Service, then Apply and Close to save the Service Delivery record.

If you receive any errors on saving, read error messages carefully. Verify that the Service Order matches the Service Delivery in all key details: Care Program, Agency, Provider, and so on. The Daily Unit Details cannot precede the Service Order's Effective Date.

Screenshot 9: Sample Report criteria for Screenings-in-progress

SAMS Consumer Service Order Report

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Service
Sort By:	Effective Date
Show Service Order Details:	Yes
Show Subservice:	No
Print Consumer Details:	Yes
Include Consumer Groups:	No

Service Order:

Agency:	Greater Lynn Senior Services, Inc.
Care Program:	CAE

Service Order Items:

Status:	Open

Note: make sure your filter is by Service Order Agency, and *not* by Care Provider > Default Agency.

Screenshot 10: Sample Report criteria, withdrawn screen within a date range.

SAMS Consumer Service Order Report

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Service
Sort By:	Effective Date
Show Service Order Details:	Yes
Show Subservice:	No
Print Consumer Details:	Yes
Include Consumer Groups:	No

Service Order:

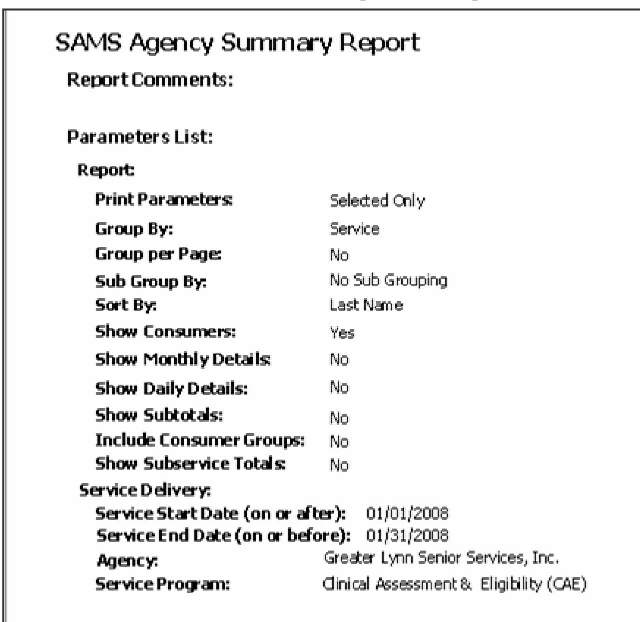
Agency:	Greater Lynn Senior Services, Inc.
Care Program:	CAE
Expiration Date (on or after):	1/1/2008
Expiration Date (on or before):	1/31/2008

Service Order Items:

Status:	Closed
Reason:	Order Item Voided

Note: make sure your filter is by Service Order Agency, and *not* by Care Provider > Default Agency

Screenshot 11: Sample Report Criteria for Monthly CAE Statistics



SAMS Agency Summary Report

Report Comments:

Parameters List:

Report:

Print Parameters:	Selected Only
Group By:	Service
Group per Page:	No
Sub Group By:	No Sub Grouping
Sort By:	Last Name
Show Consumers:	Yes
Show Monthly Details:	No
Show Daily Details:	No
Show Subtotals:	No
Include Consumer Groups:	No
Show Subservice Totals:	No

Service Delivery:

Service Start Date (on or after):	01/01/2008
Service End Date (on or before):	01/31/2008
Agency:	Greater Lynn Senior Services, Inc.
Service Program:	Clinical Assessment & Eligibility (CAE)

Note: make sure your filter is by Service Order Agency, and *not* by Care Provider > Default Agency

Activities/ Referrals for Short Term Approval
(related to PI-09-05)

July 1, 2010

Overview

This Job Aid is related to EOEA Program Instruction **PI-09-05: Nursing Facility Eligibility Assessments, Short Term Approval Tracking, and Noticing Procedures**, December 2, 2009. Please note: Data Quality will be monitored to ensure compliance with PI 09-05.

This Job Aid is mentioned under the PI's Required Actions, and defines the requirements for SAMS data entry related to Short Term Approvals (STA).

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Revision History

Date	Version	Description	Author
July 1, 2010	1.2	Corrected single error in document. Changed "Agency" to "Provider" in Step 2-b in Scenario 2 (page 11): "shares the most recent CDS-2-NF with ASAP-2, setting Assessment **Provider** to ASAP-2 so that it is visible to that agency "	
April 27, 2010	1.1	Updated draft includes instructions on how to handle the situation when a consumer moves from one Nursing Facility to another within a Short Term Approval.	Jim Ospenson
March 8, 2010	1.0	Draft for first release to SIMS Community	Jim Ospenson

Target Audience for this Job Aid

This Job Aid is targeted at ASAP staff who support Clinical Assessment & Eligibility (CAE) functions and create the SAMS data elements that allow ASAPs to be compliant with CAE regulations and policies.

Depending on local business processes at different ASAPs, the staff responsible for managing Activity/Referrals related to Short Term Approvals may be RNs, CAE Admins, or other staff.

This Job Aid is intended to explain the data requirements for Activity/ Referrals related to PI-09-05, and some techniques to ensure data quality. We recognize that some CAE users may be unfamiliar with some details related to Activity/Referrals in general. We encourage these users to consult with their agency's SIMS Trainers and Subject Matter Experts (SME's). **It is beyond the scope of this Job Aid to provide a comprehensive training in all aspects of the use of Activity/Referrals.**

Background

This Job Aid is related to EOEA Program Instruction **PI-09-05: Nursing Facility Eligibility Assessments, Short Term Approval Tracking, and Noticing Procedures**, dated December 2, 2009.

One of the new requirements of this Program Instruction is that all short term reviews ("STR's") must be tracked using a particular data element attached to the SAMS Consumer record: an Activity/ Referral ("A/R").

NOTE: All previous documentation requirements for CAE screenings are unchanged, and must continue to be recorded:

- Create/update SAMS Consumer record (as needed);
- Completion of the appropriate Comprehensive Data Set (CDS) assessment, with narrative
- Creation of Service Order and Service Delivery records; and
- Related Journal / Narrative Entry requirements.

Why use an Activity/ Referral?

The Activity/Referral ("A/R") is created at the time of a STA, regardless of where the STA was initiated. The A/R's purpose serves as a tracking system **reminder of the next short term review (STR), due at the expiration of the prior STA. The purpose is to promote consistency throughout the ASAP network**.

Each Activity/Referral stands for a planned Short Term Review Assessment at a particular Nursing Facility..

Whenever a Short Term Approval is granted to a client, it is implied that there is a Short Term Review assessment at the end of the approval period. Regardless of where the STA was initiated, the A/R's purpose serves as a tracking system **reminder of the next short term review (STR), due at the expiration of the prior STA.** For every such anticipated meeting, an agency must create an Activity/Referral as described in this Job Aid.

***Important Note**: sometimes a consumer will move from one Nursing Facility to another within the term of a Short Term Approval. For guidance on how to handle the consumer's data in this scenario, see the section **Special Case: client moves/transfers from one Nursing Facility to another Nursing Facility within the STA period** below (see pg 11 and page 12). In the instance when a client moves or transfers to a new NF, then the

original A/R must be withdrawn, and a new A/R must be created (especially if the new NF is located in a different catchment area served by a different ASAP).

Which status should I use for an Activity/Referral for a Short Term Approval?

The A/Rs in this Job Aid should only ever have a status of Not Started, Completed, or Withdrawn to be compliant with PI-09-05.

This Job Aid describes

- how and when to create these A/R's
- how to modify them when the scheduled review is performed or withdrawn,
- how to review a client's list of STR-related Activity/Referrals to understand the client's history of short-term review assessments, and
- The use of reports to ensure that all scheduled STR's are performed, and that all related data is complete and accurate.

Due date for implementation of this new process

For all Short Term Approvals with an expiration date on or after March 1, 2010, there should be one and only one Activity/Referral of type **CAE - Short Term Review - PI-09-05**.

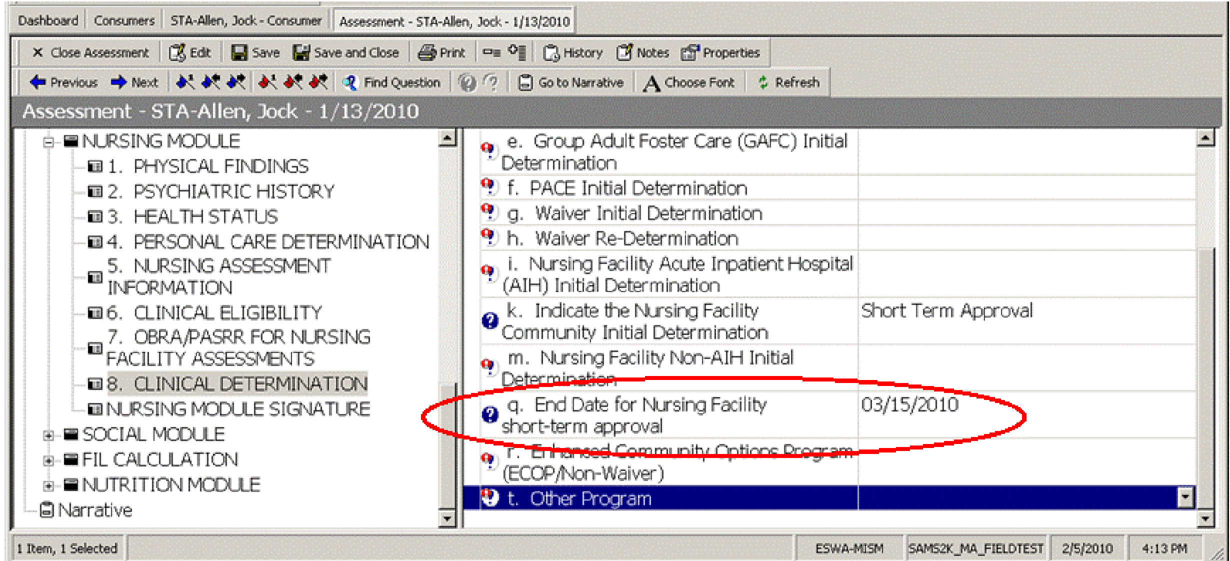
ASAPs should review these A/Rs regularly for data quality. Report criteria are described below that will indicate bad or incorrect data to be corrected.

These clients may be identified by the date entered in the CDS Nursing Module (section 8) **End Date for short-term approval into the nursing facility (question 8q).** . This question is found in Section 8 of the Nursing module in CDS-2-FULL, CDS-2-RN, or CDS-2-NF. In the Agency Reporting Tool (ART), this is QUESTION_ID 5541.

Create Activity/Referral (represents future Short Term Review)

For every scheduled Short-Term Review assessment, an ASAP must create a separate Activity/Referral of type **CAE Short Term Review - PI-09-05**.

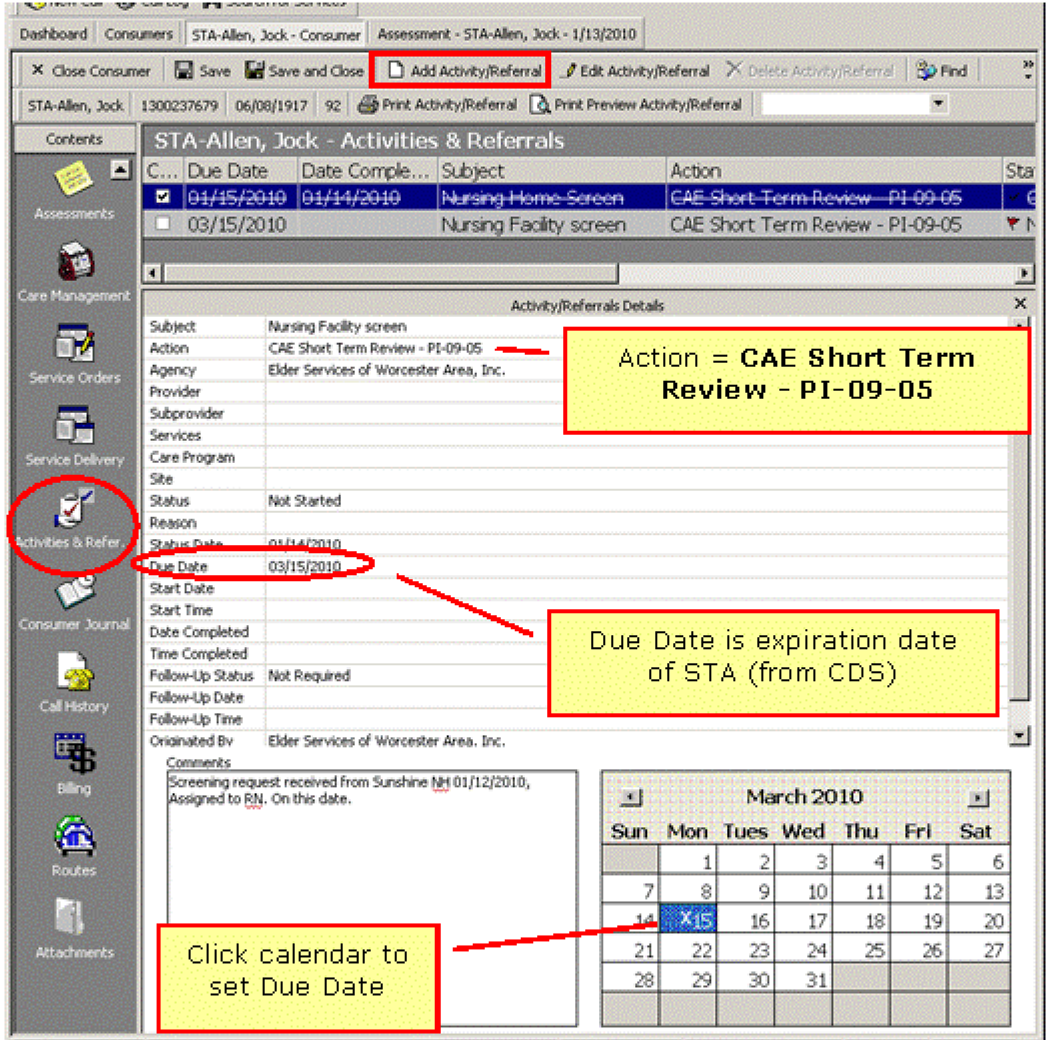
The A/R must have a due date equal to the expiration of the Short-Term Approval from the CDS.



Every time that the CDS-2 Data element for "End Date for Nursing Facility short-term approval" is filled out, it implies a future Short Term Review for that client. Therefore, an A/R of type **CAE Short Term Review - PI-09-05** is required, with the End Date as the A/R Due Date.

Add Activity/Referral

The Activity/Referral for a Short Term Review should be created at the same time the CDS containing the End Date for the Short Term Approval is saved.



Below, comments on each of the data elements of an Activity/Referral.

Data Elements for Create Activity/Referral (representing a future Short Term Review at the expiration of a Short Term Approval)				
#	Data Element	fill with	Required ?	Comment
1	**Subject**	<brief headline> Examples: ▪ Nursing Facility assessment ▪ STR at Golden Living center NF	**required**	Entered by user. Make a clear headline to appear on reports. Suggested: refer to the name of the Nursing Facility Can not be left blank.
2	**Action**	CAE Short Term Review - PI-09-05	**required**	Select dropdown element. This field can be a report criteria
3	Agency	<your agency>	**required**	automatically filled in

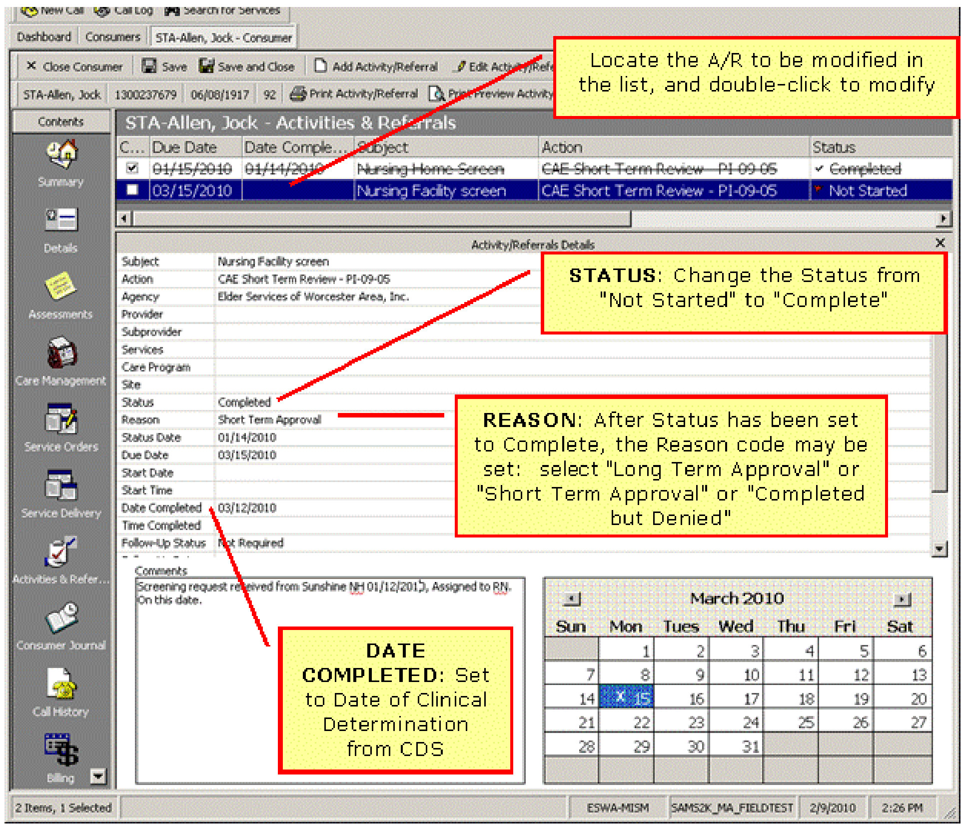
Data Elements for Create Activity/Referral
(representing a future Short Term Review at the expiration of a Short Term Approval)

#	Data Element	fill with	Required ?	Comment
4	Provider		optional	Use this element to assign to a particular user, if desired. If the A/R is assigned to a particular user, then the A/R can be displayed on the user's or the supervisor's dashboard. This element can also be a criteria used in Activity Reports, e.g. "Show me all the A/R's of type X assigned to provider Y."
5	Subprovider		ignore	
6	Services		ignore	Suggest ignore this element - all SAMS services are listed here, not just CAE services, and so it's not very useful.
7	Care Program		optional	Some agencies may wish to use this element, setting it to CAE. Can be used to filter the agency-wide A/R list, and in reports.
8	Site		ignore	
9	**Status**	Not Started	**required**	"Status" is an important field; it is automatically set to "Not Started" when A/R is created.
10	Reason		ignore	no reason code needed for Status=Not Started
11	Status Date	<today's date>	**required**	automatically applied
12	**Due Date**	<date of "End Date for Nursing Facility short-term approval" from CDS>	**required**	**IMPORTANT:** this must align with the CDS date. This date can be specified in Activity Reports
13	Start Date		ignore	
14	Start Time		ignore	
15	Date Completed		ignore	
16	Time Completed		ignore	
17	Follow-up Status		ignore	

#	Data Element	fill with	Required ?	Comment
Data Elements for Create Activity/Referral (representing a future Short Term Review at the expiration of a Short Term Approval)				
18	Follow-up Date		ignore	
19	Follow-up Time		ignore	
20	Originated By		required	automatically filled with creating user's organization
21	Creator		required	automatically filled with creating userid
22	Comments	<enter free-text notes here>	optional	These notes can be displayed on Activity/Referral reports. **Make sure that they do not contain PHI!**

Modify Activity/Referral (Completed)

Each A/R in this process represents a scheduled Short Term Review. When that scheduled Short Term Review (with on-site assessment) has been completed, the A/R should be modified: its Status should be marked "Complete", and the outcome of the meeting recorded in the Status Reason (one of the following reasons: (1) Long Term Approval, (2) Short Term Approval, or (3) Completed but Denied.)



The table below shows only the data elements that would be modified when marking the A/R complete. See the table under "Create Activity Referral" for the full table; line numbers are unchanged for easy reference.

Data Elements for Modify Activity/Referral: COMPLETE
(scheduled Short Term Review took place as scheduled)

#	Data Element	Change to	Required?	Comment
9	**Status**	Complete	**required**	Set to **Status** = **Complete** only after the scheduled on-site assessment has taken place.
10	**Reason**	Select ▪ **Short Term Approval** ▪ **Nursing Facility Approval** ▪ **Completed but Denied**	**Required**	Do not leave blank. These three (3) Reason Codes are only available when Status = Complete.
11	Status Date	<today's date>	**required**	This date field should be set to the date of data entry, the date on which the status is changed to Complete.
15	**Date Completed**	<date of clinical determination from CDS>	**Required**	The Date Completed should be the same as the date of Clinical Determination from the CDS recorded at the scheduled on-site assessment.

Data Elements for Modify Activity/Referral: COMPLETE (scheduled Short Term Review took place as scheduled)				
#	Data Element	Change to	Required?	Comment
16	Time Completed		optional	Some agencies may wish to track Time Completed.
22	Comments	<enter free-text notes here>	optional	The Comments may be updated now, if desired. These notes can appear on Activity/Referral reports. Make sure that they do not contain PHI!

Note: for every completed A/R of type CAE Short Term Review - PI-09-05, there should be a corresponding Service Order / Service Delivery. If you were to compare reports, a report showing completed A/Rs should have a one-to-one match with a service delivery report for the same time period.

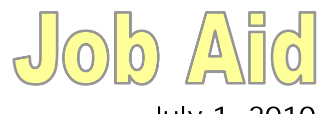
Modify Activity/Referral (Withdrawn)

Often, a scheduled Short Term Review never takes place. In this case, as soon as the ASAP learns that a Short Term Review will not take place, the A/R should be modified and marked with Status "withdrawn", and the Reason for the withdrawal recorded in the Reason Code.

These Activity/Referrals should never be deleted.

Some examples of reasons that a planned Short Term Review meeting might not be performed as expected:

- The client requests the screen to be withdrawn
- Client is discharged prior to the expiration date of the prior short term approval
- Client expires prior to the expiration date of the prior short term approval
- Client is no longer MassHealth but remains in the nursing facility (i.e. reverts to private pay)



Activities/ Referrals for Short Term Approval
(related to PI-09-05)

July 1, 2010

Locate the A/R to be modified in the list, and double-click to modify

STATUS: set to Withdrawn

REASON: set to either "Client Request" or "Client Expired" or "Nursing Facility Discharge" as appropriate

DATE COMPLETED: should be blank, since the Review never was completed; it never took place

Data Elements for Modify Activity/Referral: WITHDRAWN
(scheduled Short Term Review never took place)

#	Data Element	change to	Required?	Comment
9	**Status**	Withdrawn	**required**	This is an important field; it is automatically set to "Not Started" when A/R is created.
10	Reason	select ▪ Client Request ▪ Client Expired ▪ Nursing Facility Discharge	Required	Do not leave blank. These three (3) Reason Codes are only available when Status = Withdrawn.

Data Elements for Modify Activity/Referral: WITHDRAWN
(scheduled Short Term Review never took place)

#	Data Element	change to	Required?	Comment
11	Status Date	<today's date>	**required**	This date field should be set to the date of data entry, the date on which the status is changed to Withdrawn.
15	Date Completed	<leave blank>	required to be blank	Do not fill this data element: must be left blank if Status = Withdrawn
22	Comments	<enter free-text notes here>	optional	The Comments may be updated now, if desired. These notes can be displayed on Activity/Referral reports. Make sure that they do not contain PHI!

Special Case: client moves/transfers from one Nursing Facility to another Nursing Facility within the STA period

Throughout this document, we have tried to establish the point that each A/R for a Short Term Approval represents a Short Term Review assessment at a particular Nursing Home. The A/R is created and managed to ensure the assessment will be completed on-time.

There will be instances where a client may move/transfer from one Nursing Facility to another within the term of the original Short Term Approval.

Scenario 1: both the discharging and the admitting Nursing Facilities are covered by the same ASAP

Steps:

1. As soon as the ASAP learns the client has moved, the original A/R is updated and set **Status** = Withdrawn and **Reason** = Nursing Facility Discharge.

2. A new A/R is created for the client, representing the STR at the admitting Nursing Facility. Set **Action** = CAE Short Term Review - PI-09-05, **Status** = Not Started, Status Date = <today's date>, **Due Date** = <date of "End Date for Nursing Facility short-term approval" from CDS>. The **Subject** should refer to the name of the Nursing Facility.

3. Create a Journal Entry referring to the situation, noting the withdrawn and new Activity/ Referrals.

Scenario 2: the discharging Nursing Facility and the admitting Nursing Facility are covered by different ASAPs

For this example, assume that John Smith had an STA and was a patient at NF-1, covered by ASAP-1. His family moves him to NF-2 when a spot opens up because it's closer to his daughter's house. NF-2 is covered by ASAP-2.

Steps:

1. As soon as ASAP-2 learns that John Smith has a standing STA from NF-1, ASAP-2 contacts ASAP-1 and requests that John Smith's SAMS data is "shared" with ASAP-2.

2. ASAP-1 does the following: (a) adds Consumer Provider element to John Smith's consumer record (making the consumer record visible and editable to ASAP-2), (b) shares the most recent CDS-2-NF with ASAP-2, setting Assessment Provider to ASAP-2 so that it is visible to that agency (c) the original A/R is updated and set **Status** = Withdrawn and **Reason** = Nursing Facility Discharge, (d) any other items relating to canceling this assessment (for example cancelling an outstanding Service order if one has been created).

3. ASAP-2 does the following: (a) reviews ASAP-1's most recent CDS-2-NF in which the STA was granted, (b) creates a new Activity/Referral with the following: **Subject** = <brief headline>, **Action** = CAE Short Term Review - PI-09-05, **Agency** = ASAP-2, **Status** = Not Started, **Status Date** = <date A/R is created>, **Due Date** = <date of "End Date for Nursing Facility short-term approval" from CDS-2-NF>,

4. ASAP-2 manages the STR task: completing the STR on-time and recording all appropriate data (see Modify Activity/Referral (Completed) above) or updating the A/R appropriately if the STR commitment is withdrawn (see Modify Activity/Referral (Withdrawn) above).

Viewing and Managing Activity Referrals

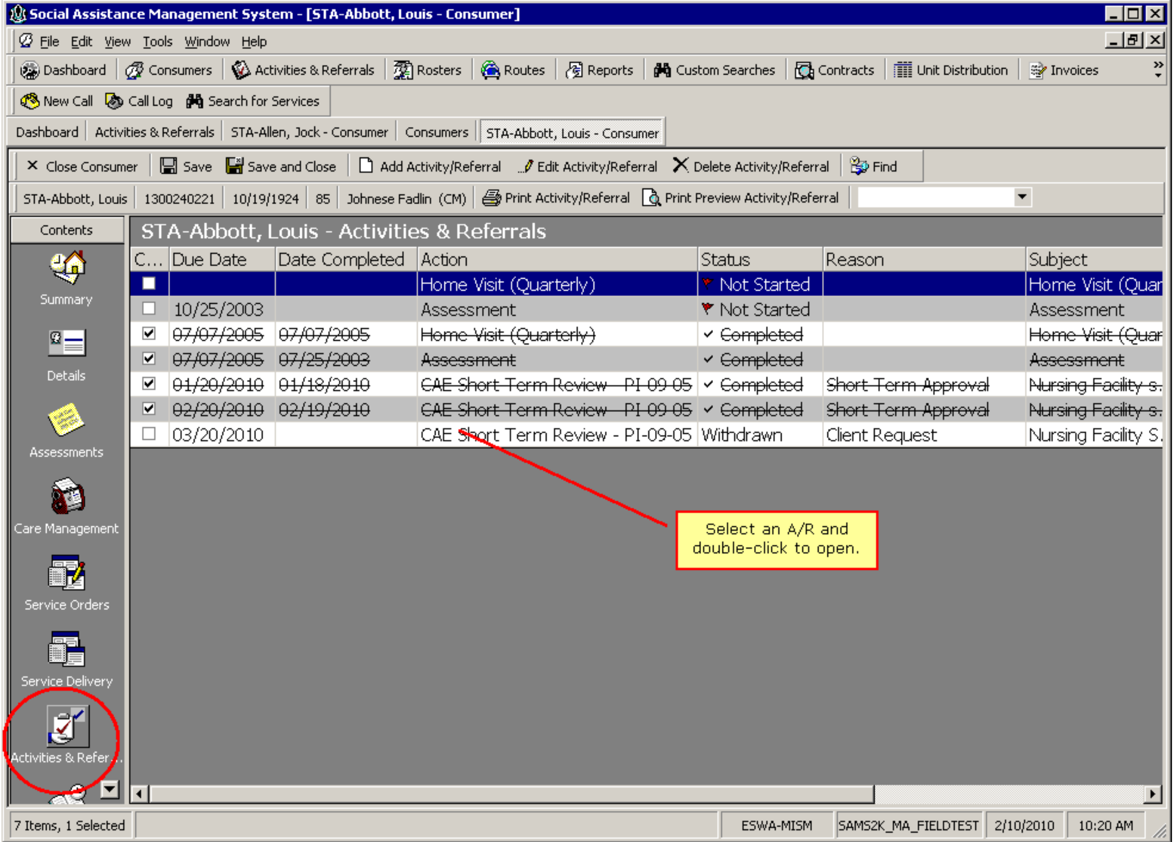
View Consumer's Activity Referrals

Open the desired Consumer Record. Click the Activity/Referral icon in the left-hand column. A list of the consumer's A/R's is displayed.

Completed A/Rs display in ~~strikeout~~ font.

Click on the column heading to sort the list by that column. For example, click on the column heading "Action" to sort the list, and all A/Rs of type **CAE Short Term Review - PI-09-05** appear together.

Double-click to open.

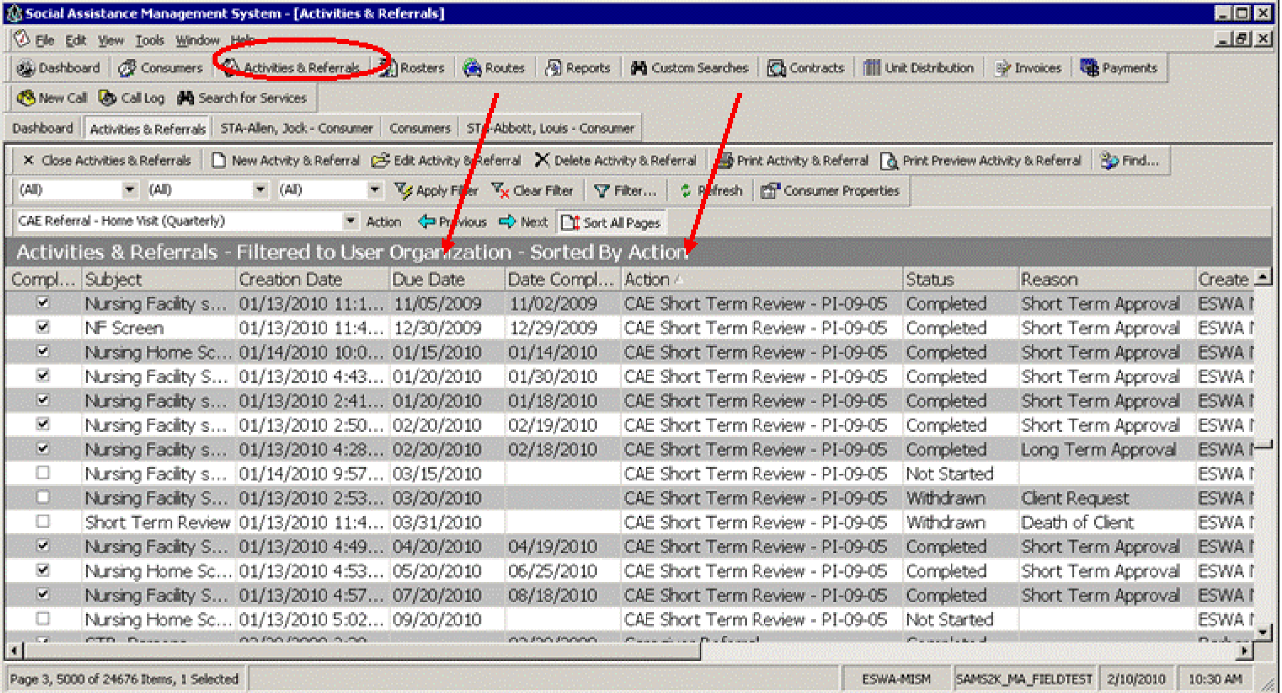


View Agency-wide Activity/Referrals

You can view all of the A/Rs visible to your agency by clicking the Activity/Referral button along the top of the SAMS screen. A list of all A/R's is displayed.

This list can be sorted, filtered and printed. Some users may prefer to filter and sort this list in place of using an Activity/Referral report.

Click on a column-heading to sort by that column. For example, (1) click first on the Due Date Column to sort all A/R's by Due Date, and (2) then click on Action to sort them by action type. The result is a list view of all A/R's by type, and within type sorted by Due Date.

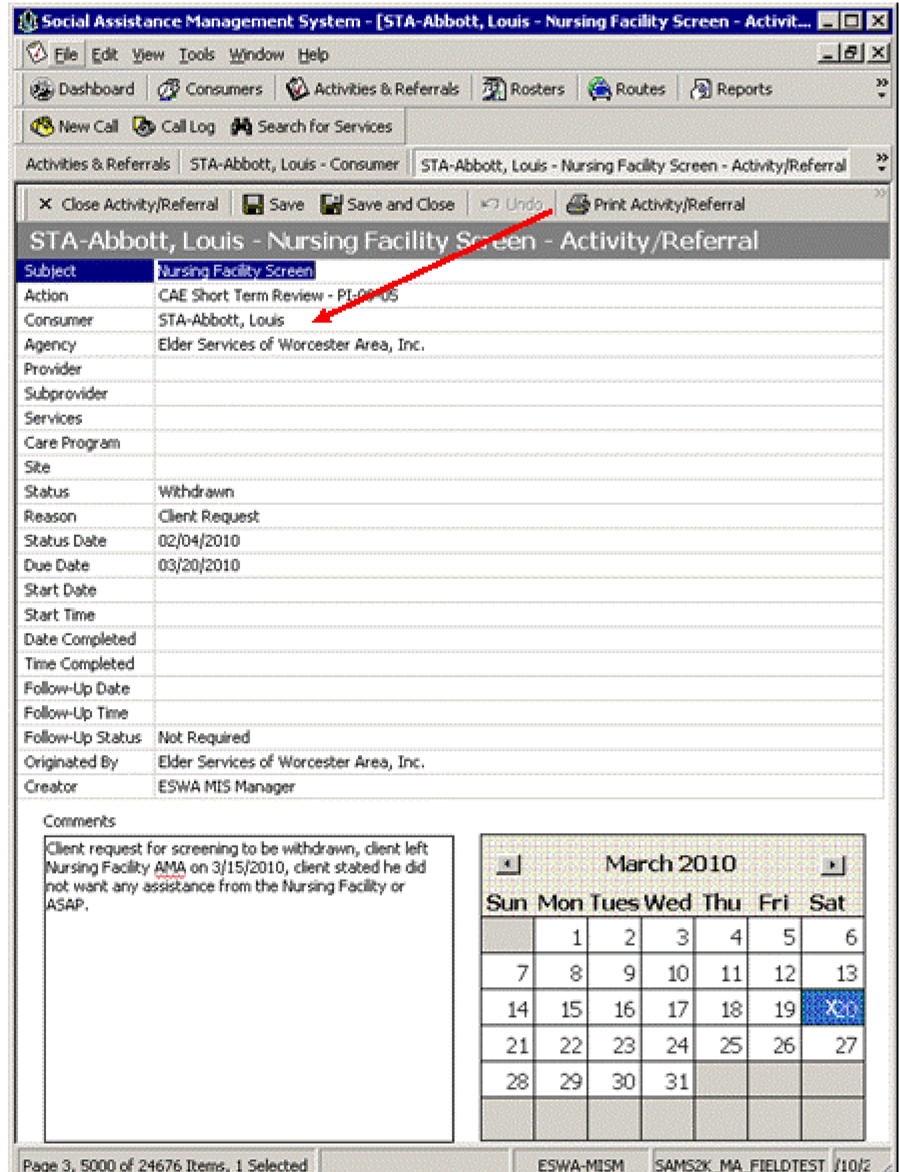


Compl...	Subject	Creation Date	Due Date	Date Compl...	Action	Status	Reason	Create
☑	Nursing Facility s...	01/13/2010 11:1...	11/05/2009	11/02/2009	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	NF Screen	01/13/2010 11:4...	12/30/2009	12/29/2009	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Home Sc...	01/14/2010 10:0...	01/15/2010	01/14/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Facility S...	01/13/2010 4:43...	01/20/2010	01/30/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Facility s...	01/13/2010 2:41...	01/20/2010	01/18/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Facility s...	01/13/2010 2:50...	02/20/2010	02/19/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Facility s...	01/13/2010 4:28...	02/20/2010	02/18/2010	CAE Short Term Review - PI-09-05	Completed	Long Term Approval	ESWA I
☐	Nursing Facility s...	01/14/2010 9:57...	03/15/2010		CAE Short Term Review - PI-09-05	Not Started		ESWA I
☐	Nursing Facility S...	01/13/2010 2:53...	03/20/2010		CAE Short Term Review - PI-09-05	Withdrawn	Client Request	ESWA I
☐	Short Term Review	01/13/2010 11:4...	03/31/2010		CAE Short Term Review - PI-09-05	Withdrawn	Death of Client	ESWA I
☑	Nursing Facility S...	01/13/2010 4:49...	04/20/2010	04/19/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Home Sc...	01/13/2010 4:53...	05/20/2010	06/25/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☑	Nursing Facility S...	01/13/2010 4:57...	07/20/2010	08/18/2010	CAE Short Term Review - PI-09-05	Completed	Short Term Approval	ESWA I
☐	Nursing Home Sc...	01/13/2010 5:02...	09/20/2010		CAE Short Term Review - PI-09-05	Not Started		ESWA I

Double click an A/R to open.

An Activity/Referral opened this way looks slightly different than the same A/R opened from within a consumer record. Note that the A/R below contains a field for the consumer name. Also, the consumer record cannot be opened directly from this screen.

Other than that, the two screens are the same.

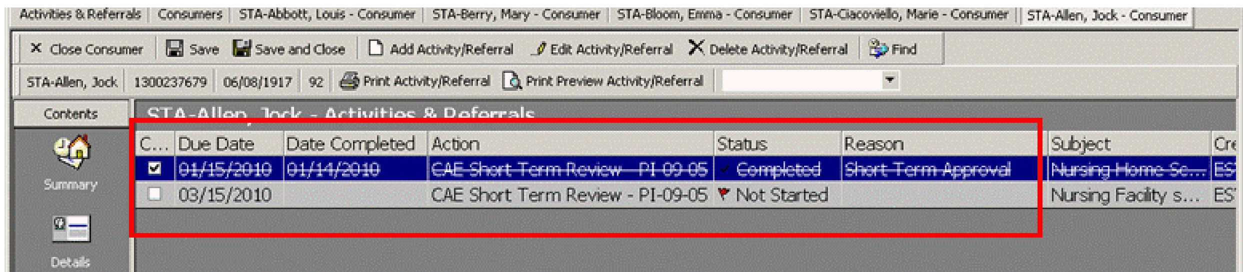


EXAMPLES: Viewing a client's history of Short Term Review A/Rs

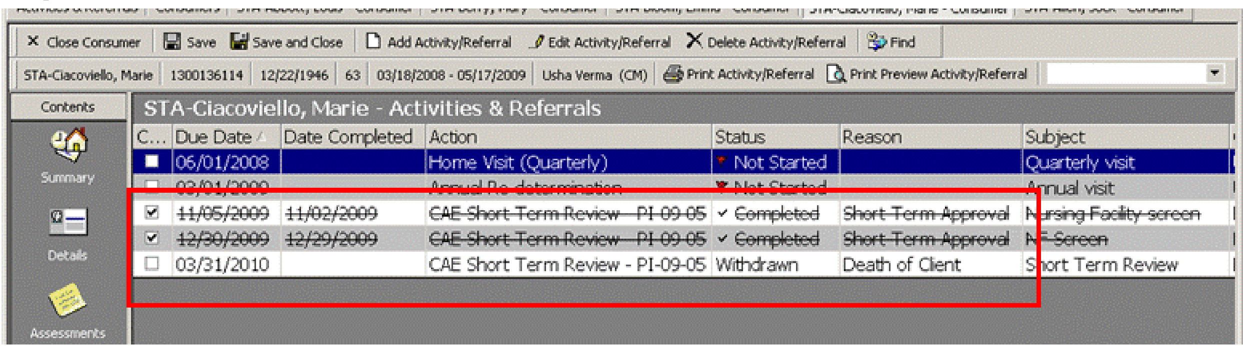
When you review a client's history of A/R's related to their Short Term Reviews, you can understand their story.

These examples assume that a client's list of A/R's has been sorted by Action and Due Date, as explained in section **View Consumer's Activity Referrals**, above.

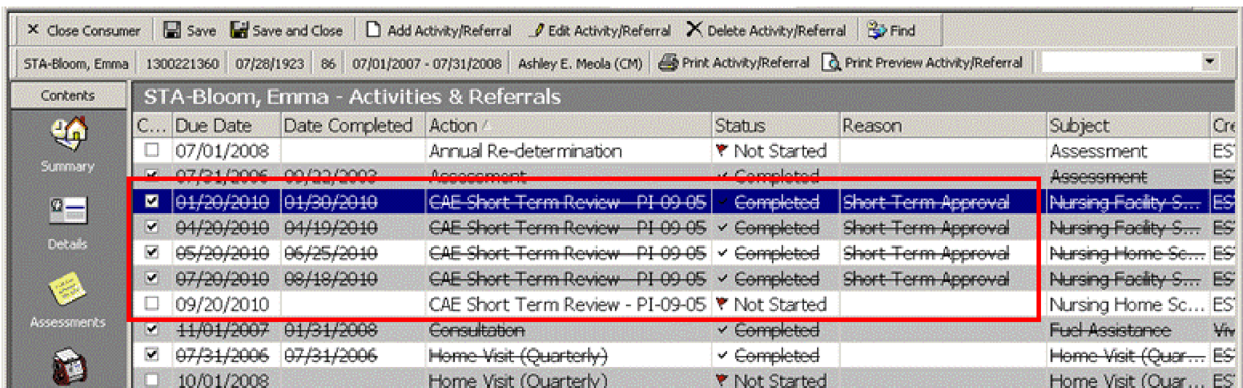
Client received one Short Term Review, another expected



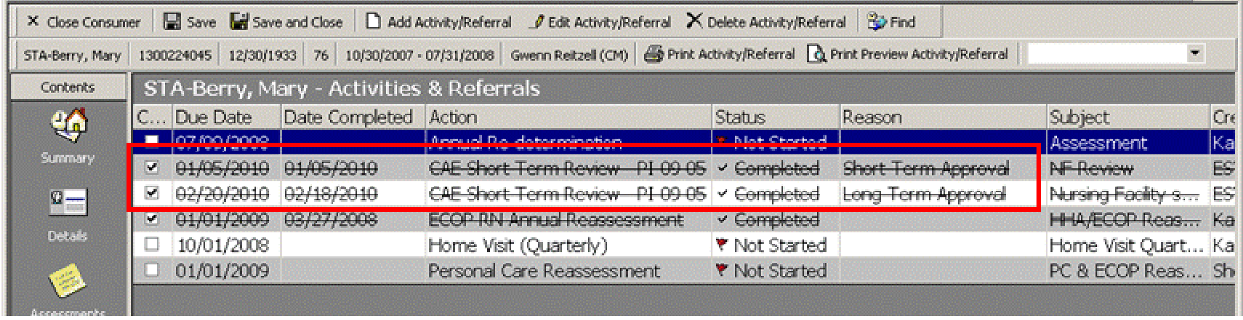
Client received two completed short Term Review assessments; client expired before the due date of the third STR.



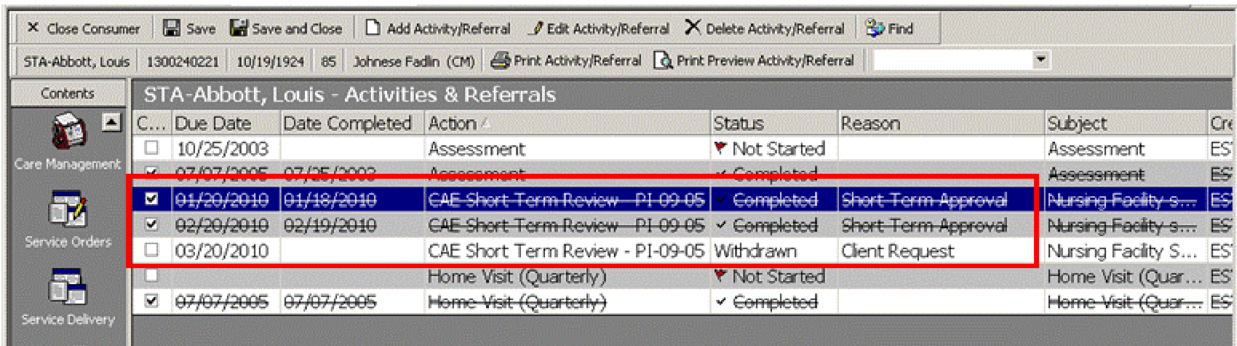
Client received four completed Short Term Reviews, waiting on fifth



Client Received Long Term Approval after one Short Term Approval



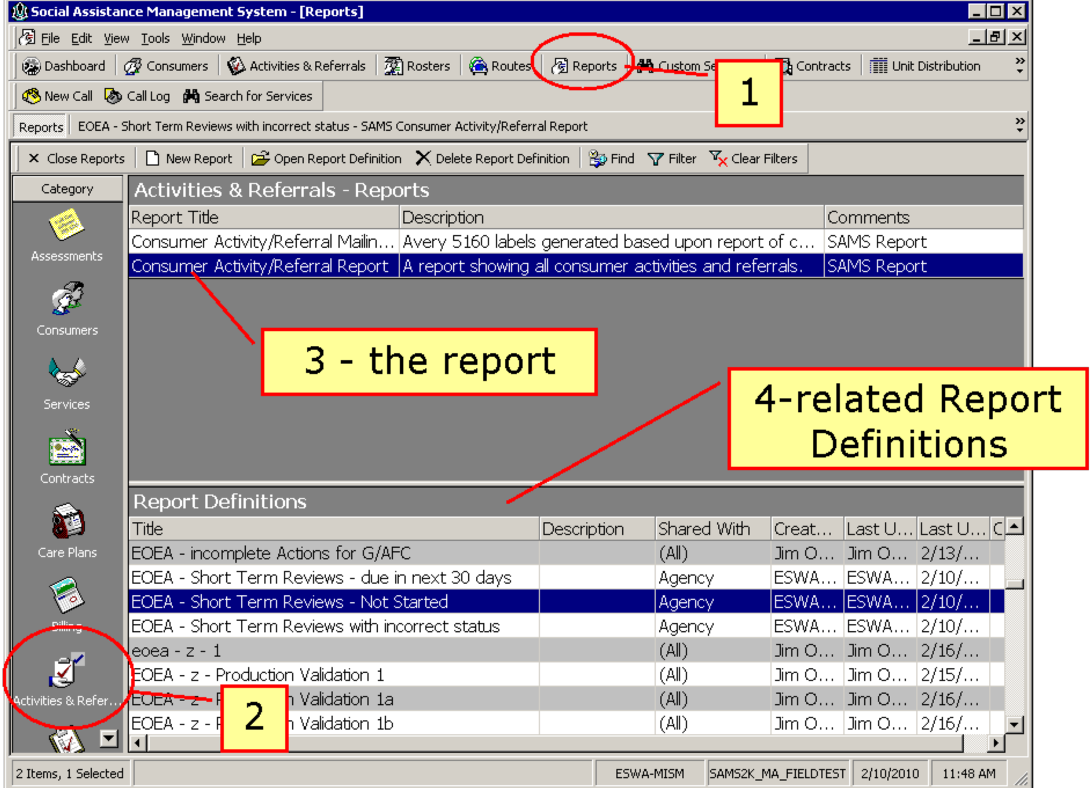
Client received two Short Term Reviews, then withdrew at client request



Reporting

Below, we provide some sample report criteria to help you manage your upcoming STAs.

All of these report examples use the Activity/Referral Report, found here.



Note on the following report definitions

The report definitions described below have *not* yet been implemented to the SAMS production environment.

Users should work with the Agency SME's and trainers to define Report Definitions to match agency business processes to manage their agency's STA's and STR's.

View all incomplete STRs

All Activity/Referrals of type **CAE - Short Term Review - PI-09-05** should have a status of Not Started, Complete, or Withdrawn. This report will show all Short Term Reviews that are not withdrawn or complete.

Do not filter this report by date: you want to make sure that all scheduled Short Term Reviews are performed as planned, or that the expected screenings are Withdrawn.

Since it's sorted by due date, any overdue A/Rs will be at the top of the report.

SAMS Consumer Activity/Referral Report
- EOEA - Short Term Reviews - Not Started

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	No Grouping
Group per Page:	No
Sort By:	Due Date
Secondary Sort By:	Client ID
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	Yes

Activities/Referral

Action:	CAE Short Term Review - PI-09-05
Status:	Not Started

View Short Term Reviews to be performed in the next 30 days.

At your agency, you may wish to view a report of all upcoming Short Term Reviews that are due in the next 30 days.

Let's say that today is March 1, 2010. This report shows all upcoming A/R's of type **CAE - Short Term Review - PI-09-05** with Status of "Not Started" and a due date 30 days from today.

Since it's sorted by due date, any overdue A/Rs will be at the top of the report.

SAMS Consumer Activity/Referral Report
- EOEA - Short Term Reviews - due in next 30 days

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	No Grouping
Group per Page:	No
Sort By:	Due Date
Secondary Sort By:	Client ID
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	Yes

Activities/Referral

Action:	CAE Short Term Review - PI-09-05
Status:	Not Started
Due Date (on or before):	3/31/2010

View Long Term Approvals

You may wish to review a list of Long Term Approvals granted by your agency. In this case, we are looking for A/R's that match

- Action type: **CAE - Short Term Review - PI-09-05**
- Status: **Complete**
- Reason: **Long Term Approval**

This example is sorted by completion date.

This report can also be easily filtered by date.

SAMS Consumer Activity/Referral Report

- EOEA - Short Term Review - Long Term Approvals

Report Comments:

Parameters List:

Report:

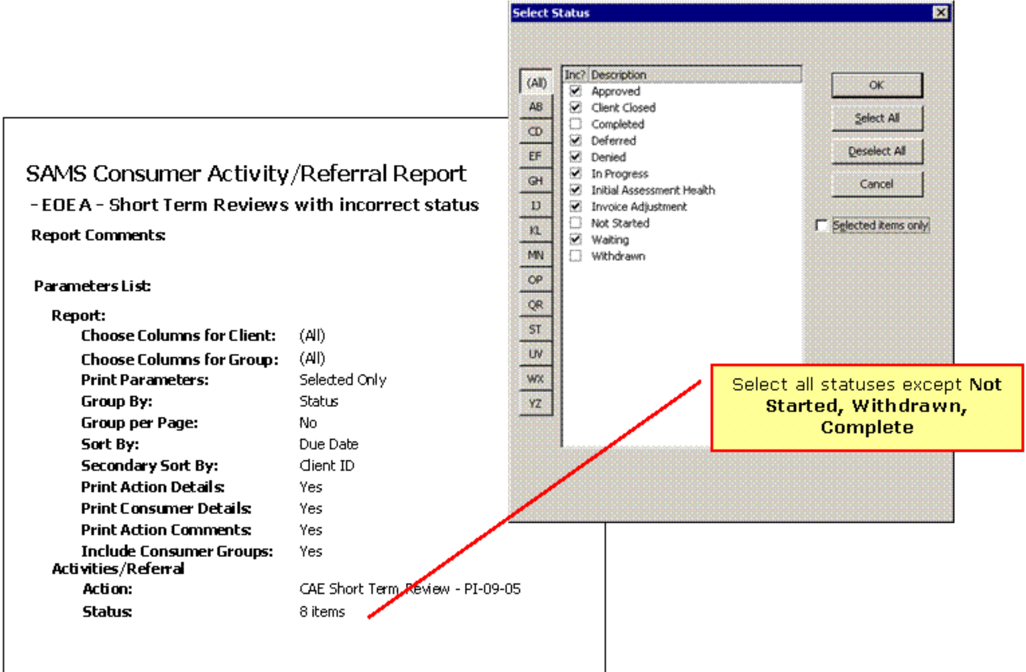
Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Reason
Group per Page:	No
Sort By:	Date Completed
Secondary Sort By:	Client ID
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	No

Activities/Referral

Action:	CAE Short Term Review - PI-09-05
Status:	Completed
Reason:	Long Term Approval

Data Quality: View Short Term Reviews that have an incorrect status

This report filters on any possible A/R status except Not Started, Withdrawn, or Complete.



SAMS Consumer Activity/Referral Report

- EOEA - Short Term Reviews with incorrect status

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Status
Group per Page:	No
Sort By:	Due Date
Secondary Sort By:	Client ID
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	Yes

Activities/Referral

Action:	CAE Short Term Review - PI-09-05
Status:	8 items

Data Quality: A/R's missing Reason Codes

All Completed or Withdrawn A/Rs must have an appropriate Reason Code.

This report filters on

- Action type: **CAE - Short Term Review - PI-09-05**
- Status: Complete or Withdrawn
- Reason: (any)

Since the report is grouped by Reason, all A/Rs with no reason code will display together, so that the data can be fixed.

SAMS Consumer Activity/Referral Report

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Reason
Group per Page:	No
Sort By:	Client ID
Secondary Sort By:	Client ID
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	No

Activities/Referral

Action:	CAE Short Term Review - PI-09-05
Status:	Completed, Withdrawn

July 15, 2010

Introduction

Coastline Elder Services reviews CDS data to make an initial determination on client eligibility for Group Adult Foster Care (GAFC) and Adult Foster Care (AFC). In this document, these two MassHealth programs are referred to together as "G/AFC".

The purpose of this document is to serve as a Job Aid and define required steps for ASAP staff involved in the clinical determination process for G/AFC determinations. Data related to these determinations will be stored in SIMS, and a new process instituted so that client data and statistics about the work performed by Coastline can be generated and tracked.

There are two categories of G/AFC providers (ASAPs and non-ASAPs), and there are likewise two flavors of this new process, reflecting the fact that ASAPs are users of SIMS, but non-ASAP providers are not SIMS users.

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Contents

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Revision History

Date	Version	Description	Author
June 15, 2010	1.3	• Edits for clarity • Updates to reflect CDS 2 RN sections • Re-emphasize steps for ASAP 1 role and responsibility with updating status reports and Activity/Referral reports.	Mary Ellen Coyne
Mar 7, 2008	1.2	• slight edits for clarity • added checklist for complete determination • added report criteria for ASAPs to determine status of Activities/Referrals • added screenshot of Activities & Referral Screen to show uncompleted Activities • removed mention of two (2) discontinued SAMS services: "Screening/AFC Conversion" and "Screening/GAFC Conversion"	Jim Ospenson
Feb 13, 2008	1.1	Slight edits after initial release • clarification of Service Order Date (step 11) • New sequencing of steps, so that Service order creation is before CDS creation. Steps re-numbered. • Additional content for free text of Action • Steps in case of incomplete application • Renumbered 2nd process flow	Jim Ospenson

Date	Version	Description	Author
		Document revised to put more focus on the Process, and improve clarity: ▪ Deleted flowcharts ▪ Updated for new SAMS feature Activities & referrals, released in SAMS 1.9.3, Feb 2008 ▪ Moved user communications and how-to add Service Contracts to bottom of document ▪ Revised Overview	
Oct 27, 2007	1.0	Draft for release to SIMS Community, related to CCF-0058-A	Jim Ospenson

Process for completing G/AFC Initial Determination: ASAP Providers (narrative)

In the steps below, "**ASAP A1**" should be understood as an ASAP who is also a provider of G/AFC, such as WestMass or Central Boston Elder Services.

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
1	ASAP A1	Identify Elder for G/AFC Initial Determination	• Note the date: this will become the effective date of the service order, and the enrollment start date (if needed).
2	ASAP A1	Search for Client in SAMS	Use [Search] to view clients statewide. The [Search] button is located on the toolbar and has the binocular icon.
3	ASAP A1	If client does not exist in SAMS, then Register Client	Steps to register a new client ▪ Click on the [Register] button ▪ Fill in the Consumer's personal information ▪ Set the **Default Agency** as ASAP A1 (i.e. your agency name) ▪ **Date Registered**= date of referral/ indication of need. ▪ Under Care Enrollment, set **Level of Care** to (Clinical Assessment & Eligibility - CAE) ▪ Under Service Program, set **Service Program** to Clinical Assessment & Eligibility See screenshot 1 below. Note: If you do not enroll the client to CAE on this step, create enrollment as in Step 5 below.

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
4	ASAP A1	Client exists, so look for existing CAE enrollment. If enrollment exists, proceed to create Service Order.	View the consumer's Care Enrollment screen. Look for a CAE enrollment with no End Date or Termination Date. If CAE Enrollment already exists, you can skip to Step 9: create Service Order.
5	ASAP A1	Look for an active [Add Care Enrollment] button. If an active button exists, then proceed to Step 7: Create CAE enrollment.	View the consumer's Care Enrollment screen. If you can see an active [Add Care Enrollment] button, then you can create an enrollment. Proceed to Step 7: Enroll Client. See Screenshots 3 & 4: active vs inactive buttons. **NOTE**: If ASAP A1 is able to successfully enroll the client in CAE, then ▪ Client Sharing via Consumer Provider is *not* necessary. ▪ The Default Agency setting does *not* need to be changed.
6	ASAP A1	If you are not able to enroll client, then (1) **Request** to share the client (ask the Default Agency to add you as Consumer Provider). (2) **Wait** until the client has been shared with you. After the client's Default Agency notifies you of the sharing, proceed to Step 7: Enroll Client.	You do not have access to the client record to create the enrollment. Contact the consumer's Default Agency, and request that you are added as consumer provider. ▪ See documentation for **Client Sharing via Consumer Provider**. This Job Aid was distributed in January 2008.
7	ASAP A1	Enroll Client in care program Clinical Assessment & Eligibility (CAE).	View the consumer's Care Enrollment screen. Click [Add Care Enrollment]. Click on ADD ENROLLMENTS on the Toolbar Set ▪ **Level of Care** = Clinical Assessment & Eligibility ▪ **Service Program** = Clinical Assessment & Eligibility ▪ **Status** = Active ▪ Set **Application Date, Received**

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			Date, and Start Date = <date the client presented for screening> ▪ If new enrollment, then set **Enrollment Start Date** = <date of referral or indication of need> from Step 1. See Screenshot 2: Enroll Client**.** **NOTE**: The Enrollment Start Date must be on or before the Service Order Effective Date.
8	ASAP A1	Save the Client Record.	
9	ASAP A1	Create Service Order.	View the consumer's Service Orders. Click on the [Add Order] button on the toolbar. Settings ▪ **Care Program** = CAE ▪ **Service** = (select one of) o Screening/AFC Initial Determination o Screening/GAFC Initial Determination ▪ Service **Agency**: <ASAP A1> ▪ Service **Provider**: Coastline ▪ **Effective Date**: <date application package is submitted for determination>. **NOTE 1**: The Enrollment Start Date must be on or before the Service Order Effective Date. **NOTE 2**: **If the Service Agency and Service Provider are incorrect, then Coastline may be unable to see the consumer record.** **NOTE 3**: Deciding which service to use: ▪ **Screening/AFC Initial Determination**: This service to be used for clients who are applying for Adult Foster Care. ▪ **Screening/GAFC Initial Determination**: This service to be used for clients applying for Group Adult Foster Care. **Note 4**: The G/AFC conversion services have been deactivated. Do not use these services.

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			▪ Screening/AFC Conversion ▪ Screening/GAFC Conversion Run Service Order reports, filtered appropriately on program, status, and provider to track work-in-progress. • The **Consumer Service Order report** is located under Reports> Consumers
10	ASAP A1	Save the Service order. Save the Client Record.	These steps ensure that Coastline has access to the consumer record. After saving the Service Order, Coastline becomes a "Service Provider" to the consumer and has access equivalent to that granted by the Consumer Provider element.
11	ASAP A1	Create CDS	View the consumer's Assessments. Click on the [New Assessment] button. Make the assessment visible to Coastline staff. Set Assessment elements ▪ **Care Program** = CAE ▪ Assessment **Agency** = <ASAP A1> ▪ Assessment **Provider** = Coastline Elder Services **Note**: **if the Agency & Provider elements are incorrect, then Coastline will not see the CDS.**
12	ASAP A1	ASAP RN enters CDS -2-RN data except for the determination section, which will be completed by Coastline. Specific Sections ASAP 1 RN completes: ▪ Module 1 (MDS-HC) Module 3 (Nursing), only sections 1,2,3,4 and 5. ▪ Nursing Module Signature section Section R (signature section) ▪	Note: ASAP 1 RN must sign the Nursing Module signature section.
13	ASAP A1	Use CDS Narrative to communicate Protected Health Information (PHI) to Coastline.	This is an optional step. Journal Entry information cannot be shared between ASAP A1 and Coastline due to organizational and data security. This approach meets HIPAA Minimal Necessary standard of information

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			sharing. Relevant information can be copied and pasted from a Journal Entry into the CDS Narrative to share with a Coastline nurse.
14	ASAP A1	Save CDS	Use the [Save and Close] button.
15	ASAP A1	Prepare and mail additional information to Coastline.	▪ Physician Summary Form and other applicable medical documents: Add SAMS Client ID to the form. ▪ If applicable, send Adult Foster Care statement.
16	ASAP A1	Create Activity & Referral .	View the consumer's Activities & Referrals. Click on [Add Activity/ Referral] button on the toolbar. Activity & Referral settings: ▪ **Action**: use either "AFC Initial Assessment" *or* GAFC Initial Assessment" ▪ **Activity Subject** (free-text) : <your Agency's name>. This is a required field. ▪ Activity **Agency:** <ASAP A1> ▪ Activity **Provider:** Coastline ▪ **Status**: Not Started ▪ **Status Date**: <today> Indicate a contact person and phone number in the free-text Comments field; Do not include any PHI in Comments field. **Note 1**: If the Agency & Provider settings on the Activity are incorrect, then Coastline may be unable to see this Activity (even if Coastline is able to see the consumer, the assessment, and the service order). **Note 2**: do not include PHI in the Action subject (headline) or free-text field. **Note 3:** If more information is requested, do *not* add another Activity/Referral. Instead, edit the existing Activity/Referral, adding comments and/or changing the status. **Note 4: It is ASAP A1 responsibility to monitor the Activity/Referral for changes to status. Please do *not* call Coastline until you have**

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			reviewed the Activity/ Referral. See section **Activity/ Referral reporting: how to monitor status** (below).
17	ASAP A1	Save the client record. End phase one.	
18	Coastline	Run Activity & Referral report	This report is located at Reports> Activities/Referrals> Consumer Activity/Referral report. Filter on Action Type = "GAFC Initial Assessment" or "AFC Initial Assessment" and status = "not started" to learn of new G/AFC Initial Determinations.
19	Coastline	Run Service Order Report	This report is located at Reports> Consumers > Consumer Service Order Report. Filter on Service and Group by Agency, Sort by Effective date, to learn of new G/AFC Initial Determinations.
20	Coastline	Identify new client for G/AFC initial determination.	
21	Coastline	Check mail for receipt of paperwork	Looking for receipt of complete (with signatures) Physician Summary Form and AFC Statement (if any).
22	Coastline	View Client Record	
23	Coastline	If paperwork is not received, then update Activity/ Referral Status and Reason	Modify the Activity/ Referral, setting ▪ **Status** = "waiting" ▪ **Reason** = "Application Not Received" ▪ **Status Date** = change to today's date. Determination shall not begin until paperwork is received and complete.
24	Coastline	If (CDS data is not complete) *or* (paperwork is received but incomplete), THEN update Activity/ Referral Status and Reason	Modify Activity/ Referral, setting ▪ **Status** = "waiting" ▪ **Reason** = "Application Received - Materials Incomplete" ▪ **Status Date** = change to today's date. Use the Activity's free-text field to communicate missing elements. Determination shall not begin until all materials are received and complete.

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			Steps to revise incomplete materials (ASAP A1): ▪ Return to Step 12 to amend & re-submit CDS data, or to Step 14 to gather and mail information, as appropriate, according to missing information reported by Coastline. ▪ At Step 19, revise Activity, setting Status = "Not Started" and Status Date = <date the application is revised and re-submitted> ▪ Note to ASAPs: If more information is requested, do *not* add another Activity/Referral. Instead, edit the existing Activity/Referral, adding comments and/or changing the status.
25	Coastline	If paperwork is received and complete, and CDS is complete, then update Activity/ Referral Status and Reason	Modify Activity/ Referral ▪ **Status** = "In progress" ▪ **Status Date** = change to today's date.
26	Coastline	Select and review most recent CDS	Verify Assessment Agency and Assessment Provider. If these are incorrect, then Coastline will not see the CDS.
27	Coastline	Review materials to make determination	
28	Coastline	Create Journal Entry	The Journal Entry will be visible only to users at Coastline.
29	Coastline	Reassess into a new CDS-2-RN	This results in two CDS-2-RN assessments - one completed by an RN at ASAP A1 and another completed by a Coastline RN, with determination. Click on the Assessment Icon; Set Assessment elements ▪ **Care Program** = CAE ▪ Assessment **Agency** = Coastline Elderly Services ▪ Assessment **Provider** = <ASAP A1> ▪ Assessment date = <date of determination> Coastline may only create and edit an assessment when they are marked as Assessment Agency. ASAP A1 can see this assessment if they are listed as Assessment Provider. **Note: make sure to check "Copy Notes and Narrative".**

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
30	Coastline	Record determination into CDS -2-RN Add data to CDS-2-RN ▪ Module 3, Sections 6a. and 8e ▪ Nursing Module Signature section	Complete CDS-2-RNassessment, filling in data values for Nursing Module, sections 6a and 8e (GAFC initial determination) These contain the eligibility citations and determination.
31	Coastline	Copy/paste Journal Entry content into CDS Narrative, if applicable.	This is optional. This is a means to share PHI and other information between Coastline and ASAP A1, sidestepping the security restrictions on Journals between Agencies. This approach meets HIPAA Minimal Necessary standard of information sharing.
32	Coastline	Save CDS	
33	Coastline	Print and Mail Notifications	The following must be printed, signed and mailed. ▪ Eligibility Notice to Client or Designated Representative. ▪ Fair Hearing Request Form to Client or Designated Representative. ▪ Language translation Babble form ▪ Eligibility Notice to Provider
34	Coastline	Update Activity/ Referral	Click on Activity & Referral Icon. Locate the client's SAMS Activity/ Referral, and update its status. ▪ Set **Status** = Complete ▪ Set **Completion** date and time if desired. NOTE: for HIPAA compliance, do *not* include any PHI in the action content.
35	Coastline	Complete Service Delivery record	This indicates that the Coastline determination effort is complete. Click on the Service Delivery Record: ▪ **Care Program**: CAE ▪ **Service**: must match the service order. ▪ Service **Agency**: <ASAP A1> ▪ Service **Provider**: Coastline ▪ **Daily Unit Details**: set to date of completion of all determination and notification tasks. Note: a Service Delivery record cannot be completed unless there is a matching Service Order. Reportability: an Agency Summary

Process for G/AFC Determination: ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			Report, filtered appropriately, can be run by users at either <ASAP A1> or Coastline.
36	Coastline	End	
37	ASAP A1	Run Activity/ Referral Report to learn of completed determination • Alternately, view the Activity through the Activity & Referral screen	This report is located at Reports> Activity/Referral > Consumer Activity/Referral Report. Activity & Referral report filtered by ▪ **Action**: GAFC Initial Assessment or AFC Initial Assessment, as applicable ▪ **Status date** on or after: <relevant date> ▪ **Status**: Complete ▪ Use **Print Preview** to view the report before printing.
38	ASAP A1	Run Agency Summary Report to learn of completed determination	This report is located at Reports> Services > Agency Summary Report. This report looks at Service Delivery Records. Filter by ▪ **Care Program**: CAE ▪ **Service Provider**: Coastline ▪ **Service End Date**: on or after <relevant date> Use **Print Preview** to view the report before printing.
39	ASAP A1	View Client Record	
40	ASAP A1	View CDS complete by Coastline RN	View the consumer's list of Assessments. Select and view CDS completed by Coastline RN
41	ASAP A1	View Clinical Determination in Module 3, Section 8 e , Questions 7 and 9	
42	ASAP A1	Copy/Paste Assessment Narrative from Coastline RN to a Journal Entry (if applicable)	This is a means to share PHI and other information between Coastline and ASAP A1, sidestepping the security restrictions on Journals between Agencies. This meets HIPAA Minimal Necessary standard of information sharing.
43	ASAP A1	If Client was approved for AFC or GAFC, then take steps to enroll, plan care, and commence appropriate services.	
44	ASAP A1	End.	

Process for completing G/AFC Initial Determination: non-ASAP Providers (narrative)

Note: The initial determination process for non-ASAP G/AFC providers is **unchanged**. Coastline's processing moves into SIMS.

Process for G/AFC Determination: non-ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
1	G/AFC Provider (not ASAP)	Identify Elder for G/AFC Initial Determination	
2	G/AFC Provider (not ASAP)	Prepare and mail information to Coastline.	▪ MDS-HC (equivalent to CDS Module 1) ▪ Request for Services ▪ Physician Summary Form and other applicable medical documentation. ▪ If applicable, Adult Foster Care statement.
3	G/AFC Provider (not ASAP)	END Phase 1	
4	Coastline	Checks mail, identifies client for G/AFC initial Determination or conversion	Note date of receipt of complete application materials. This date will become the effective date of the Service Order. Goal: within one (1) business day, complete through Step 9 of this process. This goal may be impacted if the consumer's record already exists in SAMS, but Coastline needs to take steps to share the consumer.
5	Coastline	If paperwork is incomplete or illegible, then notify provider. Suspend process until complete paperwork is received.	Coastline communicates with provider for re-submission
6	Coastline	Search for Client in SAMS	Use [Search] to view clients statewide.
7	Coastline	If client does not exist in SAMS, then Register Client	Set ▪ **Default Agency**: Coastline ▪ **Registration date**: <date of receipt of complete materials from G/AFC provider>. This date will be used as the enrollment start date and the Service Order effective date. **See Screenshot 2**
8	Coastline	If client has an active CAE enrollment, then skip ahead to Step 12: Create Service Order.	

Process for G/AFC Determination: non-ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
9	Coastline	If Coastline can create an enrollment, then skip ahead to Step 11: Enroll Client.	
10	Coastline	If Coastline is not able to enroll client, then take steps to gain ability to enroll.	• **Identify** the consumer's Default Agency. • **Request** that they add a Consumer Provider = Coastline to the consumer record. • **Wait** until the Default Agency notifies you this task is complete.
11	Coastline	Enroll Client in care program Clinical Assessment & Eligibility (CAE).	This step is not necessary if you enrolled the client during Registration (step 7) Set ▪ **Level of Care** = Clinical Assessment & Eligibility ▪ **Service Program** = Clinical Assessment & Eligibility ▪ **enrollment status** = Active ▪ **enrollment start date** = <date of receipt of complete materials from G/AFC provider> See Screenshot 3
12	Coastline	Create Service Order	Settings for Service order ▪ **Care Program** = CAE ▪ **Service** = Screening/ AFC Initial Determination *or* Screening/ GAFC Initial Determination as appropriate. ▪ Service **Agency**: Coastline ▪ Service **Provider**: Coastline ▪ **Effective Date**: <date of receipt of complete materials from G/AFC provider> **Note**: the Effective date of the service order must be on or after the Enrollment Start date. Run Service Order reports, filtered appropriately on program, status, and provider to track work-in-progress.
13	Coastline	Save Service Order. Save Consumer Record.	These steps ensure that Coastline has continued access to the consumer record, to create assessments and journal entries. • After saving the Service Order, Coastline is a "Service Agency" and

Process for G/AFC Determination: non-ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
			has access equivalent to that granted by the Consumer Provider element.
14	Coastline	Create CDS-2-RN	Make the assessment visible to Coastline staff. Set Assessment elements ▪ **Care Program** = CAE ▪ Assessment **Agency** = Coastline ▪ Assessment **Provider** = Coastline Elder Services
15	Coastline	Create Activity/ Referral	This step is optional, depending on Coastline's need for internal status reporting. Settings: ▪ **Action**: use either "AFC Initial Determination" *or* GAFC Initial Determination" ▪ Activity **Agency**: Coastline - this is a required field ▪ Activity **Provider**: if desired, you may assign this Activity to a particular Coastline person. The assigned-to person must be in the Care Manager table - i.e. you can assign them as a consumer care manager. ▪ **Status**: In Progress ▪ **Status Date**: <today> Note: do not include PHI in the Activity subject (headline) or free-text field. Run Activity reports, or view Activity & Referral screen, filtered appropriately on Activity type and status to track work-in-progress.
16	Coastline	Enter MDS data and Request for Services to CDS-2-RN ▪ Module 1 ▪ Module 3	Coastline staff to perform data entry.
17	Coastline	Review submitted materials and make determination	
18	Coastline	Record determination into CDS-2-RN Update CDS Module 3, Sections 6, 8 Nursing Module signature section.	This is Eligibility citation and determination.
19	Coastline	Save CDS	
20	Coastline	Create Journal Entry, if applicable.	The Journal Entry will be visible only to users at Coastline.

Process for G/AFC Determination: non-ASAP G/AFC Providers			
#	**Who**	**Step**	**Notes**
21	Coastline	Print and Mail Notifications	The following must be printed, signed and mailed. ▪ Eligibility Notice to Client or Designated Representative. ▪ Fair Hearing Request Form to Client or Designated Representative. ▪ Eligibility Notice to Provider
22	Coastline	Update Activity/ Referral	This step is optional, depending on Coastline's need for internal status reporting. Locate the client's SAMS Activity/ Referral, and update its status. ▪ Set Status = Complete ▪ Set Completion date and time if desired. NOTE: for HIPAA compliance, do *not* include any PHI in the Activity/ Referral content.
23	Coastline	Complete Service Delivery record	This indicates that the Coastline determination effort is complete. ▪ **Care Program**: CAE ▪ **Service**: service must match service order. ▪ **Service Agency**: Coastline ▪ **Service Provider**: Coastline ▪ **Daily Unit Details**: set to date of completion of all determination and notification tasks. Note: a Service Delivery record cannot be completed unless there is a matching Service Order. Reportability: an Agency Summary Report, filtered appropriately, can be run by users at Coastline.
24	Coastline	End	
25	G/AFC Provider (not ASAP)	If Client was approved for AFC or GAFC, then take steps to enroll, plan care, and commence appropriate services.	Use of SIMS for AFC or GAFC is not required by MassHealth.
26	G/AFC Provider (not ASAP)	End	

Checklist for complete determination package - ASAP Providers

This checklist is supplied for your convenience, so you can easily ensure that you've entered all the data elements correctly. **Your Submission for an AFC/GAFC Determination is incomplete unless you have all of the following elements**:

	Checklist for G/AFC Determination completeness: these must be done in order		
#	**Item**	**note**	**SIMS element?**
1	**Client record**	Search SAMS to see if the client has a consumer record already. If the consumer does not exist in SAMS, then Register the consumer.	yes
2	**Enrolled in CAE**	▪ **IF** an enrollment does not exist, and you cannot create one, ▪ **THEN** you must contact the client's Default Agency to share the client (add Consumer Provider). You will create the CAE enrollment after the client is shared with you.	yes
3	**Service order**	▪ **Care Program**: CAE ▪ **Service**: one of two screening services related to AFC or GAFC ▪ Service **Agency**: <your agency> ▪ Service **Provider**: Coastline Elderly Services, Inc. Make sure to save the Service Order and consumer record before proceeding to the next step.	yes
4	**Assessment**	Comprehensive Data Set (CDS) ▪ Assessment **Agency**: <your agency> ▪ Assessment **Provider**: Coastline Elderly Services, Inc. Enter CDS data ▪ Modules 1,2,3 - completely ▪ Module 4, only Sections 1,2,3,4, and 6	yes
5	**Activity/ Referral**	▪ **Activity Subject**: <your Agency Name> - ▪ **Action**: <AFC or GAFC> Initial Assessment ▪ Activity **Agency**: <your agency> ▪ Activity **Provider**: Coastline Elderly Services, Inc. ▪ **Comments**: include a contact name & phone number	yes
6	**Paperwork in the mail**	▪ **Physician Summary Form:** Add SAMS Client ID to the form. ▪ If applicable, send Adult Foster Care statement.	no

How to Monitor Status of Determinations-In-Progress

ASAP 1 must make certain they are updating the Activity/Referral reports status, this is not Coastlines responsibility, if ASAP 1 fails to update the status of the Activity/Referral reports there will be a delay in processing.

When to telephone Coastline

Please do not call Coastline staff regarding a determination until *after* you have reviewed all up-to-date client information in SAMS, including the Activity/ Referral, Service Order, or CDS. Many issues arise because of incorrect data entry -- make sure all data elements are correct before you dial the phone.

Run an Activity/Referral report to view determination status

The number of uncompleted Activities should equal the number of open Service Orders.

The report criteria below will show a Central Boston user all Activity/Referrals that are

- **Related to a G/AFC Determination**: Activity/ Referral = (AFC Initial Determination *or* GAFC Initial Determination)
- **visible to Coastline**: Activity Provider = Coastline Elderly Services
- **Not complete**: Status = (In Progress *or* Not Started *or* Waiting).

This report is grouped by Status, so all Activities of similar status will appear together.

SAMS Consumer Activity/Referral Report

Report Comments:

Parameters List:

Report:

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Status
Group per Page:	No
Sort By:	Last Name
Print Action Details:	Yes
Print Consumer Details:	Yes
Print Action Comments:	Yes
Include Consumer Groups:	No

Activities/Referral

Activities/Referral:	AFC Initial Assessment, GAFC Initial Assessment
Status:	In Progress, Not Started, Waiting
Agency:	Central Boston Elder Services, Inc.
Provider:	Coastline Elderly Services, Inc.
Active Only:	No
Primary Only:	Yes

Service Order Reporting: Determinations in Progress

The number of open Service Orders should match the number of uncompleted Activities/Referrals.

The report criteria below will show a WestMass user all Service Orders that are

- **Related to a G/AFC Determination**: Service = (Screening/AFC Initial Determination *or* Screening/GAFC Initial Determination)
- **visible to Coastline**: Service Provider = Coastline Elderly Services
- **not complete**: Status = Open

SAMS Consumer Service Order Report

Report Comments:

Parameters List:

Report:

Text Object

Choose Columns for Client:	(All)
Choose Columns for Group:	(All)
Print Parameters:	Selected Only
Group By:	Service
Sort By:	Last Name
Show Service Order Details:	Yes
Show Subservice::	Yes
Print Consumer Details:	Yes
Include Consumer Groups:	Yes

Service Order:

Agency:	WestMass ElderCare, Inc.
Provider:	Coastline Elderly Services, Inc.

Service Order Items:

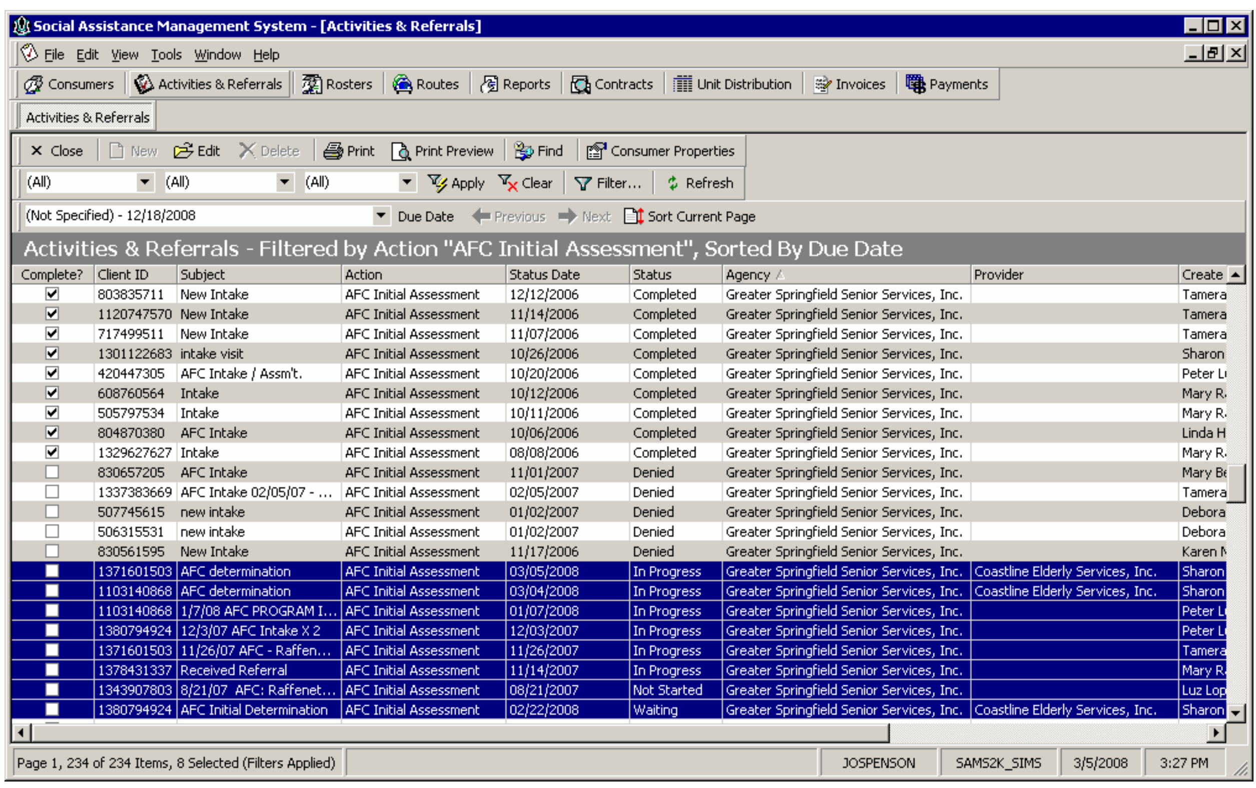
Service:	Screening/AFC Initial Determination, Screening/GAFC Initial Determination
Status:	Open

The Activities & Referrals screen

Filter & sort this screen to show all in-progress determinations. Sort the rows on this screen by clicking on the column name (sorts by Status or Status Date are especially useful).

Note: If Activity Provider is not equal to Coastline Elderly Services, then Coastline can not see the Activity, even if they can see the consumer, the service order, and the assessment. The screenshot below shows several that are invisible to Coastline (in fairness to GSSSI, these particular Activities are old).

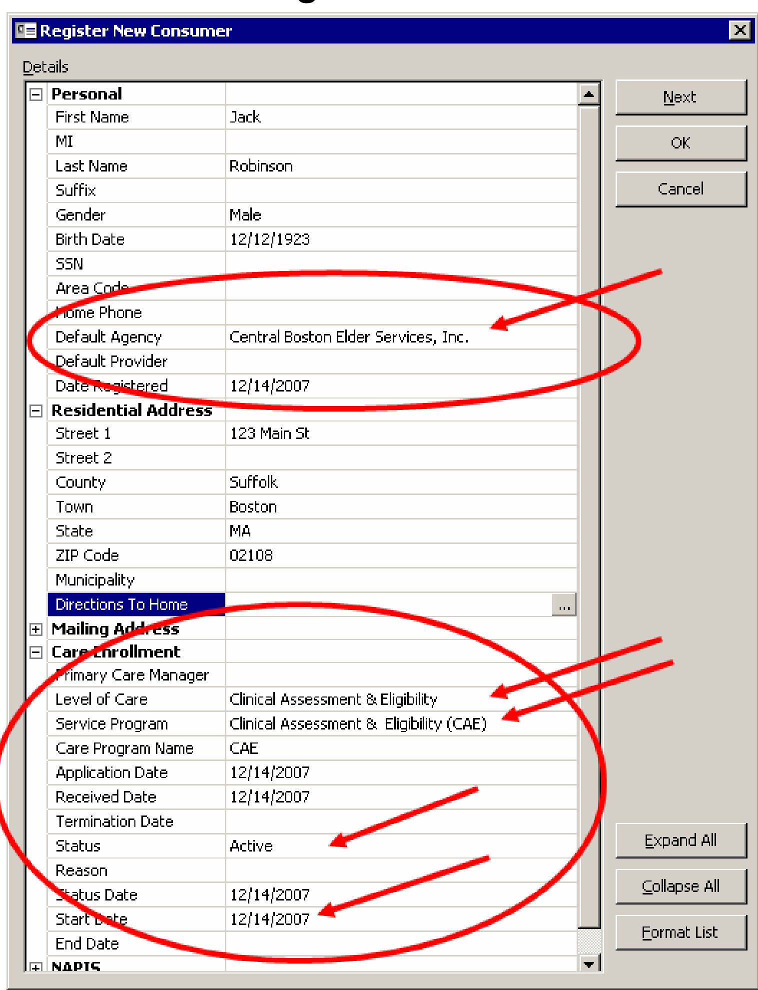
It is the ASAP's responsibility to make sure that all data elements are correctly visible to Coastline -- it is *not* Coastline's responsibility to track or monitor ASAP A1 data entry. Incorrect data entry will inevitably delay the client's determination process.



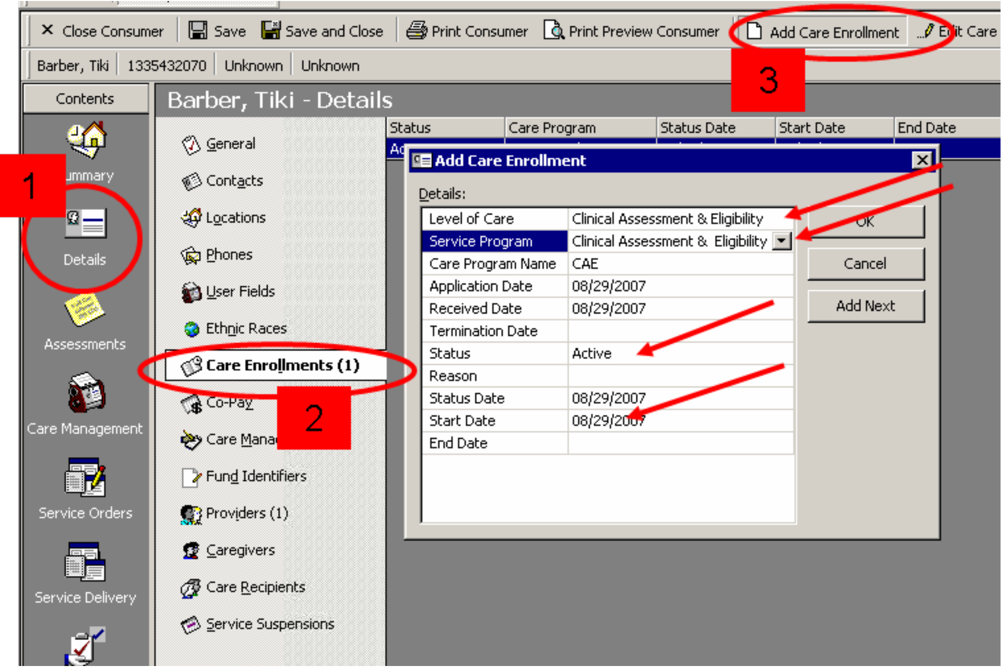
Complete?	Client ID	Subject	Action	Status Date	Status	Agency	Provider	Create
☑	803835711	New Intake	AFC Initial Assessment	12/12/2006	Completed	Greater Springfield Senior Services, Inc.		Tamera
☑	1120747570	New Intake	AFC Initial Assessment	11/14/2006	Completed	Greater Springfield Senior Services, Inc.		Tamera
☑	717499511	New Intake	AFC Initial Assessment	11/07/2006	Completed	Greater Springfield Senior Services, Inc.		Tamera
☑	1301122683	intake visit	AFC Initial Assessment	10/26/2006	Completed	Greater Springfield Senior Services, Inc.		Sharon
☑	420447305	AFC Intake / Assm't.	AFC Initial Assessment	10/20/2006	Completed	Greater Springfield Senior Services, Inc.		Peter L
☑	608760564	Intake	AFC Initial Assessment	10/12/2006	Completed	Greater Springfield Senior Services, Inc.		Mary R.
☑	505797534	Intake	AFC Initial Assessment	10/11/2006	Completed	Greater Springfield Senior Services, Inc.		Mary R.
☑	804870380	AFC Intake	AFC Initial Assessment	10/06/2006	Completed	Greater Springfield Senior Services, Inc.		Linda H
☑	1329627627	Intake	AFC Initial Assessment	08/08/2006	Completed	Greater Springfield Senior Services, Inc.		Mary R.
☐	830657205	AFC Intake	AFC Initial Assessment	11/01/2007	Denied	Greater Springfield Senior Services, Inc.		Mary B
☐	1337383669	AFC Intake 02/05/07 - ...	AFC Initial Assessment	02/05/2007	Denied	Greater Springfield Senior Services, Inc.		Tamera
☐	507745615	new intake	AFC Initial Assessment	01/02/2007	Denied	Greater Springfield Senior Services, Inc.		Debora
☐	506315531	new intake	AFC Initial Assessment	01/02/2007	Denied	Greater Springfield Senior Services, Inc.		Debora
☐	830561595	New Intake	AFC Initial Assessment	11/17/2006	Denied	Greater Springfield Senior Services, Inc.		Karen N
☐	1371601503	AFC determination	AFC Initial Assessment	03/05/2008	In Progress	Greater Springfield Senior Services, Inc.	Coastline Elderly Services, Inc.	Sharon
☐	1103140868	AFC determination	AFC Initial Assessment	03/04/2008	In Progress	Greater Springfield Senior Services, Inc.	Coastline Elderly Services, Inc.	Sharon
☐	1103140868	1/7/08 AFC PROGRAM I...	AFC Initial Assessment	01/07/2008	In Progress	Greater Springfield Senior Services, Inc.		Peter L
☐	1380794924	12/3/07 AFC Intake X 2	AFC Initial Assessment	12/03/2007	In Progress	Greater Springfield Senior Services, Inc.		Peter L
☐	1371601503	11/26/07 AFC - Raffen...	AFC Initial Assessment	11/26/2007	In Progress	Greater Springfield Senior Services, Inc.		Tamera
☐	1378431337	Received Referral	AFC Initial Assessment	11/14/2007	In Progress	Greater Springfield Senior Services, Inc.		Mary R
☐	1343907803	8/21/07 AFC: Raffenet...	AFC Initial Assessment	08/21/2007	Not Started	Greater Springfield Senior Services, Inc.		Luz Lop
☐	1380794924	AFC Initial Determination	AFC Initial Assessment	02/22/2008	Waiting	Greater Springfield Senior Services, Inc.	Coastline Elderly Services, Inc.	Sharon

Screenshots

Screenshot 1: Register Client



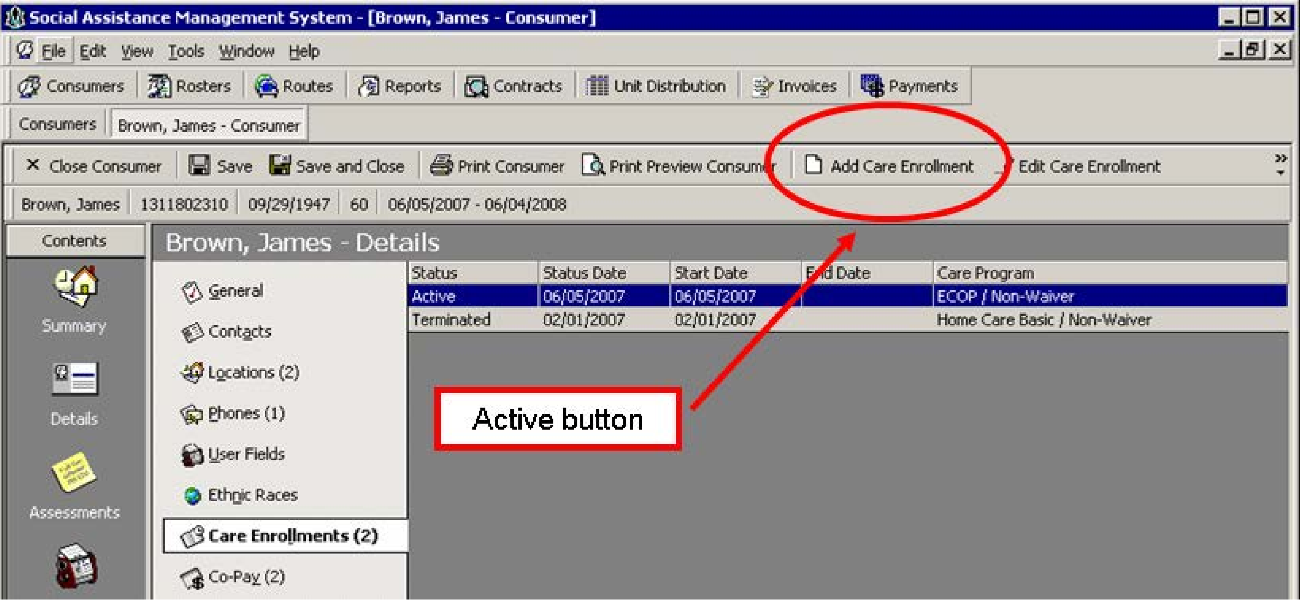
Screenshot 2: Enroll Client



1. Show Consumer Details
2. Click Care Enrollments
3. Click [Add Care Enrollment]
4. Set Enrollment field as shown by the four (4) arrows.

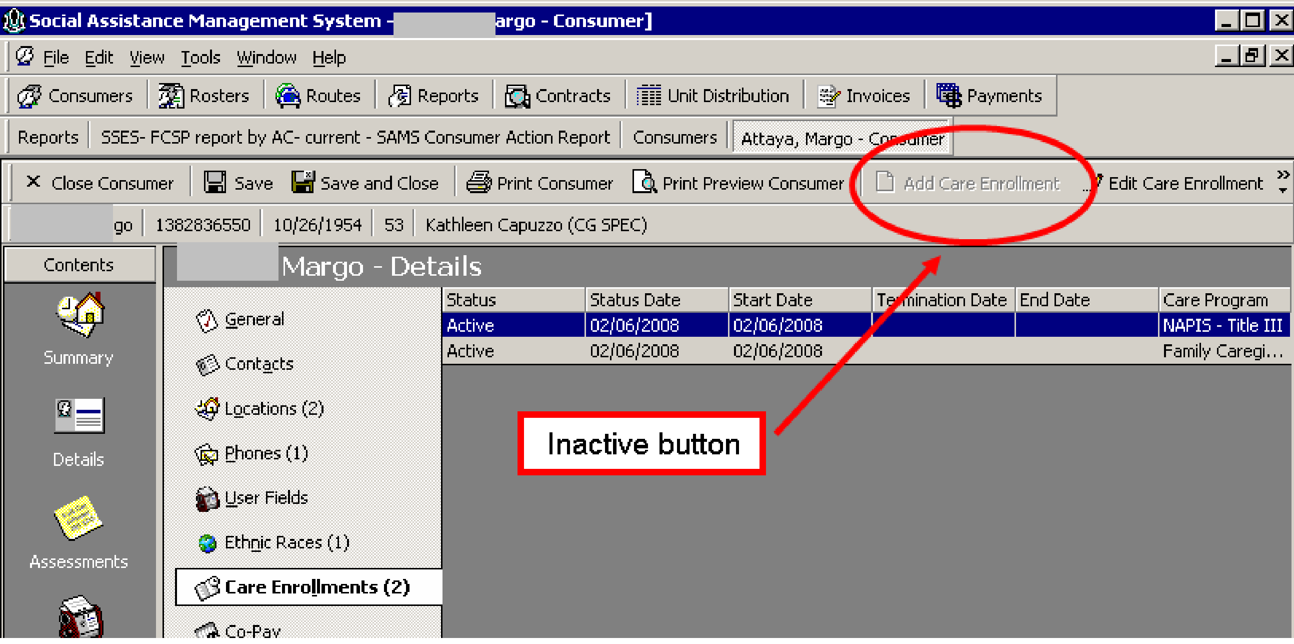
Screenshot 3: Active [Add Care Enrollment] button

This button is Active - the user is able to create an enrollment

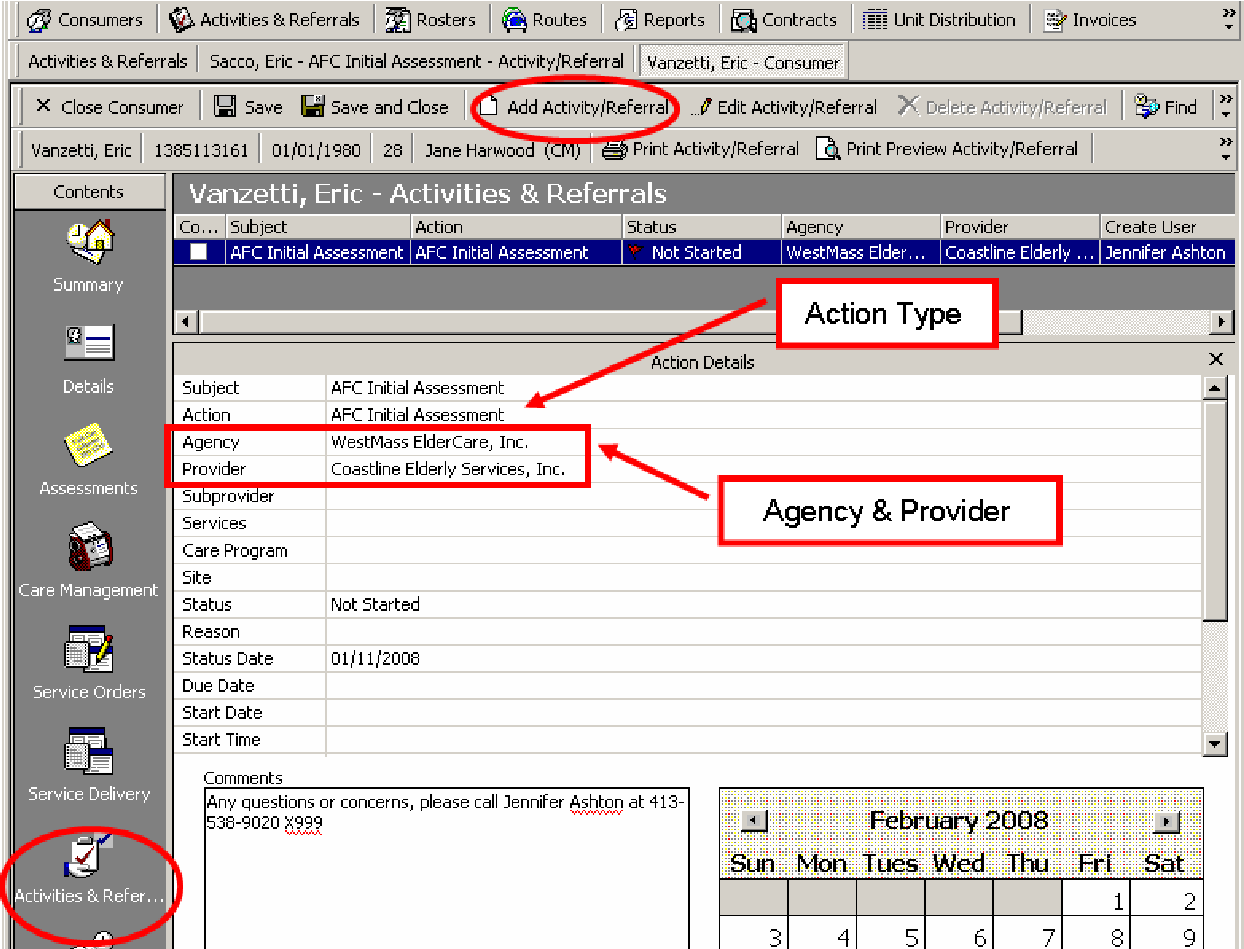


Screenshot 4: Inactive [Add Care Enrollment] button

This button is inactive - the user is *not* able to create an enrollment



Screenshot 5: Activity & Referral - from Consumer Record



Notes:

- The Activity Agency & Activity Provider elements make this Activity visible to users at both agencies. If these are not set correctly, then Coastline may not be able to see this Activity that's been assigned to them.
  - Set the **Activity Agency** (here it's WestMass) to be the same as the Service Agency.
  - Set the **Activity Provider** to Coastline. All AFC or GAFC Activities *must* show Activity Provider as Coastline, or it will not be visible to Coastline. This will be true even if the client is otherwise visible to Coastline.

- .

For more information on SIMS configuration, please contact SIMS Support, cc: ing Jim Ospenson, SIMS Business Analyst for Home Care & Clinical. For questions regarding CDS completion, please contact Mary Ellen Coyne and Shari Lemont-Moore of the EOEA Clinical Assessment unit.

How to Implement: ASAP Contracts Managers, once annually

Create SAMS Service Contract

Each ASAP who will present clients for G/AFC Initial Determination must ensure that a current SAMS Service Contract is in effect between their Agency and Coastline Elder Services, Inc. as service provider, as follows:

SAMS Service Contract: Data Element	Value	Note
Service Agency	*<your agency>*	
Service Provider	Coastline Elder Services, Inc.	
Effective Date	07/01/2007	This contract must be renewed annually, using a state fiscal year (July to June). *Please use single year contracts.*
End Date	06/30/2008	

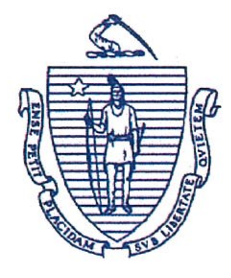
Each **SAMS Service Contract** must include the following services.

#	Contract Item (service)	Unit Price	Note
1	Screening/AFC Initial Determination	$0.00	This service to be used for clients in the community. *This service was renamed from previously existing CAE service Screening/AFC Pre-Admission.*
2	Screening/AFC Conversion	$0.00	This service to be used for private-pay AFC clients in the community who are converting to Medicaid.
3	Screening/GAFC Initial Determination	$0.00	This service to be used for clients in the community. *This service was renamed from previously existing CAE service Screening/GAFC Pre-Admission.*
4	Screening/GAFC Conversion	$0.00	This service to be used for private-pay GAFC clients in the community who are converting to Medicaid.

This step enables your staff to create Service Orders, and Coastline to create Service Delivery records for the determination services.

APPENDIX B – INFORMATION MEMORANDUM (IM)

- IM 13-03



The Commonwealth of Massachusetts
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IM-13-03

INFORMATION MEMORANDUM

TO: Aging Service Access Point (ASAP) Executive Directors

FROM: Ann L. Hartstein

DATE: July 23, 2013

RE: Process for initial clinical eligibility for consumers identified through the Senior Care Organization as potentially eligible for the Home and Community Based Frail Elder Waiver.

Purpose:
This Information Memorandum is being issued to clarify the process for ASAPs when determining initial clinical eligibility for consumers identified through the Senior Care Organization (SCO) as potentially eligible for the Home and Community Based Frail Elder Waiver (FEW).

Background and Program Implications:
The Executive Office of Elder Affairs (EOEA), in accordance with M.G.L. c. 19a, sec. 4b, retains authority for the overall management, administration, and oversight activities related to the operations of Massachusetts Home Care Program, including services provided under the 1915c Home and Community Based Services Waiver.

All consumers identified as potentially eligible for the FEW will be referred to the ASAP RN for the initial clinical determination of waiver eligibility, including those identified by a SCO who are in need of the FEW expanded income eligibility rules to qualify for MassHealth Standard in the community.

For those consumers in need of assistance with the MassHealth Senior Medical Benefit Request (SMBR) application, the SCOs have been instructed by the Office of Long Term Services & Supports (OLTSS) to offer support to the consumer during the application process.

Once the consumer is determined financially eligible for MassHealth Standard by the MassHealth Enrollment Center (MEC), the consumer must be provided the option of receiving their waiver services through a Home Care Waiver Program, SCO or other home and community based plan or program.

In addition, the ASAP must enter a SCO/FEW enrollment in SAMS. SCO/FEW enrollments identify SCO consumers who are in need of the FEW expanded income eligibility to qualify for MassHealth.

If a consumer declines enrollment in a Home Care Waiver Program or a SCO, or declines all waiver services, either the SCO or ASAP (whoever is working with the consumer) is required to submit to the MEC a Notification of Non-Participation on behalf of the consumer. The consumer must be advised that by submitting this notification their MassHealth Standard will be terminated.

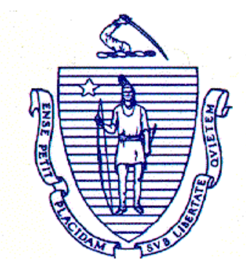
The ASAP will be responsible for all documentation of the initial waiver eligibility process according to RFR Section 9.1.3.p Eligibility Determinations. The redetermination of clinical eligibility for the FEW will be conducted by the SCO, as stated in the waiver application and communicated to the SCO through the OLTSS Unit.

Effective Date:
August 1, 2013

Contact:
Questions regarding this should be directed to Mary DeRoo, Director of Home and Community Programs at mary.deroo@state.ma.us.

APPENDIX C – PROGRAM INSTRUCTION (PI)

- PI 09-02
- PI 09-05
- PI 09-13
- PI 11-03
- PI 11-10
- PI 12-04
- PI 13-01
- PI 14-03



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Program Instruction

PI-09-02

TO: Aging Service Access Points (ASAPs)

FR: Ann L.Hartstein, Secretary

DA: December 2, 2009

RE: Retrospective and conversions requests exceeding 90 days and Out of State requests for clinical authorization of MassHealth payment for nursing facility services.

Purpose:

The purpose of this Program Instruction (PI) is to issue procedures for ASAPs when conducting retrospective clinical eligibility assessments for authorization of MassHealth payment for nursing facility services. Any previously issued instructions, regardless of the format, are hereby rendered obsolete and replaced by the requirements in this PI.

Background:

As a temporary measure to gather information, ASAPs were previously instructed to forward conversion assessment requests exceeding 90 days to the Executive Office of Elder Affairs (EOEA) for review and processing. This will no longer be the case.

Actions:

The ASAPs will process these assessments for authorization of MassHealth payment for nursing facility services and open theses cases under the Comprehensive Service and Screening Model (CSSM) when appropriate.

The ASAPs will review and process the following retrospective assessment referrals.

1. A Retrospective Screen is an assessment that is completed post-admission for clinical authorization of nursing facility services when the expected payer source is MassHealth from date of admission. It is primarily completed when the required pre-admission clinical assessment for a MassHealth admission was not completed.

2. A Conversion Screen exceeding 90 days is an assessment that is completed post admission to a nursing facility for clinical authorization of nursing facility services when the MassHealth member/applicant is converting to MassHealth from another payer source, and the length of time between the date of conversion and the date of referral to the ASAP exceeds 90 days.

3. A Short Term Review (STR) exceeding 90 days is an assessment that is completed post admission to a nursing facility for clinical authorization of nursing facility services when the MassHealth member has received one or more previous short term approvals and the length of time exceeds 90 days from the expiration of the short term approval.

MassHealth conversion applicants are excluded from this process. Any assessment that takes place for a MassHealth applicant during the MassHealth application process should be treated as a conversion screen and coded as such in SIMS.

Process

The nursing facility should refer the MassHealth member/applicant to their local ASAP prior the conversion or the STR date. The nursing facility must indicate the date or dates of services the facility is seeking MassHealth payment. The clinical assessment must be conducted during the nurse's visit to the nursing facility and coincide with an onsite face to face visit and review of the clinical record. The ASAP must validate and verify the MassHealth application date.

The ASAP RN must complete the CDS-2-NF and Nursing Module. For those cases where the member continues to reside in the nursing facility, a case must be opened to CSSM unless the member meets the criteria necessary for an initial nursing facility approval (formerly long-term approval) per PI-07-18.

The ASAP RN reviews all clinical documentation for which the nursing facility is seeking payment. In those instances where there is a change of status within that timeframe, the ASAP must issue two determinations. For example, the member may have been clinically eligible for the first 30 days of the NF stay, but was no longer clinically eligible. The ASAP RN would issue a STA for the first 30 days, and a denial beginning on day 31. Appeal rights must accompany each determination.

In those cases where the MassHealth member/applicant no longer resides in the nursing facility the clinical record is reviewed at the nursing facility and must be done in conjunction with the routine CSSM weekly visit.

The CDS-2-NF and Nursing Module Sections 6,7,8,9, a Narrative and a Journal entry are required. The narrative/journal entry must state that the individual was discharge or deceased at the time of the assessment.

Out of State Referrals

In cases where a MassHealth applicant resides outside of Massachusetts but is seeking to reside permanently in Massachusetts, a pre-admission onsite review is not possible. Applicants residing out-of-state are not exempt from the required pre-admission clinical authorization for MassHealth payment of nursing facility services. The ASAP must provide the applicant/family with an Request For Services (RFS) form, Physician's Summary Form (PSF), and an MDS-HC to be completed by a registered nurse (RN). The ASAP may accept a nursing facility MDS 2.0 and the current MDS Quarterly completed by an RN in a nursing facility as long as it is not more than 90 days old and reflects the current status of the consumer. The nursing facility must submit the current physician orders, nurses daily notes, nurses monthly summary, medication sheets, ADL flowsheets, treatment sheets and any other documentation that the ASAP may request. The ASAP, based on the documentation submitted and in the absence of a face to face assessment of the applicant, must issue a 30-day short term approval when clinical eligibility criteria is met. If the applicant is unable to provide the ASAP with the necessary documents, arrangements must be made for the consumer to be assessed in the community prior to admission to a nursing facility. All data must be entered into the CDS-2-RN assessment and Nursing Module..

For subsequent short-term reviews, the ASAP must complete the CDS-2-NF and Nursing Module. The member must be enrolled in CSSM when a community setting is appropriate..

Effective Date

The PI is effective December 15, 2009

Contact:

Contact MaryEllen Coyne, RN at MaryEllen.Coyne@state.ma.us or Shari Lemont-Moore, RN at Shari.Lemont-Moore@state.ma.us for questions related to this PI

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
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Program Instruction

PI- 09-05

TO: Aging Service Access Points (ASAP)

FR: Ann L.Hartstein, Secretary ALH

DA: December 2, 2009

RE: Nursing Facility Clinical Eligibility Assessments, Short Term Approval Tracking, and Noticing Procedures

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Purpose:

The purpose of this Program Instruction is to clarify the ASAP's role and responsibility in tracking and conducting clinical eligibility assessments for MassHealth members/applicants completed before and after nursing facility admission, and to issue relevant notices to members/applicants. Any other previously issued instructions, regardless of the format, are hereby rendered obsolete and replaced by the contents of this PI.

Background and Program Implications:

ASAP Registered Nurses conduct clinical eligibility determinations for authorization of MassHealth payment of nursing facility services for MassHealth members seeking admission to a nursing facility from the community, and for members/applicants admitted to a nursing facility, under a payer source other than MassHealth, converting to MassHealth payment.

Since January 2005, ASAPs have been required to conduct all clinical nursing facility eligibility assessments in accordance with the 2004 Comprehensive Screening and Service Model (CSSM) – Users Manual with an on-site visit to the nursing facility where a review of the clinical record and

interview/visual assessment of the MassHealth member/applicant are used as the primary sources of information for the ASAP RN's clinical assessment and determination.

ASAP RNs are required, with very few exceptions, to conduct weekly nursing facility on-site visits for purposes of all assessments and determination activities, (including conversion, short term reviews (STR), nursing facility to nursing facility transfer and retrospective cases), supporting discharge planning, and monitoring the progress of members/applicants issued a short term approval (STA).

Required Actions:

ASAPs are required to track all short term approvals and conduct all necessary subsequent reviews before the expiration of the STAs. Agencies must complete all outstanding STAs.

ASAPs must track all STAs utilizing the Activity/Referral functionality within SAMS, in addition to service delivery records already required. Doing so will permit ASAPs to generate reports necessary to manage workload, resources, and schedule nursing facility visits and Elder Affairs to monitor ASAP performance. As a quality measure all STA data in SAMS must be accurate and up to date. Based on this information ASAPs and Elder Affairs will be able to run monthly Activity Reports that identify all open STAs and their due dates. All STAs with a due date on or after January 8, 2010 must use the new activity/referral procedure with a target date of January 31, 2010 to complete any necessary transition activities such as staff training and data cleanup.

It is incumbent upon ASAPs to work with the nursing facility regarding the timely completion of short term approvals. ASAPs must complete all subsequent assessments and issue all applicable notices in a timely manner whether or not the nursing facility submits a referral and/or related documentation to the ASAP regarding a pending short term review (STR). An ASAP is required to issue notice including applicable appeal right to the member/applicant, family, next of kin, and nursing facility.

Effective Date:
This Program Instruction is effective January 1, 2010.

Contact:
Any questions regarding this Program Instruction should be e-mailed to Shari Lemont-Moore, RN at shari.lemont-moore@state.ma.us

Provider Agreement
Attachment A

Alzheimer's Day Programs provide specialized services to address the needs of people with Alzheimer's disease and related disorders (ADRD) and other dementias. The needs are unique due to changes in the brain that affect behavior and functioning. The goal of the program is to enhance cognitive functioning and improve the overall quality of life for individuals and their families. Program services help to maximize the individual's functional capacity, and reduce agitation, disruptive behavior and the need for psychoactive medication. Individuals with cognitive disabilities who require a day program benefit from a habilitative model in a therapeutic milieu.

I. Admission

A. Physician supervision of each individual must be arranged prior to admission. A medical examination must have taken place within the past three months. The provider must obtain:

- medical history that includes an indication of ADRD confirmed by the consumer's MD;
- a list of current medications and treatments;
- special dietary requirements / restrictions;
- a statement by the MD/NP approving participation in the program that must, if applicable, include any contraindications or limitations to the individual's participation in program activities;
- recommendations for specialized day programming; and
- negative Mantoux test or negative chest X-ray within the past year.

B. The provider shall have a written agreement with the individual and/or caregiver/family that specifies the services offered and a commitment from the individual to attend the program for a specified number of days per week. It shall also contain days and hours of program operations, a schedule of holidays, and procedures for unexpected closings due to disaster or inclement weather.

II. Participant Care Plan

A. Within six program days after the participant's first day, program staff in conjunction with family and other relevant health care professionals must complete a participant care plan. The care plan will be developed to address the physical, psychosocial, and ADL needs of the participant.

B. Care plans shall:

- include individual service needs;
- develop measurable objectives of care for the participant;
- provide a supportive service and activity plan designed to meet the psychosocial and therapeutic needs of the participant;
- include failure free activities in order to achieve goals and objectives and promote a sense of accomplishment and achievement;

- make special arrangements to meet the rehabilitative and adaptive equipment needs of the participants; and
- be updated quarterly by a multi-disciplinary staff.

C. A discharge plan will be in place within six (6) program days after the participants' first program day. Decisions to discharge shall be based on safety and benefit to the client and other participants. Discharge consideration may include danger to self or others, medical instability, or lack of a primary caregiver. Discharge plans shall be developed in conjunction with the individual, family, program staff and other involved professionals as appropriate. Discharge plans shall be reviewed with the care plans by a multi-disciplinary team.

D. The provider shall inform the physician of any change in the participant's care plan, health status, or behavior. Care plans shall be sent to the physician for quarterly review and signature, and returned to the program and maintained in the participant's file.

III. Program Specifications

A. Two-thirds of the program activities must be provided in separate locations from any other program.

B. Services and activities include helping participants and families adjust physically and psychologically to the illness. The care plan should include objectives that encourage the particpants to continue their daily routine, physical activities, and social contacts. Each day the program will provide two snacks and a meal prepared with the consultation of a dietician, which shall contain at least one-third of the current RDA as established by the Food and Nutrition Board of the National Academy of Science.

C. Activities should be enjoyable, habilitative, failure free, and provide:

- opportunities to maximize functional independence for high and low functioning groups;
- a positive outlet for energy and emotions;
- opportunities for self expression;
- structured time;
- individual counseling when appropriate;
- relaxation and stress release;
- accommodations for wandering in a safe environment;
- physical fitness activities;
- opportunities for peer relationships;
- contact and coordination with family, community agencies, and other professionals involved in the provision of care; and
- appropriate sensory stimulation, remotivation, expressive therapies and resocialization.

Provider Agreement
Attachment A

D. Family support and caregiver education/information will be provided including a consult on home safety issues.

E. The **Social Service Coordinator** must have at a minimum a bachelor's degree in human services from an accredited college or university and at least one year of recent experience working with adults in a professional capacity. Experience working with individuals with cognitive disabilities is preferred. Responsibilities include:

- arranging for or providing individual, group, and family counseling;
- providing family education in behavior management;
- informing participants/families of available community services and refer as necessary to agencies providing such services;
- providing family support services such as grief management;
- assisting participants/families to access available benefits;
- documenting notes in the participant's records at least quarterly;
- advocating on behalf of the client with other professionals; and
- assisting in the delivery of other required program services.

E. Nursing services must be provided in accordance with the needs of each participant. The program RN must provide and supervise nursing services. An RN's sole responsibility during the hours that she/he is employed by the program will be to meet the needs of the participants and promote the objectives of the care plan. Responsibilities include:

- administration of medications and treatments as prescribed by the participant's physician;
- on-going monitoring of each participant's health status;
- maintenance therapy treatment as recommended by a therapist
- coordination of the participant Nursing care plan and:
- active participation on the interdisciplinary care plan/discharge planning team

IV. Staffing

A. Staff shall receive an initial orientation and ongoing training in areas of dementias, verbal and non-verbal communication skills, behavior management skills, group process skills, family functioning, CPR and first aid. Staff members should be comfortable with a multi-disciplinary team approach to service delivery. Staff should receive training that will prepare them for such issues as difficulty in group participation, high anxiety, aggressive behavior, wandering, and incontinence. A staff member's sole responsibility during the hours that she/he is employed by the program will be to meet the needs of the participants and promote the goals and objectives of the careplan.

B. The program shall maintain a staff to participant ratio of at least 1:4 on site and ensure the presence of at least 2 staff members at all times.

Provider Agreement
Attachment A

V. Physical Plant

A. The physical environment should be designed to ensure the health and safety of participants and staff. It shall create an atmosphere that helps individuals compensate for cognitive losses by using specialized communication techniques, consistent behavioral approaches in personal care, and individualized failure free activities.

B. Curb cuts, gradients, handrails, and ramps shall be designed or adapted to be accessible to the population being served. To improve independent ambulation, floors should be a solid color with no shine. Due to impaired depth perception associated with ADRD, carpets may increase the risk of falls.

C. The site shall be designed or adapted to provide adequate turning space for wheelchairs. Light switches, control panels, counters, sinks, and door handles should be within easy reach of a wheelchair user. The toilet areas should be equipped with grab bars or handrails. Doorframes should be wide enough for wheelchairs, and thresholds should be eliminated.

D. Lower stimulation areas or a room with reduced auditory and visual stimulation should be made available to help maintain control of agitation.

E. Wall coverings should be simple in design on non-shiny paper or flat painted walls to improve attention and minimize distraction. Colors may be bright.

F. There shall be at least one toilet for every ten participants with one facility designed or adapted to provide access and maneuverability for disabled persons. Lavatories must have clear signage.

G. The site should be designed with adequate space for the provision of required services. Each site should include

  - a dining room;
  - a food preparation area equipped with a refrigerator and adequate counter and storage space;
  - a project area equipped with adequate table and seating (a dining area may be used);
  - a group activity area;
  - a private enclosed space free from disruption for individual nursing services or counseling;
  - a rest area equipped with at least one comfortable resting chair for every six participants per day; and
  - a personal hygiene area equipped with a sink.

H. Certification indicating the maximum daily participant occupancy shall be obtained from the local fire department approving the area for program operation. If necessary,

certification shall be obtained from appropriate local boards or departments (i.e. Health, Zoning, Building Inspector, etc.).

I. Providers shall have an emergency first aid kit, scale, blood pressure cuff,stethoscope, foot basin, digital thermometer with disposable probes, blankets, and separate storage space and refrigerator with locks for medications.

J. To accommodate the agitated pacer, adequate space (indoor or outdoor) should be available to allow pacing in a safe environment. A minimum of 50 square feet of space should be available for each participant, excluding office, toilet, hallway and other areas not used for the provision of the program.

K. Each program must have an accessible fire extinguisher and a Fire/Disaster Plan.

L. To protect participants, all exit doors must be alarmed or secured and all dividers, partitions and barriers must be secured.

M. Programs must adhere to the Americans with Disabilities Act regulations.

Provider Agreement
Attachment A

Habilitation Therapy is a service to support consumers and caregivers to create and maintain a positive experience for a person experiencing the effects of a dementia related illness. The objective is to provide education and support to the caregiver and to provide suggestions to modify elements of the environment that may exacerbate the disabilities of the disease. Habilitation Therapists provide knowledge and expertise to caregivers (and the person with the disease when appropriate) in understanding the disease process and pitfalls to avoid, as well as techniques of communication, behavior management, structuring the environment, creating therapeutic activities, and planning for future care needs.

Providers of Habilitation Therapy must be certified in Habilitation Therapy by the Alzheimer's Association, Massachusetts Chapter, and have a valid Massachusetts license for any of the following:

- Registered Nurse
- Licensed Independent Clinical Social Worker
- Licensed Certified Social Worker
- Licensed Social Worker

LCSWs must have one year of experience working with persons with a dementia related illness. LSWs must have two years of experience working with persons with a dementia related illness.

Four years experience working with persons with a dementia related illness may be substituted for the professional qualifications.

Provider Agreement
Attachment A

Wanderer Locator Service is a program designed to register people with a dementia-related illness who are at-risk of wandering and becoming lost. A person can register for life in a uniform national program, which coordinates efforts to locate and recover Alzheimer's patients and others with dementia who have wandered and become lost.

All registrants are assigned a unique code number that is kept in a central registry. Families and other primary caregivers will receive a patient ID bracelet engraved with the patient's name and code number along with other educational materials.

A toll free number is staffed 24 hours a day, 365 days a year. When a patient wanders away from a home or institution and the "800" operator is called, a fax alert goes out after local verification to area agencies such as police, hospitals, and ASAPs.

The wanderer locator service works with local providers to return the patient to a safe location and notify appropriate caregivers to provide follow-up and support to minimize the likelihood of further wandering incidents.

Provider Agreement
Attachment A

Chore services are services needed to maintain the home in a clean, sanitary and safe environment. This service includes minor home repairs, maintenance, and heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the elder nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

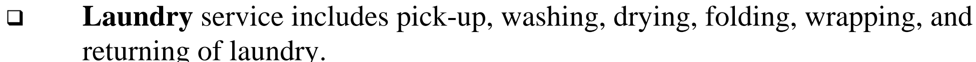
Provider Agreement
Attachment A

Companion services are non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the elder with such tasks as meal preparation, laundry and shopping. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the elder. This service is provided in accordance with a therapeutic goal in the service plan.

Provider Agreement
Attachment A

Transportation services are offered in order to enable consumers to gain access to community services, activities and resources, as specified by the service plan. For MassHealth members, this service is offered in addition to medical transportation required under 42 CFR § 431.53 and transportation services under the State plan, defined at 42 CFR § 440.170(a) (if applicable), and does not replace them. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

Provider Agreement
Attachment A



- ❑ **Laundry** service includes pick-up, washing, drying, folding, wrapping, and returning of laundry.

- ❑ **Grocery Shopping and Delivery** service includes obtaining the grocery order, shopping, delivering the groceries, and assisting with storage as needed.

Provider Agreement
Attachment A

Emergency Shelter services provide temporary overnight shelter for an elder (and his/her household) who is without a home due to eviction, fire, flood, other natural disaster, abuse, neglect, alcohol dependency, economic incapacity, or unsafe/substandard housing conditions, including lack of fuel and/or utilities.

Provider Agreement
Attachment A

- **Home Delivered Meals** provide well-balanced meals to consumers to maintain optimal nutritional and health status. Each meal must comply with the Executive Office of Elder Affairs' Nutrition Standards, and be religiously and ethnically appropriate to the extent feasible. Home Delivered Meals service includes the preparation, packaging, and delivery of meals by trained and supervised staff. More than one meal may be delivered each day provided that proper storage is available in the home. Home delivered meals do not include or comprise a full nutritional regimen.

- **Nutritional Assessment:** A comprehensive nutritional assessment conducted by a qualified nutritionist. A nutritional plan of care is developed based on the results of the assessment.

Provider Agreement
Attachment A

- **Personal Emergency Response System** (PERS) is an electronic device connected to a client's telephone line. In an emergency, it can be activated either by pushing a small button on a pendant, pressing the help button on the console unit, or by an adaptive switch set-up. When the device is activated, a person from the 24-hour-a-day, seven-day-a-week central monitoring station answers the call, speaks to the client via the console unit, assesses the need for help, and takes appropriate action. PERS includes all four of the following requirements:

    - in-home medical communications transceiver;
    - remote, portable activator;
    - central monitoring station with backup systems staffed by trained attendants 24 hours a day, 7 days a week; and
    - current data files at the central monitoring station containing pre-established response protocols and personal, medical, and emergency information for each client.

- **Enhanced PERS (EPERS**) is a service that combines the basic elements of PERS, with certain service enhancements. EPERS means the capacity to program a PERS console unit so that messages from family members or friends may be pre-recorded from a remote location and transmitted to the client at established intervals. The provider must have the capacity to install, operate and trouble shoot all EPERS equipment.

  The enhanced messaging capacity is designed to:

    - cue the client for medication compliance or other health regimens,
    - remind the client of key appointments or visits; and
    - provide "check in" calls to reduce isolation.

- **On Call** is the provision of an on-call capacity to respond to a client need either during or after regular business hours.

Provider Agreement
Attachment A

Home Health Services: Those services defined in MassHealth regulations at 130 CMR 403.00, which include Skilled Nursing, Physical, Occupational, and Speech Therapy; and Home Health Aide.

❒ **Home Health Aide Services (HHA)** are provided under the supervision of an RN, or a physical, speech or occupational therapist. This includes assistance with ADLs and personal care, including incontinence care; assistance with ambulation and transfers, including the use of a hoyer lift; medication cueing and reminders; activities that support the skilled therapies; and routine care of prosthetic and orthodic devices.

❒ **Skilled Nursing Services** are provided by an RN or an LPN under the supervision of an RN, including, but not limited to: evaluating the nursing care needs; developing and implementing a nursing care plan; providing services that require specialized skills; observing signs and symptoms; reporting to the physician; initiating nursing procedures; giving treatments and medications ordered by the physician; teaching the patient and family; and supervising other personnel.

❒ **Occupational Therapy**: Services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living. Occupational Therapy is provided by a registered occupational therapist (OTR), a certified occupational therapy assistant (COTA) or an occupational therapy student supervised by an OTR.

❒ **Physical Therapy:** Services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels. PT is provided by a registered physical therapist (RPT); a physical therapy assistant (PTA) or a physical therapy student supervised by an RTA including

❒ **Speech Therapy** is provided by a qualified speech therapist (ST), a speech therapy assistant, or a speech therapy student supervised by a qualified ST including: evaluating patient care needs; providing rehabilitating services for speech and language disorders; observing and reporting to the physician; instructing the patient, family and health care team personnel, and supervising other personnel.

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Environmental Accessibility Adaptations includes those physical adaptations to the private residence of the elder or the elder's family required by the elder's service plan that are necessary to ensure the health, welfare and safety of the elder or that enable the elder to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the elder.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the elder. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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Medication Dispensing System is an automated medication dispenser that allows a consumer with medication compliance problems to receive pill form medications at appropriate intervals through audible/visual cueing. This system organizes a pre-filled supply of pills and is programmed to deliver the correct dosage of medications when appropriate. The product is lockable and tamper-proof and has a provision for power failure.

The Medication Dispensing System shall be authorized only when a responsible formal/informal caregiver can demonstrate the ability to pre-fill medications and monitor the system. The provider must furnish detailed instructions to the caregiver regarding the operation of the system, as well as a signed, written agreement between the provider and the caregiver clearly delineating the responsibilities of each party.

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Adult Day Health provides an organized program of health care and supervision, restorative services, and socialization for elders who require skilled nursing or therapy, or assistance with activities of daily living. Nutrition and personal care services are also provided to participants.

Adult Day Health programs must be approved for operation by MassHealth and operate in accordance with 130 CMR 404.000.

Basic Level of Care is provided to those participants who meet clinical eligibility requirements as defined in 130 CMR 404.407 (A)

Complex Level of Care is provided to those participants who, in addition to meeting basic level of care criteria, have also met nursing facility eligibility criteria as outlined in 130 CMR 456.409.

Health Promotion and Prevention Level of Care is provided to those participants who met the clinical eligibility criteria at the time of admission, but who, due to improved health, no longer meet the clinical requirements.

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Respite Care services are provided to consumers unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the consumer. Federal Financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite Care may be provided to relieve informal caregivers from the daily stresses and demands of caring for a consumer in efforts to strengthen or support the informal support system. In addition to respite care provided in the elder's home or private place of residence, Respite Care services may be provided in the following locations:

- Respite Care in an **Adult Foster Care** Program provides personal care services in a family-like setting. A provider must meet the requirements set forth by MassHealth and must contract with MassHealth as an AFC provider.
- Respite Care in a **Hospital** is provided in licensed acute care medical/surgical hospital beds that have been approved by the Department of Public Health.
- Respite Care in a **Rest Home** provides residential care for clients in a supervised, supportive and protective environment. A Rest Home must be licensed by the Department of Public Health.
- Respite Care in a **Skilled Nursing Facility** provides skilled nursing care; rehabilitative services such as physical, occupational, and speech therapy; and assistance with activities of daily living such as eating, dressing, toileting and bathing. A nursing facility must be licensed by the Department of Public Health.
- Respite Care in an **Assisted Living Residence** provides personal care services by an entity certified by the Executive Office of Elder Affairs.
- Respite Care in an **Adult Day Health** program provides an organized program of health care and supervision, restorative services, and socialization for elders who require skilled services or assistance with activities of daily living. Nutrition and personal care services are also provided to participants. Adult Day Health programs must be approved for operation by MassHealth.

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- **TRANSLATION/INTERPRETING SERVICES** are provided by skilled individuals in order to communicate with and provide services to a consumer.

- **LEGAL SERVICES** are provided by an attorney on behalf of an ASAP providing Protective Services. These services include but are not limited to the preparation of court documents, filing of court petitions, and representation in court relative to a Protective Services case.

- **COMPETENCY EVALUATION** is an evaluation of the physical, mental, and social condition of an elder conducted in order to make a determination of the elder's capacity to consent to Protective Services. It also includes a statement of the care and services being received and needed, a statement of facts indicating the elder's understanding of the alleged abuse and the elder's understanding of the consequences of receiving or not receiving Protective Services.

- **FINANCIAL CONSULTATION SERVICES** are those provided by a qualified professional, including but not limited to certified public accountants, for the purpose of assisting Protective Services workers in conducting financial exploitation investigations. The role of the consultant is to help with the review of an elder's financial records and related documents so that a more informed and timely decision can be made about the presence, scope and extent of financial exploitation.

- **BILL PAYER SERVICES** are money management services provided to a person who requires assistance in managing his/her finances due to physical or cognitive difficulties, but is able to oversee and control the use of his/her finances. Client approval is necessary for the appointment of a bill payer.

- **REPRESENTATIVE PAYEE SERVICES** are money management services provided to a person who has been determined incapable of managing his/her benefits by the Social Security Administration or other appointing entity. Client approval is not required for the appointment of a representative payee.

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HOMEMAKER and PERSONAL CARE SERVICES:

- HOMEMAKER (HM) service includes assistance with: shopping, menu planning, laundry, and the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

- PERSONAL CARE (PC) service may take the form of hands-on assistance (actually performing a task for the person) or cuing and supervision to prompt the participant to perform a task. Such assistance may include assistance in bathing, dressing, personal hygiene, other activities of daily living, and reminders with medications in accordance with Elder Affairs' Personal Care Guidelines. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the care plan, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the individual, rather than the individual's family. Personal care services may be provided on an episodic or on a continuing basis.

- SUPPORTIVE HOME CARE AIDES perform personal care and/or homemaking services in accordance with waiver definitions, in addition to providing emotional support, socialization, and escort services to clients with Alzheimer's Disease/Dementia or emotional and/or behavioral problems.

(Refer to Elder Affairs' Personal Care Guidelines.)

I. PROVIDER POLICIES AND PROCEDURES

- A sufficient number of HM/PC workers should be available to meet the needs of clients accepted for service. The provider shall accept or reject an ASAP service request by the end of the next business day.

- Providers shall have job descriptions and salary scales.

- A Criminal Offender Record Information (CORI) check shall be performed in compliance with the laws of the Commonwealth and any applicable regulations and guidelines issued by the Executive Office of Elder Affairs.

- Personnel files shall be maintained with documentation on the results of the interview and references; completed CORI investigation; training/in-service certificates, waivers

and exemptions; if appropriate, PC skills checklist; supervisory visits; and performance reports and annual evaluations.

- Providers shall have policies regarding client privacy and confidentiality and non-discrimination in service delivery. These policies shall prohibit discrimination against persons with AIDS/HIV and ensure that information concerning AIDS/HIV status is not apparent or accessible and is not released to anyone without specific written consent.

- Providers shall have an infection control plan to prevent occupational exposure to blood-borne illnesses including AIDS/HIV and Hepatitis B. The Center for Disease Control/OSHA guidelines for standard precautions shall be followed.

- Providers shall have policies to ensure annual tuberculosis screening and testing is performed for all provider staff who come into direct contact with clients.

- Providers shall have policies for handling allegations of loss, theft, and/or damage of client property.

- Providers shall have a policy that prohibits the handling of the client's money that includes, but is not limited to: reconciling checkbooks, writing checks, using bank cards/Automated Teller Machines or providing banking services. Checks may be used to pay for groceries if the check is written to the store. The ASAP may establish these special arrangements, including use of the Electronic Benefit Transfer card for grocery shopping, with the store.

- A plan shall be in place for dealing with emergencies in the client's home including accessing emergency medical services and contacting provider supervisors.

- Providers shall have a policy for incidents when the client does not answer the door including the use of reasonable efforts (e.g. telephone) to gain access to the home. The provider will contact the ASAP immediately to determine the next course of action.

- Providers shall have policies to ensure compliance with the Department of Public Health's (DPH) requirements regarding prevention, reporting and investigation of abuse by homemakers and home health aides under 105 CMR 155.000 et seq. as outlined in EOEA-PI-07-03. Specifically, providers shall comply with all DPH regulatory requirements regarding hiring staff and reporting abuse.

II. REPORTABLE INCIDENTS

- If there is reasonable cause to believe an elder has been abused, neglected, or financially exploited, the provider must immediately contact the 24-hour ELDER ABUSE HOTLINE at 1-800-922-2275.

- Reports of client or worker injury, theft, and/or damage to property, shall be reported to the ASAP immediately. Upon ASAP request, the provider will follow the initial oral report with a written report.

- The client and ASAP must be notified of a canceled visit or a variation in service delivery from the written authorization.

- If the client is not at home to receive scheduled services or the provider has been informed that the client is hospitalized, this information shall be reported to the ASAP on the same business day.

- Changes in household members, client complaints, and new relevant client information shall be reported to the ASAP as soon as possible.

III. QUALIFICATIONS

- Providers shall ensure that HMs and PC Workers are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures, and standards of living.

- Providers shall ensure that supervision is provided by Social Workers, Registered Nurses, and/or professionals with expertise related to the client profiles.

IV. TRAINING AND IN-SERVICE EDUCATION

- Prior to placement, all HMs and PC Workers shall receive a 3-hour orientation (Mass Council's Training Curriculum or equivalent) with a 1/2-hour session on communicable disease including AIDS/HIV and Hepatitis B, infection control, and the principles of standard precautions.

- **40-Hour Homemaker Training:** In addition to the 3-hour orientation, all HMs must complete 37 hours of training within the first 6 months of employment. The training shall include the nature and transmission of HIV/AIDS, standard precautions and other infection control practices, and protection of client confidentiality regarding AIDS/HIV. The Mass Council’s Home Care Aide course is recommended. Other courses may be used that contain the same subject matter and number of hours per subject.

- **60-Hour Personal Care Training:** PC Workers must have completed the 20-hour PC training and the 40-hour HM training before providing PC. The Mass Council's PC training outline is recommended, with 17 hours of class instruction including a review and demonstration on universal precautions and a 3-hour practicum. The 3-hour

practicum shall include an assessment of competency in each PC task before placement by using the Mass Council's skills checklist.

Training must be conducted by an R.N. with a valid license in Massachusetts. A Registered Physical Therapist is recommended for the training on mobility. Return demonstrations are required on the hygiene and mobility sections of the training. The use of gaits belts is strictly prohibited.

- **90-Hour Supportive Home Care Aide Training:** SHCAs must complete the following 90 hours of training before providing Supportive Home Care Aide Services:

  - A 3-hour orientation (Mass Council's for Home Care Aide Services Training Curriculum) with a 1/2-hour session on communicable disease including AIDS/HIV and Hepatitis B, infection control, and the principles of universal precautions.

  - The 57-hour Personal Care training set forth in the Personal Care Homemaker Standards issued by Elder Affairs.

  - An additional 15 hours of Home Health Aide (HHA) training. The 75-hour HHA course prepared by the Mass Council is recommended. Other courses may be used if they contain the same subject matter and same number of hours for each subject.

  - An additional 15 hours of training related to the responsibilities of a SHCA. The following topics are recommended: limit setting; depression; personality and character disorders; substance abuse; abuse and neglect; Alzheimer’s Disease; and the stigma of mental illness and behavioral disorders. The Mass Council’s curriculum is recommended.

- **Certificates:** Providers must award a certificate to those who have successfully completed the HM and/or PC training.

- **Training Exemptions:** The following individuals are exempt from training requirements:

  - Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) with a valid Massachusetts license,
  - Certified Nurse’s Aides with documentation of successful completion of a certified nurse’s aide training program,
  - Home Health Aides with documentation of successful completion of a home health aide training program,
  - PC Workers with documentation of having successfully completed the 60-Hour PC Training Program.

- HMs with documentation of having successfully completed the 40-Hour Training Program, and
- HMs with documentation of having successfully completed the Training Waiver Procedure described in the Mass Council's HWTP Guide are exempt from the 37-hour HM training program.
- No exemptions for the additional 15-hour SHCA training.

NOTE: All new employees exempt from any of the training components must receive the 3-hour orientation described in the Mass Council Training Outline.

- **Training Facilities.** Agencies providing PC training shall have appropriate training facilities and equipment. A minimum standard of equipment shall include a bed with side rails, linen and blanket, running water and basins, towels and washcloths, chair, commode, wheelchair and walker. A variety of teaching methodologies such as lectures, equipment demonstrations, visual aids, videos, and handouts shall be used.

- Supervisors and other professionals shall provide on-going in-service education and on-the-job training aimed at reinforcing the initial training and enhancing skills. This may be carried out with videos, lectures, group discussions, and demonstrations.

- A minimum of 6-hours per year of on-going education and training is required for all HMs and PC Workers. These hours shall be pro-rated for part-time employees. One to one PC supervision may comprise one-half the required hours. Instruction and reinforcement of universal precautions and infection control procedures count toward the required hours.

V. SUPERVISION

- Supervision shall be available during regular business hours, and on weekends, holidays and evenings for HMs and PC Workers providing services to clients during these times.

- Supervision shall be carried out at least once every three months by a qualified supervisor. In-home supervision shall be done in a representative sample of clients.

- **PC Introductory Visits:** On the first day of service in the client's home, a PC Worker shall receive an orientation from an R.N. to demonstrate the PC tasks. During this visit the PC Worker will demonstrate competence in the PC tasks assigned in the care plan. LPNs may carry out the orientation visits if the LPN has a valid license in Massachusetts, is working under the direction of an RN, and an RN from the purchasing agency has conducted an initial home visit to assess the need for PC prior to implementing the care plan.

- **PC Supervision:** An RN shall provide in-home supervision of PC Workers at least once every 3 months with a representative sample of clients. A written performance of PC skills shall be completed after each home visit. LPNs may provide in-home supervision if

the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision a minimum of 20-hours per week and is responsible for the field supervision carried out by LPN.

- **SHCA Weekly Support**. Each SHCA shall receive weekly support through training/in-services, team meetings, or supervision that includes in-home, by telephone or in person. Team meetings shall be held a minimum of two hours each month and shall include SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA.

VI. CLIENT RECORDS

Providers shall maintain a record in a secure setting for each client receiving service. Access to client records shall be limited to provider staff involved with direct care of the client and appropriate administrative staff in compliance with Elder Affairs Program Instruction on Privacy and Confidentiality. The record shall contain client information provided by the ASAP and the following information:

- source/date of referral and medical and/or functional status,
- release of information forms, if applicable,
- names of ASAP case managers, physicians, family/friends,
- date of service initiation and tasks to be performed,
- hours and duration of service/subsequent changes,
- record of services provided,
- notes regarding supervisory visits, team meetings, etc.
- reportable incidents (Section B), and
- date of and report on termination.

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Supportive Day Programs provide support services in a group setting to help participants recover and rehabilitate from an acute illness or injury, or to manage a chronic illness, or for participants who have an assessed need for increased social integration and/or structured day activities. The services include assessments and care planning, health-related services, social services, therapeutic activities, nutrition, and transportation. These services focus on the participant's strengths and abilities, while maintaining their connection to the community and helping them to retain their daily skills.

The interactions of the physical and human environment combine to create the milieu of each center. The physical environment and the program design provide safety and structure for participants. The center staff builds relationships and creates a culture that supports, involves, and validates the participant. This milieu then forms the framework in which therapeutic activities, health monitoring, and all the services offered by the center occur. All therapeutic components of adult day services (meals, activities, interactions with staff and other participants and health services) are reinforced by the warm, caring, affective tone of the center's milieu.

Adult day services shall be culturally responsive and respectful. No individual shall be excluded from participation in or be denied the benefits of or be otherwise subjected to discrimination in the adult day services program on the grounds of race, sex, religion, national origin, sexual orientation, or disability.

I. Program Goals

- Maximize the functional level of the participant and encourage independence to the greatest degree possible;
- Build on the participants' strengths, while recognizing their limitations and impairments;
- Establish for the participant a sense of control and self-determination, regardless of his/her level of functioning; and
- Assist in maintaining the physical and emotional health of the participant.
- Provide respite to caregivers providing care that helps elders remain in their homes and communities.

II. Essential Components of Day Care Centers:

- An interdisciplinary approach to meeting program goals;
- A variety of services offered to meet the needs of participants;
- A regular daily schedule to provide structure for the participants;
- Sufficient flexibility to accommodate unanticipated needs and events;
- Verbal and non-verbal communication between staff and participants to create a caring environment; and
- Sensitivity to various personalities and health conditions to form supportive and therapeutic relationships.

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III. Admission and Assessment

Supportive Day programs serve individuals who are in need of supervision, supportive services, socialization and minimal assistance with ADLs. This person may have multiple physical problems but is stable and does not need nursing observation or intervention while attending the program. There may be some cognitive impairment, but resulting behavior can be handled with redirection and reassurance. The participant must be able to communicate personal needs.

The center's assessment process shall identify the individual's strengths and needs, what services are required, and who is responsible for providing those services. The assessment shall be conducted by professional staff such as the social worker, paraprofessionals, consultants, health providers, or a combination of the above.

The assessment must include the following: health and cognitive status, personality, psychosocial background, level of interest in other people and things, mood, cognitive status/judgment, attention span, task focus, energy level, responsiveness to stimulation in the environment, distractibility, communication, sensory capacity, motor coordination, and spatial relationships.

Special consideration should also be given for all participants in areas including ambulation, physical and functional capacity, physical and functional ADLs. If no diagnostic evaluation has been done, the participant and family/caregiver should be referred to their physician for evaluation.

Assessment Procedures:

- An intake/screening shall be completed in order to gain an initial sense of the appropriateness of the program for the individual.

- Each participant shall designate a health provider to contact in the event of an emergency and for ongoing care. A report from the physician that reflects the current health status of the participant shall be obtained.

- Centers shall conduct an assessment and develop an individual written plan of care for each participant within the first two weeks of attendance.

- The participant and caregiver shall have the opportunity to contribute to the development, implementation, evaluation and reassessment of the care plan including schedules, care plan goals and conditions of participation. The care plan shall be developed in conjunction with the services provided by that agency.

- An enrollment agreement shall be completed and shall include: identification of services to be provided, agreed upon by the participant and/or caregiver and/or payer; a disclosure statement that describes the center's range of care and services; admission and discharge criteria; fees and arrangements for reimbursement and payment; and identification of and authorization for third party payers.

- Reassessment of the participant's needs and appropriateness of the care plan shall be done as needed but at least semi-annually.

- The center shall develop a discharge policy that includes criteria and notification procedures. Each participant and caregiver shall receive written information regarding this policy.

- Each participant and family/caregiver shall receive notice if the participant is to be discharged from the program.

IV. Program Policies and Procedures

- The center shall have procedures for orientation of the participant and/or family/caregiver to policies, programs, and facilities.

- A confidential record shall be maintained for each participant. Progress notes shall be written as indicated, at least quarterly, and maintained as part of each participant's record.

- The center shall comply with the state mandatory reporting procedures for reporting suspected abuse or neglect to the adult protective services agency. Staff will be trained in signs and indicators of potential abuse.

V. Quality Assurance

- Each program shall develop a written continuous quality improvement plan that is updated annually.

- A grievance procedure shall be established to enable participants and their families/caregivers to have their concerns addressed without fear of recrimination.

- A participant bill of rights and responsibilities shall be developed, posted, distributed and explained to all participants or their representatives, families, staff and volunteers in a language understood by the individual.

VI. Program Services:

1. Activities. Activities shall be designed to promote personal growth and enhance the self-image and/or to improve or maintain the functional capacity of participants. The activity plan shall be an integral part of the total plan of care for the individual based on the interest, needs, and abilities of the participant (social, intellectual, cultural, economic, emotional, physical, and spiritual).

Participants shall be encouraged to take part in activities, but may choose not to do so or may choose another activity. Participants shall be allowed time for rest and relaxation and to attend to personal and health care needs.

2. **Health Services**. The program shall refer to and assist with the coordination of health services as needed. The center shall have a written procedure for handling medical emergencies. Emergency first aid and emergency response procedures shall be provided as needed. Each participant shall have a physician responsible for his or her care. The physician of record shall be clearly identified in the participant's chart.

3. **Activities of Daily Living** (ADLs). Assistance with and/or supervision of ADLs shall be provided in a safe and hygienic manner that recognizes an individual's dignity and right to privacy.

Assistance with ADLs may be provided by staff or trained volunteers and is limited to providing a verbal or visual prompt to initiate the ADL in a manner that encourages the maximum level of independence. The participant must be able to physically complete the ADL.

4. **Social Services**: Education and support shall be provided to participants and their families/caregivers on issues jointly agreed upon. Staff shall assess the families' needs and assist them in gaining access to additional services as needed.

5. **Nutrition:** Programs must provide at least one meal per day that is of suitable quantity and quality and supplies at least one-third of the daily nutritional requirements. Morning and afternoon snacks must also be available. Programs must be able to accommodate special diets when indicated by a physician or in the participant's care plan.

Nutrition services may be provided as a direct service by the provider; through a Title III Nutrition Program; or by purchase through an ASAP home care program home delivered meals service with the meals being delivered to the supportive day program instead of the participant's home.

6. **Transportation**: The center shall arrange or contract for transportation to enable persons, including persons with disabilities, to attend the center and to participate in center-sponsored outings.

VII. Staffing Policies:

- The organization shall provide an adequate number of staff whose qualifications are commensurate with defined job responsibilities to provide essential program functions.

- Processes shall be designed to ensure that the competence of all staff members is regularly assessed, maintained, demonstrated, and improved.

- Orientation, in-service training, and evaluations shall be provided to all employees and volunteers, including the use of standard protocols for communicable diseases and infection control;

- There shall be at least two responsible persons (one a paid staff member) at the center

at all times when there are two or more participants present.

VIII. Staffing Pattern

- The staff-participant ratio must be a minimum of one to eight (1:8)

- The Administrator is responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the Supportive Day Program.

- The Program Director shall organize, implement, and coordinate the daily operation of the program in accordance with participants' needs and any mandatory requirements. This individual may also have the responsibilities of the administrator.

- The Activities Coordinator shall have a high school diploma or the equivalent plus one year of experience in developing and conducting activities for the population to be served in the program.

IX. PROGRAM ADMINISTRATION

- Each program shall have a governing body with full legal authority and fiduciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements. Each program shall have an advisory committee which is representative of the community and the participant population.

- Each program shall have a written plan of operation that is reviewed and updated annually. The program shall also have written emergency plans that include plans for evacuation and relocation of participants in the event of an emergency. These shall be easily accessible in the center.

- The program shall maintain an updated organizational chart. The administrator shall be responsible for the planning, staffing, direction, implementation, and evaluation of the program. The Administrator or his/her designee shall be onsite to provide the center's day-to-day management during hours of operation.

- Each program shall demonstrate fiscal responsibility and accountability. Fiscal policies, procedures, and records shall be developed to enable the administrator to meet the fiscal reporting needs of payers. A fee schedule shall be formally established and should include discounts, waivers, and deferral of payment.

X. **PHYSICAL PLANT**

- The physical plant must create an environment that supports the principles of supportive day services and promotes the safety of each participant and staff.

- Programs may be housed in hospitals, nursing facilities, senior centers, councils on

aging, or other community centers.

- The facility shall be designed, constructed, and maintained in compliance with all applicable local, state, and federal health and safety regulations, codes or ordinances. The facility shall also comply with the requirements of the Americans with Disabilities Act of 1990.

- If a program is co-located in a facility housing other services, the program shall have its own separate identifiable space for main activity areas during operational hours.

- The facility shall provide at least 50 square feet of program space for multipurpose use for each participant.

- There shall be an identified separate space available for participants and/or family/caregivers to have private discussions with staff.

- There shall be storage space for program and operating supplies.

- The facility shall include at least one toilet for every ten (10) participants and shall be located as near the activity area as possible.

- The facility shall have a rest area for participants.

- Outside space that is used for outdoor activities shall be safe, accessible to indoor areas, and accessible to those with a disability.

XI. SAFETY AND SANITATION

- The facility and grounds shall be safe, secure, clean, and accessible to all participants.

- For programs that store medications, there shall be an area for locked medications, secured and stored apart from participant activity areas.

- Programs shall have a written infection control plan to prevent occupational exposure to blood-borne illnesses, including AIDS/HIV and Hepatitis B. The Center for Disease Control/OSHA guidelines for universal precautions shall be followed.

- Providers shall have policies to ensure annual tuberculosis screening and testing is performed for all provider staff who come into direct contact with clients.

- Safe and sanitary handling, storing, preparation, and serving of food shall be assured.

- An evacuation plan shall be posted in each room.

- All stairs, ramps, and bathrooms accessible to those with a disability shall be equipped

with properly anchored handrails and be free of hazards.

- Procedures for fire safety as approved by the state or local fire authority shall be adopted and posted.

- Emergency first aid kits shall be visible and accessible to staff.

- Insect infestation control shall be scheduled at a time when participants are not in the center.

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Transitional Assistance services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. Transitional Assistance Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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Attachment A

Vision Rehabilitation is a service intended (1) to evaluate the status and needs of persons who are visually impaired, and (2) to instruct the visually impaired in the use of compensatory skills and aids that will support safe, productive, and independent living. Vision Rehabilitation professionals seek to maximize the consumer's skills in home management, personal health care, communication, travel and mobility, accessing community resources, and participating in social and cultural activities. Vision Rehabilitation supports clients in understanding their vision loss and its effect on significant others, developing appropriate coping mechanisms, and enhancing the quality of their lives.

Providers of Vision Rehabilitation must be professionals certified by the Academy for Certification of Vision Rehabilitation and Education Professionals. Licensed Occupational Therapists who have received additional training and education related to vision impairment may also provide Vision Rehabilitation services.

Provider Agreement
Attachment A

Behavioral Health Services provide mental health services to non-waiver consumers in the Home Care Program and the Enhanced Community Options Program. All behavioral health services must be provided through a community mental health center (CMHC) that contracts with MassHealth, a hospital outpatient behavioral health center under contract to MassHealth, or a provider under contract to one of the MassHealth agency's behavioral health MCOs.

Home Care and ECOP Purchase of Service dollars may also be used to facilitate access to Behavioral Health Services.

Services must be provided in accordance with a mental health plan of care developed by a qualified individual employed by the provider, subject to approval by the ASAP. Rates of payment are established by the Division of Health Care Finance and Policy (114.3 CMR 6.00). Services must be provided by qualified individuals in accordance with MassHealth regulations or MassHealth behavioral health contractor rules. Services are arranged in accordance with the Protocol included in EA PI-08-08.

- □ **Diagnostic Services:** The examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan.
- □ **Individual Therapy:** Psychotherapeutic services provided to an individual.
- □ **Couple/Family Therapy:** The psychotherapeutic treatment of more than one member of a family simultaneously in the same session.
- □ **Group Therapy:** The application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.
- □ **Case Consultation:** A scheduled meeting of at least one-half hour's duration between the clinical staff at the mental health center and other providers of treatment concerning a member who is a center's client. Other providers of treatment are professional staff who are not employed by the mental health center but who are actively providing care or treatment for the member. The purpose of case consultation must be at least one of the following:

1) to identify and plan for additional services;
2) to coordinate a treatment plan with other members involved in the member's care;
3) to review the member's progress;
4) or to revise the treatment plan as required.

- □ **Emergency Services:** Services providing *immediate* face-to-face mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, up to 24 hours a day, seven days a week, to individuals showing sudden, incapacitating emotional stress.
- □ **Reevaluation:** A session between a client and one or more staff members who are authorized to render mental health services for the determination and examination by interview techniques of a patient's physical, psychological, social, economic, educational and vocational assets and disabilities for the purpose of reevaluating the diagnostic formulation, treatment plan and procedures in order to assess aspects of an individual's functioning.

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PI-11-03
Ref: PI-10-17

PROGRAM INSTRUCTION

TO: Aging Service Access Points (ASAPs)
Executive Directors
Nurse Managers
Program Managers

FROM: Ann L. Hartstein

DATE: January 12, 2011

RE: Conditions for Certain Nursing Facility Approvals

Purpose:

The Executive Office of Elder Affairs is issuing this Program Instruction (PI) to clarify requirements regarding the ASAPs' role in performing clinical eligibility determinations for authorization of MassHealth payment for nursing facility services. This PI modifies instructions previously issued in PI-07-18 and the ASAP RFR section 9.4.1.5.b.

Background and Program Implications:

The Executive Office of Elder Affairs requires that all MassHealth members and applicants seeking nursing facility services receive a comprehensive assessment. Members/applicants must be both financially and clinically eligible in accordance with MassHealth regulations 130 CMR 456.408 for authorization of MassHealth payment for nursing facility services for a specified length of stay (currently called Short Term Approval or STA) or an indefinite length of stay

(currently called Nursing Facility Approval or NFA), subject to periodic review.

Required Actions:

For all MassHealth members and applicants in, or seeking admission to, nursing facilities for an indefinite length of stay, the ASAP shall, upon initial assessment, issue a clinical authorization for MassHealth payment of nursing facility services for an indefinite length of stay only where a member/applicant meets one or more of the following criteria, subject to periodic review:

1. has a diagnosis of mid-late stage Alzheimer's disease or a related disorder;
2. has an end-stage (less than 6 months) terminal illness, as certified by a physician;
3. is comatose/unresponsive;
4. has complex multi-system failure resulting in permanent dependence in all of the following ADLs: bathing, dressing, toileting, transfer, mobility.

For all other MassHealth members/applicants, including those meeting the above criteria who intend to return to the community, ASAPs must issue an STA for a specified length of stay or a denial. For nursing facility residents converting to MassHealth, the duration of the STA must be determined by the ASAP's CSSM Team.

In most instances, the ASAP may issue an NFA only on the basis of an on-site, in-person, comprehensive assessment performed by the ASAP RN and documented in accordance with Elder Affairs' instructions. The sole exception to this rule occurs when all of the following conditions are met:

1. a nursing facility resident is transferring directly from one nursing facility to another nursing facility with less than 48 hours notice to the ASAP; and,
2. the resident was previously assessed by an ASAP RN in conjunction with an in-person on-site visit; and,
3. at the time of that assessment by the ASAP RN, the nursing facility resident was assessed as meeting at least one of the initial Nursing Facility Approval criteria listed above; and,
4. the ASAP RN issued an NFA at that time on the basis of his/her assessment; and,
5. there is a completed CDS in the consumer record that supports the criteria for an NFA and indicates the date of the previous ASAP RN's on-site assessment.

If all of the conditions listed above are met, the ASAP RN may issue an NFA on the basis of a paper review of the required documentation sent to the ASAP by the nursing facility without performing an in-person, on-site assessment. The documentation must continue to support at least one of the initial NFA criteria.

In those instances where clinical authorization for MassHealth payment is requested for a nursing facility to nursing facility transfer with less than 48 hours notice and the member or applicant does not meet one of the four initial long term approval criteria, or has a current short term approval, the ASAP may only issue up to a 30 day short term approval, or up to the

expiration date of the previously issued short term approval, based on a paper review provided the member or applicant continues to meet the clinical eligibility criteria in 130 CMR 456.409.

The ASAP RN must issue a new notification authorizing MassHealth payment of nursing facility services accompanied by appeal rights and send copies to all appropriate parties. A narrative note in the CDS and journal note must detail the ASAP RN's actions and indicate that this is a nursing facility to nursing facility transfer based on a prior nursing facility approval that meets the above conditions. No other action with the CDS is necessary other than to update the nursing module from the previous nursing facility approval, specifically the signature section updating the date of determination.

If an STA is issued and the new nursing facility is outside of the ASAP's service area, the ASAP must forward a copy of the clinical notification to the new ASAP. The new ASAP is required to track the STA and follow all business rules related to STAs within SIMS.

Effective Date:

January 12, 2011

Contact:

Please direct any questions regarding this program instruction to Shari Lemont-Moore, RN at shari.lemont-moore@state.ma.us.

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PI-11-10
Ref: PI-09-02

To: Aging Services Access Points
Executive Directors
Nurse Managers

From: Ann L. Hartstein

Date: July 19, 2011

RE: Retrospective Clinical Eligibility Determinations for Discharged and Deceased MassHealth Members

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Purpose:

The Executive Office of Elder Affairs is issuing this Program Instruction (PI) to modify requirements for clinical eligibility determinations for authorization of MassHealth payment of nursing facility services. This PI modifies instructions contained in PI-09-02. All other requirements of PI-09-02 not referenced in this PI remain in effect.

Background:

PI-09-02 requires ASAP RNs to complete retrospective clinical eligibility determinations for MassHealth payment of nursing facility services during weekly on-site visits to nursing facilities. In addition, ASAP RNs are required to complete the Comprehensive Data Set (CDS)-2-NF. This PI eliminates the requirements for a complete CDS-2-NF and an on-site review of the medical record for retrospective clinical eligibility determinations in those instances in which the MassHealth member is deceased or has left the nursing facility prior to the request for payment.

Required Actions:

Although Elder Affairs recommends an on-site review of the medical record, for discharged or deceased members, the ASAP may conduct a review of medical information transmitted to the ASAP by the nursing facility. The ASAP must ensure that the member is clinically eligible for the entire length of stay for which the nursing facility is seeking payment. The ASAP must also have all documentation required to support its determination.

If the ASAP does not perform an on-site review, the nursing facility must transmit the following information at a minimum:

1. Full MDS 3.0
2. Quarterly MDS 3.0 (if available)
3. Signed physician's orders
4. Medication and treatment sheets

The ASAP may not make a clinical determination of eligibility in the absence of any of the above, regardless of the length of time the member resided in the nursing facility. The documentation provided must cover the entire period for which the nursing facility is seeking payment. For example, if more than one MDS 3.0 was completed during the timeframe for which the nursing facility is seeking payment, the nursing facility must transmit or make that available to the ASAP for review.

The ASAP may request additional documentation in order to determine clinical eligibility.

In the event of a denial of MassHealth payment for nursing facility services, the ASAP must conduct an on-site review of the medical record.

The ASAP RN must complete the Nursing Module of the CDS-2-NF, sections 5b, 5c, 6a, 7 a-c, and 8. If the ASAP RN has not reviewed the record on-site, s/he may not enter a date for an on-site visit in the Nursing Module, Section 5e. The ASAP RN must complete both a narrative and a journal entry, which must state that the member was either deceased or discharged at the time of the assessment.

As applicable, the ASAP must continue to ensure that the nursing facility is in compliance with all PASRR requirements.

Effective Date:

July 1, 2011

Contact:

Questions concerning this PI may be directed to Shari Lemont-Moore at Shari.Lemont-Moore@state.ma.us.

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To: ASAP Executive Directors **EOEA-PI-12-04**

From: Ann L. Hartstein

Date: April 27, 2012

Re: Review of Pre-Admission Screening and Record Review (PASRR) requirements prior to authorization of MassHealth Payment of Nursing Facility (NF) services

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Purpose:

The purpose of this Program Instruction is to clearly delineate the practice for PASRR documentation review by ASAP Clinical Assessment Eligibility (CAE) staff when approving pre admission and post admission assessments in a NF. This is being presented in order to improve NF compliance with PASRR to prevent inappropriate NF admissions for those individuals with a diagnosis of mental illness (MI), intellectual disability/mental retardation (ID, intellectual disability is the current preferred terminology) and/or developmental disability (DD).

Background:

Since the implementation of the Omnibus Reconciliation Act of 1987 (OBRA), a condition of MassHealth payment of NF services has been pre-screening individuals for MI, ID, and DD. If an individual is diagnosed with one or more of these conditions, the appropriate PASRR authority must conduct a Level II PASRR evaluation and determination and approve admission to or a continued stay in a NF.

The PASSR authority for MI is the Department of Mental Health (DMH) which contracts with Northeast Behavioral Health. The PASRR authority for ID/DD is the Department of Developmental Services (DDS).

MassHealth retains the overall responsibility for PASRR and must ensure full compliance with all requirements. Among its responsibilities, the MassHealth agency cannot countermand the determination of the PASRR authorities, and must withhold payment for NF services for any person with MI or ID/DD who is admitted to a NF without a Level II PASRR evaluation and determination until such time as an evaluation and determination is completed by the applicable PASRR authority.

Currently, in the course of issuing authorization of payment for NF services for pre-admission and post-admission clinical assessments, ASAPs' Clinical Assessment and Eligibility (CAE) staff reviews for PASRR compliance prior to issuing authorization of MassHealth payment of NF services.

In an effort to improve upon PASRR compliance, the ASAPs will, as of the effective date of this Program Instruction, complete the PASRR monitoring activities prior to issuing an authorization of MassHealth payment for post-admission assessments including conversions, short term reviews, continuation of stay, retrospective assessments and transfers between NFs.

Required Actions:

During all pre-admission and post-admission assessments, ASAPs must ensure PASRR compliance is met prior to authorizing MassHealth payment for NF services for any MassHealth member or applicant.

The ASAP must review the clinical record and the Level I Pre-Admission Screening (PAS) Form for a diagnosis of MI, ID and/or DD prior to authorizing MassHealth payment on all pre- and post-admission referrals.

For conversion assessments, where the ASAP finds that a required Level II PASRR was not completed, the ASAP may not issue authorization for MassHealth payment of NF services until the NF can demonstrate that PASRR requirements have been met. The ASAP must report to the MassHealth Office of Long Term Services and Supports (OLTSS) the dates the NF was out of compliance with PASRR. The OLTSS will then instruct the ASAP with regard to payment.

A secure email must be sent to the designated person at MassHealth OLTSS, NF Program Manager, with the following information:

Name of the NF
Name of the Consumer
MassHealth 12 digit number OR date of birth if consumer is an applicant
Date of admission to the NF
Dates NF is seeking payment
Date of PASRR compliance (date of PASRR referral on the PASRR exemption letter or the date the PASRR authority completed the Level II)
Date of discharge from the NF if applicable.

If the ASAP completed a conversion or previous short term approval and found the NF to be in compliance with PASRR at that time, it is not necessary to review for PASRR again on subsequent short term reviews.

For other post-admission referrals, including retrospective, continuation of stay, and NF transfer assessments, the ASAP CAE staff must provide the information above to the designated person at MassHealth OLTSS if the NF was found to be out of compliance with PASRR.

The ASAP process for DDS 90 Day PASSR has not changed. This ensures that the expiration date on the PASRR is consistent with the expiration date on the authorization of MassHealth payment of NF services. The ASAP may only issue a Nursing Facility Approval (NFA) if DDS has issued a PASRR notice approving NF admission or continued stay with no end date.

The ASAP will now process all DDS provisional notices. When DDS issues a PASRR denial with a 30 day provisional notice, the ASAPs will issue a short term approval and a denial at the same time. The denial for authorization of MassHealth payment of NF services should be same date as the date the PASSR provisional approval period ends. A short term approval must be issued terminating the date prior to the date the provisional period ends.

A copy of the DDS PASRR notice must accompany any authorization or denial of MassHealth payment of NF services.

All notices issued by the ASAP must be accompanied by a Right to a Fair Hearing.

For those members who enter a NF on a 30 day convalescent stay exemption and convert to MassHealth as the primary payer source, the ASAP may only issue a short term approval through day 30 of the 30 day convalescent stay exemption period. At that time the ASAP must conduct a short term review and ensure PASRR requirements are met prior to authorizing any further MassHealth payment for NF services.

If an ASAP encounters other scenarios where PASRR compliance is in question, the ASAP should contact OLTSS (contact information below) before issuing authorization of MassHealth payment for NF services.

The ASAP must always deny authorization of MassHealth payment for NF services in the event there is a PASRR denial.

ASAPs should update applicable CAE policies and procedures to reflect this change, and ensure that impacted staff receive a copy of the revised policies and procedures.

Effective Date:

The Program Instruction is effective May 15, 2012

Contact Person:

Please contact MaryEllen Coyne, RN with any questions or concerns regarding the Program Instruction at 617- 222 -7554 or at MaryEllen.Coyne@state.ma.us

Attachments:

Copy of Level I PAS Form.
Copy of PASSR Non-Compliance Information Request Form for OLTSS.

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EOEA-PI-13- 01

TO: Aging Service Access Points (ASAPs)
Executive Directors
Nurse Managers

FROM: Ann L. Hartstein

DATE: 01/17/2013

RE: Requirements for Comprehensive Screening and Service Model (CSSM) Activities

1. Purpose

The purpose of this Program Instruction is to issue requirements for Aging Service Access Points (ASAPs) in the performance of Comprehensive Screening and Service Model (CSSM) program related activities. This Program Instruction requires all ASAPs to adopt a specified management and staffing model and protocols to perform CSSM-related activities.

This Program Instruction revises and restates CSSM program requirements, and supersedes the following previously issued instructions regarding CSSM: the ASAP RFR Sections 9.4.4, Section 9.4.3.9 and PI 11-03 Conditions for Certain Nursing Facility Approvals.

2. Background

The CSSM program, in effect since January 2005, is intended to ensure that MassHealth members and applicants seeking MassHealth coverage for nursing facility services, as well as their family members and caregivers, receive the information and care planning supports on the least restrictive setting necessary to make decisions about their future care plans and residential settings. The model is designed to ensure that consumers can participate directly in their care planning through face to face meetings with members of an Interdisciplinary Discharge Planning Team (IDPT). In addition, the

program is intended to provide the support necessary to consumers and discharge planners of nursing facilities that will ensure that consumers returning to the community receive the appropriate care and supports necessary to ensure that discharges are successful. The program model recognizes the value of communication and collaboration between consumers, CSSM staff, nursing facilities, state agency staff, and community resource agencies. This collaboration enables the development of an appropriate plan as it relates to the consumer's unique situation.

The Executive Office of Elder Affairs (Elder Affairs) has worked with the ASAP network to evaluate the CSSM program design. Our collaborative Assessment and Eligibility Workgroup has identified opportunities for improvement, including clarifications of specific staff role requirements, standardization of program protocols across the Commonwealth, and the implementation of best practices.

The CSSM program is designed to ensure that the MassHealth member or applicant and his/her family or caregivers are aware of all potential community service options. The role of the ASAP is to work with the member/applicant, family, and nursing facility to overcome barriers and assist with discharge planning by formulating and implementing a care plan that meets the member/applicant's needs in the community.

3. Definitions

3.1. **Case Closure & Tracking Form (CCTF)** – The Elder Affairs issued assessment form designed to record monthly actions and outcomes of the IDPT.

3.2. **Clinical Assessment and Eligibility (CAE)**– Assessment process by which ASAP RNs evaluate MassHealth members or applicants for clinical eligibility for nursing facility care, adult day health, adult foster care, group adult foster care, PACE, and Waiver Services.

3.3. **Community Service Planning** – The Care Manager directed process, including the coordination, arranging, and tracking of services required, to facilitate a safe discharge.

3.4. **Comprehensive Screening and Service Model (CSSM)** – A service offered by ASAPs intended to ensure that MassHealth members and applicants in nursing facilities and their family members and caregivers are actively involved in considering discharge options and, where a discharge plan is established, the consumers receive the appropriate care and support necessary to ensure a successful discharge.

3.5. **Core Team** – Those ASAP staff members who are responsible for CSSM activities, including the CSSM Program Manager and at least one Care Manager (CM) and one Registered Nurse (RN).

3.6. **CSSM Program Manager** –The key designated ASAP staff member responsible for the administration of the CSSM program and who serves as the primary contact with Elder Affairs.

3.7. **Denial** – The finding issued by an ASAP RN when a consumer does not meet the clinical eligibility criteria for nursing facility services.

3.8. Initial Assessment –The first clinical assessment for authorization of MassHealth payment of nursing facility services completed by an ASAP RN, including a visual observation of the consumer and a personal interview, unless the consumer's cognitive status would prohibit such an interview.

3.9. Nursing Facility Approval – An approval issued by an ASAP RN when a consumer meets the clinical criteria for MassHealth payment for nursing facility services for an indefinite length of stay after all attempts to overcome identified barriers to discharge have ended. In limited circumstances, a Nursing Facility Approval may be issued based on the initial clinical assessment. See further clarification in "Nursing Facility Approval" on page 6 of this PI.

3.10. Request for Services Form (RFS) – A Nursing Facility referral form to request an ASAP assessment to determine clinical eligibility for:

1. Dually-eligible consumers with both Medicare and MassHealth;
2. MassHealth members;
3. MassHealth applicants, (the date the MassHealth application was submitted to the MEC must be written on it);
4. MassHealth members who have expressed an interest, either directly, through a representative, or a positive response to Section Q of the MDS, to receive services in a community setting;
5. MassHealth members, previously approved for a long term stay, (i.e. those to whom the ASAP has previously issued a "Long Term Approval"), who the nursing facility has now identified as having potential to reside in a community setting;
6. Any dually eligible MassHealth member converting to MassHealth as their primary payer source within the next 10 days; and
7. Any member who previously received a short term approval set to expire within the next 10 days.

3.11. Retrospective Referral – A MassHealth referral that is received post-admission or post-conversion that requests retroactive MassHealth payment of nursing facility services to the date of admission or date of conversion.

3.12. Short Term Approval - An approval issued by an ASAP RN when a consumer continues to meet the clinical criteria for MassHealth payment for nursing facility services **and** requires time in a nursing facility to rehabilitate or recuperate, **and** time is needed to develop and implement a community service plan.

4. Actions

4.1 ASAP Staffing Requirements

Each ASAP shall establish a CSSM Core Team. The ASAP must identify a lead staff person, hereafter known as the CSSM Program Manager, who will be responsible for the following:

1. Ensuring the quality of the overall administration of the CSSM program in accordance with program requirements;
2. Ensuring the timeliness and quality of all CSSM documentation, including consumer and service data in SIMS; and,
3. Serving as the primary contact for the program to Elder Affairs staff.

The individual may have additional responsibilities within the organization and does not necessarily have to directly manage the nurse(s) and care manager(s) who perform CSSM activities.

In addition to the CSSM Program Manager as the lead, the ASAP CSSM Core Team must include at least one Care Manager and one Registered Nurse. Elder Affairs encourages the inclusion of an Administrative Assistant as part of the Core Team for clerical and data entry purposes. Each ASAP must attest that the CSSM Core Team staffing level is sufficient within each discipline to perform CSSM program activities in the manner and timeframe required.

4.2 CSSM Interdisciplinary Discharge Planning Team (IDPT) Members

The CSSM staff must convene an IDPT for each CSSM consumer. The IDPT must include, at a minimum, the following:

- the MassHealth Member or Applicant;
- any family members or caregivers identified by the MassHealth Member or Applicant;
- the CSSM Care Manager (CM) as appropriate;
- the CSSM Registered Nurse (RN);
- the nursing facility discharge planner;
- as appropriate and available, a representative from the local Independent Living Center; and
- Other professionals or representatives as needed or requested by the MassHealth member or applicant.

4.3 Responsibilities of IDPT Members

CSSM Registered Nurses (RN):

The ASAP RN is responsible for:

- Timely completion of nursing facility clinical determination activities, including visiting all consumers within 5 business days of the receipt of a referral;
- Weekly on-site comprehensive assessments for the purpose of reviewing the clinical data, meeting with all pertinent nursing facility staff, meeting and assessing face to face with the consumer;
- Reviewing all clinical records related to assessment activities on-site in nursing facilities; the ASAP may request that the nursing facility submit required documentation that was inadvertently not obtained or available during an on-site visit;

- Prioritizing who should begin receiving the active assistance of the CSSM Care Manager and other IDPT members to be discharged from the nursing facility, according to their current stage of rehabilitation and/or recuperation;
- Per section 9.4.3.1 of the RFR, in instances where a nursing facility is small or has minimal admission and discharge activity, on site visits may be less frequent than weekly, but never less than monthly.

CSSM Care Managers (CM):

An ASAP CM is responsible for:

- All aspects of service planning, including coordination, arranging and tracking of services to facilitate a safe discharge;
- Attending IDPT meetings as appropriate;
- Scheduling visits to each nursing facility based on the individualized needs of the consumer(s).

Nursing Facilities:

MassHealth-participating nursing facilities are responsible for assigning a Discharge Planner to work in collaboration with the IDPT to participate in regularly scheduled meetings.

4.4 Clinical Determinations

Clinical determinations with regard to authorization/denial of MassHealth payment of nursing facility services is the responsibility of the ASAP RN. Each consumer's assessment must include a visual observation of the consumer and a personal interview to determine the consumer's goals and preferences.

- Elder Affairs no longer requires an on-site assessment if the consumer is receiving hospice services or is certified by a physician to qualify for hospice services.
- At the conclusion of the determination process, the RN must issue one of the following determinations: 1.) Short Term Approval (STA), 2.) Nursing Facility Approval (NFA) (formerly known as a "Long Term Approval"), or 3.) Nursing Facility Denial.
- As noted in the RFR section 9.4.9, the ASAP must issue within two business days of making the clinical determination, the appropriate Notice of Eligibility to the MassHealth member or applicant, his/her legal guardian or eligibility representative, the provider of the Nursing Facility or community long-term care; and a MassHealth Appeal Rights and Fair Hearing Request Form with each Notice of Eligibility.

In those cases where a nursing facility has requested a nursing facility transfer and has given the ASAP less than two business days' notice, the ASAP may do a paper review based on documentation submitted to the ASAP. This documentation must include a Request for Service Form submitted by the

nursing facility and date/time stamped by the ASAP upon receipt of the referral. In this instance, the ASAP may issue a short term approval for 30 days.

- If the member received a nursing facility approval (NFA) after numerous STA's, the ASAP nurse may issue a NFA on a transfer if the consumer was transferring within the ASAPs service area. If the consumer is transferring outside the ASAP's area a 30 day approval can be given. This is to allow the receiving ASAP time to review and explore community options in their geographic area that may not have been available in the original nursing home/ASAP areas. The on-site assessment of the consumer will be done by the new ASAP to determine any new community resources to meet the member's needs.

Short Term Approval (STA):

A short term approval is issued when a consumer meets the clinical criteria for nursing facility services and requires nursing facility services to rehabilitate or recuperate, and time is needed to develop and implement a community service plan.

- Multiple short term approvals may be issued as necessary to meet the needs of the consumer and ensure the successful implementation of the community service plan, as long as the consumer continues to meet the nursing facility clinical eligibility criteria.

- The RN, in consultation with the consumer, IDPT, nursing facility, and in consideration of the consumer's needs, must determine the duration of the short term approval.

- The CDS-NF, Nursing Module, Narrative and Journal entry must be completed and the end date of the short term approval must be recorded in Nursing Module.

- The ASAP is responsible for tracking all short term approvals, utilizing the Activity/Referral functionality and Service Delivery within SAMS, as outlined in PI-09-05 (Nursing Facility Clinical Eligibility, Short Term Approval Tracking, and Noticing Procedures).

- The ASAP is responsible for notifying the nursing facility one week in advance of the expiration of the short term approval.

- The ASAP nurse must complete a Short Term Review prior to the expiration of the STA.

Nursing Facility Approval (NFA): (formerly known as a "Long Term Approval")

A nursing facility approval, issued for an indefinite length of stay, may be issued by the ASAP RN at the time of initial assessment only if the MassHealth member or applicant meets the clinical requirements for nursing facility services and meets at least one of the following criteria:

- Has a confirmed diagnosis of Alzheimer's Disease or Related Disorder when supervision for consistent interventions for safety are needed;
- Has end stage (less than 6 months) terminal illness, as certified by a physician;
- Is comatose / unresponsive;

- Has complex multi-system failure resulting in permanent dependence in all of the following: bathing, dressing, toileting, transfers, and mobility.

The CDS-NF, Nursing Module, Narrative and Journal entry must be completed, and the criteria for nursing facility approval must be recorded in Nursing Module.

- If, after the issuance of an initial short term approval or multiple short term approvals, the IDPT cannot develop a successful community service plan, the RN may issue a Nursing Facility Approval, as long as the member/applicant continues to meet nursing facility eligibility criteria.

- All barriers to discharge and attempts to overcome those barriers must be documented in the nursing module and the journal notes. The "Other" selection is not permissible to use for this purpose.

In cases of an initial Nursing Facility Approval and of Nursing Facility Denial, the CDS-NF, and Nursing Module, Narrative and Journal entry are required.

4.5 Documentation Requirements: Journal Entry, CDS, CCTF

Journal Entry:
The date the CSSM case is opened, as well as all related CSSM activities including but not limited to: phone calls, onsite visits/assessments and meetings must be documented in the consumer journal. The documentation should include community services the IDPT is attempting to secure to meet the consumer's needs.

CDS Documentation:
The RN is required to complete the current CDS-NF, as a new assessment, Narrative and Journal entry for all conversions (includes retrospective screenings), nursing facility transfers, continuation of stay and short term reviews.

If a consumer is discharged from a nursing facility and enrolled in any Home Care Service Program, the CM must complete the CDS-CM thus using the most current CDS for assessment. If the RN and CM are both doing an assessment then it would be appropriate to use the CDS-Full.

For consumers participating in Money Follow the Person (MFP), the risk plan and back up plan must be completed and also identified in the journal entry.

Case Closure and Tracking Form (CCTF) Documentation:

For **any** consumer that the CSSM team assisted with discharge, a CCTF is required with the following exceptions:

- For DDS consumers;

- When an initial Nursing Facility Approval is granted;

- When a Nursing Facility Denial is granted.

For any consumer who is participating in MFP, the questions in the MFP section must also be completed on the CCTF.

The SIMS CCTF assessment form must be completed within 5 business days from the date of discharge, and at days 30, 60, and 90.

4.6 Monitoring Consumer Well-Being After They Have Returned to a Community Setting:

Each CSSM consumer must be monitored by either the CM or RN for 90 days after discharge from a nursing facility. This includes those consumers with whom the ASAP assisted with the discharge planning but never converted to MassHealth as the primary payer source.

Monitoring of the consumer's well-being and the appropriateness of their community service care plan will be done at 30, 60 and 90 days.

All tracking must be conducted by telephone and/or a home visit. Documentation of the contact must be included in the consumer's Journal and include the following:

- Purpose of the call (e.g. post-discharge tracking at day 30);
- The consumer's health and functional status;
- Any changes in the consumer's condition since the prior monitoring call;
- Any adjustments in the consumer's care plan, (e.g. new living arrangements), including readmission to a hospital or nursing facility;
- Any anticipated activities to be completed before the next scheduled call;
- A summary statement of the consumer's status and the effectiveness of the community service plan at the end of the post-discharge monitoring calls.

4.7 Requirements for Reporting to Elder Affairs:

Changes in CSSM Core Team Staffing Requirements:
The CSSM Program Manager must report any issues that have interfered with, or will interfere, with the ASAPs ability to perform CSSM program activities in the timeframes and manner described in this Program Instruction. An ASAP cannot suspend in-person visits to nursing facilities at any time without prior consultation with and permission from Elder Affairs.

Effective Date:
This PI is effective February 1, 2013.

Contact Information:
All questions regarding this Program Instruction should be directed to Mary DeRoo, RN, Director of Home and Community Programs, at Mary.deroo@state.ma.us.

APPENDIX D – GUIDELINES

- GAFC Guidelines
- PC Guidelines

COMMONWEALTH OF MASSACHUSETTS

DIVISION OF MEDICAL ASSISTANCE

GROUP ADULT FOSTER CARE GUIDELINES

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SECTION 1: INTRODUCTION

The purpose of the Adult Foster Care Program is to provide room, board, and personal care services in a protected housing environment to elderly or disabled individuals who are at imminent risk of institutional placement. These individuals, and the Adult Group Foster Care Program provider must meet the criteria and guidelines set forth by the Department of Public Welfare (Medical Assistance Program).

SECTION 2: DEFINITIONS

A. **Adult** – any person twenty-two (22) or over.

B. **Department** – The Department of Public Welfare, Medicaid Division.

C. **Medical Leave of Absence** -- a period of time during which the participant is temporarily receiving care in a hospital or nursing home.

D. **Non-Medical leave of Absence** – a period of time during which the participant is absent from their home for other than medical reasons.

E. **Participant** – and elderly or disabled person residing in a Department-approved group foster home setting.

F. **Personal Care Services** – services prescribed by a physician in accordance with a plan of treatment and provided under the supervision of a licensed nurse. Such services provided through adult foster care may include; assistance with and management of medications: assistance with activities of daily living such as bathing, dressing, ambulation; and other services which are necessary for the maintenance of a healthful environment.

G. **Provider** – the agency/organization that contracts with the Department to administer an Adult Foster Care Program.

H. **Recipient** – a Medicaid-eligible person receiving Medicaid-purchased adult foster care services.

I. **Respite** – a period of time when the foster care provider requires special home health or ADH services to provide appropriate care of the participant.

J. **Room and Board** – an amount that the participant contributes from SSI, SSA or other personal resource to the Provider for living space and meals, if applicable.

K. **Twenty-Four Hour Supervision** – the foster care provider is obligated to assume responsibility for the participants safety and well-being at all times. The foster care provider will make an assessment regarding the ability of a participant to manage safely in the foster care setting and provide whatever assistance is needed to assure each participants safety and well-being twenty four (24) hours a day, seven (7) days a week.

L. **Unit** – a residential setting in which no more than three (3) people share a single bedroom and bathroom.

SECTION 3: PROVIDER ELIGIBILITY

Providers of adult foster care programs for disabled/elderly adults may include certified home health agencies, licensed hospitals, home care corporations and other community agencies or housing organizations who wish to offer services and can meet the requirements outlined herein. To be eligible, Providers must also assure that their group facilities comply with all applicable local and state fire safety code and that no more than three (3) individuals reside in a unit.

SECTION 4: PROVIDER RESPONSIBILITY

The Provider:

A. Ensures that all regulations and guidelines of the Department for the Adult Foster Care Program are met. The Provider must sign a written agreement to that effect.

B. Ensures that agreements are signed with local acute care facilities, whereby they agree to accept and treat participants in the appropriate setting (i.e., in emergency rooms, OPD clinics, or as an inpatient), if the participant is in crisis.

C. Notifies the Local Welfare Office and Medicaid central office within one (1) work day when the participant is admitted to a nursing home.

D. Establishes a liaison network with the hospital continuing care coordinators, home care corporation outreach workers, certified home health agencies, church groups, and other social and health agencies for the purpose of identifying potential participants and identifying local social service resources which could be utilized by group foster care program participants.

E. Identifies and interviews potential participants.

F. Completes Department-approved participant assessment forms.

G. Sends a copy of the initial participant assessment form to the Department for approval before the participant start date in the foster care program.

H. Plans, implements, and evaluates orientation sessions for the foster care staff to include physical, social, and emotional aspects of aging and basic health-related practices such as bathing, transferring and other activities of daily living.

I. Ensure that agreements are signed between the participant and the group foster care provider before the participant start date in the foster care program.

J. Provides the personal care staff with specialized teaching sessions focusing on the identified needs of the participants. Examples of sessions could be: ostomy care, multiple medications, explanation of self-help devices, etc. If there is a skilled nursing component, a certified home health agency nurse could provide this instruction with follow-up.

K. Visits the participant within three (3) days of the placement, while the personal caregiver is present. Visits then occur weekly for the next four (4) weeks, then monthly.

L. Provides participant with a twenty-four hour emergency assistance device.

M. Arranges for alternate placement for participants who must leave the foster care setting.

N. Identifies and secures medical approval for participation in the program from the participant's primary care physician.

O. Assess ability of participant to manage safely in the particular group foster placement. The program must assess each participant in terms of the following characteristics:

- orientation to time, place, person;
- good judgment;
- functional independence to care for his/her personal needs; and
- physical ability to leave the home in case of an emergency.

P. Submits semi-annual participant health status reports and patent care plans to the participants primary care physician for review and approval. Participants must receive an annual physical examination.

Q. Notifies the Department when a recipient requires "respite", i.e. home health, ADH or placement out of their home.

R. Ensures coordination of health-related services.

S. Establishes an outreach plan designed to reach that population which is at high risk of institutionalization and informs the community at large of the program services.

T. Submits a discharge plan on a Department-approved form to the Department for each participant leaving the program within one (1) week of the participant's discharge.

U. Agrees to keep such records as are necessary to disclose fully the services provided to participants and to furnish the Department, upon request, with such information and other program statistics necessary for monitoring and evaluation of the program.

V. The Adult Foster Care Program Director or his/her designee shall be responsible for notifying the Department by telephone immediately by written confirmations in the following situations:

- fire, accident, injury or evidence of serious communicable disease contracted by staff or participants;
- participants unplanned departure from the foster home;
- change of personnel;
- plans to increase the program's capacity (i.e., would not be approved beyond 1:10 staff ratio);
- discrepancies in the management of participants funds; and
- termination of program operation.

SECTION 5: HOURS OF OPERATIONS

The Provider's administrative office shall be open at least eight (8) hours a day, five (5) days a week. The agency must arrange for emergency twenty-four hour service to participants.

SECTION 6: STAFFING

A. PROGAM DIRECTOR

The Provider shall employ a full-time, qualified program director to administer the required program services. The program director must possess a minimum of a masters degree in social work and previous experience in working with disabled/elderly adults in a community setting. An equivalent degree and/or experience may be substituted for the educational requirement. The program director should be carefully chosen for his/her ability to assume an administrative, leadership role, and to perform the following responsibilities:

- direction and supervision of all aspects of the program;
- supervision of all staff;

- development and implementation of the program's outreach plan;
- coordination of the admission process;
- performance of program and staff evaluation;
- fulfillment of the reporting requirements of the Department; and
- fiscal administration of the Adult Foster Care Program including billing, budget preparation and required financial reports.

The Provider shall arrange for backup coverage for the program director during his/her absence due to illness or vacation.

B. REGISTERED NURSE

The Provider shall employ a registered nurse (RN) to assist the program director in administrative responsibilities and to work within the medical component of the program. The responsibilities of the registered nurse will include and not be limited to:

- evaluation of potential participants;
- contact with participants primary care physician to obtain medical information and physician clearance;
- completion of the medical components of the participant assessment form;
- monitoring of the participants health status and completion of semi-annual participant health status report and patient care plan;
- planning, implementation, and evaluation of foster care setting;
- provision of case management: and
- review and supervision of personal care services at least every sixty (60) days.

C. PERSONAL CAREGIVER

The Provider shall employ or retain services of personal caregivers who are certified personal care homemakers or certified home health aides. Equivalent training or experience could be substituted for the certification. The responsibilities of the personal caregiver shall include executing the approved care plan.

D. STAFF RATIO

The Provider will ensure that there is a staff ratio of one (1) professional/caregiver staff to each ten (10) participants.

E. CLERICAL STAFF

The Provider will also ensure adequate clerical support from an individual(s) who has a basic understanding of medical terminology and who has experience in office management (typing, billing, communications via telephone, etc).

SECTION 7: PARTICIPANT ELIGIBILITY

The Department pays for Adult foster care services provided to adult medical assistance recipients (Categories of Assistance 01, 01, 02, 03, 05, 06, 07, and 08) who meet the eligibility requirements below.

A. Participants may include, but are not limited to the following:

1. individuals who currently reside in the community or are hospitalized and are at high risk of requiring nursing home placement;
2. patients discharged from nursing homes; and
3. chronically disabled individuals who require supervision.

B. Eligible adult foster care participants are likely to require twenty-four hour supervision, routine assistance with activities of daily living such as bathing, dressing, walking, and assistance with management of medications.

C. Participants must submit certification from their primary care physician that adult foster care services are appropriate to meet the medical needs of the participant.

D. Participants must be able to meet the participant characteristics and responsibilities outlined in Section 8.

SECTION 8: PARTICIPANT CHARACTERISTICS AND RESPONSIBILITIES

A. **PARTICIPANT CHARACTERISTICS**

The participant:

- understands responsibilities inherent in his/her role as a participant in the program;
- can communicate his/her needs;
- is oriented to time, place and person but may have intermittent periods of confusion or forgetfulness;
- may require one-person assist with transfers and ambulation;
- requires daily supervision and may require some assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting;
- may need assistance with feeding;
- is continent on admission or an active participant in an ongoing bladder/bowel program;

- may require supervision with medications; and
- does not exhibit behavior harmful to himself or others.

E. RESPONSIBILITIES OF THE PARTICIPANT

The participant must:

- sign an agreement outlying his/her responsibilities;
- pay the foster care provider room and board at the beginning of each month. If the participant is placed during the month, he/she will pay a pro-rated amount;
- must give a two (2) week written notice of intent to discontinue program services;
- agree to follow the plan of care established with Provider and physician;
- notify the foster care provider if there is any change in his/her health status; and
- sign a "release from responsibility" agreement releasing the foster care provider if he/she decides to leave without two (2) week prior notice. This release is signed the day of entrance to the foster care program home.

SECTION 9: ELIGIBILITY CRITERIA

A. PERSONAL CAREGIVERS

1. Personal caregivers who are responsible for the participants well being, must not have a physical or emotional problem which would interfere with normal daily functioning and the provision of appropriate care.

2. The Department does not reimburse family members either natural or in-laws for providing personal care services.

B. PHYSICAL REQUIREMENTS FOR FOSTER CARE UNITS/FACILITIES

1. Exterior must show adequate maintenance in regard to paint, stairs, railings, windows, screens, storm windows, and grounds. The interior of the unit must be adequately heated and clean, and show evidence of continued household maintenance.

2. Interior floors, ceilings, walls and furnishings must be free of vermin, clean, in good repair, and adequately maintained. For example:

   - **Safety and Fire Protection**: Hallways used by participants must have night lights. There must be a written predetermined fire plan for exiting in an emergency which shall be reviewed monthly with the participant. The participant

must have an unobstructed fire escape route out of the unit. There must be smoke detectors powered by batteries. These detectors, when activated, must set off an alarm that is audible in all sleeping areas. Periodic fire drills must be conducted during which the participant must be instructed in following available escape routes.

- **Stairs**: Stairs that are located inside or outside the home must have a railing.
- **Accessibility for Physically Handicapped**: The facility and the unit must be accessible to meet the specific needs of a physically handicapped participant. Architectural Barriers Board Guidelines may be consulted.

SECTION 10: FOSTER CARE PROGRAM RESPONSIBILITIES

A. Ensures that the facility and the unit are properly maintained so that it is consistently in compliance with all eligibility criteria.

B. Is responsible for providing twenty-four hour supervision of the participant.

C. Ensures that the following are provided as needed:

1. Laundry services for bedding, towels, and washable personal clothing.
2. Laundry equipment and telephone for local calls for use by the participant.
3. Supervision and assistance with activities of daily living.
4. Cleaning and general housekeeping in participants areas.
5. Assistance with shopping.
6. Assistance with arrangements for transportation.
7. Periodic evaluation of participant's clothing to ensure adequate apparel, especially during the colder months.

D. Provides ongoing supervision of the participant's health related activities such as:

1. Reminding participant to take prescribed medications;
2. Refilling prescriptions in a timely manner;
3. Assisting with or arranging for transporting participant to the attending physicians office;
4. Complying with health care instructions explained by the attending physician, sponsoring agency, and/or home health agency; and
5. Promptly obtaining medical care from attending physician or hospital emergency room if participant becomes ill.

E. Must notify Medicaid as soon as possible upon the occurrence of any of the following crises:

1. Fire, accident, injury or evidence of serious communicable disease contracted by staff, participants or foster families;
2. Participant's unplanned departure from foster adult care.

SECTION 11: ADMISSION PROCEDURE

A. PHYSICIANS CLEARANCE

The Provider shall obtain the following information from the participants attending physician prior to admitting the participant to the program:

- a listing of active and pertinent inactive medical problems;
- a medical history that indicates that a physical examination has taken place within the past three (3) months;
- a current list of medications, diet, and treatments;
- a statement indicating any physical/emotional limitations to the candidate's participation in activities planned by the foster care program; and
- a statement from the attending physician certifying that the adult foster care service is appropriate to meet the medical needs of the participant.

B. PRE-ADMISSION PROCEDURE

The program director or designee will review all foster care participant applications. A pre-admission interview shall be conducted with the participant and his/her family by the program director and/or designee in their home or other appropriate setting. The interview should provide the staff with information on the general health characteristics, psycho-social condition and nutritional habits of the individual, a description of the participants previous home support system and other relevant data. The interview process should acquaint the participant and his/her family with the services offered by the Provider. The participant assessment form shall be completed following the pre-admission interview. If the potential participant is appropriate for the group adult foster care program, he/she and the family shall be notified within one (1) week after the interview. Likewise, if the potential participant is not appropriate, he/she and family must be notified within one (1) week after the interview. The reason the participant was not selected must be explained.

When the program director and/or his designee has determined that a participant is suitable, arrangements must be made for a personal care provider.

C. ADMISSION AGREEMENT

The participant and the Provider shall sign a letter of agreement. This agreement states clearly each party's responsibilities. The agreement must be signed in the presence of the program director/designee on the day of, or prior to, the participant's admission into the program. A copy of the agreement is given to each interested party. The original is kept on file by the Provider.

D. EVALUATION

The program director will conduct routine on-site visits to the foster care setting. On-sites shall occur weekly during the first four (4) weeks when the personal are provider is present and then at least monthly. If problems arise, the program director can use his/her discretion as to the need for more frequent visits.

SECTION 12: DISCHARGE PROCEDURE

A. A participant shall be discharged from the program under the following circumstances:

- (s)he demonstrates sufficient improvement for more independent living and has attained maximum benefit from the program;
- (s)he requires specialized institutional care due to illness;
- (s)he develops behavioral problems and may endanger other participants or caregivers;
- (s)he wishes to discontinue participation in the Program; or
- (s)he does not fulfill the obligations of the written agreement.

B. When a participant is to be discharged from the program, the Provider shall prepare a discharge plan for the participant on a Department-approved discharge form which shall include the following:

- reason for leaving the program;
- participants destination;
- recommendations for continuing care, (e.g., home care corporation, home health agency, nursing home, chronic hospital); and
- referral to community service agencies, if appropriate, when the participant is returning to more independent living.

The Provider shall discuss and agree upon the discharge plan with the participant as far in advance of discharge as possible. Documentation of this must be included in the participants record.

SECTION 13: ADMINISTRATIVE PROCEDURES

A. MANAGEMENT OF PARTICIPANTS FUNDS BY FOSTER CARE PROVIDER

The participant is responsible for the management of his own funds. If, however, the participant elects to have the foster care provider manage his monies, he must sign a written agreement requesting this service. One copy of the agreement is to be maintained by the Provider in the participant's record, the second is to be kept by the participant.

If the funds are managed by the foster care provider, the following procedures must apply:

1. The participant submits his check(s) (SSI, SSA, etc.) to the foster care provider; and
2. The foster care provider records the date of receipt, the type of income, and the amount of each check in a ledger book with pre-numbered pages. All the participants monthly expenses, including room, board, medical, and personal expenses are to be accurately accounted for. Receipts are to be collected for expanses over five dollars (5.00). When the monies accrue to the amount of $200, the money should be deposited into an interest bearing account. The passbook is to be in the participants name.
3. The program director or his/her designee will review the ledger book semi-annually or on request in order to ensure timely and accurate accounting of monies.

B. **RESPITE CARE**

1. Respite care may be provided if the recipient meets other eligibility criteria for those services. The Department will reimburse existing service providers for respite services as follows:

   - eight (8) hours/week (non-cumulative) may be taken in two (2) four (4) hour periods; or
   - two (2) days/week in adult day health setting (non-cumulative); and
   - fourteen (14) 24-hour periods per year (non-cumulative).

2. Respite care may be arranged in several ways depending on the needs of the participant.

   - a homemaker/home health aide may be brought into the home;
   - a companion may be assigned to the participant;
   - the participant may be temporarily placed with an approved foster family program for the period of respite; or
   - the participant may be admitted to a nursing home or rest home.

F. MEDICAL LEAVES OF ABSENCE FOR MEDICAID RECIPIENTS

The Department will pay the costs of personal care and the administrative fee exclusive of the participant-paid amount, where applicable, to reserve a bed for up to thirty (30) days of medical absence per calendar year. The purpose of a medical absence allowance is to minimize the physical and emotional stress related to acute hospitalization or admission to a nursing home and to ensure that the participant can return to the foster care setting without administrative delay following such an admission.

G. NON-MEDICAL LEAVES OF ABSENCE FOR MEDICAID RECIPIENTS

The Department will pay the costs of personal care and the administrative fee exclusive of room and board, where applicable, for up to fifteen (15) days per calendar year when the participant is absent from the foster care program for non-medical reasons. A day of absence is defined as an absence from the program for the purpose of spending the night at another location and an absence of greater than twelve (12) consecutive hours during any twenty-four hour period from midnight to midnight.

H. OTHER HEALTH AND SOCIAL SERVICES

Participation in this Program will not preclude the participant from receiving any other needed health or social services, except for those specifically included in the adult foster care agreement. The participant is not eligible to receive home health aide services while participating in foster care, unless this service is part of the approved respite plan.

SECTION 14: RECORDKEEPING REQUIREMENTS

Group Adult Foster Care Programs are required to keep the following records for all applicants and participants. Records must be retained for a period of four (4) years.

A. APPLICANT RECORD

The following records must be kept for each applicant, or participant:

- application and supporting documents;
- statement of decision and reasons for decision; and
- any other relevant data.

B. PARTICIPANT RECORD

The following records must be kept for each participant:

- participant assessment form;
- participant information (family names, addresses, telephone numbers; physician name, address, and telephone number; service agency names and telephone numbers, etc.);
- physician assessment and approval to participate;
- copy of written agreement between participant and foster care program;
- copy of request for foster care program to manage participant personal funds, if applicable;
- participant care plan developed by a registered nurse;
- copy of ongoing monitoring/assessment of participant and unit from site visits (progress notes);
- participant health status report; and
- official Department notice of monthly income of recipient.

SECTION 15: REIMBURSEMENT

The Department of Public Welfare determines the maximum allowable fee for adult foster care services and recommends rates to the Office of Purchased Services for approval. Such services include personal care and administrative services provided by the Medicaid certified program. The Department can only reimburse for personal care and administrative services provided to Medicaid eligible recipients. The Medicaid participant will directly pay the foster care provider a fee for room and board.

ATTACHMENT A
HOMEMAKER STANDARDS AND PERSONAL CARE GUIDELINES
05/01/2014

HOMEMAKER (HM) service includes assistance with: shopping, menu planning, laundry, and the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

PERSONAL CARE (PC) service may take the form of hands-on assistance (actually performing a task for the consumer) or cuing and supervision to prompt the consumer to perform a task. Such assistance may include assistance in bathing, dressing, personal hygiene, other activities of daily living, and reminders with medications in accordance with EOEA's Personal Care Guidelines. This service may include assistance with preparation of meals. When specified in the care plan, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the consumer, rather than the consumer's family. Personal Care services must be provided in accordance with EOEA's Personal Care Guidelines contained in this attachment.

SUPPORTIVE HOME CARE AIDES (SHCA) perform personal care and/or homemaking services in accordance with the definitions in this attachment, in addition to providing emotional support, socialization, and escort services to consumers with Alzheimer's Disease/Dementia or emotional and/or behavioral problems.

In accordance with PI-11-01, Standards for Home Care Program Consumers with Alzheimer's disease or a related disorder (ADRD Standards), Care Planning section 4.d. Supportive Home Care Aide; The standard personal care service is not recommended for persons with a cognitive impairment and ASAP Training and Care Coordination section 3.; All care plans for consumers who are at risk due to a cognitive impairment are reviewed by an interdisciplinary team that includes an ASAP staff member trained by the Alzheimer's Association. If the care plan includes personal care, the personal care plan must be developed or reviewed by an ASAP RN who has received the required training.

The 87-hour SHCA training includes the 75-hour HHA course and an additional 12 hours of training relating to the responsibilities of a SHCA. When a Provider Agreement is in place to provide Home Health Services, the SHCA may provide assistance with ADLs and personal care as defined in the Home Health Services Attachment A Description for Home Health Aide Services (HHA).

Refer to PI-14-03, Coordination and Reimbursement of Home Health Services Protocol, regarding the plan of care.

1. PROVIDER POLICIES AND PROCEDURES

a. A sufficient number of HM/PC workers should be available to meet the needs of consumers accepted for service. The provider shall accept or reject an ASAP service request by the end of the next business day.

b. Providers shall have job descriptions and salary scales.

c. A Criminal Offender Record Information (CORI) check shall be performed in compliance with the laws of the Commonwealth and any applicable regulations and guidelines issued by EOEA.

d. Personnel files shall be maintained with documentation on the results of the interview and references; completed CORI investigation; training/in-service certificates, waivers and exemptions; if appropriate, PC skills checklist; supervisory visits; and performance reports and annual evaluations.

e. Providers shall have policies regarding consumer privacy and confidentiality and non-discrimination in service delivery. These policies shall prohibit discrimination against persons with AIDS/HIV and ensure that information concerning AIDS/HIV status is not apparent or accessible and is not released to anyone without specific written consent.

f. Providers shall have an infection control plan to prevent occupational exposure to blood-borne illnesses including AIDS/HIV and Hepatitis B. The Center for Disease Control/OSHA guidelines for standard precautions shall be followed.

g. Providers shall have policies to ensure tuberculosis screening and testing is performed for all provider staff who come into direct contact with consumers, using the CDC Tuberculosis Guidelines.

h. Providers shall have policies for handling allegations of loss, theft, and/or damage of consumer property.

i. Providers shall have a policy that prohibits the handling of the consumer's money that includes, but is not limited to: reconciling checkbooks, writing checks, using bank cards/Automated Teller Machines (ATMs), or providing banking services. Checks may be used to pay for groceries if the check is written to the store. The ASAP may establish these special arrangements, including use of the Electronic Benefit Transfer card for grocery shopping, with the store.

j. A plan shall be in place for dealing with emergencies in the consumer's home, including accessing emergency medical services and contacting provider supervisors.

k. Providers shall have a policy for incidents when the consumer does not answer the door, including the use of reasonable efforts (e.g. telephone) to gain access to the home. The provider will contact the ASAP immediately to determine the next course of action.

l. Providers shall have policies to ensure compliance with the Department of Public Health's (DPH) requirements regarding prevention, reporting, and investigation of abuse by homemakers and home health aides under 105 CMR 155.000 *et seq*. as outlined in EOEA-PI-07-03. Specifically, providers shall comply with all DPH regulatory requirements regarding hiring staff and reporting abuse.

2. REPORTABLE INCIDENTS

a. If there is reasonable cause to believe a consumer has been abused, neglected, or financially exploited, the provider must immediately, day or night, contact the 24-hour ELDER ABUSE HOTLINE at 1-800-922-2275.

b. The Provider must report to the ASAP the same business day any hospitalization, addition or loss of a household member, consumer's absence from the home, alleged theft, alleged breakage of consumer's possessions, injury to employee or consumer, or consumer complaint.

c. The consumer and ASAP must be notified of a canceled visit or any variation in service delivery from the written authorization.

d. The provider must report to the ASAP by the next business day a new consumer address, name, or telephone number; new MD, new diagnosis, and employee complaints.

3. QUALIFICATIONS

a. Providers shall ensure that PCHMs are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures, and standards of living.

b. Providers shall ensure that supervision is provided by Social Workers, Registered Nurses, and/or professionals with expertise related to the consumer profiles.

4. TRAINING AND IN-SERVICE EDUCATION

a. Prior to placement, all HM/PCHMs shall receive a 3-hour orientation (Mass Council's Training Curriculum or equivalent) with a 1/2-hour session on communicable disease including AIDS/HIV and Hepatitis B, infection control, and the principles of standard precautions.

b. 40-Hour Homemaker Training: In addition to the 3-hour orientation, all HMs must complete 37 hours of training within the first 6 months of employment. The training shall include the nature and transmission of HIV/AIDS, standard precautions and other infection control practices, and protection of consumer confidentiality regarding AIDS/HIV. The Mass Council's Home Care Aide course is recommended. Other courses may be used that contain the same subject matter and number of hours per subject.

c. 60-Hour Personal Care Training: PC Workers must have completed the 20-hour PC training and the 40-hour HM training before providing PC. The Mass Council's PC training outline is recommended, with 17 hours of class instruction, including a review and demonstration on universal precautions, and a 3-hour practicum. The 3-hour practicum shall include an assessment of competency in each PC task before placement by using the Mass Council's skills checklist.

d. Training must be conducted by an RN with a valid license in Massachusetts. A Registered Physical Therapist is recommended for the training on mobility. Return demonstrations are required on the hygiene and mobility sections of the training. The use of gaits belts is strictly prohibited.

e. 87-Hour Supportive Home Care Aide (SHCA) Training: SHCAs must complete the following 87 hours of training before providing Supportive Home Care Aide Services:

i) A 3-hour orientation (Mass Council for Home Care Aide Services Training Curriculum or equivalent) with a 1/2-hour session on communicable disease, including AIDS/HIV and Hepatitis B, infection control, and the principles of universal precautions.

ii) The 57-hour Personal Care training set forth in the Personal Care Homemaker Standards issued by EOEA.

iii) An additional 15 hours of Home Health Aide (HHA) training. The 75-hour HHA course prepared by the Mass Council is recommended. Other courses may be used if they contain the same subject matter and same number of hours for each subject.

iv) An additional 12 hours of training related to the responsibilities of a SHCA. There are two SHCA training tracks: Mental Health Supportive Home Care Aide and Alzheimer's Supportive Home Care Aide.

a. **Mental Health Supportive Home Care Aide** - The following topics are recommended for Mental Health Supportive Home Care Aide: limit setting, depression, personality and character disorders, substance abuse, abuse and neglect, and the stigma of mental illness and behavioral disorders. The Mass Council's curriculum is recommended.

b. **Alzheimer's Supportive Home Care Aide** - The following topics are recommended for Alzheimer's Supportive Home Care Aide: understanding Alzheimer's and Dementia, habilitation therapy, communication skills, personal care, behavior as communication, and working with families. The Alzheimer's Association curriculum is required.

f. Certificates: Providers must award a certificate to those who have successfully completed the HM, PC, or SHCA training.

g. Training Exemptions: The following individuals are exempt from training requirements:

i) Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) with documentation of successful completion of a nursing program approved by the Massachusetts Board of Registration in Nursing or, when applicable, the appropriate nurse training approval authority in the state where the training was conducted;
ii) Physical Therapists (PTs) and Occupational Therapists (OTs) with documentation of successful completion of a training program approved by the Massachusetts Board of Registration or, when applicable, the appropriate training approval authority in the state where the training was conducted;
iii) Students enrolled in a nursing program approved by the Massachusetts Board of Registration in Nursing, with documentation of satisfactory completion of "Fundamentals of Nursing" course and/or one Medical /Surgical clinical nursing rotation;
iv) Certified Nurse's Aides with documentation of successful completion of a certified nurses aide training program;
v) Home Health Aides with documentation of successful completion of a home health aide training program;
vi) PCHM's with documentation of having successfully completed the 60-Hour PC Training Program;
vii) HM's with documentation of having successfully completed the 40-Hour Training Program; and
viii) HMs with documentation of having successfully completed the Homemaker Training Waiver Procedure, described in the Mass Council's HTWP Guide, are exempt from the 37-hour HM training program.
ix) No exemptions for the additional 12-hour SCHA training.

h. NOTE: All new employees exempt from any of the training components must receive the 3-hour orientation described in the Mass Council Training Outline.

In addition to providing a basic three-hour orientation, agencies should determine based on each individuals training how much, if any, supplemental training to homecare is recommended.

i. Training Facilities: Agencies providing PC training shall have appropriate training facilities and equipment. A minimum standard of equipment shall include a bed with side rails, linen and blanket, running water and basins, towels and washcloths, chair, commode, wheelchair, and walker. A variety of teaching methodologies such as lectures, equipment demonstrations, visual aids, videos, and handouts shall be used.

j. Supervisors and other professionals shall provide on-going in-service education and on-the-job training aimed at reinforcing the initial training and enhancing skills. This may be carried out with videos, lectures, group discussions, and demonstrations.

k. A minimum of 6-hours per year of on-going education and training is required for all HMs and PC HMs. These hours shall be pro-rated for part-time employees. One to one PC supervision may comprise one-half of the required hours. Instruction and reinforcement of universal precautions and infection control procedures count toward the required hours.

l. Providers shall ensure that SHCAs receive a minimum of 12-hours per year on-going in-service education and on-the-job training provided by supervisors and other professionals. This may be carried out in a variety of ways such as video presentations, lectures, group meetings and demonstrations.

5. SUPERVISION

a. Supervision shall be available during regular business hours and on weekends, holidays and evenings for HMs, PC Workers, and SHCAs providing services to consumers during these times.

b. Supervision shall be carried out at least once every three months by a qualified supervisor. In-home supervision shall be done in a representative sample of consumers.

c. PC Introductory Visits, including SHCAs providing personal care: On the first day of service in the consumer's home, a PC Worker shall receive an orientation from an RN to demonstrate the PC tasks. During this visit the PC Worker will demonstrate competence in the PC tasks assigned in the care plan. LPNs may carry out the orientation visits if the LPN has a valid license in Massachusetts, is working under the direction of an RN, and an RN from the ASAP has conducted an initial home visit to assess the need for PC prior to implementing the care plan.

d. PC Supervision: An RN shall provide in-home supervision of PC Workers at least once every 3 months with a representative sample of consumers. A written performance of PC skills shall be completed after each home visit. LPNs may provide in-home supervision if the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision a minimum of 20-hours per week and is responsible for the field supervision carried out by LPN.

e. SHCA Weekly Support: Each SHCA shall receive weekly support through training/in-services, team meetings, or supervision that includes in-home, by telephone, or in person. Team meetings shall be held quarterly and shall include SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA.

6. CONSUMER RECORDS

Providers shall maintain a record in a secure setting for each consumer receiving service. Access to consumer records shall be limited to provider staff involved with direct care of the consumer and appropriate administrative staff in compliance with EOEA’s Instruction on Privacy and Confidentiality. The record shall contain consumer information provided by the ASAP and the following information:

Consumer Information available for viewing in Provider Direct:

- source/date of referral,
- documented Risk level,
- names of ASAP care managers, physicians, family/friends,
- date of service initiation and tasks to be performed,
- hours and duration of service/subsequent changes,
- record of services provided, and
- date of and report on termination.

Consumer information not available for viewing in Provider Direct:

- medical and/or functional status,
- release of information forms, if applicable,
- notes regarding supervisory visits, team meetings, etc., and,
- reportable incidents (Section B).

PERSONAL CARE GUIDELINES

The goal of Personal Care (PC) Services is to provide care in a community setting, with the aim of maintaining the dignity and independence of consumers in a community setting for as long as possible.

Personal Care (PC) services provide physical assistance and verbal cuing with personal care tasks such as bathing, dressing, grooming, ambulation, and transfers. PC services are provided to consumer who, based on an assessment performed by an Aging Service Access Point Registered Nurse (ASAP RN), need assistance with these types of services.

The ASAP RN assesses the consumer's overall functional and clinical status, the type and amount of care needed, the consumer's environment, and current support systems, both formal and informal, in determining the appropriateness for PC.

Consumers with conditions/diagnoses that may not be appropriate for PC services include, but are not limited to: consumers with extensive paralysis or total immobility, consumers requiring assist of two or use of a mechanical lift, severe contractures, open wounds, certain types of fractures including, but not limited to those casted to immobilize, unstable medical conditions, and those that require special skin care.

The ASAP RN collaborates with the provider RN to ensure an individualized, comprehensive, and effective care plan for each consumer. The provider RN is responsible for orientation and ongoing supervision of the PC Homemaker (PCHM) to the care plan developed in collaboration with the ASAP RN. Licensed Practical Nurses (LPN), working under the supervision of an RN, may perform PCHM orientation and supervision in accordance with Attachment A Homemaker Standards.

1. BATHING

a. Sponge bathing is allowed to maintain personal hygiene.

b. Hot water must be well controlled and utilized with extreme caution.

c. Bath oil products may not be used.

d. Tub baths and showers are allowed on a case-by-case basis only after the ASAP RN has completed a nursing assessment. Consumers with conditions/diagnoses that may not be suitable for tub and shower baths include but are not limited to: consumers with a history of falls, severe osteoarthritis, severe osteoporosis, compression fractures, advanced neuromuscular disease, unmanageable seizure disorders, cancer with metastasis to the bone, peripheral vascular disease, severe cardiac/respiratory disease, vertigo, obesity, open wounds, and certain types of fractures including, but not limited to those immobilized with a cast. This may include a fairly recent hip fracture.

e. Prior to approving a tub bath or shower, the ASAP RN must determine that no physical barriers exist that prohibit immediate access to the consumer in the event of an emergency.

f. The following safety equipment is required for tub baths and showers: grab bar(s); a rubber mat, nonskid surface, or decals inside of the tub/shower; and a rubber backed floor mat outside of tub/shower. A tub/shower stool must be present when determined to be necessary by the ASAP RN.

g. In certain cases, when it is not feasible to install safety equipment such as grab bars, the ASAP RN may waive the requirement of safety equipment when determining that the lack of safety equipment does not put the consumer's safety at risk. The requirements regarding nonskid surfaces and the use of a rubber backed floor mat outside of the tub may not be waived.

h. Complete bed baths are allowed on a case-by-case basis after the ASAP RN has completed a nursing assessment. The PCHM cannot take responsibility to turn, lift, or roll the consumer, but may assist the primary caregiver who is taking responsibility for these tasks.

2. SKIN CARE

a. The application of over the counter emollients, excluding bath oil products, is allowed on a case-by-case basis as determined by the ASAP RN. The consumer must be alert, able to assume responsibility for the product, and able to direct the PCHM, but unable to complete the task independently because of physical limitations.

b. Application of medicated creams and lotions is not allowed. This includes, but is not limited to over the counter products such as cortisone creams, Aspercream, Ben-Gay, anti-fungal products, Bacitracin and Neosporin or their generic counterparts.

c. Care of ulcers/open wounds is not allowed.

d. Treatments involving the application of heat are not allowed. This includes, but is not limited to hot packs, hot water bottles, and electric heating pads.

e. Treatments involving the application of cold are not allowed. This includes, but is not limited to cold packs and ice.

3. FOOT CARE

a. Foot soaks, limited to 10 minutes, and toenail filing are allowed.

b. Foot soaks and toenail filing are not allowed on consumers with diabetes, severe peripheral vascular disease, or if the ASAP RN feels the consumer has a condition that would make this task inappropriate, such as an infection or an injury.

c. Toenail cutting is not allowed in any instance.

4. GROOMING

a. Shampoos may be provided unless restricted by the ASAP RN. The PCHM may comb, set with curlers/pins, and blow-dry the consumer's hair. The blow dryer must be used on the low setting and in accordance with the safety recommendations of the manufacturer. The use of curling irons and/or electric curlers is not allowed. Hair cutting is not allowed.

b. The use of any chemical hair product is not allowed. This includes, but is not limited to hair color, permanent wave products, henna etc.

c. Fingernail cutting is not allowed.

d. Fingernail filing is allowed unless the ASAP RN feels that the consumer has a condition that renders this task inappropriate such as an infection or an injury.

e. Facial shaving with an electric razor may be provided. Safety or straight razors are not allowed.

5. DRESSING

a. Assistance with dressing may be provided. Assistance with the application and removal of prescription and non-prescription anti-embolism stockings is allowed on a case-by-case basis as determined by the ASAP RN.

6. PERSONAL APPLIANCES

a. Assistance with personal items such as denture care, assistance with hearing aids and eyeglasses, and help with the application of certain braces, splints, slings, and prostheses is determined on a case by case basis, based on the assessment of the ASAP RN.

b. With the approval of the ASAP RN, consumers who have been using artificial limbs, splints, or braces on a continuing basis, may receive assistance with the application only if the consumer is: mentally alert, has received instruction and understands the correct application of the appliance, and the tension strap has been marked by the primary nurse or therapist to indicate the correct degree of tension. In the case of an arm or leg prosthesis, the residual limb must be well healed and shaped.

c. Care of or insertion of contact lenses and application of new braces, splints, prostheses or slings is not allowed.

7. INCONTINENCE MANAGEMENT

a. Incontinence management may be provided. This includes assistance with the use of the toilet, commode, bedpan, or urinal. When assisting with the use of the bedpan, the consumer must be able to lift his/her buttocks onto the bedpan independently or with the aid of a trapeze. Assistance on and off the commode must comply with transfer guidelines listed below. Incontinence assistance includes assisting with bowel/bladder training regimes, disposable incontinent briefs/pads, and personal hygiene. With the approval of the ASAP RN, the PCHM may remind the consumer to perform pelvic strengthening exercises, e.g. Kegal exercises.

b. The emptying of urinary drainage bags, the application of urinary leg bags, and routine catheter care are allowed with ASAP RN approval. The PCHM must be able to demonstrate competency by means of return demonstration of these techniques to the Provider RN.

c. The application of a condom/Texas catheter is not allowed.

d. Ostomy care, in most cases, is not allowed. With approval of the ASAP RN, occasional exceptions may be made when the ostomy is long-term, well-healed, and without complications. In those cases when a consumer has received and understands instruction in stoma bag application, but is not able to manage it due to physical limitations such as poor vision or severe arthritis, assistance may be given by the PCHM in applying the bag. The PCHM must be able to demonstrate competency by means of a return demonstration of this technique to the Provider RN.

e. Manual disimpactions and the administration of douches and enemas are not allowed.

8. TRANSFERS

a. Assistance with transfers is allowed when the consumer is able to bear at least 50% of his/her weight when moving from a sitting to a standing position and while transferring. The ASAP RN may approve transfer assistance when the consumer’s caregiver provides support for 50% of

the consumer's weight. The ASAP RN may also approve assistance with slide board transfers. The PCHM must demonstrate competency by means of a return demonstration to the Provider RN.

b. Use of mechanical lifts and participation in a two-person carry of a totally dependent consumer is not allowed.

9. AMBULATION

a. The PCHM may assist the consumer with ambulation inside and outdoors, as well as with a walker, wheelchair, and/or cane that has been properly fitted to the consumer. The personal care plan shall specify where ambulation assistance may take place, e.g. "consumer may be assisted with ambulation outside". The ASAP RN, on a case-by-case basis, may approve assistance with stair use.

b. Consumers who are following a written exercise program may be coached by the PCHM in carrying out active range of motion and strengthening exercises. The care plan must be very specific with regard to the exercises to be performed and supported with orders/instructions from either a physician or a physical therapist.

c. Active participation in an exercise program, or passive range of motion exercises are not allowed.

10. NUTRITION

a. The PCHM may prepare and set up meals, and provide encouragement and/or cuing for food/fluid intake as appropriate. The ASAP RN may approve feeding consumers on a case-by-case basis.

b. Tube feedings, syringe feeding, and the feeding of consumers with a history of choking and/or swallowing difficulties are not allowed.

11. MEDICATION ASSISTANCE

a. Administration of medication, prescription or non-prescription, and/or oxygen is not allowed.

b. The PCHM may not participate in any aspect of automated medication dispensing systems.

c. The PCHM may remind the consumer to take his/her medications.

d. The PCHM may place the medications within reach of the consumer.

e. On a case-by-case basis, the ASAP RN may approve that the consumer direct the PCHM to act as the hands and/or eyes of the consumer.

f. If, by reason of poor vision or other physical limitation, the consumer needs help with the mechanical aspects of medication administration, e.g. reading medication labels or opening medication packaging, the PCHM may provide mechanical assistance.

g. The ASAP RN must determine and document in the consumer record that the consumer has met the following criteria:

- The consumer is aware that they are taking medications.
- The consumer is alert and assumes responsibility for taking his/her medications, but requires assistance because of physical limitations.
- The consumer is able to direct the PCHM in assisting him/her with the mechanical aspects of medication administration.
- The medication is an oral medication.
- The PC plan includes a directive to provide the assistance.

12. RESTRAINTS

The PCHM is not allowed to provide care to the consumer when a physical restraint is in use. This excludes the use of side rails if the use of side rails has been approved by the ASAP RN as a necessary safety measure and the consumer is in agreement with and understands their use.

APPENDIX E – BUSINESS RULES

- CSSM Business Rule July 1, 2014

Tracking CSSM Enrollment in SAMS

Elder Affairs has identified the importance of tracking the volume and the length of time the ASAP Comprehensive Service and Screening Model (CSSM) Team works with consumers during their nursing facility stay, as well as the reason for termination of CSSM involvement. This business rule communicates data entry instructions for tracking consumers in SAMS through the **CSSM Care Enrollment** and termination reasons. The expectation is for all ASAPs to begin using this new Care Enrollment effective August 1st, 2014.

The role of the ASAP has not changed, and the expectation remains; to work with the member/applicant, family, and nursing facility to overcome barriers and assist with discharge planning by formulating and implementing a care plan that meets the member/applicant's needs in the community. Please refer to PI 13-01 and Section 9.4.4 of the 2010 RFR for further explanation.

Function of CSSM Care Enrollment

CSSM Consumer Eligibility:

- A MassHealth Member or Applicant (or their representative) aged 22 years of age or older seeking MassHealth coverage for nursing facility services.
- A consumer aged 22 years of age or older who has answered positively to Section Q questions prompting a Section Q Referral to the ASAP.
- The consumer is currently in a nursing facility and expresses a wish to return to the community.

ASAP Responsibilities:

- Utilization of an Interdisciplinary Team to assist the consumer with identification of options, and decision support.
- ASAP RN onsite assessments as required; meeting both consumer and facility staff in the nursing facility.
- ASAPs will continue to monitor all consumers at 30,60,90 days post nursing facility discharge utilizing the CCTF as required.
- ASAPs will continue to complete and track clinical determinations through the current process for all consumers.

Creating the CSSM Care Enrollment:

- CSSM ASAP creates a CSSM Care Enrollment, which is designed to remain open until the consumer disposition is completed.
  - Creating a CSSM Care Enrollment in SAMS.
    - **Level of Care**= Clinical Assessment & Eligibility
    - **Service Program**= CSSM
    - **Care Program**= CSSM
    - **Application Date** = on or after 1-1-2014 (CSSM enrollment will not appear as a service program option if the application date is prior to 1-1-2014)
    - **Received Date** = (ASAP Business Practice)
    - **Status** = Active while consumer is actively working with CSSM team
    - **Reason** = Blank while consumer is actively working with CSSM team
    - **Status Date** = Data entry date
    - **Start Date** = First day the consumer's record is reviewed by ASAP RN

- **End Date** = Leave Blank while consumer is actively working with CSSM team

Terminating the CSSM Care Enrollment:

- Terminate the CSSM Care Enrollment when the CSSM team is no longer working with the consumer toward the goal of community placement. The CSSM Care Enrollment is terminated when consumer has transitioned and disposition is completed. Some examples may include; Consumer was formally long term approved for nursing facility placement, consumer was discharged to a community living setting, consumer refuses to work with the CSSM Team about care planning, or death.
  - CSSM ASAP terminates CSSM Care Enrollment:
    - **Level of Care**= Clinical Assessment & Eligibility
    - **Service Program**= CSSM
    - **Care Program**= CSSM
    - **Application Date** = on or after 1-1-2014 (CSSM enrollment will not appear as a service program option if the application date is prior to 1-1-2014)
    - **Received Date** = (ASAP Business Practice)
    - **Status** = Terminated
    - **Reason:**
      1. **<u>Client Refused</u>**
         a. Use when the consumer refused to continue working with CSSM care team.
      2. **<u>Death</u>**
         a. Use when the consumer expired after beginning to work with the CSSM care team.
      3. **<u>Discharge to Community</u>**
         a. Use when the consumer transitions from the Nursing Facility to a community living arrangement. Use of this reason would include discharge to an Assisted Living or Rest Home Setting.
      4. **<u>Long-Term Placement</u>**
         a. Use when a consumer remains in the nursing facility for long term care, or is discharged from the nursing facility to another long term care setting
      5. **<u>Moved From Service Area</u>**
         a. Use when the consumer moves out of service area to another setting, including moving to another ASAP SNF coverage area.*
    - **Status Date** = Data Entry Date
    - **Start Date** = Remains the first day consumer's record was reviewed by ASAP RN
    - **End Date** = The date consumer transitioned to community setting (could be date of Nursing facility Discharge or date of clinical approval for long term care)

* When the consumer transfers to another SNF, it is expected that the consumer will have another CSSM Care Enrollment opened by the ASAP associated with the new nursing facility.