STANDARD OPERATING PROCEDURES

between

Providence ElderPlace and Oregon Case Management Entities

I. PURPOSE

This purpose of the Standard Operating Procedures (SOP) between State Case Management entities (AAA/APD Case Managers) and Providence ElderPlace is to define and differentiate operational roles and responsibilities of each entity in the administration of the Program of All-Inclusive Care for the Elderly (PACE). Case Management refers to the functions described in OARs. Case Manager refers to a Department of Human Services employee or an employee of the Department's designee as defined in OAR.

II. PROVIDENCE ELDERPLACE PROGRAM & PHILOSOPHY

Providence ElderPlace, a Program of All-Inclusive Care for the Elderly (PACE), was founded in 1990 to help older adults with chronic medical conditions live as independently as possible in community settings - such as their own homes, with family, in assisted living facilities or adult care homes. The PACE philosophy is based on the experience that older adults with complex medical needs are best served, with highest quality of life, in a community setting rather than a nursing home or hospital. Providence ElderPlace offers one of the most comprehensive sets of services available to older adults in Oregon. (See Attachment A for Services and Coverage)

Providence ElderPlace provides highly coordinated care based on each participant's needs and choices. ElderPlace participants have access to a highly skilled interdisciplinary team of physicians, nurse practitioners, nurses, social Workers, therapists, life enrichment specialists, home care coordinators, clinical pharmacists, dieticians, chaplains, personal care aides and transportation team members who have expertise in respectful care of older adults. When a participant joins Providence ElderPlace, we make every effort to meet their physical, spiritual and emotional needs.

Our collaborative PACE approach offers significant benefits by:

- Emphasizing prevention
  Our team members know participants well; follow them over time and can recognize subtle changes that signal a need for follow up. Throughout enrollment, we focus on health, wellness and quality of life for participants.

- Coordinating primary and specialty health care

Our team members provide a wide array of primary care and therapy directly. When a participant needs a specialist, we schedule, authorize and provide transportation to these medical appointments, as well as providing critical information about your unique medical history to our specialists.

- Reducing hospitalizations
  While a participant might need hospitalization or nursing home placement at times, older adults are highly vulnerable to complications from medication errors, hospital acquired infections, invasive tests, and loss of strength when bedbound. We strive to protect our participants from these medical complications by seeking to avoid admissions or shorten length of stay in the hospital.

- Providing access to palliative care
  Throughout enrollment, we work together with the participant to define goals of care. Our team members are experienced in providing palliative care support when needed - a holistic approach to address physical, spiritual and emotional needs when facing life-limiting illness.

At Providence ElderPlace, we support each participant's uniqueness, dignity, and independence as we carry out the Providence Health & Services values of respect, compassion, justice, excellence and stewardship in the care we provide every day.

III. CASE MANAGEMENT DESCRIPTION & RELATIONS

Through APD, Aging and People with Disabilities have easy access to a wide range of social and health services, housing alternatives and support systems needed to continue to live safely and with dignity in the least restrictive living situation. APD uses local, state and federal funds and programs to help keep elderly persons and people with disabilities at home and as independent as possible.

Case Management Entities provide the following:

- Case management/need assessment, eligibility, case plan development, and service monitoring for persons who are elderly and for persons with disabilities.
- Assistance with connecting to any available community resources
- Access to long term care including in-home services
- Food Stamp authorization
- Authorization for all Medicaid-related medical programs
- Authorization of any applicable OSIPM special needs funds
- Home Care Worker licensing and orientation
- Adult care home regulation and licensing
- Adult Protective Services
- Behavioral Support Services

APD Mission: The mission of APD is to assist older adults and persons with disabilities to live as independently as possible with a range of accessible, quality services that meet their diverse needs and preferences.

IV. ELDERPLACE ELIGIBILITY

An individual is eligible for Providence ElderPlace if at the time of enrollment, they:

- Reside in our service area
- Are 55 years of age or older
- Are eligible for services as determined by a county or state Case Manager to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services
- Are able to live in a community based setting at the time of enrollment without jeopardizing their health or safety or the health or safety of others
- Are Medicaid eligible or willing to pay private pay fees
- Are willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE program and our contracted or referred providers

The following constitute situations or unsafe behaviors that may cause denial of enrollment, if they cannot be remediated. The individual:

- Have a physician documented condition that meets the criteria for Medicare skilled care and they do not appear to be able to be discharged to the community within the next 30 days
- Are in need of imminent nursing facility placement
- Are determined to be appropriate for Enhanced Care Services (ECS) in a locked facility or placement at the Oregon State Hospital (OSH), or they require intensive intervention in an outpatient mental health program
- Have evidence in their clinical record that they have been repeatedly placed in appropriate care settings and despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements
- Demonstrate behavior that is physically harmful to their self or others, including, but not limited to:
    a. Suicidal or self-injurious behaviors
    b. Threatening or assaultive behaviors
- Wish to remain in their own home but require 24-hour care in order to be safely maintained in their home, and they lack the support of a capable and willing caregiver. For any individual who cannot be safely left alone, the individual or the individual's responsible party must demonstrate at the time of application for enrollment that there is a designated adult caregiver who has agreed to provide, and is capable of providing, personal care and other services during those hours when ElderPlace services are not being provided.
- Reside in a home environment that is dangerous to homecare workers or prevents delivery of care

If after review of the above, there are questions regarding their enrollment in the ElderPlace program, they or their representative or the referring agency may initiate a collaborative care planning process that may include referral to an ElderPlace contracted specialist.

To enroll with Providence ElderPlace, they must sign an Enrollment Agreement form and agree to abide by the conditions of Providence ElderPlace, as explained in the Enrollment Agreement handbook.

If they have signed an Enrollment Agreement form and are hospitalized prior to their effective date of enrollment, their enrollment may be postponed. ElderPlace staff may complete a reassessment post hospitalization to determine if they remain eligible to enroll.

Enrollment Decisions

If either the PACE program or the Case Manager has concerns about the safety of a potential enrollee, a case conference can be convened to review the case with outside consultants as needed for further evaluation.

Potential enrollees may be excluded from enrolling in the program if, after a collaborative care planning process between Case Managers and ElderPlace Intake and Enrollment staff on a questionable enrollment, it is agreed the consumer would not be able to be maintained in a community based setting without jeopardizing his/her health or safety, or the health or safety of others.

The final decision belongs to ElderPlace. However, if the consumer and/or Case Manager is in disagreement with the ElderPlace decision not to enroll a consumer, they may appeal the decision through the State Administrative Hearing process. All denials of enrollment must be forwarded to the APD PACE Policy Analyst.

V. REFERRAL/SCREENING & ELDERPLACE INTAKE

At the point of screening and intake or at a time of change in a consumer's health status, Case Managers will consider ElderPlace as one of the options available to persons age 55 and older (See Attachment B for Advantages of Enrolling). In the event an ElderPlace referral is appropriate, the staff of both agencies will consult each other about the most appropriate and available service plan for the older adult that will meet the individual's needs based on the CAPS.

ElderPlace Intake and Enrollment staff will respond to APD referrals within one business day. Case Management screening and intake Case Managers will determine eligibility for Medicaid services and ElderPlace will assess for appropriateness of enrollment into Providence ElderPlace. ElderPlace and Case Managers will work closely together to ensure information is shared, and issues, and concerns are resolved at each step of this process. Because screening, referral, and intake are

important functions for assisting persons to obtain services to meet their specific needs, Case Managersand ElderPlace staff will collaborate with each other during this process as needed to ensure services are provided in a timely manner.

A. Case Management Responsibilities

- As part of choice counseling, Case Managers will provide initial information on ElderPlace to those persons who meet ElderPlace eligibility criteria at intake, when there is a change in physical condition and at the annual assessment.
- Case Managers will refer and/or assist those persons who express interest in participating in ElderPlace services to Providence ElderPlace for further assessment. Upon referral to ElderPlace, Case Managers will ensure the appropriate release of information forms (DHS 2098 and 2099) are completed and provide ElderPlace with a copy of the 001N & 0002N forms.
- Case Managers determine eligibility for Medicaid assistance and services for those persons referred to ElderPlace. The Case Manager will complete the Medicaid application and CAPS assessment. For non-Medicaid eligible persons referred to ElderPlace, Case Managers will do an abbreviated 4 ADL courtesy CAPS assessment.

    - Once enrollment has been confirmed with ElderPlace, Case Managers enter the necessary information into the DHS computer system by compute deadline to ensure the consumer is enrolled into ElderPlace. New intakes may be enrolled on a weekly basis; existing consumers will be enrolled for first of next month. If there are exceptions or unusual delays, they will be handled by the Case Manager in conjunction with the State PACE Policy Analyst.
    - The Case Manager will complete all other appropriate documentation for enrollment at the time of referral to ElderPlace.
    - Case Managers will arrange for the provision of necessary supplies and services, including special needs and move planning, prior to enrollment/ date of capitation in ElderPlace.

B. ElderPlace Responsibilities

- ElderPlace Intake staff will consult with Case Managers regarding ElderPlace eligibility criteria and process as needed.
- ElderPlace staff will ensure that Case Managers are notified about PACE eligibility assessment outcomes.
- ElderPlace Intake staff will confirm eligibility and enrollment with Case Managers as soon as enrollment paperwork is signed or three working days before end of month or by Wednesday for weekly enrollment via phone call and/or email.
- ElderPlace will confirm eligibility and enrollment via weekly census memo to the State PACE Policy Analyst, branch managers and supervisors.
- ElderPlace staff will notify the Case Manager of any unusual delays or exceptions in enrollments; for example, if a participant changes their mind or becomes hospitalized.
- ElderPlace Intake staff will confirm Medicare benefit eligibility with Case Managers including SSD

eligibility and start dates.

VI. CASE MANAGEMENT RESPONSIBILITIES FOR ENROLLMENT & ONGOING

A. Enrollment

- Upon notification that the consumer has chosen to enroll in ElderPlace, Case Managers will update OACCESS as follows:

    - Use case descriptor PAC in Case Descriptor field.
    - Use case descriptor NCP if consumer is NOT eligible for a cash payment. Consumers who receive a SIP payment and/or a special need payment (LAU, TEL) are in cash payment status and will not have an NCP in the case descriptor.

- Notify the state Buy-in Unit if consumer is eligible for, but has not purchased, either/or both Medicare Part A or Part B. Case Manager will notify the buy-in Unit upon notification from Providence ElderPlace that the application has been completed.
- The consumer must pay-in each month any income above the OSIP standard for their living costs.
- For consumers receiving Medicaid Waivered services and/or nursing home services at time of enrollment, the Case Manager will notify current providers if their services are being terminated and ensure payment systems reflect the updates (closing 512, stop voucher ONGO).
- All cases will be transferred to one of the Case Managers at the appropriate geographic area within 30 days of completion of the intake and/or enrollment by the intake or ongoing Case Manager.
- Case Managers will complete a courtesy assessment/ 4 ADL CAPS on private pay persons referred by ElderPlace within 10 days of referral. Case Managers will also be responsible for completion of an annual 4 ADL CAPS on private persons enrolled in ElderPlace in accordance with federal Pace regulations.
- If ElderPlace disagrees with the results of a CAPS Assessment, ElderPlace staff will contact the Case Manager who completed the assessment and discuss the areas of concern. If they are not able to reach agreement, ElderPlace staff will contact the Supervisor or Area Manager.
- If the consumer is currently enrolled in another Medicaid managed care plan, the Case Manager must disenroll the consumer from that plan. The effective date will generally not be until the first of the following month.
- Once a consumer enrolls, ElderPlace receives a capitated payment from Medicare and Medicaid to provide the full range of medical, social and long-term care services that the participant needs. If an existing consumer needs to be enrolled before the first of the month, a pro-rated Medicaid capitation may be made. If he/she is enrolled in a Medicare HMO, enrollment may not be able to be completed until the first of the following month unless the Plan so agrees**.**

The Case Manager and the ElderPlace Social Work staff must work closely together to ensure continued services are provided to the ElderPlace participant. The ongoing Case Management

includes advocacy, ongoing financial and service priority eligibility, including the CAPS assessment, and pay-in monitoring. Assisting with grievance and State appeals is the responsibility of the Case Manager.

B. Ongoing Case Management Responsibilities

- Completion of an annual redetermination

  Once a person is Medicaid eligible for ElderPlace, the Case Manager will be required to complete an individualized annual service assessment for ongoing eligibility or change in condition. Case Managers pull what service assessments need to be completed monthly for their caseloads.

  The redetermination is based on Oregon Administrative Rules, 411-015-0000-0100. When assessing an individual, the time frame reference for evaluation is how the person functioned during the thirty days prior to the assessment date, with consideration of how the person is likely to function in the thirty days following the assessment date, per 411-015-0005 (Effective 04/27/04). Also, per OAR 411-015-0000-0100, cognition and behavior refers to how the brain functions in the areas of adaptation, awareness, judgment, memory, and orientation. Cognition includes three components of behavioral symptoms which are demands on others, danger to self or others, and wandering. Evaluation of functional limitation without support is based on eight components. To be considered Assist, the individual must require Assistance in at least three of the eight components. To be considered Full Assist, the individual must require Full Assistance in at least three of the components.

- Deeming

  Deeming is only used within the PACE program at APD, per federal guidelines, and the State contract between Oregon APD and Providence ElderPlace. Per 42 CFR § 460.160(b), the State Administering Agency (SAA) may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program if, in the absence of continued coverage under the program, the SAA determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months. If a PACE Participant should score above the current nursing home eligibility level determined by APD/AAA during their annual Assessment, the Local Office, in conjunction with the Social Worker, will review the PACE Participant's previous Assessments to evaluate the effect of disenrollment on the PACE Participant's health status, activities of daily living, and social functioning. If it is determined that without PACE services, the Participant would, within the next six months, deteriorate to the point of eligibility, the PACE Participant may be deemed eligible until the next annual Assessment. (See Attachment C for Deeming Process)

The Case Manager will ensure that Elder Place is notified in a timely manner of any change during the redetermination assessment of level of care.

- Monitoring Pay-In

  The participant or their representative will make payment directly to APD for the monthly pay-in amount. The Case Manager will be responsible to monitor payments to assure the amount is being paid monthly. In the event payment is not made, the Case Manager will notify the ElderPlace Social Worker in a timely manner and work collaboratively with the participant and/or their representative to resolve the payment issue; for example, clarifying financial manager or other key contacts, making an APS referral as needed, requesting ElderPlace become rep payee. This action will occur prior to any disenrollment action relative to eligibility status by APD.

- Best practice regarding a pay-in tracking system: PACE liability payments are to be tracked locally at each APD/AAA office or district, as there is currently no centralized method to perform this function. Payments should be recorded and receipted as they are received, and tracked on a monthly basis. Tracking of these payments can be accomplished by maintaining a list of participants and cross referencing those who have paid their liability with those participants who owe one. It is recommended that this accounting occur on or before the 20th of each month to allow for the required follow up with those participants who have missed a liability payment.

- Processing Requests for Administrative Hearings

  The State Administrative Hearing process and/or a local ElderPlace Grievance and Appeals process are available for resolution of appeals. Case Managers are encouraged to use the local ElderPlace Grievance and Appeals process outlined in this agreement prior to the filing of a hearing. Case Managers, however, may file an Administrative Hearing on behalf of the consumer at any time. The APD PACE Policy Analyst is also available for problem resolution prior to the filing of an administrative hearing. The Case Manager is responsible for completing the Hearing Request Form (0443) and following the State Hearing Request Protocol and Procedures. Once the hearing material is returned from the APD Hearings office, the Case Manager may request an informal meeting. The Case Manager will forward the hearing request to the ElderPlace Social Worker so ElderPlace may begin to review the appeal.

- Advocacy

  The Case Manager will serve as a resource to the ElderPlace Interdisciplinary team decision-making process. The Case Manager serves as consumer's advocate and representative of state policy within the Interdisciplinary Team and at care planning meetings. The Case Manager is a mandatory reporter for protective services. The Case Manager shall visit their consumers a minimum of once a year. Case Managers may visit their consumers without prior notification at

any ElderPlace facility; they are encouraged to coordinate with ElderPlace Social Work staff in advance to help assure consumer availability.

- Mandatory Reporting

  ElderPlace shall immediately report any evidence of elder abuse, neglect or threat of harm to Adult Protective Services or AAA office or law enforcement officials in full accordance with the mandatory Elder Abuse Reporting law (ORS 124.050 to 124.095). If law enforcement is notified, ElderPlace shall notify the case manager within 24 hours. ElderPlace shall immediately contact the local Adult Protective Services or AAA office if questions arise whether an incident meets the definition of elder abuse or neglect.

VII. ELDERPLACE RESPONSIBILITIES ONGOING

- Social Work Services

  ElderPlace Social Workers provide service within the construct of an interdisciplinary team for all the comprehensive services and benefits provided under the PACE model. Specifically, Social Work provides semi-annual biopsychosocial assessment, care planning and coordination; including advance care planning, family conferences, palliative care, living environment support, crisis intervention and mental health treatment planning, hospital discharge and transition planning, and collaboration with Case Managers and other community resources.

- Treatment & Placement Decisions

  Decisions regarding treatment and facility placement are a collaborative decision between the Interdisciplinary Team and the participant and his/her Representative. Placement decisions are based on the medically indicated level of care. If either the participant or his/her Representative indicates dissatisfaction with the decision, ElderPlace will send a notice of denial of service including information on the participant's appeal rights and administrative hearing process to the Case Manager. Provide all letters of concern from participant and/or family, and Case Manager as a part of the IDT review process so that affected parties are fully informed. Prior to a placement change, ElderPlace will contact and involve the participant and family in all placement decisions. Social Work will consult with Case Manager as needed and notify of all placement decisions.

- Monitoring PIF

  When ElderPlace is the representative payee, ElderPlace will provide timely notification to the Case Manager of any change in participant income and notify the Case Manager of any financial issues that might affect eligibility of Medicaid.

- Monitoring of Residential Placements

  ElderPlace staff are responsible to monitor the service plan delivery and quality of care provided to ElderPlace residents in contracted community living environments. ElderPlace staff meet regularly with community partners to coordinate care plan and resident service plans, to assure the participant is at the appropriate level of care and that effective, timely communication is occurring between ElderPlace and the residential setting for optimum care of the resident.

- Processing special needs requests

  Participants enrolled in PACE, who qualify and have IDT approval, have access to Special Needs to the level defined under the state Medicaid program. Special needs include home repairs, community transition services, diversion services, moving costs, room and board, laundry allowance, property taxes, and home adaptations to accommodate a participant's physical condition.

- Room and board payments

  Room and board payments in an ALF, AFH, MCU or RCF are the responsibility of the participant or their representative and are paid directly to the facility. Room and Board is not part of the capitated payment to ElderPlace. ElderPlace provides facilities with 14 days written notice of a move unless ElderPlace has reason to believe that continued placement in the facility threatens the health, safety, or welfare of the participant; or threatens any applicable licensure; or the participant requires a different level of care.

- Participant Information

  ElderPlace will provide to the Case Manager the biannual care plan for each participant and care plan schedules for each month. Case Managers are encouraged to attend ElderPlace care plan meetings in person or via phone. Social Workers will notify Case Managers of all permanent moves, changes in financial status, deaths and disenrollments.

VIII. DISENROLLMENT

An ElderPlace participant may voluntarily disenroll at any time; however, the effective date of disenrollment is generally the first of the following month. There are also situations in which involuntary disenrollment may occur. It is important that ElderPlace and Case Managers work closely together to ensure that disenrollment is the best plan for the person and that the transition is completed with the least amount of disruption to the participant.

- Choice

A participant can chose to disenroll from ElderPlace at any time. ElderPlace will notify the Case Manager of the participant's choice. ElderPlace will provide the Case Manager with documentation as to the reason for disenrollment, and medical and psychological information to the Case Manager to assist with post enrollment care planning. ElderPlace will invite the Case Manager to attend a transition meeting to ensure a smooth transition for the participant.

- Financial Eligibility

An ElderPlace participant may lose Medicaid financial eligibility. The Case Manager will immediately notify ElderPlace of the situation. The Case Manager and ElderPlace Social Worker will review the financial and service assessment to determine other possible plans prior to closure of Medicaid eligibility. If the person is not Medicaid eligible, they may pay the private fee to ElderPlace and remain enrolled in the program.

ElderPlace participants may fail to pay-in to maintain their long-term care service eligibility. Nonpayment is cause to terminate services, although the person may maintain eligibility for other Medicaid programs. It is important that Case Managers and ElderPlace collaborate to address the issues behind the nonpayment and determine the best possible plan to address the participant's service needs. If the person chooses to not make their pay-in, and has been informed of the consequences, then that person may be involuntarily disenrolled from ElderPlace. ElderPlace will provide them with their appeal rights. Case Managers will notify the consumer and the ElderPlace Social Worker of potential termination of benefits to be effective the last day of the following month. This allows ElderPlace to provide the required 30 day notice of Involuntary disenrollment.

- Service Eligibility

Service eligibility is determined on an annual basis by the Case Manager. The Case Manager will notify ElderPlace of any changes in eligibility as soon as possible. (See Attachment C for Deeming Process)

- Participant Death

Upon a participant's death, ElderPlace will immediately notify the Case Manager so that they may close the case in a timely manner.

- Service Area

If the participant moves out of an ElderPlace service area, they will be disenrolled from ElderPlace the first of the following month. ElderPlace and Case Management shall work closely to assure a smooth transition of care.

- Involuntary Disenrollment

It may become necessary for ElderPlace to involuntarily disenroll a participant. In these cases ElderPlace must give a 30-day notice of intent to disenroll and include the reasons and the participant's appeal rights. A copy of the notice provided the participant and/or their representative will be sent to the Case Manager, the APD PACE Policy Analyst and Region X CMS. The APD PACE Policy Analyst must approve all involuntary disenrollments. ElderPlace will work with the Case Manager and the participant to assure a smooth transition to long-term care or other services once approval is received from APD/AAA.

Involuntary disenrollment may occur in the following cases if:

- the participant's behavior jeopardizes his or her safety or the health or safety of others and alternative placements and treatment have proven unsuccessful and the participant can no longer be maintained in a community based care setting; or
- the participant chooses not to pay the monthly premium; or
- the participant no longer meets the eligibility criteria as determined by the CAPS assessment, and the IDT team and Case Manager do not believe the participant's condition would deteriorate if not enrolled in the ElderPlace program; or
- The participant moves out of the ElderPlace service area or is out of the service area for 30 days without prior approval from the IDT; or
- The participant is admitted to a state psychiatric facility; or
- The state or CMS choose to terminate the contract with ElderPlace; or
- ElderPlace cannot provide the necessary medical services due to loss of contracts with medical providers; or
- Providence decides to discontinue offering the PACE program.

- Disenrollment Transition

The ElderPlace Social Worker will facilitate a transition planning conference with the Case Manager for all Medicaid consumers. The Social Worker will collaborate with Case Managers to transition consumer to the APD/AAA system, i.e. enrollment with another health plan, attaining necessary equipment and supplies etc. The Social Worker will communicate with contracted care provider (if applicable) regarding consumer disenrollment and provide name and number of Case Manager. For cases when the participant will be receiving a notice of case closure, the Social Worker and Case Manager will determine appropriate resource for case follow-up and inform the consumer of consequences of losing Medicaid and\or ElderPlace coverage. Case Managers will send the consumer a written, timely Notification of Planned Action. ElderPlace will notify CMS of disenrollment by end of the month.

IX. ELDERPLACE GRIEVANCE AND APPEALS PROCESS

A. Grievances

Grievances (any expression of dissatisfaction) regarding ElderPlace care, services, or any other activities related to this agreement may be filed with the participant's site Operations Manager. ElderPlace is responsible for timely response and resolution of all participant grievances. The participant, their representative or a Case Manager may also contact the APD PACE Policy Analyst for assistance. At any time during the process, if the grievance is not resolved to a Medicaid eligible participant's satisfaction, the participant or their Representative may also file for an Administrative hearing with the Case Manager. The Case Manager will complete an Administrative Hearing Request form 0443.

B. Appeals

The participant or representative will be notified of the decision to approve or deny a request for a covered service, a reduction or termination of a covered service for non-payment of a covered services, or involuntary disenrollment. ElderPlace is responsible for timely response and resolution of all participant appeals.

At any time during the process, if a Medicaid eligible participant chooses to appeal to ElderPlace and the appeal is not resolved to their satisfaction, the participant or their Representative may file for an Administrative hearing with the Case Manager. The Case Manager will complete an Administrative Hearing Request form 0443.

X. PROTECTIVE SERVICES PROTOCOLS

- Case Management has the responsibility to notify protective services of possible abuse or neglect for the following persons:
    - Persons 18 and older who are aged, blind or disabled residing in their own home, foster care, residential care or assisted living facilities who are not currently being served through the Mental Health or Development Disabilities programs and all persons residing in nursing facilities.

- Protective service situations that require an investigation include:
    - Sexual Abuse
    - Physical Abuse
    - Neglect
    - Financial Exploitation
    - Verbal and Emotional Abuse
    - Abandonment

- Self-Neglect

- Mandatory Reporting
  ElderPlace employees are mandatory reporters and must report all suspected abuse or neglect to Adult Protective Services (APS) or the local AAA office.

- Investigation/Assessment
  APS or AAA will conduct an investigation and assessment on all abuse or neglect complaints. APS or AAA will refer all suspected criminal activity to law enforcement for criminal investigation.

- Intervention
  APS will work with ElderPlace staff to provide emergency intervention. ElderPlace will provide ongoing Case Management.

- Reports
  APS, when allowed by Oregon Administrative Rule, ~~upon completion of the investigation, will provide ElderPlace, the consumer and others with the non-confidential findings of all APS investigations of licensed facilities. For situations involving community based care, APS~~ will communicate ~~conduct a staffing in which they will share~~pertinent information with ElderPlace staff.

- Follow Up
  ElderPlace will provide the necessary Case Management resulting from the findings of the investigations, if this is deemed appropriate by APS. The Case Manager will ensure the results from any finding/ remedy of the investigation are appropriately and adequately implemented.

XI. QUALITY ASSURANCE AND DATA SHARING

Representatives from AAA/APD will serve as part of the ElderPlace Quality Council. The APD PACE Policy Analyst will also share ElderPlace utilization and quality assurance information with AAA/APD Management.

XII. CONFIDENTIALITY

HIPAA Privacy Rules require that the entire health community adhere to regulations designed to protect the privacy and security of individually identifiable health information. HIPAA law is not intended to be a barrier between covered entities that need to conduct business. Under HIPAA, AAA/APD and ElderPlace can continue to conduct business and exchange health information that is necessary for functions that are considered Treatment, Payment, and Health Care Operations.

Under HIPAA law, functions relating to Treatment, Payment and Operations (TPO), do not require authorization or consent from the consumer or participant. TPO also does not require DHS to enter into a Business Associate agreement for the purpose of conducting these functions.

Keeping consumers' records confidential has always been and continues to be a priority for DHS. If there is any question about releasing information, please make sure the DHS 2099 is signed and current.

XIII. AAA/APD RELATIONSHIP WITH DHS

DHS and the PACE Policy Analyst are available for problem resolution if the AAA/APD staff has not been able to resolve the issue to their satisfaction. The PACE Policy Analyst is also available for problem resolution prior to filing an administrative hearing. The PACE Policy Analyst will involve Case Managers and the ElderPlace staff in reviewing complaints filed with DHS. The PACE Policy Analyst will include the AAA/APD staff in ongoing review activities and any future expansion requests.

XIV. TERM OF AGREEMENT

This agreement is in effect until review. Reviews will occur on a periodic and timely basis.

_____		_____	
APD	Date	Providence ElderPlace	Date
Director		Director	

Review and Approval participants, December 2, 2016:

Cindy Susee, APD PACE Policy Analyst
Beckie Cornett, Multnomah County Program Manager
Tatyana Gannotskiy, Multnomah County Program Supervisor
Sarah Bristol, Multnomah County Program Specialist
Kristina Wells, Washington County Program Supervisor
Catherine Walters, Washington County Case Management Supervisor
Melissa Johnstone, Clatsop and Tillamook Counties Services Manager
John Henry Crippen, Clackamas County Program Manager
Cindy Noordijk, Providence ElderPlace Director of Clinical Services & Compliance
Sarah Booth, Providence ElderPlace Social Work Program Manager
Jeannie Frederick, Providence ElderPlace Marketing & Enrollment Manager

Attachment A

Services and Coverage

Participants will get to know their team members as they work closely with them to help them be as healthy and independent as possible. The interdisciplinary team will develop a plan of care with them, their representative and caregiver. Their interdisciplinary team coordinates all care arrangements. **Before they can receive any service from Providence ElderPlace, other than emergency services, their team must approve it.** The team will assess their needs on a regular basis, generally every six months, and more frequently if necessary. Care planning and care decisions are made with them, and if they wish, their family, representative and/or other caregiver.

The interdisciplinary team approves services based on individual need and potential benefit to the participant. All approved services are fully covered and provided by Providence ElderPlace and include the following:

Health and Social Services

- Health and social center visits, including meals
- General medical and specialist care, including consultation, routine care, preventive health care and physical examinations
- Nursing care
- Social Work services
- Physical, occupational and speech therapies
- Nutritional counseling and education
- Laboratory tests, x-rays and other diagnostic procedures
- Medications, including over-the-counter medications prescribed by their primary care provider (ElderPlace uses a special formulary developed by a team of experts in geriatric health care.)
- Durable medical equipment, prostheses and medical appliances
- Foot care (with referrals to podiatry as indicated)
- Vision care, including examinations, treatment and corrective devices such as eyeglasses
- Dental care (Our goal is preventative dental care and good oral hygiene with priorities on treating pain and acute infections and maintaining oral functioning.)
- Audiology, including evaluation, hearing aids, repairs and maintenance
- Mental health services, including evaluation, consultation, medication, diagnostic and treatment services
- Chemical dependency services
- Medical supplies, including incontinence products, diabetic and other supplies

Home and Community Care

- Nursing services
- Physician visits when necessary
- Physical, speech, and occupational therapies
- Social Work services, Case Management, counseling, assistance with locating community-based housing
- Personal care
- Homemaker chore services
- Home-delivered meals, including special diets (eg. Meals on Wheels)
- Respite care services
- Emergency alert devises

Hospital Care

- Semi-private room and board
- General medical and nursing services
- Medical surgical/intensive care/coronary care unit, as needed
- Laboratory tests, x-rays and other diagnostic procedures
- Prescribed medications
- Blood and blood derivatives
- Surgical care, including the use of anesthesia
- Use of oxygen
- Physical, speech, occupational, and respiratory therapies
- Medical social services and discharge planning
- Emergency room and ambulance services

Private room and private duty nursing, unless medically necessary, and non-medical items for their personal convenience, such as telephone charges and radio or television rental are not included.

Nursing Facility Services

When needed, their ElderPlace team provides oversight for the following:

- Semi-private room and board
- Physician and skilled nursing services
- Custodial care
- Personal care and assistance
- Prescribed medications
- Physical, speech, occupational and respiratory therapies
- Social Work services
- Medical supplies

In-home Services

When they live in their own home or with family, ElderPlace offers the following services in partnership with contracted in-home agencies and/or family caregivers:

- Meal preparation, shopping, errands
- Housekeeping
- Medication reminders
- Personal care, such as bathing, dressing and grooming

Community Living Support Services

Our staff will assist them in locating appropriate housing for their needs. When they reside in these facilities, in-home and community care will be provided to them.

- ElderPlace Supported Housing
- Adult Care Home
- Residential Care Facility
- Retirement Apartment
- Assisted Living Facility
- Memory Care Community

Transportation

Providence ElderPlace will coordinate and provide transportation for all

their medical appointments, visits to the health and social center, outings, and other appointments as scheduled by the interdisciplinary team. If they need to be taken to the hospital, our ElderPlace medical provider will arrange transportation to come to pick them up.

Palliative Care and End of Life

Palliative care is medical care that focuses on helping participants live with the best quality of life possible when it is understood that medicine can no longer cure illness. It takes the focus away from being sick and puts the emphasis back on living the best life possible. Care and Services are focused on pain and symptom management, and to minimize any physical, emotional, and spiritual suffering.

The Providence ElderPlace interdisciplinary team provides end-of-life care and service to each participant as needed; maintaining autonomy, dignity, and comfort.

Additional Services

Support services include escort services, translation services, interpreter services, and financial management. Translation, interpreter and signage services will be made available to non-English speaking and deaf or blind participants during the intake and enrollment process and for care delivery purposes after enrollment.

Attachment B

ADVANTAGES OF ENROLLING

Providence ElderPlace was designed and developed specifically to promote independence among frail elders by offering comprehensive and coordinated services through a single organization. Our unique organizational and financial arrangements allow us to provide the most flexible benefits of any health care plan in the state. No other health care plan links managed healthcare, long-term care services, and prescription drug coverage. Advantages of participating in the plan include:

- A strong history of Providence Health and Services serving the community and the elderly
- Primary medical care by geriatric-trained physicians and nurse practitioners
- Comprehensive care coordination by dedicated, qualified health care professionals
- Specialty medical care, including dental, hearing, vision and foot care
- Complete long-term care coverage in a variety of care settings
- Physical, occupational and speech therapies
- Medicare Prescription Drug Coverage, including over-the counter medications
- Support for family caregivers
- All necessary equipment and medical supplies
- Individualized care planning
- Recreational and therapeutic activities
- Clearly defined costs with no deductibles, co-payments or claim forms
- Inpatient hospital care and outpatient surgery
- Physicians and nursing staff coverage 24 hours a day
- In-home care and caregiving services
- Transportation to and from medical appointments and the health and social center

Attachment C

Deeming Process

1. Participant Annual Review – ADS Case Manager and IDT (Social Worker) will work together to identify participants that appear to fit the deeming criteria for eligibility.

- Deeming criteria – the participant would deteriorate to the level of nursing home eligibility, if ElderPlace services were absent for the next six months.
- The ADS Case Manager will not close the case on any Participant who is undergoing a Deeming Review. The ADS manager will document the request in "Oregon Access".

2. Deeming Request - ElderPlace SW will notify the SW program manager of the deeming request. ADS Case Manager will notify the assigned ADS leadership of deeming request.

- ADS Case Manager and the ElderPlace Social Worker will gather the most pertinent information regarding the Participant's need for Deeming from the following documentation list.
  - Documentation of the most recent recertification and reassessment.
  - Documentation of the most recent plan of care.
  - Documentation of PACE services that if not received would allow the participant's condition to deteriorate to the point of requiring LTC services within the 6 month period.
  - Documentation of risk for institutionalization.
  - Current diagnosis list.
  - Assessment of continued LTC needs
  - Any other supporting documentation such as medical records, progress notes, or medication regimen.

Deeming Review – Upon receipt of the preceding documents, ADS leadership will coordinate a Deeming Review Team. Deeming Review Team will complete a review of the submitted documentation to determine if the deeming criteria for service dependency are met. ADS Leadership will communicate the outcome of the Deeming Review Team to the SW Program Manager within 10 days of receipt of the documents.
The possible outcomes of this review are:

- Participant Deemed Eligible: Deeming Review Team completes the review and determines that participant meets Deeming Criteria.
- Participant Deemed Ineligible: Deeming Review Team completes the review and determines the participant does not meet the Deeming Criteria.
- Cases contesting this decision would then follow the process for a State Administrative Hearing.

3. In cases when The Deeming Review Team determines the participant is ineligible for continued Medicaid services, the Site Operations Manager will contact the Clinical/Compliance Manager for preparation and delivery of a ElderPlace Notice of Action with State only Appeal Rights for Involuntary Disenrollment.